MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003—Continued

Ms. PELOSI. Mr. Speaker, the Democratic plan does just that. This Republican bill, I repeat, is not guaranteed. It is not affordable. It is not a defined prescription drug benefit under Medicare that our seniors want and deserve. The Republican plan is a plan to end Medicare. I urge my colleagues to reject this raw deal for America's seniors and vote no on the Republican bill and yes on the very excellent Democratic proposal.

Mr. TAUZIN. Mr. Speaker, I yield myself the balance of my time.

Mr. Speaker, when we test the arguments made on the floor of the House on a major piece of legislation such as this, it is important to test the credibility of those arguments. The best way to test that credibility is to first of all tell Members a fairy tale.

Once upon a time Bill Clinton proposed Medicare prescription drug coverage for America. Once upon a time my Democratic friends, the gentleman from California (Mr. STARK), the gentleman from Michigan (Mr. DINGELL), the gentleman from California (Mr. WAXMAN), the gentleman from New York (Mr. RANGEL), the gentleman from Ohio (Mr. BROWN), and many others introduced a bill, H.R. 1495.

Once upon a time Democrats recommended a bill with a $200 deductible, 80 percent cost sharing by the government up to $1,700 of drug expenses, a doughnut hole, and then $3,000 out-of-pocket catastrophic coverage with no defined premium. And guess what, once upon a time their bill provided that the benefits would be provided through a PBM. Members might ask how would the PBM be selected: By competitive bidding.

Members might further ask how would the contracts be awarded under this privatization of Medicare, and the answer in a fairy tale world would be shared risk capitation of performance. But the truth is this is not a fairy tale. It happens to be the truth. That was the Democratic proposal on Medicare prescription drugs, but tonight Democrats have come to the floor one after the other and criticized this plan because it contained many of those same features. Different, however, in some respects because this plan provides better coverage for seniors on the bottom.

In fact, while some of my friends came to the floor and called this a sad day and said how sorry they were for the citizens of California, this bill we proposed would put 14 million California senior citizens in plans that would cost them no premiums, no deductibles, free entry for drugs in California for 14 million senior citizens, half a million in Indiana, half a million in Ohio, half a million in Pennsylvania, almost a million in Texas, and so on and so forth, free drug coverage under this plan, and yet the fantasy plan offered by the Clinton administration just a few years ago containing many of the same elements is somehow forgotten. It is somehow put away in a closet. It is somehow not to be remembered, and this plan is to be attacked. When we test credibility of arguments on the floor of the House, test them against the reality of the plan offered by the Democrats and the reality of the plan offered today.

I want to thank the gentleman from Michigan (Mr. DINGELL) for the courtesies and the respect and the statesmanship he has always shown me in debates in committee and on the floor of House. The gentleman is a dear friend. I wish I could say that about all Members all the time. But let me say something, I am offended that anyone would accuse anyone in this House of wanting to get old people. Do Members think for a second they love their moms and dads any more than we love ours?

I ask the gentleman from California (Mr. STARK), do you really believe that? God bless them. That is the sort of uncompassionate words that should never enter the halls of this House. There is nobody in this House that loves their mother more than I love my mother. I challenge Members on that. She is a three-time cancer survivor, she is 84 years old, and she won first place at the Senior Olympics this year in shotput, and if you give her trouble, I will sic her on you.

There are Members who have come to the floor and said seniors cannot understand choice. Let me tell Members something, I grew up in a poverty family. My mom and dad never earned above poverty. They made hard choices all their life for us. They sent three out of their four children to college. They fed and clothed us and gave us a great education and a chance for me to come to Congress. I love that woman and I loved my dad as long as I had him. How dare anyone suggest otherwise. We love our parents and grandparents the same.

We differ on how to structure this program today. Apparently we did not a few years ago, but we do now. That is a legitimate debate and that is worthy of this House, but to suggest that any of us care less about old people, to suggest that any of us love those citizens who gave so much and made those hard choices for us any less than we do is a shame. My parents made hard choices. My mother knows how to make hard choices. If we give her choices, she will make the right ones. Just like she did all her life. I trust her and I trust seniors in America. We are going to give them drug coverage in Medicare and we are going to give them other choices, too, if they want to make those choices. And if Members do not want to help us do it today, I suggest in a month from now when the conference

□ This symbol represents the time of day during the House proceedings, e.g., □ 1407 is 2:07 p.m.

Matter set in this typeface indicates words inserted or appended, rather than spoken, by a Member of the House on the floor.
Mr. ISTOOK. Mr. Speaker, this bill will have the ten day when Medicare will go bankrupt, and it also threatens to unravel our children's future.

Medicare is already on shaky financial legs, and this will add enormous extra expenses that will make it worse. Do we expect our children to pay a lifetime of higher taxes, and still find there's nothing left for them when they retire? That is what we face.

I would like to add prescription drug benefits, but it's wrong to promise something we cannot pay for.

I want to preserve what's good about Medicare, not destroy it by making extravagant promises for political gain.

The enormous extra spending under this bill will be far more than projected. Because today's Medicare is a huge price control system, many doctors already refuse to see Medicare patients. In just a few years this will make it worse, including price controls that will destroy the incentives for companies to create new medicines.

What should we be doing?

Since 76 percent of seniors already have drug coverage, we could focus on helping those who don't. But this bill undoes the coverage that is already in place, and puts them in a confusing new medical experiment.

We should be stabilizing Medicare, so it can keep the promises already made, not making new promises that we don't have the money to keep.

We should address the reasons why drug prices and healthcare costs are so high. By banning re-imported drugs, we're forcing Americans to subsidize far-lower drug prices in other countries. We should change our policies so Americans only pay the lower world price, not a higher price.

We should end the 130,000 pages of federal regulations that have driven the costs of medicine and healthcare through the roof. On average, for every hour they spend with a patient, doctors and nurses spend another half-hour doing paperwork.

We should stress personal responsibility in healthcare, just as we did in welfare reform, so government resources are focused on those who cannot care for themselves, not on those who can.

Bit-by-bit, Congress is undoing the principles of welfare reform, and undercutting basic American principles in the process. Both political parties are making extravagant promises today, trying to outbid each other to win votes. Unfortunately, they are bidding with taxpayer's own money, and our children's hopes will be crushed by the bills they will inherit.

Mr. UDALL of New Mexico. Mr. Speaker, for far too long, as I traveled around the state of New Mexico, seniors have told me their heartache, doctors and nurses spend another half-hour doing paperwork.

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My second amendment would have assured that the prescription drug benefits we members of Congress enjoy would be comparable to those of Medicare beneficiaries. My colleagues in the Senate passed such an amendment, but the Members of the House Rules Committee seem reluctant to subject themselves to the same benefits they would give our Nation's seniors. They have sent the clear message that these benefits are not good enough for them, the relatively young and healthy, but are adequate for our Nation's seniors and disabled persons.

One report done for the House Administration Committee has proven that the Democratic process is not working. Not only are the voices of America's seniors not being heard, but neither are those of Members of Congress. As we go home to celebrate our Nation's independence, we will have to explain to our seniors that yes, a prescription drug bill passed, but it will not benefit them. It will not benefit middle America, it will not benefit the poor, it will not benefit those who are already struggling to buy their prescription drugs. It will only benefit those who can currently afford their drug—afford to pay for more hospital services, and afford to pass this bill. Mr. Speaker, I oppose this rule and I oppose the underlying bill.

Mr. HOLT. Mr. Speaker, for forty years, the federal government has kept a promise to our nation’s seniors. This promise is called Medicare, and it means that every senior will receive affordable, reliable health care in their later years.

Four years ago, I came to this Congress having made a promise to the seniors in my Congressional district that I would work to bring Medicare into the twenty-first century by including coverage for prescription drugs. Coverage that, like the original Medicare program, is comprehensive, voluntary, universal, and reliable—without hampering the innovation that has brought us so many miraculous drugs over the past few decades.

Today I am voting to keep that promise by opposing a bill that would undermine the Medicare program itself. H.R. 1 purports to offer seniors coverage for the prescription drugs they rely on every day. Unfortunately, it falls far short when held up to the spirit and practice of Medicare.

The most distressing aspect of this bill, to me, to my constituents, and to the AARP, is that it takes the entire Medicare program down a short road to privatization. By the year 2010, Medicare would be converted to a voucher program with competition between managed care plans and traditional fee-for-service—only the deck would be stacked against the traditional plans.

Seniors would find themselves with for-profit managed care programs, like the Medicare-Choice programs that have failed so miserably in central New Jersey.

Rather than giving seniors what they want and deserve—a reliable, affordable drug benefit under Medicare, this provision, glibly called “premium support,” will destabilize the program and lead to substantially higher costs for seniors who want to stay in traditional Medicare.

Yet another element of confusion comes from the bill’s “out-of-pocket” coverage under this bill. Seniors would find themselves paying 20 percent of drug costs up to $2000 in drug costs—then having no coverage until they reach $4900 in drug costs, when a catastrophic cap finally kicks in. Not only is this extremely convoluted, it ends up leaving seniors with a very paltry benefit. A beneficiary with $5000 in annual drug costs would pay nearly $4000 out of their own pocket!

This may be alarming to seniors who currently have no drug coverage. There are millions out there, however, who may think this debate won’t really affect them because they already have coverage under their company’s retiree benefit packages. I want them to know that the Republicans have quite a surprise in store for them.

If this bill passes, nearly one-third of employers currently offering retiree drug benefits—covering 11 million seniors—would drop that coverage. Retiree benefits would not count towards the beneficiary’s out-of-pocket limit, making it almost impossible for seniors with retiree coverage to ever reach the catastrophic cap. So the bill actually discriminates against seniors with existing coverage and will have the practical effect of employers ending their benefits. This provision makes no sense—why on earth do we want to have less private sector drug coverage?

While I am disappointed with the underlying bill, I am pleased to see that the Rules Committee made the Dingell-Rangel substitute bill in order. This legislation would go a long way to fulfilling the promise I mentioned—it would provide a reliable, stable benefit under Medicare. Beneficiaries know exactly what they would pay—20 percent of drug costs up to $2000 in out-of-pocket costs with a defined premium of $25 per month and a defined deductible of $100.

Tonight, here in this body, by passing H.R. 1 we could be bringing about the end of a program that served seniors so well. Instead, we should pass the Dingell-Rangel substitute. That is what seniors need and deserve.

Ms. CHRISTENSEN. Mr. Speaker, I rise in strong opposition to the Republican prescription drug bill, and in favor of the Dingell-Rangel Substitute.

We have been talking about a Medicare drug benefit for at least as long as I have been here—seven years. It is time to deliver. We owe it to seniors who need it because their lives depend on it.

I have lobbied for the day when all people living in this country have reliable, comprehensive insurance coverage. Today we can bring this within the reach of every person on Medi-care.

About 25 percent of my patients when I was in practice were on Medicare. Many could not get a full month’s supply of medication because they could not afford it on their fixed income. We would try to make it up with sampling; but it has not been as effective but was within their price range, and better than nothing, and with a lot of prayer. It is probably the latter which got them through.

The bill, H.R. 1, as usual comes with a good sounding name, but true to form it does nothing good at all. Instead, it misleads the older Americans who have been looking to us for help.

We need a benefit that is truly a benefit—one that is affordable and fair—through a program they know, have used all along and trust.

It needs to be available to all beneficiaries without having to navigate through the maze of managed care.

And we need to make it reliable—no holes to fall through when they might need it most; no dropping them like hot potatoes like happened with Medicare + choice.

And our plan strengthens Medicare, while the Republican plan would slowly kill it.

No tricky numbers, no fancy words, just a simple Medicare prescription drug plan. That is what the senior and disabled citizens have been asking for and that is what they deserve. It is what God-willing; I hope I would have when I am on Medicare.

The Dingell-Rangel substitute bill would provide a much-needed benefit for Medicare beneficiaries, who have played an important role in making this country what it is, and paved the way for all of us, and those who have special needs, what I want for my family and myself.

The Democratic substitute, developed under the leadership of John Dingell and Charles Ringell, is the only bill before either body, which honors our seniors’ gift to all of us. Let us do the right thing. Reject the Republican bill and pass the Democratic substitute.

Mr. HINOJOSA. Mr. Speaker, I rise today in opposition to the Republican prescription drug bill. For years, our seniors have been begging for help to obtain affordable prescription drugs.

Unfortunately, however, the bill before us today gives relief not to our vulnerable seniors, but to the large drug companies.

It forces Medicare patients into multiple private drug plans and out of Medicare. It undercuts seniors’ collective purchasing power and enables the drug industry to maintain its unjustifiably high prices.

Those who live in rural and undeserved areas will find themselves without any coverage because insurance companies will not be required to serve them and are given no incentives to provide coverage. Because of a large coverage gap, over half of all seniors will still be required to pay thousands of dollars a year for prescription drugs as well as the program premiums.

Hidden in this bill is also another provision that will change the way cancer patients are treated and subject them to delays and reduced access to care.

By contrast, the Democratic plan offered by Mr. Rangel would provide voluntary prescription drug coverage for all Medicare beneficiaries. The plan curbs drug costs by allowing this Secretary to use the collective bargaining power of Medicare’s 40 million beneficiaries to negotiate lower drug prices.

I urge my colleagues to oppose the sham Republican proposal and support the Rangel substitute that provides real benefit to our Nation’s most vulnerable seniors.

Ms. MILLENDER-McDONALD. Mr. Speaker, I stand here with my colleagues tonight to talk about the need for affordable prescription drug coverage for women. Because women suffer more from chronic illnesses requiring medication than men do, they pay more out of pocket for those medications though their financial resources are often limited.

The proposed House bill would fail to offer meaningful prescription drug coverage to the millions of low-income women with incomes below the 135 percent poverty level who do not currently have insurance. Also, the House bill would raise the amount of co-payments that our country’s poorest women Medicare beneficiaries are forced to pay.
Unlike the House bill, the Senate proposal, while not perfect, would be far more helpful to elderly women who range from 74 to 160 percent of the poverty level. Under the House bill, the out-of-pocket costs paid by elderly women will still make it difficult for them to get their much-needed prescriptions. In contrast to the House bill is a prescription drug benefit that the elderly women who are in greatest need of assistance will receive up to 40 percent fewer prescrip-

tions than those seniors who are able to afford pri-

vate insurance. Our elderly women, who are among our most vulnerable citizens, deserve far better treatment than this. It is critical that, as Members of Congress, we help women and all seniors by expanding Medicare to offer a prescription drug benefit that is universal, afford-

able, dependable, and voluntary. We can do no less than to offer elderly women access to adequate healthcare that they can afford and easily access.

Our Republican colleagues are offering a plan that gives no real guarantees or assistance to those who need quality prescription drug coverage the most.

Furthermore, the House plan would force seniors to purchase their own private insurance, a tactic that will benefit insurance com-

panies, and not seniors. This is a catastrophe we can avoid if we craft the right policy to benefit our elderly now. When it come to our elderly women, we know that:

Women make up 58 percent of the Medi-

care population at age 65, and 71 percent of the Medicare population at age 85.

Overall, elderly women have more chronic health problems than elderly men do.

On average, elderly women live another 19 years after retirement, while men typically live another 15 years after retiring.

Due to the obstacles they face in enrolling, almost half of elderly women with incomes under the poverty limit are not enrolled in Medicare.

As compared to married women, widows are four times as likely, and divorced or single women are five times as likely to live in pov-

erty upon retiring.

Many elderly women survive on fixed in-

comes. Over half of the older women age 65 and above earn less than $10,000 annually, and three out of four earn under $15,000 yearly. In contrast to elderly men, older women age 65 and above earn $14,820 as compared to $26,543 for men in the same age group.

Once retired, women earn less than men be-

cause:

Women tend to save less than men do throughout their lives which decreases their lifetime earnings.

Elderly women often usually have smaller Social Security benefits and pension incomes than men do.

Minority women are much more likely to earn less and live in poverty than are White women. Even when they have similar edu-

cational backgrounds, minority women tend to earn less than their White counterparts.

The sad fact is, the older and poorer a woman is, the higher her out-of-pocket health care costs will be, and the less help an elderly woman requires, the less likely she is to receive assistance. As a nation, though we are facing a great economic crisis, we are still ob-

ligated to provide assistance to our most needy citizens. Let us take good care of our elderly women and men by not enacting a pre-

scription drug policy that will force them to choose between either buying food or paying for necessary medication.

Mr. COSTELLO. Mr. Speaker, I rise in strong opposition to H.R. 1, the Medicare Pre-

scription Drug and Modernization Act of 2003. In recent years in my district that I would not support legislation that would fundamentally change the nature of Medicare and provide a prescription drug ben-

efit that relies solely on insurance companies. I am opposing the bill because it does just that.

Medicare has been a success because it provides guaranteed coverage for all elderly and disabled Americans. H.R. 1 would end Medicare as we know it and may particularly harm rural areas that depend on the traditional Medicare program. Beginning in 2010, H.R. 1 would force the Medicare fee-for-service program for doctors and hospitals visits to com-

pete with private insurance plans. People who wanted to remain in traditional Medicare would find their premiums going up as other bene-

ficiaries opted for bargain private insurance coverage that their enrolled would es-

sentially be forced out of the traditional fee-for-

service program and into some form of man-

aged care.

In addition, the Republican approach does not guarantee the same benefits for all seniors. Senators who live in rural areas and doctors negotiate lucrative contracts with man-

aged care plans would have to pay more; sen-

iors with higher incomes would have to pay more; seniors in rural areas would have fewer choices of doctors and pharmacies; and sen-

iors with lower incomes but with assets such as a savings account might not get nothing at all. These provisions violate the central promise of Medicare: to provide a consistent, guaranteed benefit that allows everyone, no matter where they live, how much they have, or how sick they are, access to quality medical care.

Finally, H.R. 1 is flawed because it offers seniors an inadequate prescription drug ben-

efit. I support a voluntary prescription drug benefit paid for by Medicare. I am committee to providing a comprehensive benefit that is comprehensible to beneficiaries and provides guaranteed coverage with no gaps or gimmicks in its coverage. The Senate is currently working on a prescription drug bill that provides a government fallback provision, providing Americans with more of a reliable, consistent benefit. The Senate is moving in the right direction and I am hopeful, progress will continue to be made when this legislation goes to conference.

H.R. 1 relies too heavily on the insurance industry to bring drug costs down and does not guarantee seniors access to the medicine prescribed by their doctor or that they can get prescriptions and doctor visits at their local pharmacy. Seniors deserve fair drug prices and a real, afford-

able prescription drug plan.

Mr. Speaker, for these reasons, I oppose H.R. 1. I urge my colleagues to do the same.

Mr. FILNER. Mr. Speaker, I rise today to discuss the prescription drug benefit proposal that my colleagues on the other side of the aisle have rammed through the legislative process. I rise to decry this bill because it does not give seniors what they deserve. It seems pretty simple to me: a prescription drug benefit under Medicare ought to work the same way that Medicare has always worked. That is, it is a guaranteed benefit for all seniors, no matter where they live, how ill they are, or what kind of illness they have. This bill proposes to turn the prescription drug benefit over to HMOs and the private insurance industry. The premium prices are not guaranteed—the insurance industry would be able to charge what ever they wanted for the premium. In addition, it would be the insurance companies that get to decide what drugs would be covered. What this means for seniors is that there will not be a consistent, reliable program for all seniors is that there will not be a consistent, reliable program for all seniors across the country. Seniors in my district might pay higher pre-

miums and get less coverage than their counterparts in other areas of the country. Or, they may get better cov-

erage for lower premiums. We just don't know because it will be left up to the private insurance companies and the HMOs.

This bill also raises out-of-pocket costs for those who need the protection that Medicare had traditionally pro-

vided: the sickest and the poorest bene-

ficiaries. In addition to the “mystery” aspects of prescription drug costs, Medicare beneficiaries will pay for the first $250 worth of drugs without any help from the Federal Government.

When they reach $2,000 of medica-

tion, seniors will have to pay for another $2,000 until they reach $4,900 worth of drug costs. So, once they get to $2,000, in addition to the premium, the $250, the 20 percent copay, they must cover all of their prescription costs until they get to $4,900. That is quite a lot of money.

Allowing HMOs and private insur-

ance companies to take over the Medi-

care Prescription Drug benefit also pre-

sents a problem for rural areas. A very large percentage of people in rural areas aren't as profitable for insurance companies, so there is less incentive for them to offer benefits in those areas. This means that there will be fewer choices—if any choices at all—for seniors in rural areas.

In one fell swoop, this bill takes the great success story that is Medicare: Universal healthcare for all bene-

ficiaries, and crushes it. Under the Re-

publican approach, seniors who live in rural areas aren't as profitable for insurance companies, the bottom line rules. Rural areas aren't as profitable for insurance companies, so there is less incentive for them to offer benefits in those areas. This means that there will be fewer choices—if any choices at all—for seniors in rural areas.

I urge my colleagues on the other side of the aisle to support a consistent, reliable program that is comprehensive, and affordable for all beneficiaries, and crushes it. Under the Re-

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I urge my colleagues in the House to support a consistent, reliable program that is comprehensive, and affordable for all beneficiaries, and crushes it. Under the Republican approach, seniors who live in rural areas aren't as profitable for insurance companies, so there is less incentive for them to offer benefits in those areas. This means that there will be fewer choices—if any choices at all—for seniors in rural areas.
Dear Sir, I am writing my Senators and Representatives to plead our case regarding Medicare proposals that could endanger patient access to chemotherapy. I am a lung cancer survivor, age 72, and my husband, age 76, is now undergoing chemo, for liver cancer. Chemo drugs are required for my husband’s quality of life now and MRI’s have shown the tumors have diminished in size, so “it’s working!”

She goes on to say, “We in the cancer community want one thing: for all critical cancer services, including chemotherapy and patient care services to be covered fully and fairly by Medicare.”

Mrs. Monk makes a good point. Services must be covered fully and fairly by Medicare. It does seniors no good to have unequal coverage of medications. That is why I cannot support the Republican bill and urge my colleagues to vote against this poison pill for Medicare!

Mr. PASTOR. Mr. Speaker, I rise today in opposition to the Medicare Prescription Drug and Modernization Act. This bill, long heralded by the Republican majority as a comprehensive overhaul of the Medicare system, will do nothing to alleviate the harsh effect on our seniors of the high cost of prescription drugs. It will only continue to aggravate the cause of health care inflation.

Department of Commerce confers to the contrary, the bill, which calls for private drug-only plans, would not make drugs affordable. It has no mechanism for keeping prices down, no negotiation for acceptable terms, no guarantee of defined and stable costs. Seniors would be at the mercy of private plans. They would lose their choice of doctor. They would be at risk of continuous coverage.

Private plans would only have to promise to stay in the program for one year. We’ve had these problems before with the Medicare Plus Choice program which failed to deliver its expanded benefits, leaving millions of seniors out on a limb.

Seniors have voiced their concerns. They fear the absence of provisions to limit drug prices and the lack of certainty about the future of the program. Seniors in rural areas are particularly concerned with the “gap-in-coverage” that means no coverage at all for drug spending between $2,000 and $5,100.

Instead of passing this plan which would privatize Medicare, we should support a plan that would establish a real Medicare prescription drug benefit within the Medicare program. The plan should be available to everyone regardless of income or place of residence. It should be voluntary and comprehensive. And, most importantly, it should be affordable.

The Medicare Prescription Drug and Modernization Act fills none of these requirements. Therefore, Mr. Speaker, I vote “no” on H.R. 1.

Ms. WOOLSEY. Mr. Speaker, this debate is a question of priorities, and it’s a question of values. Under the Republican plan, after seniors have incurred $2,000 in prescription drug benefits, they will still pay a premium, but they better not expect anything in return. And why is that?

It’s because just last week, the Republican leadership decided that they would rather eliminate estate taxes for millionaires than help seniors afford prescription drugs. They insisted on spending a total of $820 billion to help 8,000 millionaires. For almost the same cost, we could give millions of seniors a real prescription drug benefit.

Millionaires or millions of seniors? The Republicans give new meaning to the phrase “better off dead.” If you’re rich and dead, Republicans don’t want to lose a dime. But if you’re alive and can’t afford the high cost of prescription drugs—well, good luck.

You might want to be dead. I dare my Republican colleagues to tell their mothers what they’re doing to Medicare.

My priority is giving every American senior a real prescription drug benefit, like the one in the Democratic alternative. Oppose the Republican bill, support the Democratic alternative.

Mr. OBERSTAR. Mr. Speaker, Medicare, the most successful social service program since Social Security, will be dramatically transformed and, in the long run, unraveled by this Republican bill we are debating tonight.

Their plan will convert Medicare from a defined benefit and contribution voucher plan. In plain English, it means that seniors will lose the guaranteed coverage and the security of knowing which benefits are covered. Instead of having predictability about Medicare premiums and copayments, seniors will essentially receive a voucher for services to negotiate with insurance companies for insurance plans.

If this plan does not pay for the services they need, seniors will have to cover the difference—which could be a big figure—out of their own meager income.

As a result, this untested, speculative health care experiment is going to abandon all seniors, especially rural seniors. The Republican plan replaces Medicare with an illusory promise that private health insurance companies will offer health insurance policies in rural America. Under current law, health insurance companies have found it unprofitable to offer policies in rural America; worse, the Republican plan does not guarantee that rural seniors will have access to the same benefits as seniors in metropolitan areas enjoy.

Not only does this bill undermine Medicare, it fails to provide an affordable prescription drug benefit. I don’t understand how the majority, on the one hand can justify trillion dollar tax cuts, and on the other hand, impose an arbitrary limit on Medicare and prescription drug benefits. To comply with this artificial limitation, the Republican plan offers a complicated and untested prescription drug benefit, with an enormous gap in coverage.

The Republican plan is difficult to explain, but let me try: it begins with uncertain private health insurance premiums; then, seniors must pay $2,000 to $3,000 or more in deductible and assistance, and there is a large coverage gap, the “hole” in the doughnut, where seniors will be paying premiums but receiving no assistance at all. Seniors first have to spend to pay $250 a year, then they will pay 20 percent co-insurance for up to $2,000 in drug costs. However, no assistance would be provided between $2,000 and $5,100 in drug spending, forcing seniors to pay $3,100 out-of-pocket in drug costs. This plan is as unfair as it is complicated and costly to older Americans living on fixed incomes.

In contrast, the Democratic plan is guaranteed, defined, dependable, and understand- able. It sets a premium of $25 a month; a $100 per year deductible; a 20 percent co-insurance payment for beneficiaries, with Medicare paying 80 percent; and a limit of $2,000 in out-of-pocket costs per beneficiary per year. Health care is essential in greater Minnesota. The hospitals in many small communities throughout northern and northeastern Minnesota are the major employer in town, and the health care they offer is critical for economic development and tourism. The Range/Dingell bill offers a substantial improvement in payments to the hospitals and doctors in rural Minnesota who provide those critical health care services.

In particular, I am pleased that the Democratic Substitute includes numerous provisions to improve reimbursement for rural providers. The increased funding for low-volume, “critical access” and “sole community” hospitals, rural home health and ambulance providers, and rural physicians adds up to very significant improvements for hospitals in my district, and will assure their continued viability for years to come.

To be specific, the Democratic bill eliminates the 35-mile rule presently in place for Critical Access Hospitals and their services. That improvement would save the hospital in Ely, Minnesota, and would strengthen ambulance services at nine other Critical Access Hospitals in my district.

The Democratic plan would provide an additional $100 billion for rural providers, allowing their survival by increasing payments for ambulance services. The increases we propose would ensure the financial solvency of St. Mary’s Life Flight, enabling it to continue assisting, for example, people who are injured while vacationing in the Boundary Waters Canoe Area Wilderness.

On the whole, rural health care providers plan are better served, better funded, and treated more fairly under the Democratic plan, which also has the advantage of preserving Medicare. For that reason, I will be supporting the Range/Dingell bill.

Mr. BURR. Mr. Speaker, as vice chairman of the Energy and Commerce Committee and a member of the Health Subcommittee, I have worked on Medicare prescription drug legislation for more than four years. The House has passed Medicare prescription drug legislation twice and I voted for both bills.

Mr. Speaker, I will not vote for this bill.

The $400 billion allocated for the Medicare drug benefit is not being spent widely under this legislation. High-income Medicare beneficiaries like Warren Buffett are subsidized 73 percent by the Federal government for their drug-only insurance plans. Low-income seniors who are not dually eligible have no cost-sharing assistance for their drug spending between $2,000 and $3,100. This is irresponsible and unfair. The House has passed Medicare prescription drug legislation twice and I voted for both bills.

Mr. Speaker, I will not vote for this bill.

The Medicare Prescription Drug Modernization Act will do nothing to alleviate the harsh effect on our seniors of the high cost of prescription drugs. It will only continue to aggravate the cause of health care inflation.

Despite all Republican claims to the contrary, the bill, which calls for private drug-only plans, would not make drugs affordable. It has no mechanism for keeping prices down, no negotiation for acceptable terms, no guarantee of defined and stable costs. Seniors would be at the mercy of private plans. They would lose their choice of doctor. They would be at risk of continuous coverage.

Private plans would only have to promise to stay in the program for one year. We’ve had these problems before with the Medicare Plus Choice program which failed to deliver its expanded benefits, leaving millions of seniors out on a limb.

Seniors have voiced their concerns. They fear the absence of provisions to limit drug prices and the lack of certainty about the future of the program. Seniors in rural areas are particularly worried because they have no access to private plans and would have no “fallback” to offer coverage. Seniors are particularly concerned with the “gap-in-coverage” that means no coverage at all for drug spending between $2,000 and $5,100.

Instead of passing this plan which would privatize Medicare, we should support a plan that would establish a real Medicare prescription drug benefit within the Medicare program. The plan should be available to everyone regardless of income or place of residence. It should be voluntary and comprehensive. And, most importantly, it should be affordable.

The Medicare Prescription Drug and Modernization Act fills none of these requirements. Therefore, Mr. Speaker, I vote “no” on H.R. 1.
that they do not want to insure Medicare beneficiaries’ drug expenditures, but we keep throwing money at them in the hope that they will finally say yes. The premium subsidy used to be 67 percent, now it is 73 percent and Congress demands that it grow to 99.99 percent if need be. At the end of the day, who are we kidding? Of course it will be 99.99 percent.

Our problem is that the Congressional Budget Office has written this bill. The last time I checked, Mr. Speaker, it was not the job of the Congressional Budget Office to create a highly technical and important health care legislation. But policymakers are so convinced that a purely insurance-based product will work that they are willing to follow CBO’s instructions and tweak the product one thousand different ways—and cut provider payments at the same time—to fit it under some magical budget ceiling. If CBO is wrong in its estimate, and this drug benefit costs more than $400 billion, our entire health care system will be at risk. This is not wise health care policy.

Where do my colleagues think the extra money is going to come from? When CBO realizes that their estimated insurance penetration rate was off by 10 percent that money will come out of future physician, hospital, nursing home, and home health care reimbursement rates. If only 65 percent of seniors sign up for drug coverage and plans’ subsidies skyrocket, that money will come out of Food and Drug Administration modernization efforts, National Institutes of Health research, and bioterrorism preparedness. Congress is working with a limited pot of money, but we are promised savings from drug coverage and plans’ subsidies skyrocket. Obviously, the experiences of the private sector have taught us nothing.

If Congress listened to the private sector, we would mirror the success of defined contribution plans and individual empowerment by offering choice. Seniors could choose between twenty different discount drug cards based on the cards’ formularies, pharmacy networks, and drug discounts. The government would set up accounts and contribute money to those accounts based on the seniors’ needs. Seniors, as covered workers, friendly co-owners, or workers who could have caught up in the mid nineties, would have chosen plans and would not be in the current Medicare drug plan mess. What is the rub here? Obviously, the experiences of the private sector have taught us nothing.

If Congress listened to the private sector, we would mirror the success of defined contribution plans and individual empowerment by offering choice. Seniors could choose between twenty different discount drug cards based on the cards’ formularies, pharmacy networks, and drug discounts. The government would set up accounts and contribute money to those accounts based on the seniors’ needs. Seniors, as covered workers, friendly co-owners, or workers who could have caught up in the mid nineties, would have chosen plans and would not be in the current Medicare drug plan mess.

Taken together, I think these provisions undermine the traditional Medicare program. By opening traditional Medicare to competitive bidding and with no fallback mechanism, I fear that our country will revert to the time before Medicare was established in 1965 when private insurers wouldn’t provide affordable coverage to seniors. That’s a step backward, not a step forward, in fixing Medicare.

I also have problems with the home health copayment provision in the bill, which I believe will discourage seniors from accessing home health care, which is more cost effective than accessing treatment an emergency room or a skilled nursing facility. And I am concerned that opening durable medical equipment to competitive bidding will give seniors less choice and put many small businesses out of business.

On top of everything, this 692-page bill was introduced at midnight last night. How can anyone know what’s in it, except the people who wrote it? Our seniors deserve greater respect.

Mr. Speaker, it is misguided at best that Medicare will pay for a senior’s care following a stroke but will not pay for the anti-hyper tension drugs that prevent them. The time is ripe to pass a Medicare prescription drug benefit, but not this one. I regret I can’t support it. I hope that a bill can be worked out in conference that I can support. We need to put ideological and partisan politics aside and get it done this year.

Mr. CROWLEY. Mr. Speaker, I rise in support of the Democratic substitute because this bill meets the 4 basic tenets that any prescription drug plan under Medicare should absolutely provide for.

First, it means lower drug prices. The House Democratic bill allows HHS to negotiate lower drug prices. The Republican bill, unfortunately, does not.

Second, this bill guarantees coverage under Medicare.

Because of this, a senior knows what his premium, cost-sharing level, and catastrophic coverage is. The Republican bill has no such guarantees.

Third, this bill provides coverage for all drugs prescribed by a doctor. Under the Republican bill, a payer could deny coverage for a drug if the payer decides to not include it in its formulary.

Fourth, this bill has no gaps in coverage. Under the Democratic plan, when a senior has spent $2,000 on drugs, the government picks up the remaining costs. The Republican has spent $2,000 under the Republican plan, they’re dropped. They get zero coverage until they’ve spent $4,900.

The Republican bill does not simply have one big problem. It has several huge problems.

Only the Democratic substitute provides seniors in my district guaranteed, quality coverage. I urge an “aye” vote.

Mr. BUYER. Mr. Speaker, I rise in opposition to the bill, H.R. 1, the Medicare Prescription Drug and Modernization Act.

I fully support the effort to provide prescription drug coverage to Medicare beneficiaries. The successes in modern medicine that we see today can be partly attributed to the advances in safer and more effective pharmaceutical drug therapy. Illnesses and serious diseases that often required hospitalization 40 years ago, when Medicare was created, can now be treated with outpatient care and pharmaceuticals. This is a testament to the many scientists in numerous companies that toil daily to find compounds to treat and manage disease. The pharmaceutical industry is a testament to the free market system of the United States that rewards hard work, initiative, and enterprise. As the great minds of the world push the bounds of modern science, new discoveries in pharmacology lead to the betterment of mankind.

While H.R. 1 has some positive features, including addressing medical doctor and dentist provider reimbursement concerns and regulations requirements, an important part of an insurance product built and guaranteed by the government is not the approach to provide a drug benefit under Medicare.

And, make no mistake, we MUST get it right. I have serious levels of concern.

First, the legislation before us has the government assuming 73 percent of the risk of offering the insurance, 43 percent of the initial...
benefit and 30 percent of reinsurance retro-
spectively. This is the floor! We must all un-
derstand that the taxpayer’s exposure to risk 
can only increase. The bill permits the govern-
ment to assume more risk, up to 99.9 percent if 
it is necessary to entice an insurance prod-
cut into a region. And this is an unknown fac-
tor. We nor cannot know what this provision will cost the taxpayers.

Today, Medicare already consumes nearly 
12 percent of the federal budget. It is ex-
pected to be 30 percent or 35 percent of the federal budget without the inclusion of prescription drugs, or any other benefit. It is im-
possible of this Congress to simply add a 
prescription drug benefit without also address-
ing the budgetary impact of this benefit. H.R. 
1 leaves the federal budget and the taxpayers 
exposed to unknown expenditure levels in the 
future. I do not believe that this drug bill will 
remain within the proposed budget of $400 bil-
on over the next 10 years.

Second, there is no provision in the House 
bill on how to provide a benefit to seniors in 
areas where two insurance products are not 
available in 2006. It is simply more realistic, 
or fair, for seniors in one region to have 
products available and seniors in another 
region to not have choice because two plans 
have not been forthcoming.

Furthermore, I am adamantly opposed to 
the proposal in this bill, and to the body, 
that the government provide this cov-
ervation. This will only lead to the government 
determining what prescription drugs a senior 
can have and ultimately the imposition of price 
controls that will have a chilling effect upon re-
search and development of pharmaceutical 
therapies.

Third, the premium charged to seniors for 
the drug-only insurance plan is estimated to 
be $35 per year initially. This premium number 
is not found in the bill—it is an estimate by the 
Congressional Budget Office. What if it is 
more? Will seniors decide that this premium is 
worth the benefit they will receive under a 
drug insurance plan? There will be a great 
deal of kitchen table math being done by sen-
iors in 2005 to decide whether this new benefit 
meets their drug needs and their wallet reali-
ties.

I am also concerned about a number of 
modifications made under the bill to reim-
bursement for providers and to the last minute 
incursion of language regarding the Patent 
Term Restoration Act, the so-called Hatch-
Waxman law. Although some very nec-
essary reimbursement changes were 
made in the bill, particular regarding doctors 
and rural areas, nonetheless, I am concerned 
about the changes to the market basket up-
date for Medicare as well as the changes in 
the skilled nursing facilities and home health care 
providers. In addition, I share the concern of 
others regarding the sufficiency of the reim-
bursement to oncologists. It is very true that 
the Congress needed to address the use of the 
“average wholesale price,” which was nei-
ther average nor wholesale, and left Medicare 
beneficiaries paying 20 percent of an inflated 
drug price, but oncologists need to be reason-
ably compensated for the level of care they 
provide to Medicare patients, I am not con-
vinced that this has been sufficiently ad-
dressed.

I also have grave reservations over the in-
clusion of provisions regarding patent term 
and generic drugs, the changes to the Hatch-
Waxman law. Initiating more litigation of patent 
rights is not conducive to encouraging innova-
tion in pharmaceuticals. Unfortunately, this is 
exactly what this provision will do.

The vast majority of seniors have drug cov-
erage today through either an existing govern-
ment prescription drug plan, or private sector. 
However, 27 percent of seniors have nothing. 
These seniors pay the highest prices when 
they go to the pharmacy because they have 
no means to bargain for lower costs. These 
seniors also tend to be those between 100 
percent and 175 percent of the federal poverty 
level who should not be made to simply 
displace existing coverage and should 
address the needs of those seniors who do not 
have coverage.

The government should encourage employ-
families and others to help seniors with 
the purchase of expensive prescription drugs. 
It is time that we admit that no proposal that 
comes to the House floor that meets the budg-
et requirements will fully address all the pre-
scription drug requirements of seniors. Every 
plan will have a “so-called donut hole.” There 
should be new ways to put our heads in the sand and expecting it to 
simply “work out.”

We live by a system of checks and bal-
ances. We run into the limitations with every-
thing that we do. How can we then create a 
proposed system or system that is unknown? 
The government’s assistance to beneficiaries 
should be a defined contribution. This type of 
benefit would be manageable and known.

I am committed to providing a prescription 
drug benefit for seniors. Seniors should have 
access to drugs that are available in the private sector to drive down 
costs and improve health care services.

Along with four of my colleagues on the En-
ergy and Commerce Committee, we submitted 
legislation, that would address these issues 
and provide a prescription drug benefit under 
Medicare. I testified before the Rules Com-
mittee to request a vote on our bill. The 
request was denied. This benefit would have 
been delivered through a prescription drug dis-
count, or value, card that would be available 
and provide assistance related to an 
annual $30 fee. This is an approach that has 
been recommended by the President.

Any entity qualified by the Centers for Medi-
care and Medicaid Services could offer a drug 
value card to seniors. Card issuers would ne-
gotiate with pharmaceutical manufacturers for 
discounts on drug utilizing the same tech-
niques that are found in the marketplace 
today. These discounts would range from 15 
percent to 35 percent of current retail prices. 
The competition among these card issuers 
would help relieve some of the tremendous regu-
latory burden imposed on health care pro-
viders by the Federal Government. I am also 
pleased that the drafters of H.R. 1 in-
corporate a regulatory relief legislation, which 
I have supported in the past, into the bill. This 
will help relieve some of the tremendous regu-
latory burden imposed on health care pro-
viders. Under both plans, federal spending and con-
trol over health care will rise dramatically. 
The only difference is that the alternative puts sen-
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as Medicare and/or HMO bureaucracies attempt to control costs by reducing the reimbursements paid to pharmacists to below-market levels (thus causing pharmacists to refuse to participate in Medicare), and restricting the types of pharmacies seniors may use in the name of "safety". Both types of actions may go so far as to forbid seniors from using their own money to purchase Medicare-covered pharmaceuticals. I remind my colleagues that today the federal government prohibits seniors from using their own money to obtain private prescription drugs for disaster. This plan is enacted. This number is certain to skyrocket once the pharmaceutical companies begin to see their profits caused by Medicare price controls to private plans.

Furthermore, these private plans will be subject to government regulations. Thus, even seniors who are able to maintain their private coverage will fall under federal control. Thus, H.R. 1 will reduce the access of many seniors to the prescription drugs of their choice!

Setting up a system where by many of those currently receiving private coverage are kicked into the government program exacerbates the problems with this bill; it hastens the bankruptcy of the Medicare program and the federal government. According to Medicare Trustee, and professor of economics at Texas A&M University, Tom Saving, the costs of this bill could eventually amount to nearly 40 percent of private plans that currently provide prescription drug coverage to seniors will stop providing such coverage if this plan is enacted. This is certain to skyrocket once the pharmaceutical companies begin to see their profits caused by Medicare price controls to private plans.

Joint Economic Committee has estimated that the costs of this bill could eventually amount to $3.8 trillion! Of course, estimates such as this often widely underestimate the costs of government programs. For example, in 1965, the estimate that the Medicare Part B hospitalization program would cost $9 billion in 1990, but Medicare Part B costs $66 billion in 1990.

This new spending comes on top of recent increases in spending for "homeland security," foreign aid, federal education programs, and new welfare initiatives, such as those transformative churches into agents of the welfare state. In addition we have launched a seemingly endless program of global reconstruction to spread "democratic capitalism." The need to limit spending is never seriously discussed: it is simply assumed that Congress can spend whatever it wants, mainly on the Federal Reserve to bail us out of trouble. This is a prescription for disaster.

At the least, we should be debating whether to spend on warfare or welfare and choosing between Medicare and welfare for the poor instead of simply increasing spending on every program. While I would much rather spend federal monies on prescription drugs then another unconstitutional war, increasing spending on any program without corresponding spending reductions endangers our nation's economic future.

Congress further exacerbates the fiscal problems created by this bill by failing to take any steps to reform the government policies responsible for the skyrocketing costs of prescription drugs. Congress should help all Americans by reforming federal patent laws and FDA policies, which provide certain large pharmaceutical companies a government-granted monopoly over pharmaceutical products. Perhaps Congress can do to reduce pharmaceutical policies is liberalize the regulations surrounding the reimportation of FDA-Approved pharmaceuticals.

As a representative of an area near the Texas-Mexico border, I often hear from angry constituents who cannot purchase inexpensive quality imported pharmaceuticals in their local drug store. Some of these constituents regularly travel to Mexico on their own to purchase pharmaceuticals. It is an outrage that my constituents are being denied the opportunity to benefit from a true free market in pharmaceuticals by their own government.

Supporters of H.R. 1 claim that this bill does liberalize the rules governing the importation of prescription drugs. However, H.R. 1's importation language in H.R. 1 is a smokescreen designed to fool the gullible into thinking Congress is acting to create a free market in pharmaceuticals. The alternative suffers from the same flaws, and will have the same (if not worse) negative consequences. H.R. 1. There are only two differences between the two: First, under the alternative, seniors will not be able to choose to have a federally subsidized HMO bureaucrat deny them their choice of prescription drugs; instead, seniors will have to accept the control of bureaucrats at the Center for Medicare and Medicaid Services (CMS). Second, the alternative is even more fiscally irresponsible than H.R. 1.

Mr. Speaker, our seniors deserve better than a "choice" between whether a private or a public sector bureaucrat control their health care. Meaningful prescription drug legislation should be based on the principles of maximum choice and flexibility for senior citizens. For example, my H.R. 1617 provides seniors the ability to use Medicare dollars to cover the costs of prescription drugs in a manner that increases seniors' control over their own health care.

H.R. 1617 removes the numerical limitations and sunset provisions in the Medicare Medical Savings Accounts (MSA) program. Medicare MSAs are not designed to contain Medicare funds for seniors to use for their routine medical expenses, including prescription drug costs. Unlike the plans contained in H.R. 4504, and the Democratic alternative, Medicare MSAs allow seniors to use Medicare funds to obtain the prescription drugs that fit their unique needs. Medicare MSAs also allow seniors to use Medicare funds for other services not available under traditional Medicare, such as mammograms.

Medicare MSAs will also ensure that seniors have access to a wide variety of health care services by minimizing the role of the federal bureaucracy. As many of my colleagues know, an increasing number of health care providers have withdrawn from the Medicare program because of the paperwork burden and constant interference with their practice by bureaucrats from the Center for Medicare and Medicaid Services. The MSA program frees seniors and providers from this burden, thus making it more likely that quality providers will remain in the Medicare program.

There are claims that this bill provides seniors access to MSA. It is true that this bill lifts the numerical caps on Medicare MSAs; however, it also imposes price controls and bureaucratic requirements on MSA programs.

One claim is that MSAs contain nothing to free seniors and health care providers from third party control of health care decisions!

Mr. Speaker, seniors should not be treated like children by the federal government and told what health care services they can and cannot have. We in Congress have a duty to preserve and protect the Medicare trust fund. We must keep the promise to America's seniors and working Americans, whose taxes finance Medicare, that they will have quality health care in their golden years. However, we also have a duty to make sure that seniors can get the health care that suits their needs, instead of being forced into a cookie cutter program designed by Washington, DC-based bureaucrats! Medicare MSAs are a good first step toward allowing seniors the freedom to control their own health care.

Finally, Mr. Speaker, I would like to comment on the procedure under which this will was brought before the House. Last week, the committees with jurisdiction passed two separate, but similar Medicare prescription drug bills. In the middle of last night, the two bills were merged to produce H.R. 1. The bills reported out of Committee were each less than 400 pages, yet the bill we are voting on today is 692 pages. So in the middle of the night, the bill mysteriously doubled in size! Once again, members are asked to vote on a significant piece of legislation with far reaching effects on the American people without having had a public hearing, study, or even seen major portions of the bill.

In conclusion, Mr. Speaker, both H.R. 1 and the alternative force seniors to cede control over which prescription medicines they may receive. The only difference between them is that H.R. 1 gives federal and HMO bureaucrats control over seniors' prescription drugs, whereas the alternative gives government bureaucrats the power to tell seniors which prescription drug they can (and can't) have. Congress can, and must, do better for America's seniors, by rejecting this command-and-control approach. Instead, Congress should give seniors the ability to use Medicare funds to purchase the prescription drugs of their choice by passing my legislation that gives all seniors access to Medicare Medical Savings Accounts (MSA).

Mr. THORNBERY. Mr. Speaker, health care is an important but complex issue for Congress and for America's seniors. Two facts, however, seem clear:

One is that Medicare has already been head-ed toward financial collapse. The latest report of the Medicare trustees shows that in nine years the income of the Medicare trust fund will not be enough to cover its expenses. After that, the problem gets much worse with the retirement of the baby boom generation.

A second clear fact is that Medicare was enacted in 1965 and has been largely unchanged since then. It does not reflect modern
medical practices, including our reliance upon prescription drugs. If we were designing a new federal health care program for seniors today—rather than in 1965 when Medicare was created—we would unquestionably include some form of prescription drug coverage.

Our objective then should be to update and strengthen Medicare so that it does a better job of providing health care for seniors and at the same time put Medicare on a sound financial footing so that it can be sustained through the baby boom generation retirement.

This bill takes some steps in that direction. It contains some reforms that improve Medicare and give beneficiaries more control over their health care. It also adds prescription drug coverage, and there are too many seniors in my district who are not able to afford the prescription medicines they need, forcing them either to do without and become sick or to sacrifice other necessities of life.

I am gravely concerned, however, that the reforms take too long to implement and that the new drug benefit will cost far more than expected. Without changes, this bill may add a major new benefit to Medicare but, at the same time, hasten the day of its financial collapse.

At the same time if we do nothing, we are guaranteeing that Medicare will not survive for long. The alternative proposals are far more expensive and are fiscally irresponsible.

I have other concerns with this bill, such as the reductions in payments for cancer treatments. Today, however, I will vote to send the House bill to conference with the Senate. I strongly urge that improvements be made to ensure Medicare solvency and to improve the quality of health care for America's seniors. We can do better. If improvements are not made, I will not be able to support the final conference report.

Mr. KIND. Mr. Speaker, providing affordable Medicare prescription drug coverage for our nation's seniors is one of the most pressing issues facing our country today. Even though the elderly use the most prescriptions, more than 75 percent of seniors on Medicare lack reliable prescription drug coverage. It is time they modernize Medicare to reflect our current health care delivery system. The use of prescription medications is as important today as the use of hospital beds was in 1965 when Medicare was created.

I have heard from a number of seniors in western Wisconsin regarding the problems they have paying for prescription drugs. One woman from Deer Park, Wisconsin, a small town in my district, wrote to me and said:

My medication is $135.00 per month. Fortunately, I am not on any Medicaid.

If we both were not working part-time, I guess that we would have to make a choice between food and Medication—does one eat to survive or take the medication for a "long and happy life"?

What is to happen to this couple if the husband falls ill and has high drug costs too?

The cost of prescription medicines should not place financial strains on seniors that would force them to choose between buying drugs and buying food. We need to make prescription medicines affordable and accessible to all of our seniors.

I came to Congress to work toward a real solution to this problem. Unfortunately, today's debate is a sham. We will not have the opportunity to discuss this issue in a fair and open process. There were several alternatives presented at the Rules Committee late last night and they should be debated on the floor today. The majority, however, chose to dedicate only one day to this debate and allowed only one alternative and no amendments to be made. The only alternative is designed better. They deserve an open process, but the Republican leadership has failed to deliver this.

The leadership has also failed seniors with their prescription drug proposal. The Republican plan of the day relies on health insurance companies to offer drug only policies which they have said they won't offer. Further, there is no fall back option. So, if insurance companies won't offer these policies, how will seniors actually obtain prescription drug coverage under the leadership plan?

Providing a drug benefit through private plans could be problematic, specifically for folks living in rural and small communities. There are no requirements as to what has to be covered, leaving seniors exposed. There is concern that the healthy seniors will leave traditional Medicare and the premiums will increase dramatically, up to 47 percent. In addition, under the leadership bill, each local area will have a different premium for fee-for-service Medicare. For example, seniors in Wisconsin might have to pay more to enroll in fee-for-service Medicare than seniors in Florida. This is a drastic departure from Medicare's fundamental principle that seniors across the country pay the same premium for the fee-for-service benefit.

Mr. Speaker, we have a real solution to the problem of prescription drug coverage for our seniors. The Republican plan falls woefully short. All of the Democratic alternatives offered at the Rules Committee would be better than the leadership bill. One proposal, the Medicare Rx NOW Act, is a simple straightforward plan that provides assistance to the seniors most in need, those with low incomes and seniors with high drug costs. This proposal builds on the Medicare program seniors know and provides them with a guaranteed benefit for no additional premium.

Another proposal put forward by the Blue Dogs is based on the bipartisan Senate bill. Unlike the House bill, this proposal includes a fall back provision to ensure that all seniors would have access to a prescription drug plan. In addition, this bill does not include the privatization component of the leadership plan.

In addition, both of these alternatives provide substantial improvements to Medicare payments for rural providers. Both pieces of legislation include equalizing the disproportionate share hospital payments for rural hospitals, an increase in the bed limit for critical access hospitals, and a geographic adjustment for rural physicians. None of these provisions are included in the leadership's bill.

It is unfortunate that the Republican leadership has squandered an excellent opportunity to try and solve the problem of prescription drug coverage in a bipartisan fashion. Instead they have steamrolled ahead and present our nation's seniors with an unworkable solution to a grave problem. I urge my colleagues to reject this flawed proposal.

Mr. RAMSTAD. Mr. Speaker, I rise in strong support of the Medicare Prescription Drug and Modernization Act.

Today is an historic day. Congress is finally delivering on our promise to create a meaningful and long overdue prescription drug benefit for Medicare seniors and people with disabilities.

This bill means seniors will no longer have to choose between purchasing life-savings drugs or the basic necessities of food and housing.

In addition to this important new prescription drug benefit, the bill modernizes and improves Medicare to give seniors better choices and greater access to state-of-the-art health care.

I am grateful for the many important provisions in this package from my Medicare Innovation Responsiveness Act (H.R. 941), which will increase seniors' access to lifesaving medical technology.

As founder and co-chair of the Medical Technology Caucus, I have seen first-hand the incredible advances that medical technology has made to treat and cure debilitating conditions. The current Medicare system is crying out for reform with its failure to incorporate these critical improvements.

Currently, seniors and people with disabilities face unconscionable delays of up to five years before Medicare provides access to technology that can literally be a matter of life or death.

The bill before us incorporates many of the reforms I have proposed in Medicare's coverage, coding and payment process that will speed access to lifesaving technology.

Thanks to this legislation, we are finally tearing down barriers that discourage innovation and deny America's seniors the medical technologies they desperately need. Seniors have waited too long for access to the same treatment options as other Americans.

In addition to the excellent work and leadership of Chairman THOMAS and Chairman JENKINS, I want to thank my colleagues—John McManus and Deb Williams—who have worked so tirelessly on these provisions.

I am also pleased the bill includes H.R. 841, legislation I introduced with Mr. CARDIN to break down regulatory barriers facing specialized Medicare+Choice plans that serve the frail elderly.

Mr. Speaker, this package of reforms will improve the lives of our seniors and generations to come who count on Medicare. I urge my colleagues to support this landmark legislation and deliver on our promise to modernize and strengthen Medicare.

Mr. BACA. Mr. Speaker, I rise in opposition to H.R. 1, the Medicare Prescription Drug & Modernization Act of 2003.

This Republican plan is bad for seniors! It’s bad for Hispanics! And it’s simply bad for the American people!

For millions of Americans, this plan will replace traditional Medicare with vouchers that won’t guarantee benefits. It forces seniors into risky HMO plans and new private fee-for-service plans that will not cover all of seniors’ costs!
Forty-seven percent of seniors in Medicare will have a $1,900 gap in their drug coverage. How are our seniors supposed to make up for that gap?

How are our parents and grandparents going to afford that? Most seniors are on fixed incomes with nothing to spare.

Forty percent of poor and disabled seniors won’t get the additional help they need to pay deductibles and premiums. 40 percent.

This plan will not give taxpaying pregnant women and children benefits! It will not help the twenty million Hispanics without Health insurance!

And it will not help our parents and grandparents pay for their medicines!

We must take care of our seniors! We must not gamble with their health and well-being. Seniors deserve to be protected in a safe and fair healthcare plan.

In my district, San Bernardino, California, seniors are boarding buses to Tijuana so they can afford to buy prescription drugs.

Our seniors have to go all the way to Mexico to get the life-saving medicine they need. Mexico!

This is not safe and it is not fair.

I am angered when I think about all of the people that the Republicans are leaving behind in this bill, with nothing to spare!

Why are we letting this happen to our abuelos? Our parents and grandparents? How can we be so heartless?

When I think about this bill, I think about all of the seniors who can’t afford life saving prescription drugs.

I think about the senior who has glaucoma and prostate cancer and makes only $8,000 a year.

Like 750,000 other Hispanics, he won’t get help paying for his prescription drugs, because he is lucky enough to have assets and own a car.

According to Republicans, that is wealthy!

They will give tax breaks to millionaires, but under their plan, a man who makes $8,000 a year and is lucky enough to own a car, is too wealthy to get medicines that will ease his pain and save his life!

This is an outrage!

Under the Republican plan he would have to sell his car and pass an assets test to be poor enough to receive aid for low-income seniors.

When I think about this plan, I think about the senior who might make $10,000 a year.

That senior will pay one-fifth of his or her income to cover the Republican coverage gap.

One-fifth! This won’t get him off the bus to Tijuana!

Like 63 percent of Americans, seniors in my district want and need the security of Medicare.

Under the Republican plan they may start in Medicare.

But after a couple of years, Medicare will only be a voucher program and where will seniors be?

In an HMO plan and still in a pharmacy in Tijuana buying medicine.

My constituents deserve better than the Republican plan!

They deserve more!

They deserve the Democratic plan that we have been fighting for for years!

A plan that cares about the health and safety of America’s seniors!

A plan that actually works for America’s seniors!

For all these reasons, groups from AARP to the National Committee to Preserve Social Security and Medicare have sharply criticized this plan. I supported a number of alternative bills that would address the problems with this plan and vastly improve the benefit available to seniors. Unfortunately, the leadership of the House leadership refuses to pass any bill through as quickly as possible with providing a quality benefit for seniors, and they weren’t willing to fix the serious flaws in the bill that could hurt seniors. In fact, the House leadership refused to allow even one real amendment to the bill.

I want to pass a real prescription drug benefit—but I would not vote for a plan that hurts Maine’s seniors. I am disappointed with the legislation that was passed by the House, however the fight for a real Medicare benefit is not over. It is my hope that this legislation will be improved in the upcoming conference with the Senate. I will continue to fight to make sure that all Maine seniors receive an affordable and real Medicare prescription benefit.

Mr. LANGEVIN. Mr. Speaker, I rise in opposition to H.R. 1, the Medicare Prescription Drug & Modernization Act. Like many of my colleagues, I held sincere hope that the 108th Congress would overcome the inaction that has plagued this issue, at the expense of America’s senior citizens, for many years. I am extremely disappointed that the bill before the House this week not only fails to offer a structurally sound prescription drug benefit for Medicare beneficiaries, but also contains provisions that threaten the stability of the program that has provided health benefits for millions of elderly people and younger adults with disabilities for the past 38 years.

In particular, I want to call attention to the fact that this bill does nothing to address the rapidly rising costs of prescription drugs. It not only fails to address this crisis, it contains a “noninterference” clause prohibiting the agents of the Department of Health & Human Services from using the bulk purchasing power of Medicare beneficiaries to negotiate for lower prices for senior citizens. Without taking measures to curb the escalating prices of prescribed medications, it is impossible to stay alive, the benefit is rendered meaningless.

Seniors will pay more out of pocket in 2007 with the prescription drug benefit than they are paying in 2003 without it.

I urge my colleagues to pay careful attention to the details of the Medicare Prescription Drug & Modernization Act and to think critically about the effect—or lack thereof—it will have on the seniors in their districts.

Mr. ISRAEL. Mr. Speaker, I am proud to be a Democratic Member of this body. I have always been proud to be a Democrat. And always will be.

But I came to Congress 2½ years ago with a promise to my constituents that I would work hard to break through partisan gridlock. I promised that when I agreed with the Republicans I would vote with them; and when I disagreed I would vote against them. But that I would always work to develop consensus and move our country forward.

That is what brings me here today, Mr. Speaker.

A couple of those 2½ years, I have focused on a health care crisis for seniors on Long Island. We used to have 12 Medicare HMOs in my communities. Now we have two
left. Eighty-five thousand seniors have been tossed out of their Medicare HMOs. One out of five is skipping their medication because they can’t afford them.

And in those 2 1/2 years, I have listened to Republicans blame Democrats for this crisis; Democrats blame Republicans; the House blame the Senate; the Senate blame the House; Congress blame the White House; the White House blame Congress; and everyone blame the insurance companies.

There is plenty of blame to go around. But all the blame in the world isn’t going to help a single senior get their prescription drugs at a more affordable price.

It is time to stop blaming. It is time to stop finger pointing. It is time for conservatives to stop railing against a $400 billion prescription drug plan because it’s too liberal. It is time for liberals to stop railing against a $400 billion prescription drug plan because it’s too conservative. It’s time for everyone to stop rejecting the imperfect because we can’t get the perfect. It’s time to move this process forward.

Mr. Speaker, I believe the Democrats are right. They believe an $800 billion to provide America’s seniors with a truly comprehensive, voluntary prescription drug plan.

Is an $800 billion prescription drug plan better than a $400 billion program that’s before us today? Of course. $400 billion is only half the size of the House bill—a $800 billion plan— and it is $400 billion better than nothing. And nothing is exactly what we will leave our seniors if we reject this proposal today.

To reject the largest expansion of Medicare in its 38-year history because it’s $400 billion instead of $800 billion just doesn’t make sense to me.

Mr. Speaker, only a short time ago, President Bush argued for a $190 billion prescription drug plan. My side of the aisle proposed an $800 billion plan. Some say we have ended up at a $400 billion plan.

I disagree. I think we are beginning with a $400 billion plan. It is the largest expansion of Medicare in its 38-year history. It is, in my view, a down payment. An investment.

Is this plan flawed? I believe it is. I believe the Senate version supported by Ted Kennedy, is much better. But we can’t get near that plan unless we go to a House-Senate conference. And we can’t go to a House-Senate conference unless we pass this bill today.

Yesterday at the White House, I listened carefully to President Bush. He said clearly we must move this process forward and pledged to work on a bipartisan basis to develop a final bill that represents consensus.

But there’s no hope for consensus, no hope for a penny of prescription drug spending, if we sit on the brakes on the process today by killing this bill today.

Mr. Speaker, of particular importance to me and the constituents I represent is that this bill contains the Greenwood-Israel-Fossella amendment, which ends the economic discrimination in federal reimbursement formulas to suburban Medicare HMOs that have forced 85,000 of my constituents out of their prescription drug plans.

Those seniors are watching us today. They are tired of blame, tired of gridlock, tired of excuses. They don’t care whether it’s a Democratic or Republican solution, as long as it’s a good solution.

This is not a perfect solution. But it is a good start. It is the largest expansion of Medicare in its 38-year history. It ends the price discrimination on Long Island and other suburbs around the nation.

Mr. Speaker, let me close by repeating this: $400 billion is only half as good as $800 billion . . . but it is $400 billion better than nothing. And nothing is exactly what we will leave our seniors if we reject this proposal today. In the spirit of advancing the process, I will support this bill. I reserve the right, however, to vote against a bill that emerges from Congress that does not address the significant flaws in the legislation before us tonight.

But I want to make this clear. This Republican Medicare bill falls well short of what our country’s retirees deserve. And I believe, that if this Congress and this President had not squandered the budget surplus we could afford to give our seniors a benefit they deserve.

It is well past time to assist our seniors with prescription drug costs. The Democratic substitute provides a reliable and affordable benefit to America’s seniors. This voluntary prescription drug coverage costs only $25 a month with a $100 deductible and provides a $2000 stop-loss protection with no gaps in coverage. There are also special provisions to help the poorest seniors with either full payment or assistance on a sliding fee scale.

The Democratic substitute I support also allows the Secretary of Health and Human Services to negotiate the drug prices of the 40 million Medicare beneficiaries to negotiate lower drug prices. And as the ranking member on the Veterans’ Affairs Committee, I was proud to help craft a similar plan which has helped our nation’s veterans lower their out of pocket drug costs.

As a member representing a rural district, I also want to highlight the rural health care provisions included in the Democratic substitute. These provisions are essential to create equity in the reimbursement system between urban and rural hospital. They allow fair payments to hospitals that have a disproportionate share of low-income patients, increases payments to rural home health providers without requiring a co-pay, and adjusts low-volume payments for small hospitals. It also takes into account the physician shortage in rural areas by finally correcting the huge disparity between urban rural hospitals, that drives providers from our small towns.

All of these reasons make the Democratic alternative to H.R. 1 the right answer to the spiraling costs for prescription drugs for seniors. Medicare works for America’s seniors but, I oppose the GOP’s efforts to privatize this system and provide a second-rate prescription drug benefit. I proudly support the Democratic substitute and I urge my colleagues to vote down H.R. 1 and vote Yes on the substitute.

Mr. CUMMINGS. Mr. Speaker, I rise today to speak against the inadequate Medicare prescription drug bill being considered today, H.R. 2473 and in support of the Rangel/Dingell Substitute.

With over 40 million elderly and disabled persons covered under the 38-year-old Medicare entitlement, Congress’ chief objective should be to ensure that these Americans have access to quality health care coverage. However, today we consider legislation that will do more harm than good because it is the first step in privatizing the Medicare program and as former Speaker Gingrich predicted, causing it to “wither on the vine.” Passage of this legislation will cause many of our seniors to wither right along with the Medicare program—which will no longer be seen as the social compact with our seniors that this nation embraces.

Medicare is the nation’s second largest social insurance program. As an entitlement program, it is imperative to realize that with the implementation of H.R. 2473, fee-for-service Medicare payments would naturally increase. This will result in many seniors facing the horrid prospect of being unable to afford the increased payments. I think many of my colleagues would agree that this is a very troubling proposition and a totally unnecessary result.

Additionally, with the re-establishment of the Voluntary Prescription Drug Benefit Program, seniors again would lose because of the lack of negotiated prices for the prescription drugs. Also, although federal subsidies would be provided to encourage participation, the bill would increase the annual out-of-pocket threshold for many beneficiaries. Once again a pseudo-solution to a prescription drug benefit while increasing the cost for persons who need the benefit but will not be able to afford its costs.

Furthermore, the use of health maintenance organizations (HMOs) and other private organizations to obtain prescription drugs would deter many seniors from getting the benefit. As Rep. Charles B. Rangel, Ranking Democrat on the Committee on Ways and Means stated, “to get prescription drug coverage, seniors would have to go to an HMO by another name. Then, all the choices would belong to the private insurance provider—which drugs are covered, which pharmacies you can choose, who your doctor is, etc.” Mr. Speaker, this bill is an empty pipette—it is a paltry solution to the problem of providing adequate prescription drug coverage to our seniors; rather, it is creating an inadequate system—based on a provider concept that does not currently exist and will not likely work in practice.

A better alternative to H.R. 2473 is The Medicare RX Drug Benefit an Discount Act (H.R. 1199) offered by my friend Charlie Rangel of New York. This prescription drug plan would guarantee that every Medicare beneficiary, no matter where they live, could have a benefit with a $25 monthly premium, a $2000 out-of-pocket limit, 100 percent co-insurance and $2000 out-of-pocket limit. The bill would also:

Lower prescription drug cost for all Americans, regardless of whether they are covered by Medicare;

Give all Medicare beneficiaries the option of a reasonably priced guaranteed prescription benefit under Medicare;

Ensure that senior citizens and people with disabilities receive coverage for the drug that their doctor prescribes; and

Provide additional assistance for low-income beneficiaries such that many seniors would pay nothing for their prescription drugs.

Unlike the proposal put forth by the Bush Administration and endorsed and worsened by the House GOP Leadership, H.R. 1199 would not require seniors to join an HMO or similar private plan in order to get a prescription drug benefit. In fact, Medicare beneficiaries would be guaranteed a prescription drug benefit rather than offered a marginal, voluntary plan under H.R. 2473. This plan would ensure that we keep our social compact with our seniors. The Republican plan fails to do that.
Care, not destroy it by making extravagant promises that we cannot keep.

We should address the reasons why drug prices and healthcare costs are so high. By banning re-imported drugs, we're forcing Americans to subsidize far-lower drug prices in other countries. We should change our policies so Americans only pay the lower world price, not a higher price.

We should end the 130,000 pages of federal regulations that have driven the costs of medicine and healthcare through the roof. On average, for every hour they spend with a patient, doctors and nurses spend another half-hour to a full hour doing government paperwork.

We should stress personal responsibility in healthcare, just as we did in welfare reform, so government resources are focused on those who cannot care for themselves, not on those who can.

Bit-by-bit, Congress is undoing the principles of welfare reform, and undercutting basic American principles in the process. Both political parties are making extravagant promises today, trying to outbid each other to win votes. Unfortunately, they are bidding with taxpayers' own money, and our children's hopes will be crushed by the bills they inherit.

Mr. PORTMAN. Mr. Speaker, I rise to speak in suppur of provisions in H.R. 1. The Medicare Prescription Drug and Modernization Act, that are designed to address the special pharmacy needs of beneficiaries residing in nursing homes.

Nursing home residents are not in a position to fill prescriptions like everyone else. They cannot simply walk into a pharmacy and have their prescription filled. Many nursing home residents, because of their physical or mental condition, are not able to take their prescription drugs on their own, especially if they have to take multiple medications throughout the day. Their unique circumstances require specialized pharmacy care that retail and mail order pharmacies do not provide. Long-term care pharmacies meet these special needs. They contract with nursing homes to provide specialized packaging, 24-hour delivery, infusion therapy services, geriatric-specific formulations, clinical consultation and other services that are critical to a nursing home.

Importantly, long-term pharmacies play a critical role in preventing medication errors that add to the cost of care and suffering of Medicare patients. In fact, one study estimates $3.6 billion in medication errors have been avoided. Unfortunately, all too often these pharmacies are shortchanged.

Mr. BASS. Mr. Speaker, as a member of the Energy and Commerce Committee, I am extremely pleased to have had the opportunity to develop a strong Medicare modernization package that will significantly improve this critical program.

The seniors of New Hampshire have long clamored for a prescription drug benefit under Medicare, and it is the case in the rest of the nation. I am pleased to represent those same seniors today as we pass this bill and take one step closer toward our goal of creating a new and voluntary prescription drug benefit that makes lifesaving medications more accessible.

This benefit is the product of years of research, study, testimony, and compromise. I have no doubt whatsoever that each of us might wish for a slightly different version of this bill. We represent different regions with different demographics.

And, I am sure we all wish lifesaving drugs were more affordable for our families, friends, and constituents. This bill makes a fiscally responsible plan that will remain solvent in years to come, is easily accessible, and increasingly beneficial to seniors of all ages and means, was a daunting one.

Yet, the bill makes a number of Medicare improvements for care providers in New Hampshire. This proposal represents one of the most generous rural packages ever contemplated by the House. Notably, after several years of efforts on the part of the rural medical community, uniform standards for Medicare reimbursements will be established for rural and small urban facilities.

Beginning October 1, Medicare reimbursements to rural areas would finally mirror those for large urban ones. Having lamented for a
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number of years over the inequity of this provi-
sion within the Medicare reimbursement sys-
tem, I am particularly pleased that this is being
addressed in the bill. A drug benefit for seniors and a rejuvena-
tion of the Medicare system are essential to
seniors and their caregivers. The delivery of
Medicare has changed enormously since this
program was first conceived, and the pro-
gram ought to be modernized to reflect the in-
creases in medical technology and the utiliza-
tion of a wide range of care options.

As I have noted many times, no plan can be
as all-encompassing and immediately satis-
fying as what we might prefer. However, this bill
puts the framework in place for a system that
can be adjusted and improved upon over time and
will directly and immediately help the popu-
lation most in need.

I applaud all Members of the Energy and
Commerce Committee and the Members of
the Ways and Means Committee for the joint
work on this essential legislation. It is my hope
that upon completion of our floor vote today,
we will see this measure moved forward im-
mediately toward conference with the Senate.

Mr. KOLLENBERG. Mr. Speaker, today we have an opportunity to provide our seniors
with a new prescription drug benefit and im-
proved access to health care. It is a long over-
due step in updating and improving Medicare.
Today, we will provide help for those who need it most. Our 6.5 million low-
income seniors will receive a fully covered
premium and a cost sharing benefit when their
drug benefit switches from Medicaid to Medi-
care, paying no more than $2 per generic pre-
scription and no more than $5 for name brand
drugs. This will also save states about $6.8
billion a year in Medicaid costs.

It is imperative that Medicare advance with
technology. Prescription drugs are an increas-
ingly important part of modern medicine, help-
ing to relieve pain, cure disease, and enhance
the lives of millions of Americans. Adding a
drug benefit and updating how existing bene-
fits are provided will be a very significant ac-
complishment.

Mr. Speaker, I encourage my colleagues to
vote for this plan that helps our seniors
by providing a prescription drug benefit that they
deserve.

Mr. MOORE. Mr. Speaker, I rise today to
express my opposition to this legislation and
my support for the Blue Dog substitute, of-
fered by Rep. THOMPSON, which we have not
been allowed to debate on the House floor
today, despite support on both sides of the
Capitol.

We in Congress have been talking for years
now about the necessity of adding a prescrip-
tion drug coverage to Medicare. We know, as
seniors know, that this talk has been cheap
and it is imperative that a compromise be
reached this year. The Senate has been pro-
ceeding in a bipartisan way toward a com-
promise that adds a substantial, but not per-
fect, benefit to Medicare and protects the long-
term integrity of the social insurance program.
Instead of following the Senate’s lead and
working toward a compromise that will im-
prove Medicare, a wildly popular and success-
ful program, the House Republican leadership
has chosen instead of add provisions to this
legislation that attacks the foundation of the
Medicare program. The bill does not include a
federal fallback if private plans choose not to
offer a benefit. The experience that my con-
stituents have had with Medicare-Choice show
that private health care plans are at best
an unstable partner for Medicare, and financial
analysts have consistently publicly questioned
whether “drug only” plans will ever be offered.
For these reasons, it is absolutely vital that
Medicare provide a viable and guaranteed fall-
back for Medicare beneficiaries.

Additionally, H.R. 1 would transform Medi-
care, beginning in 2010, from a defined-benefit
program to a defined-contribution program.
This provision would gradually shift enormous
costs on to seniors when they are sick and in
most need of care, and destroy the fabric of
this program that has served seniors well for
nearly 50 years.

The Senate has crafted legislation that has
broad support among Senators across the ide-
ological spectrum. This legislation has won the
support of both President Bush and Senator TED KENNEDY. Together with Representative
THOMPSON and the Blue Dog Caucus, I am
supporting legislation that uses the framework of the Senate compromise and improves on it,
making it a much stronger bill. The Thompson
plan includes a Medicare fall-back plan for all individuals eligible for Medicare and Medicaid. Finally, the Blue Dog substitute includes language that will
reduce the high cost of prescription drugs by
allowing Americans to reimport drugs from
Canada and speeding approval of generic
drugs.

The House bill falls short on several other
fronts as well. It ignores the needs of commu-
nity and teaching hospitals, meaning that hos-
pitals in my district stand to lose over $11 mil-
lion in denied inflation updates. Kansas teach-
hospitals, like KU Med, would additionally
lose out to the tune of $3.9 million in 2003 and
$21 million over five years due to the Federal
Government’s failure to help pay for the ex-
cess costs of medical education. The Thomp-
son substitute provides an adequate inflation
update for all hospitals. Finally, H.R. 1 would
cut $16 billion over 10 years from oncology
services. Cancer patients all over the country
will have to pay for provisions in this bill that
sharply cut funding for cancer-fighting drugs
and allow Medicare to continue to underpay
for costs associated with providing chemo-
therapy services.

I cannot support the Democratic substitute
because I believe that it is simply too expen-
sive. The cost estimate issued by the_matched
tax cut out because I believe that it is irresponsible for
Congress to run up bills for our children to
pay, and the Democratic substitute, although
a much more robust benefit for our seniors, is
simply more than our country can afford at this
time. The Senate bill and the Blue Dog sub-
stitute both have to the budget agreed to by
the House and Senate. Neither bill is perfect,
but I believe that the Thompson substitute
builds a strong foundation for a prescription
drug benefit on which we can build in future
years.

Mr. CAPUANO. Mr. Speaker, today we have
the opportunity to provide our seniors with a
real prescription drug benefit, but instead of
giving seniors the plan they deserve, we are
taking steps to dismantle a program that older
Americans have known and trusted for 38
years.

The Republican plan before us today fails to
offer the types of guarantees that our seniors
need and deserve. There is no defined benefit
and no standard premium. So when my sen-
iors ask now much their premiums will be or
how much their drugs will cost, I cannot an-
swer them. This is unacceptable.

This bill allows private insurance companies
to decide premiums, preclude prescription cov-
erage benefits and even where coverage will be
offered. This proposal threatens to dis-
mantle Medicare and replace it with private
health insurance coverage for all seniors. This
is precisely the problem many seniors face—
they cannot afford private insurance, and de-
pend on Medicare.

This bill also provides additional funding for
rural hospitals, but not urban teaching hos-
pitals. This is a serious oversight. Urban
teaching hospitals are facing incredible budget
deficits and play a crucial role in training
tomorrow’s physicians, and their needs must
also be addressed. If the Federal Government
is going to offer additional funding to some
hospitals, it must offer additional funding to
urban teaching hospitals.

The Federal Government has a responsi-
bility to ensure that Americans who contribute
to the Medicare program during their working
years will have access to dependable, equi-
table, and affordable health coverage. The
Democratic substitute just that—it lowers
drug prices, guarantees coverage and enables
seniors to get their medicines at the pharmacy
of their choice. The Rangel/Dingell substitute
addresses my concerns more effectively and I
will strongly support it.

Mr. LEACH. Mr. Speaker, seldom has there
been a more important bill for the State of
Iowa.

On the one hand, this legislation provides
for greater equity in Medicare reimbursement
which will bring millions of additional dollars
to the state and help maintain and attract
healthcare providers from rural counties.

In addition, the brunt of the bill is about pro-
viding voluntary prescription drug coverage
to Medicare eligible individuals. There is a con-
servative critique that the program is far too
expensive, and a liberal critique that it is not
genorous enough. Both philosophical perspec-
tives have a degree of validity, but the big pic-
ture is that Congress is moving in a direction
of providing health security for millions of citi-
zens. Low income individuals will, for the most
part, be provided full comprehensive prescrip-
tion drug coverage. Higher income citizens on
a sliding scale will be provided partial cov-
verage and all citizens will be provided cov-
verage for catastrophic expenses.

There will be a cost to society in providing
these benefits but the benefits far outweigh
the costs. There may be better approaches
that can be envisioned now or developed
later, but this is the only framework approach
that has a chance of receiving majority sup-
port. The Democrats wisely opted for a roman-
tic approach. It may not be enough and it may be too
deferred in implementation but it nevertheless
marks an important first step to meeting the
most challenging need of many senior citi-
zens.

Ms. DeGETTE. Mr. Speaker, I want to high-
light a piece of the Dingell/Rangel substitute
that pertains to Disproportionate Share Hos-
itals.
This was an amendment I offered in the Energy & Commerce Committee and I understand that since our mark-up the DSH allocation has been increased and I want to commend this action. I know there is real bipartisan support on this issue and I want to just reiterate how important it is that we get funding to our DSH hospitals.

The provision in the substitute would give DSH hospitals a large portion of the funding that has been cut in the past year. It would expend a billion dollars in FY '03 and then adjust payments in future years to ensure that our vital DSH hospitals do not go bankrupt.

The reason it is so important that this money is available next year is that our DSH hospitals have already suffered a cut of a billion dollars in the past year and now are in such bad shape financially, if we help them in dribs and drabs then many of them won't be around ten years from now.

There are public hospitals who are currently planning to make cuts of 25 percent next year in order to try to stay afloat.

Mr. Speaker, our public hospitals cannot afford the cuts that are in real danger of losing numerous DSH hospitals over the next few years if we do not assist them right now.

This provision also helps the low-DSH hospitals which are the most strapped of all. Eighteen states have low DSH hospitals due to historic and current conditions that were basically frozen in place at a certain point.

These low-DSH states have been struggling for years with their Medicaid payments and they are currently held to only 1 percent of their Medicaid expenditures. My amendment, which accomplishes the same thing that a bill Rep. HEATHER WILSON introduced, would raise this to 3 percent which would help these states considerably.

While low-DSH states have been dealing with this situation for years, recently it has gotten much worse. The pressure on these hospitals has increased due to numerous factors such as increasing numbers of the uninsured, increasing numbers of Medicaid patients, the extreme situation so many states are in in terms of budget crises.

The fact of the matter is that DSH hospitals need help and need help now. They can't wait and we need to rectify this situation while the DSH hospitals are still around to help our most vulnerable citizens.

Mr. DeLAURO. Mr. Speaker, in my 13 years in Congress, this House has sometimes risen to the occasion on matters of great national importance. My very first vote on the first Gulf War followed days of debate in which Members stated their heartfelt views on the prospect of war. After September 11th, we came together as a country and Republicans—in bind the nation's wounds and provide for the national security of the nation's victims of that terrorist act.

I wish I could say that this is one of those occasions—I wish I could say that, as we consider the very future of Medicare, we could rise above partisan politics and ideological viewpoint and do the right thing by our senior citizens. Medicare is one of the most important and successful government programs ever enacted, a program that has provided quality health care and a measure of economic security to millions of individuals over the past four decades. Together, Medicare and Social Security represent the twin pillars of a social safety net and constitute what is in effect a social contract between the generations—that if you work hard all your life you may look forward to a dignified retirement and economic security in your old age.

I understand that we bear the responsibility of meeting the newest challenges that face our seniors—of finding new ways to care for those poor individuals that Medicare need to be made. Central to that process is dealing with the cost of prescription drugs and helping seniors afford them.

Unfortunately, the legislation before the House this week fails on both counts. It does not deliver an acceptable or adequate pre-

scription drug benefit and it will not hold down the cost of drugs.

What it does do is open the door to privatization of Medicare—in other words, a return to the way things were before, when 1 out of every 3 seniors lived in poverty, largely due to the cost of medical expenses. Today, thanks to Medicare, that rate is closer to 1 in 10.

This bill sets in motion the privatization of Medicare by converting the program into a voucher system—essentially turning it over to the HMOs, the organizations that have dropped 52 percent of the Medicare enrollees in my state over the last four years.

And it does nothing to contain costs. It prohibits the Secretary of Health and Human Services from even engaging in negotiations with the pharmaceutical companies. As a result, many seniors will pay more than they do now and their premiums will rise as the cost of drugs rises.

But the most inexplicable aspect of this bill is the huge gap in coverage. Once a senior receives drug benefits totaling $2,000, he or she is cut off until her bills total $4,900, necessitating that they pay $2,900 out of her own pocket—at the same time that they pay premiums for this supposed drug benefit.

It makes no sense. Throughout my time in Congress, the single most common concern I have heard from seniors at the local Stop N' Shop every weekend is how expensive their prescription drug bills are. Seniors know they are being taken advantage of. They know they can get drugs cheaper in Canada and overseas.

And I assure you when they find out we are doing nothing to hold down the excessive profiteering of the pharmaceutical companies, they are going to be angry. When seniors find out that their coverage essentially stops during mid-month while they still have to pay premiums, they are not only going to be con-
fused, they are going to feel utterly betrayed.

Mr. Speaker, we must provide a meaningful drug plan with guaranteed, defined benefits—with no gaps and no doughnut holes. We should ensure that they do not destroy the Medicare system, where seniors will not be forced to shop around for a plan only to be unceremoniously dropped soon thereafter. Giving them a plan that seniors have come to rely on and feel safe with is what we should be doing. That is real economic security. Medicare—the same plan my 89-year-old mother relies on today.

This debate is as important and historic as any I have been a part of in this body. If we allow this bill to become law, we are essen-
thail people that Medicare need to be made. Central to that process is dealing with the cost of prescription drugs and helping seniors afford them.

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Mr. Speaker, we must provide a meaningful drug plan with guaranteed, defined benefits—with no gaps and no doughnut holes. We should ensure that they do not destroy the Medicare system, where seniors will not have to pay more than seniors in other countries for the same drug.

And perhaps most importantly we should honor our social contract with America's seniors by not privatizing Medicare and subjecting seniors to the uncertainties of the private health care market. We should not be penalizing seniors who live in rural communities, where pharmacies and private plans are scarce at best. We should be giving them a plan that is based on the Medicare sys-

tem, where seniors will not be forced to shop around for a plan only to be unceremoniously dropped soon thereafter. Giving them a plan that seniors have come to rely on and feel safe with is what we should be doing. That is real economic security. Medicare—the same plan my 89-year-old mother relies on today.

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"CONGRESSIONAL RECORD — HOUSE" June 26, 2003
Mr. ROGERS of Alabama. Mr. Speaker, one of the promises I made when I came to Washington was to improve the lives of East Alabama seniors. Unlike retirees in our country's metropolitan areas, the seniors of the Third District face far greater challenges.

For starters, most Third District seniors live in rural areas with few choices in health care providers. This undoubtedly means higher health costs and fewer choices when it comes to doctors, and higher out-of-pocket expenses for covering the same level of basic medical needs.

Part of the problem, Mr. Speaker, is Medicare does not fairly and adequately reimburse doctors for their services. This is not fair, especially when retirees just across the Georgia border have far better access to doctors who are reimbursed by Medicare at higher rates. Seniors should not be penalized just because they live in rural areas.

But assuming we fix the reimbursement problem, this still leaves Medicare as a program designed for the 1960s, yet providing care in 2003. That's why I'm pleased to be in the House today to offer my full support for adding a prescription drug benefit under Medicare.

Earlier this year, Speaker HASTERT appointed me to his Prescription Drug Action Team to help craft a prescription drug benefit for Medicare. I've taken this responsibility around the Third District to listen to seniors describe what they think this benefit should do, and how it should be designed.

First and foremost, we must reduce the costs of prescription drugs. Modern medicine relies on these life-saving drugs more than ever, and doctors shown no signs of slowing the expected growth in prescriptions. But with Alabama seniors now paying an average of $4000 per year in prescriptions, these costs are getting out of hand.

Consider seniors on fixed incomes, Mr. Speaker. These Alabamians, already strapped out of 5 seniors don't want the GOP proposal. According to a survey conducted by AARP: 4 do and exactly what seniors want. In fact, don't want. Let's tell the Republicans don't try to sell seniors something they don't want.

Mr. JANKLOW. Mr. Speaker, I would like to submit the following letter into the CONGRESSIONAL RECORD.


Hon. Dennis Hastert, Speaker, U.S. House of Representatives, Washington, D.C.

Dear Speaker HASTERT: We urge you to pass legislation as part of Medicare reform that will improve the Drug Price Competition and Patent Term Restoration Act, and the patent listing requirements under the Federal Food Drug, and Cosmetic Act (FFDCA).

States spend billions of dollars annually and provide prescription medicine to residents, state employees, and retirees. Tax payers are forced to pay hundreds of millions of dollars in excess costs for the medicine because of loopholes in the Hatch-Waxman Act that restrict timely access to lower-cost generics and biotechnicals. As a result, BAM members, including states, companies, and labor groups, support changes to the Hatch-Waxman Act that will provide greater pharmacetical competition and more timely access to generic.

Bipartisan legislation passed by the Senate last week will provide all purchasers with greater access to generics, and will produce hundreds of millions of dollars in savings for federal and state programs. We urge the House to adopt similar legislation as part of the effort by Congress to add a prescription drug benefit to Medicare, and urge you to resist changes or amendments that would weaken the most important cost-savings provisions in the Senate bill.

Specifically, BAM supports the proposed limit of one 30-month stay against FDA approval of generic products, as well as provisions to limit the use of late-listed patents—those filed after generic applications are submitted—to obtain additional stays. Litigation under the Hatch-Waxman Act is increasing, and whenever in this country, if there's a patent, the patent will be listed after the filing of generic applications, resulting in the need for legislation to restrict the use of 30-month stays to only those patents listed in the Orange Book prior to the filing of related generic applications. We also support changes to provisions in the act that allow drug manufacturers to intentionally delay the listing of certain drug patents until the end of any 30-month stay.

In addition we are concerned that consumers, taxpayers, and institutional purchasers have no standing under current law to challenge abusive listing. As a result, all purchasers have been forced at times to pay millions of dollars more than necessary for products that should have faced more timely competition from generics. We support efforts to ensure generic manufacturers will be provided with the most effective avenues possible for relief from unlawful listing.

BAM is committed to working with all members of Congress to restore balance to the Hatch-Waxman Act and improve pharmaceutical competition. We look forward to assisting your efforts.

Sincerely,

GOVERNOR BOB WISE, West Virginia.
GOVERNOR BRAD HENRY, Oklahoma.
GOVERNOR DON BROWN, Missouri.
GOVERNOR RONNIE MUSGROVE, Mississippi.
GOVERNOR THOMAS VILSACK, Iowa.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. RANGEL:

MR. RANGEL. Mr. Chairman, I offer an amendment in the nature of a substitute

The SPEAKER pro tempore. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the nature of a substitute is as follows:

Amendment in the nature of a substitute offered by Mr. Rangel;

MR. RANGEL. I offer an amendment in the nature of a substitute.

This is hardly a perfect bill, but it is a good bill. The legislation helps Alabama's seniors receive better health care under Medicare and provides immediate relief from high prescription drug costs. President Bush supports it, and is ready to sign this bill should the House and Senate pass it.

Mr. Speaker, I'm proud to be in this House today and have the chance to improve the lives of Alabama's seniors. I will continue to work with my colleagues on both sides of the aisle, as well as those in the Senate, to help pass this important legislation now, and send it to the White House for President Bush to sign into law.

Mr. TAUZIN. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore. (Mr. HASTINGS of Washington). All time for general debate has expired.

GENERAL LEAVE

Mr. TAUZIN. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 1.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

AMENDMENT IN THE NATURE OF A SUBSTITUTE OFFERED BY MR. RANGEL:

Mr. RANGEL. Mr. Chairman, I offer an amendment in the nature of a substitute.

The SPEAKER pro tempore. The Clerk will designate the amendment in the nature of a substitute.

The text of the amendment in the nature of a substitute is as follows:

Section 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

(a) Short Title.—This Act may be cited as the "Medicare Prescription Drug and Modernization Act of 2003".

(b) Amendments to Social Security Act.—Except as otherwise specifically provided, any amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.

(c) BIPA; Secretary.—In this Act:

(1) BIPA.—The term "BIPA" means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 111(a)(6) of Public Law 106–554.

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

(d) Table of Contents.—The table of contents of this Act is as follows:

Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

Title I—Medicare Prescription Drug Benefit

Sec. 101. Voluntary Medicare outpatient prescription drug program.
"Sec. 1859A. Negotiating fair price with pharmaceutical manufacturers.
"Sec. 1859B. Contract authority.
"Sec. 1859C. Eligibility; voluntary enrollment.
"Sec. 1859D. Provision of, and entitlement to, benefits.
"Sec. 1859E. Administration; quality assurance.
"Sec. 1859F. Federal Medicare Prescription Medicine Trust Fund.
"Sec. 1859G. Compensation for employers covering retiree medical costs.
"Sec. 1859H. Medicare Prescription Medicine Advisory Committee.
Sec. 102. Provision of medicare outpatient prescription medicine coverage under the Medicare+Choice program.
Sec. 103. Medigap revisions.
Sec. 104. Transitional assistance for low income beneficiaries.
Sec. 105. Expansion of membership and duties of Medicare Payment Advisory Commission (MedPAC).
Sec. 106. State Pharmaceutical Assistance Transition Commission.

TITLE II—MEDICARE+CHOICE

Sec. 201. Medicare+Choice improvements.
Sec. 202. Making permanent change in Medicare+Choice reporting deadlines and annual, coordinated election period.
Sec. 203. Specialized Medicare+Choice plans for special needs beneficiaries.
Sec. 204. Medicare MSAs.
Sec. 205. Extension of reasonable cost contracts.
Sec. 206. Extension of municipal health service demonstration projects.

TITLE III—COMBATTING WASTE, FRAUD, AND ABUSE

Sec. 301. Medicare secondary payor (MSP) provisions.
Sec. 302. Competitive acquisition of certain items and services.
Sec. 303. Reform of payment for drugs and biologicals under the medicare program.
Sec. 304. Demonstration project for use of recovery audit contractors.

TITLE IV—RURAL HEALTH CARE IMPROVEMENTS

Sec. 401. Fairness in the medicare disproportionate share hospital (DSH) agreement for rural hospitals.
Sec. 402. Immediate establishment of uniform standardized amount in rural and small urban areas.
Sec. 403. Establishment of essential rural hospital classification.
Sec. 404. More frequent update in weights used in hospital market basket.
Sec. 405. Improvements to critical access hospital program.
Sec. 406. Redistribution of unused resident positions.
Sec. 407. Two-year extension of hold harmless provisions for small rural hospitals and sole community hospitals; coverage under prospective payment system for hospital outpatient department services.
Sec. 408. Exclusion of certain rural health clinic and federally qualified health center services from the prospective payment system for hospital outpatient facilities.
Sec. 409. Recognition of attending nurse practitioners as attending physicians to serve hospice patients.
Sec. 410. Improvement in payments to retain emergency capacity for ambulance services in rural areas.
Sec. 411. Two-year increase for home health services furnished in a rural area.
Sec. 412. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
Sec. 413. GAO study of geographic differences in payments for physicians' services.
Sec. 414. Treatment of missing cost reporting periods for sole community hospitals.
Sec. 415. Extension of telemedicine demonstration project.
Sec. 416. Adjustment to the medicare inpatient hospital PPS wage index to revise the labor-related share component.
Sec. 417. Medicare incentive payment program improvements for physician scarcity.
Sec. 418. Medicare inpatient hospital payment adjustment for low-volume hospitals.
Sec. 419. Treatment of certain clinical diagnostic laboratory tests furnished by a sole community hospital.
Sec. 420. Establishment of floor on geographic adjustments of payments for physicians' services.
Sec. 421. Ambulance payment rates.

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services
Sec. 501. Adjustment for indirect costs of medical education (IME).
Sec. 502. Recognition of new medical technologies under inpatient hospital pps.
Sec. 503. Increase in Federal rate for hospitals in Puerto Rico.
Sec. 504. Wage index adjustment reclassification reform.
Sec. 505. Clarifications to certain exceptions to medicare limits on physician payments.

Subtitle B—Other Provisions
Sec. 506. Payment for covered skilled nursing facility services.
Sec. 512. Coverage of hospice consultation services.

TITLE VI—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services
Sec. 601. Revision of updates for physicians' services.
Sec. 602. Studies on access to physicians' services.
Sec. 603. MedPAC report on payment for physicians' services.

Subtitle B—Preventive Services
Sec. 611. Coverage of an initial preventive physical examination.
Sec. 612. Coverage of cholesterol and lipid screening.
Sec. 613. Waiver of deductible for colorectal cancer screening tests.
Sec. 614. Improved payment for certain mammography services.

Subtitle C—Other Services
Sec. 621. Hospital outpatient department (HOPD) payment reform.
Sec. 622. Payment for ambulance services.
Sec. 623. Renal dialysis services.
Sec. 624. One-year moratorium on therapy caps; provisions relating to reextension.
Sec. 625. Adjustment to payments for services furnished in ambulatory surgical centers.
Sec. 626. Payment for certain shoes and inserts under the fee schedule for orthotics and prosthetics.
Sec. 627. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
Sec. 628. Extension of coverage of intravenous immune globulin (IVIG) for the treatment of primary immune deficiency diseases in the home.
Sec. 629. Medicare coverage of diabetes laboratory diagnostic tests.

TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services
Sec. 701. Update in home health services.
Sec. 702. MedPAC study on medicare margins of home health agencies.
Sec. 703. Demonstration project to clarify the definition of homebound.

Subtitle B—Chronic Care Improvement
Sec. 721. Voluntary chronic care improvement under traditional fee-for-service.
Sec. 722. Chronic care improvement under Medicare+Choice plans.
Sec. 723. Institute of Medicine report.
Sec. 724. MedPAC report.

Subtitle C—Other Provisions
Sec. 732. Demonstration project for medical adult day care services.
Sec. 733. Improvements in national and local coverage determination process to respond to changes in technology.
Sec. 734. Treatment of certain physician pathology services.
Sec. 735. Medicare pancreatic islet cell transplant demonstration project.

TITLE VIII—MEDICAID

Sec. 801. Continuation of medicare DSH allotment adjustments under BIPA 2000.
Sec. 802. Increase in floor for treatment as an extremely low DSH State to 3 percent in fiscal year 2003.
Sec. 803. Clarification of inclusion of inpatient drug prices charged to certain public hospitals in the best price exemptions for the medicare drug rebate program.

TITLE IX—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform
Sec. 901. Construction; definition of supplier.
Sec. 902. Issuance of regulations.
Sec. 903. Compliance with changes in regulations and policies.
Sec. 904. Reports and studies relating to regulatory reform.

Subtitle B—Contracting Reform
Sec. 911. Increased flexibility in medicare administration.
Sec. 912. Requirements for information security for medicare administrative contractors.

Subtitle C—Education and Outreach
Sec. 921. Provider education and technical assistance.
Sec. 922. Small provider technical assistance demonstration program.
Sec. 923. Medicare provider ombudsman; medicare beneficiary ombudsman.

Sec. 924. Beneficiary outreach demonstration program.
Sec. 925. Inclusion of additional information in notices to beneficiaries about skilled nursing facility benefits.
Sec. 926. Information on medicare-certified skilled nursing facilities in hospital discharge plans.

Subtitle D—Appeals and Recovery
Sec. 931. Transfer of responsibility for medicare appeals.
Sec. 932. Process for expedited access to review.

Sec. 933. Revisions to Medicare appeals process.

Sec. 934. Prepayment review.

Sec. 935. Recovery of overpayments.

Sec. 936. Provider enrollment process; right of appeal.

Sec. 937. Process for correction of minor errors and omissions without pursuing appeals process.

Sec. 938. Prior determination process for certain items and services; advance beneficiary notices.

Subtitle V—Miscellaneous Provisions

Sec. 941. Policy development regarding evaluation and management (E & M) documentation guidelines.

Sec. 942. Improvement in oversight of technology and coverage.

Sec. 943. Treatment of hospitals for certain services under Medicare secondary payor (MSP) provisions.

Sec. 944. EMTALA improvements.

Sec. 945. Emergency medical treatment and active labor act (EMTALA) technical advisory group.

Sec. 946. Authorizing use of arrangements to provide core hospice services in certain circumstances.

Sec. 947. Application of OSHA bloodborne pathogens standard to certain hospitals.

Sec. 948. BIPA-related technical amendments and corrections.

Sec. 949. Conforming authority to waive a requirement to reassign provisions.

Sec. 950. Treatment of certain dental pathogens standard to certain hospitals.

Sec. 951. Furnishing hospitals with information to compute dish formula.

Sec. 952. Revisions to reassignment provisions.

Sec. 953. Other provisions.

TITLE XI—ACCESS TO AFFORDABLE PHARMACEUTICALS

Sec. 1001. Importation of prescription drugs.

TITLE XII—ACCESS TO AFFORDABLE PHARMACEUTICALS

Sec. 101. CSRB.

Sec. 1011. Short title.

Sec. 110. 30-month stay-of-effectiveness period.

Sec. 1101. Forfeiture of 180-day exclusivity period.

Sec. 1102. Bioavailability and bioequivalence.

Sec. 1103. Refinery for coordination guidelines.

Sec. 1104. Conforming amendments.

TITLE I—MEDICARE PRESCRIPTION MEDICINE BENEFIT

SEC. 101. VOLUNTARY MEDICARE OUTPATIENT PRESCRIPTION MEDICINE PROGRAM.

(a) In General.—Title XVIII (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating section 1859 and part D as section 1858 and part E, respectively; and

(2) by inserting after part C the following new part:

"PART D—VOLUNTARY PRESCRIPTION MEDICINE BENEFIT FOR THE AGED AND DISABLED"

"MEDICARE OUTPATIENT PRESCRIPTION MEDICINE BENEFIT"

"SEC. 1859A. (a) AUTHORITY TO NEGOTIATE PRICES WITH MANUFACTURERS.—The Secretary shall, consistent with the requirements of this part and the goals of providing quality care and containing costs under this part, negotiate contracts with manufacturers of covered outpatient prescription medicines that provide for the maximum prices that may be charged to individuals enrolled under this part by participating pharmacies for dispensing such medicines to such individuals.

"(b) PROMOTION OF BREAKTHROUGH MEDICINES.—In conducting negotiations with manufacturers under this part, the Secretary shall take into account the goal of promoting the development of breakthrough medicines as defined in section 1859M(b)."

"CONTRACT AUTHORITY"

"SEC. 1859B. (a) CONTRACT AUTHORITY.—

"(1) IN GENERAL.—The Secretary is responsible for the administration of this part and shall enter into contracts with appropriate pharmacy contractors on a national or regional basis to administer the benefits under this part.

"(2) PROCEDURES.—The Secretary shall establish procedures under which the Secretary—

"(A) accepts bids submitted by entities to serve as pharmacy contractors under this part in a region or on a national basis;

"(B) awards contracts to such contractors to administer benefits under this part to eligible beneficiaries in the region or on a national basis; and

"(C) provides for the termination (and non-renewal) of a contract in the case of a contractor's failure to meet the performance requirements of the contract and this part.

"(3) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 445 of the Office of Government Ethics and Conflict of Interest Policy Act (41 U.S.C. 403(5))) shall be used to enter into contracts under this part.

"(4) TERMS AND CONDITIONS.—Such contracts shall have terms and conditions as the Secretary shall specify and shall be for such terms (of at least 2 years, but not to exceed 5 years) as the Secretary shall specify and shall be consistent with the requirements described in subparagraph (A).

"(5) PROMOTION OF BREAKTHROUGH MEDICINES.—Such contracts shall require the contractor to meet certain requirements that provide for maximum prices for covered outpatient prescription medicines that are lower than the maximum prices negotiated under section 1859A(a), if applicable. The price reductions shall be based on eligible beneficiaries and the Secretary shall hold the contractor accountable for meeting performance requirements with respect to price reductions and limited price increases.

"(6) AREA FOR CONTRACTS.—

"(A) REGIONAL BASIS.—

"(i) IN GENERAL.—Except as provided in clause (ii) and subject to subparagraph (B), the contract entered into between the Secretary and a pharmacy contractor shall require the contractor to administer the benefits under this part in a region determined by the Secretary under subparagraph (B) or on a national basis.

"(ii) PARTIAL REGION.—

"(I) IN GENERAL.—If determined appropriate by the Secretary, the Secretary may permit the benefits to be administered in a partial region determined appropriate by the Secretary.

"(III) REQUIREMENTS.—If the Secretary permits administration pursuant to subparagraph (I), the partial region in which administration is effected is no smaller than a state and is at least the size of the commercial service area of the contractor for that area.

"(B) DETERMINATION.—

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

"(I) take into account the number of individuals enrolled under this part in an area in order to encourage participation by pharmacy contractors; and

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

"(II) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of administrative areas under this paragraph shall not be subject to administrative or judicial review.

"(7) SUBMISSION OF BIDS.—

"(A) DETERMINATION.—

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

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

"(B) REQUIRED INFORMATION.—The bids described in subparagraph (A) shall:—

"(i) a proposal for the estimated prices of covered outpatient prescription medicines and the projected annual increases in such prices, including the additional reduction in price negotiated below the Secretary's maximum price and differentials between preferred and nonpreferred prices, if applicable;

"(ii) a statement regarding the amount that the entity will charge the Secretary for administering the benefits under the contract;

"(iii) a statement regarding whether the entity will reduce the applicable coinsurance percentage pursuant to section 1859A(a)(1)(A)(ii) and if so, the amount of such reduction and how such reduction is tied to performance requirements described in subsection (c)(4)(A)(ii); and

"(iv) a detailed description of the performance requirements for which the administrative fee of the entity will be subject to risk pursuant to subsection (c)(3); and

"(v) a detailed description of access to pharmacy services provided by the entity, including information regarding whether the pharmacy contractor is part of the pharmacy network, and, if so, how the pharmacy contractor will ensure access to pharmacies that choose to be outside of that network, and whether there will be increased cost-sharing for beneficiaries if they obtain medicines at such pharmacies;

"(vi) a detailed description of the procedures and standards the entity will use for—

"(I) selecting preferred prescription medicines; and

"(II) determining when and how often the list of preferred prescription medicines should be modified;

"(vii) a detailed description of any owner or shared financial interests with pharmaceutical manufacturers, pharmacies, and other entities involved in the administration or delivery of benefits under this part as proposed in the bid; and

"(viii) a detailed description of the entity's estimated marketing and advertising expenditures related to enrollment of administering eligible beneficiaries; and

"(IX) such other information that the Secretary determines is necessary in order to carry out this part, including information relating to the bidding process under this part.
The procedures under clause (vi) shall include the use of a pharmaceutical and therapeutics committee or the membership of which includes practicing pharmacists.

(A) NUMBER OF CONTRACTS.—The Secretary shall, consistent with the requirements of this part and the goals of providing quality and cost-effective pharmacy services in both urban and rural areas in a year is provided the benefits under this part throughout the entire year.

(B) QUALITY, FINANCIAL, AND OTHER STANDARDS AND PROGRAMS.—In consultation with appropriate pharmacy contractors, the Secretary shall establish standards and conforming programs of this part to ensure appropriate prescribing, dispensing, and utilization of outpatient medicines under this part, to avoid adverse drug reactions, and to reduce errors in the delivery of medically appropriate covered benefits. The Secretary shall not award a contract to a pharmacy contractor unless the Secretary finds that the contractor agrees to comply with such standards and programs and other terms and conditions as the Secretary shall specify. The standards and programs under this subsection shall be applied to any administration agreement described in subsection (a) the Secretary enters into. Such standards and programs shall include the following:

(I) ACCESS.

(A) IN GENERAL.—The pharmacy contractor shall ensure that covered outpatient prescription medicines are accessible and convenient to eligible beneficiaries enrolled under this part. Yardsticks and measures are administered by the pharmacy contractor, including by offering the services 24 hours a day and 7 days a week for emergencies.

(B) On-line review.—The pharmacy contractor shall provide for on-line prospective review available 24 hours a day and 7 days a week in order to evaluate each prescription for medicine therapy problems due to duplication, interaction, or incorrect dosage or duration of therapy.

(C) Guaranteed access to medicines in rural and hard-to-serve areas.—The Secretary shall ensure that all beneficiaries have guaranteed access to the full range of pharmaceuticals under this part, and shall give special attention to access, pharmacist counseling, and delivery in rural and hard-to-serve areas, including through the use of incentives such as bonus payments to retain pharmacy contractors under this part.

(D) Price data.—

(i) IN GENERAL.—If a pharmacy contractor uses a preferred pharmacy network to deliver benefits under this part, such network shall meet the standards established by the Secretary.

(ii) Standards.—In establishing standards under clause (i), the Secretary shall take into account variations in pharmacy services in both urban and rural areas.

(E) Adherence to negotiated prices.—The pharmacy contractor must have in place procedures to assure compliance of pharmacies with the requirements of subsection (d)(3)(C) (relating to adherence to negotiated prices).

(F) Continuity of care.—

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

(ii) Limited period.—In no event shall a pharmacy contractor be required to provide the extended coverage required under clause (i) beyond the date which is 30 days after the contractor's notice to such beneficiary that such coverage would have terminated but for this subparagraph.

(2) Enrollee guidelines.—The pharmacy contractor shall, consistent with State law, enrollee guidelines for counseling enrollees regarding—

(A) the proper use of covered outpatient prescription medicines;

(B) interactions and contra-indications;

(3) Education.—The pharmacy contractor shall apply methods to identify and educate providers, pharmacists, and enrollees regarding—

(A) instances or patterns concerning the unnecessary or inappropriate prescribing or dispensing of covered outpatient prescription medicines;

(B) instances or patterns of standard care;

(C) potential adverse reactions to covered outpatient prescription medicines;

(D) inappropriate use of antibiotics;

(E) appropriate use of generic products; and

(F) the importance of using covered outpatient prescription medicines in accordance with the instructions of prescribing providers.

(4) Coordination.—The pharmacy contractor shall coordinate with State prescription medicine programs, other forms of care, pharmacy contractors, and other relevant entities as necessary to ensure appropriate coordination of benefits with respect to enrolled individuals when such individual is traveling outside the home service area, and under such other circumstances as the Secretary may specify.

(5) Cost data.

(A) The pharmacy contractor shall make data on prescription medicine negotiated prices (including data on discounts) available to the Secretary.

(B) The Secretary shall require, either directly or through a pharmacy contractor, that participating pharmacists, physicians, and manufacturers—

(i) maintain their prescription medicine cost data (including data on discounts) in a form and manner specified by the Secretary;

(ii) make such prescription medicine cost data available for review and audit by the Secretary; and

(iii) certify that the prescription medicine cost data are complete, accurate, and reflect all discounts obtained by the pharmacist or physician in the purchase of covered outpatient prescription medicines.

(6) Reporting.—The pharmacy contractor shall provide the Secretary with periodic reports on—

(A) the contractor's costs of administering this part;

(B) utilization of benefits under this part;

(C) marketing and advertising expenditures related to enrolling and retaining individuals under this part; and

(D) grievances and appeals.

(7) Records and audits.—The pharmacy contractor shall maintain adequate records related to the administration of benefits under this part and afford the Secretary access to such records for auditing purposes.

(8) Enrollee materials and application forms.—The pharmacy contractor shall comply with requirements of...
Trust Fund and enrollees, as measured by generic substitution rates, price discounts, and other factors determined appropriate by the Secretary that do not reduce the access of beneficiaries to medically necessary covered outpatient prescription medicines.

(b) Percentage of Payment Tied to Risk.—

(ii) In general.—Subject to clause (i), the Secretary shall determine the percentage of the administrative payments to a pharmacy contractor that will be tied to the performance requirements described in subparagraph (A)(ii).

(iii) Limitation on Risk to Ensure Program Stability.—The Secretary may not establish a percentage to be adjusted under this paragraph at a level that jeopardizes the ability of a pharmacy contractor to administer the benefits under this part or administer such benefits in a quality manner.

(c) Risk Adjustment of Payments Based on Risk Factors.—To the extent that a pharmacy contractor is at risk under this paragraph, the procedures established under this paragraph may include a methodology for risk adjustment for risk factors such as the pharmacy contractor specifies under this section.

(d) Authority Relating to Pharmacy Participation.—

(1) In general.—Subject to the following requirements described in subparagraph (A), the Secretary shall determine the percentage of payments to be adjusted under this subsection, a pharmacy contractor shall establish a percentage to be adjusted under this subsection in a manner similar to the pharmacy contractor's risk adjustment methodology. The pharmacy contractor shall meet the requirements of this subparagraph in order to participate in the program. Such standards shall require the pharmacy—

(i) not to refuse to dispense covered outpatient prescription medicines to any individual or to enroll any individual under this part, without regard to whether such prescription medicines dispensed to such enrollees are dispensed under this part; and

(ii) to keep patient records (including records on expenses) for all covered outpatient prescription medicines dispensed to such enrollees.

(2) Initial Enrollment Period.—

(a) Applicable Requirements.—The pharmacy shall meet (and throughout the initial enrollment period shall meet) all applicable Federal requirements and State and local licensing requirements.

(b) Access and Quality Standards.—In the case of an individual who satisfies subsection (a) is enrolled in a group health plan, such pharmacy shall establish procedures for making payments to each pharmacy contractor with a contract under this part for the administration of the benefits under this part. The procedures shall provide for the following:

(i) Administrative Payment.—Payment of administrative fees for such administration.

(ii) Risk Requirement.—An adjustment of a percentage (determined under subparagraph (B) of the administrative fee payment percentage) of the pharmacy's fixed and variable costs to ensure that the contractor, in administering the benefits under this part, pursues performance requirements established by the Secretary that include the following:

(1) Quality Service.—The contractor provides eligible beneficiaries for whom it administers benefits with quality services, as measured by factors such as the services available to pharmacy network access, timeliness and accuracy of service delivery in claims processing and card production, pharmacy and member service support access, and timely action with regard to appeals and current beneficiary service surveys.

(2) Quality Clinical Care.—The contractor provides such services with quality clinical care, as measured by such factors as providing notification to such beneficiaries and to providers in order to prevent adverse drug reactions and reduce medication errors and specific clinical suggestions to improve health and patient and pre-scriber education as appropriate.

(3) Medicare Costs.—The contractor contains costs under this part to the Federal Medicare Prescription Medicine
(ii) has elected not to enroll (or to be deemed enrolled) under this subsection during the individual's initial enrollment period, there shall be a special enrollment period of 6 months beginning with the first month that includes the date that the plan substantially terminates outpatient prescription medicine coverage and ending 6 months later.

(3) LOSS OF MEDICARE CHOICE PRESCRIPTION MEDICINE COVERAGE.—In the case of an individual who is enrolled under part C in a Medicare Choice plan that provides prescription medicine benefits, if such enrollment is terminated because of the termination or reduction in service area of the plan, there shall be a special enrollment period of 6 months beginning with the first month that includes the date that such plan is terminated or such reduction occurs and ending 6 months later.

(4) LATE ENROLLMENT WITH PREMIUM PENALTY.—The Secretary shall permit an individual who satisfies subsection (a) to enroll other than during the initial enrollment period under paragraph (2) or a special enrollment period under paragraph (3). But, in the case of such an enrollment, the amount of the monthly premium of the individual is subject to an increase under section 1857(c)(1)(I).

(5) INFORMATION.—

(A) IN GENERAL.—The Secretary shall broadly distribute information to individuals who satisfy subsection (a) for purposes of this part. The Secretary shall periodically make available information on the cost differentials to enrollees for the use of generic drugs as compared to the use of drugs that are not generic.

(B) TOLL-FREE HOTLINE.—The Secretary shall maintain a toll-free telephone hotline (which may be a hotline already used by the Secretary) for purposes of providing assistance to beneficiaries in the program under this part, including responding to questions concerning coverage, enrollment, costs, grievances and appeals procedures, and other aspects of such program.

(6) ENROLLEE DEFINED.—For purposes of this part, the term 'enrollee' means an individual enrolled under this part.

(c) COVERAGE PERIOD.—

(1) IN GENERAL.—Once an enrollee has initiated such coverage under such a plan or plan part, the individual shall be provided the benefits under this part through the end of the period that begins on the date such enrollee was covered under a group health plan that provides coverage of the cost of prescription medicines whose actuarial value (as defined by the Secretary) to the enrollee equals or exceeds the actuarial value of the benefits previously provided in the outpatient prescription medicine benefit program under this part.

(2) APPLICATION.—This subparagraph shall only apply to a coverage period for which occurs before the end of the 60-day period that begins on the first day of the month which includes the date on which the plan terminates or reduces its service area (in a manner that results in termination of enrollment), ceases to provide, or reduces the value of the prescription medicine coverage under such plan to below the value of the coverage provided under the plan part on the date of such enrollment.

(d) INCORPORATION OF PREMIUM PAYMENT PROVISIONS.—The provisions of sections 1880 and 1884(a)(1) shall apply to enrollees under this part in the same manner as they apply to individuals who are enrolled under part B. For purposes of this subsection, any reference in a section referred to in a previous subsection to the Federal Supplementary Medical Insurance Trust Fund is deemed a reference to the Federal Medicare Prescription Medicine Benefit Trust Fund.

(e) ELECTION OF PHARMACY CONTRACTOR TO ADMINISTER BENEFITS.—The Secretary shall establish a process whereby each enrollee may only be dispensed upon prescription, and—

(i)—which is a new drug (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a medicine, and (II) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 310 of the Public Health Service Act); and

(ii) which is a product that would meet the requirements of section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such a product.

(f) PROVISION OF, AND ENTITLEMENT TO, COVERED OUTPATIENT PRESCRIPTION MEDICINE BENEFITS.—

(1) IN GENERAL.—Upon the termination of enrollment of the individual (within the meaning of section 1857(b)(1) of title 21 of the Code of Federal Regulations) for a medicine, an enrollee shall be entitled to have payment made on the individual's behalf for covered outpatient prescription medicines.

(2) LIMITATION ON COST-SHARING FOR PART B OUTPATIENT PRESCRIPTION MEDICINES.—For purposes of this section, the term 'countable cost-sharing' means—

(i) out-of-pocket expenses for outpatient prescription medicines with respect to which benefits are payable under part B, and

(ii) cost-sharing under subsections (c)(3)(B)(iv) and (c)(3)(B)(v).

(g) COVERED OUTPATIENT PRESCRIPTION MEDICINE BENEFITS.—

(1) IN GENERAL.—The term 'covered outpatient prescription medicine benefits' means any of the following products:

(A) A medicine which may be dispensed only upon prescription, and (B) which is a medicine which is subject to a stop-loss limit specified in subsection (c)(4) for additional expenses incurred in the year for outpatient prescrip-

(iii) which is a biological product which—

(A) is a group health plan that provides a prescription drug benefit to which is a biological product which—

(i) satisfies subsection (a);

(ii) loses eligibility for benefits (that is, coverage with respect to the expenses of an individual enrolled for benefits under this part, the term 'enrollee' means an individual enrolled for benefits under this part, the term 'enrollee' means an individual enrolled under this part and residing in an area that is not covered by such a plan or plan part); and

(iii) is not otherwise enrolled under this subsection at the time of such loss of eligi-

(3) The Secretary shall permit an enrollee to enroll under a State plan after having been enrolled (or deemed enrolled) under such a plan under part C in a Medicare Choice plan that provides prescription medicine benefits, if such enrollment is terminated because of the termination or reduction in service area of the plan, there shall be a special enrollment period of 6 months beginning with the first month that includes the date that such plan is terminated or such reduction occurs and ending 6 months later.

(4) LATE ENROLLMENT WITH PREMIUM PENALTY.—

(A) IN GENERAL.—In the case of a late enrollment described in subsection (b)(4), subject to the succeeding provisions of this paragraph, the Secretary shall establish procedures for increasing the amount of the monthly premium under this part applicable to such enrollee by an amount that the Secretary determines is actuarially sound for each such period.

(B) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under subparagraph (A), there shall be taken into account months of lapse in coverage in a manner comparable to that applicable under the second sentence of section 1859(b).

(C) PERIODS NOT TAKEN INTO ACCOUNT.—

(i) IN GENERAL.—For purposes of calculating any 12-month period under subparagraph (A), there shall not be taken into account months for which the enrollee can demonstrate that the enrollee was covered under a group health plan that provides a prescription drug benefit to which is a biological product which—

(A) is a group health plan that provides a prescription drug benefit to which is a biological product which—

(1) IN GENERAL.—The Secretary shall permit an individual who is enrolled under part B in a Medicare+Choice plan that provides prescription medicine benefits, if such enrollment is terminated because of the termination or reduction in service area of the plan, there shall be a special enrollment period of 6 months beginning with the first month that includes the date that such plan is terminated or such reduction occurs and ending 6 months later.
"(2) EXCLUSION.—The term 'covered outpatient prescription medicine' does not include—

(A) medicines or classes of medicines, or their equivalents, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents) or under paragraph (5)(B) or (6), which the Secretary may specify and does not include such other medicines, classes, and uses as the Secretary may specify consistent with the goals of providing quality care and containing costs under this part;

(B) except as provided in paragraphs (1)(D) and (1)(E), any product which may be distributed to individuals without a prescription;

(C) any product when furnished as part of, or as incident to, a diagnostic service or any other item or service for which payment may be made under this title; or

(D) any product that is covered under part B of this title.

(3) PAYMENT OF BENEFITS.—

(I) COVERED OUTPATIENT PRESCRIPTION MEDICINES.—There shall be paid to the Federal Medicare Prescription Medicine Trust Fund, in the case of each enrollee who incurs expenses with respect to which benefits are payable under this part under section 1859(a)(1), amounts equal to the sum of—

(A) the price for which the medicine is made available under this part (consistent with sections 1859A and 1859B), reduced by any applicable cost-sharing under paragraphs (2) and (3); and

(B) a reasonable dispensing fee.

The price under subparagraph (A) shall in no case exceed the retail price for the medicine involved.

(II) DEDUCTIBLE.—The amount of payment under paragraph (1) for expenses incurred in a year beginning with 2006, shall be reduced by an annual deductible equal to the amount specified in section 1859(c)(2)(B) subject to adjustment under paragraph (4). Only expenses for countable cost-sharing (as defined in subsection (a)(2)(B)) shall be taken into account in applying this paragraph.

(3) COVERAGE.—

(A) IN GENERAL.—The amount of payment under paragraph (1) for expenses incurred in a year shall be reduced (subject to the stop-loss limit under paragraph (4)) by coinurance as provided under this paragraph.

(B) PREFERRED MEDICINES.—The coinsurance under this paragraph in the case of a preferred medicine (including, a medicine treated as a preferred medicine under paragraph (5)), is equal to 20 percent of the price applicable under paragraph (1)(A)(i) or such lower percentage as may be provided for under section 1859E(a)(1)(A)(ii). In this case, the term 'preferred medicine' means, with respect to medicines classified within a therapeutic class, those medicines which have been designated as a preferred medicine by the Secretary or the pharmacy contractor involved with respect to that class and (in the case of a nongeneric medicine) with respect to which a contract has been negotiated under this part.

(C) NONPREFERRED MEDICINES.—The coinsurance under this paragraph in the case of a nonpreferred medicine that is not treated as a preferred medicine under paragraph (5) is equal to the sum of—

(i) the per-drug cost-sharing for the lowest price preferred medicine that is within the same therapeutic class; and

(ii) the amount by which—

(A) the price of such lowest price preferred medicine exceeds

"(4) NO COINSURANCE ONCE OUT-OF-POCKET EXPENDITURES EQUAL STOP-LOSS LIMIT.—Once an enrollee has incurred applicable cost-sharing under paragraph (3) (including cost-sharing under part B attributable to outpatient prescription drugs or biologicals) equal to the amount specified in section 1859(c)(4) (subject to adjustment under paragraph (8)) for expenses incurred in a year—

(A) there shall be no coinsurance under paragraph (3) for expenses incurred in the year involved; and

(B) there shall be no coinsurance under part B for expenses incurred in the year involved for outpatient prescription drugs and biologicals.

(5) APPEALS RIGHTS RELATING TO COVERAGE OF NONPREFERRED MEDICINES.—

(A) PROCEDURES REGARDING THE DETERMINATION OF MEDICATIONS THAT ARE MEDICALLY NECESSARY.—Each pharmacy contractor shall have in place procedures on a case-by-case basis to treat a nonpreferred medicine as a preferred medicine under this part if the preferred medicine is determined to be not as effective or are not in any way inferior, nor are there significant adverse effect on the enrollee. Such procedures shall require that such determinations are based on professional medical judgment, the medical condition of the enrollee, and other medical evidence.

(B) PROCEDURES REGARDING DENIALS OF CARE.—Such pharmacy contractor shall have in place procedures to ensure—

(i) a timely internal review for resolution of denials of coverage (in whole or in part and including those regarding the coverage of nonpreferred medicines) in accordance with the medical exigencies of the case and a timely resolution of complaints, by enrollees in Medicare+Choice organizations under part C; and

(ii) that the entity complies in a timely manner with requirements established by the Secretary that (I) provide for an external review by an independent entity selected by the Medicare+Choice organization for a nonpreferred medicine and (II) are comparable to such requirements for Medicare+Choice organizations under part C;

(C) ESTIMATION OF INCREASE IN PER CAPITA PROGRAM EXPENDITURES.—The Secretary shall adjust such percentage increase in such aggregate expenditures in order to provide for reconciliation of deductibles, stop-loss limits, and premiums under the second sentence of section 1859(c)(1)(G) and clause (II) of subparagraph (A) of this section.

(6) TRANSFER OF FUNDS TO COVER COSTS OF ADMINISTRATION; QUALITY ASSURANCE.

"(7) PERMITTING APPLICATION UNDER PART B OF NEGOTIATED PRICES.—For purposes of making payment under part B for medicines that would be covered outpatient prescription medicines but for the exclusion under subparagraph (B) or (C) of section 1859(c)(1) (relating to cost-sharing for non-preferred medicines) to the extent applicable under paragraph (1), the Secretary may establish a per-dose basis for payment under part B for medicines that would be covered outpatient prescription medicines under this part that is not a multiple of $1. If it results in a lower cost to the program.

(B) INFLATION ADJUSTMENT.—

(8) INFLATION ADJUSTMENT FOR SUBSEQUENT YEARS.—The monthly premium rate for a year after 2006 for prescription medicine benefits under this part is equal to the monthly premium rate for the previous year increased by the percentage increase in per capita aggregate expenditures from the Federal Medicare Prescription Medicine Trust Fund for the year involved compared to the previous year.

(9) PERMITTING APPLICATION UNDER PART B OF NEGOTIATED PRICES.—

"(6) TRANSFER OF FUNDS TO COVER COSTS OF ADMINISTRATION; QUALITY ASSURANCE.

"(7) PERMITTING APPLICATION UNDER PART B OF NEGOTIATED PRICES.—For purposes of making payment under part B for medicines that would be covered outpatient prescription medicines but for the exclusion under subparagraph (B) or (C) of section 1859(c)(1)(G) (relating to cost-sharing for non-preferred medicines) to the extent applicable under paragraph (1), the Secretary may establish a per-dose basis for payment under part B for medicines that would be covered outpatient prescription medicines under this part that is not a multiple of $1. If it results in a lower cost to the program.

(B) INFLATION ADJUSTMENT.—

(8) INFLATION ADJUSTMENT FOR SUBSEQUENT YEARS.—The monthly premium rate for a year after 2006 for prescription medicine benefits under this part is equal to the monthly premium rate for the previous year increased by the percentage increase in per capita aggregate expenditures from the Federal Medicare Prescription Medicine Trust Fund for the year involved compared to the previous year.

(9) PERMITTING APPLICATION UNDER PART B OF NEGOTIATED PRICES.—

"(6) TRANSFER OF FUNDS TO COVER COSTS OF ADMINISTRATION; QUALITY ASSURANCE.

"(7) PERMITTING APPLICATION UNDER PART B OF NEGOTIATED PRICES.—For purposes of making payment under part B for medicines that would be covered outpatient prescription medicines but for the exclusion under subparagraph (B) or (C) of section 1859(c)(1)(G) (relating to cost-sharing for non-preferred medicines) to the extent applicable under paragraph (1), the Secretary may establish a per-dose basis for payment under part B for medicines that would be covered outpatient prescription medicines under this part that is not a multiple of $1. If it results in a lower cost to the program.

(B) INFLATION ADJUSTMENT.—

(8) INFLATION ADJUSTMENT FOR SUBSEQUENT YEARS.—The monthly premium rate for a year after 2006 for prescription medicine benefits under this part is equal to the monthly premium rate for the previous year increased by the percentage increase in per capita aggregate expenditures from the Federal Medicare Prescription Medicine Trust Fund for the year involved compared to the previous year.
(B) Construction.—Nothing in this subsection shall be construed to prevent the Secretary (directly or through the contracts with pharmacy contractors from using incentive payments to encourage enrollees to select generic or other cost-effective medicines, so long as—

(i) such incentives are designed not to result in a decrease in the aggregate expenditures on medicines by the Federal Medicare Prescription Medicine Trust Fund; and

(ii) a beneficiary’s coinsurance shall be no greater than 40 percent in the case of a preferred medicine (including a nonpreferred medicine treated as a preferred medicine under section 1890(d));

(2) Construction.—Nothing in this part shall preclude the Secretary or a pharmacy contractor from—

(A) not granting prescribing providers, pharmacists, and enrollees information about medical and cost benefits of preferred medicines; (B) requesting prescribing providers to consider using therapeutic interchange programs, including use of therapeutic interchange programs, disease management programs, and notification to the beneficiary that a more affordable cost-effective medicine is available in accordance with standards established by the Secretary; and

(C) utilizing information on medicine prices of OECD countries and of other payors to encourage enrollees to select cost-effectives medicines or less costly means of receiving medications, including use of therapeutic interchange programs, disease management programs, and notification to the beneficiary that a more affordable cost-effective medicine is available in accordance with standards established by the Secretary; and

(D) FRAUD AND ABUSE SAFEGUARDS.—The Secretary, in consultation with the Inspector General, is authorized and directed to issue regulations establishing appropriate safeguards to prevent fraud and abuse under this part. Such safeguards, at a minimum, should include compliance programs, certification data, audits, and recordkeeping practices. In developing such regulations, the Secretary shall consult with the Attorney General and other law enforcement and regulatory agencies.

(FEDERAL MEDICARE PRESCRIPTION MEDICINE TRUST FUND)

SEC. 1859F. (a) Establishment.—There is hereby established on the books of the Treasury of the United States a trust fund to be known as the ‘Federal Medicare Prescription Medicine Trust Fund’ (in this section referred to as the ‘Trust Fund’). The Trust Fund shall consist of such gifts and bequests as may be received in section 203(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part.

(b) Application of SMI Trust Fund Provisions.—The provisions of subsections (b) through (i) of section 1841 shall apply to this part and to the Trust Fund in the same manner as they apply to part B and the Federal Supplementary Medical Insurance Trust Fund, respectively.

COMPENSATION FOR EMPLOYERS COVERING RETIREE MEDICINE COSTS

SEC. 1859C. (a) In General.—In the case of an individual who is eligible to be enrolled under this part and is a participant or beneficiary in a plan that provides outpatient prescription medicine coverage to retirees the actuarial value of which is not less than the actuarial value of the coverage the Federal Medicare Prescription Medicine Trust Fund provides to such individual, such retiree's subsidy may be determined in accordance with subsection (b) of this section.

(b) Computation of Monthly Government Contribution Amount.—For purposes of subparagraph (A), the monthly government contribution amount for a month in a year is equal to the amount by which—

(i) the average premium of a State for a comparable plan, for each such covered individual, is less than the Federal Medicare Prescription Medicine Trust Fund's average premium for such month; and

(ii) the amount specified in paragraph (2) for each individual described in subsection (a) who during the quarter is enrolled in the insurance program under this part.

(2) Amount of Payment.—(A) In General.—The amount of the payment for a quarter is the amount specified in paragraph (2) for each such individual described in subsection (a) during the quarter, determined in accordance with section 1859(d)(3) for the 3-month period ending such quarter.

(B) Computation of Monthly Government Contribution Amount.—For purposes of subparagraph (A), the monthly government contribution amount for a month in a year is equal to the amount by which—

(i) the average premium of a State for a comparable plan is less than the Federal Medicare Prescription Medicine Trust Fund's average premium for such month; and

(ii) the amount specified in paragraph (2) for each such covered individual, is less than the Federal Medicare Prescription Medicine Trust Fund's average premium for such month; and

(iii) the monthly premium rate under section 1859(d) for the month involved.

MEDICARE PRESCRIPTION MEDICINE ADVISORY COMMITTEE

SEC. 1859H. (a) Establishment of Committee.—There is established a Medicare Prescription Medicine Advisory Committee (in this section referred to as the ‘Committee’).

(b) Functions of Committee.—The Committee shall advise the Secretary on policies related to—

(1) the development of guidelines for the implementation and administration of the Medicare prescription medicine benefit program under this part; and

(2) the development of paragraph 45x130
"(A) standards required of pharmacy contractors under section 1899D(c)(5) for determining if a medicine is as effective for an enrollee or has a significant adverse effect on an enrollee involved.

(B) standards for—

(i) defining therapeutic classes;

(ii) adding new therapeutic classes;

(iii) assigning to such classes covered outpatient prescription medicines; and

(iv) identifying breakthrough medicines;

(C) procedures to evaluate the bids submitted by pharmacy contractors under this part;

(D) procedures for negotiations, and standards for entering into contracts, with manufacturers, including identifying covered medicines or classes of medicines where Secrecy

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Secrecy notification is most likely to yield savings under this part significantly above those that could be achieved by a pharmacy contractor; and

(E) procedures to ensure that pharmacy contractors with a contract under this part are in compliance with the requirements under this part.

For purposes of this part, a medicine is a 'breakthrough medicine' if the Secretary, in consultation with the Committee, determines it is a new product that will make a significant and major improvement by reducing physical or mental illness, reducing mortality or morbidity as required by the Secretary, and that no other product is available to beneficiaries that achieves similar results for the same condition.

The Committee may consider cost-effectiveness in establishing standards for defining therapeutic classes and assigning drugs to such classes under subparagraph (B).

(C) STRUCTURE AND MEMBERSHIP OF THE COMMITTEE.—

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

(2) MEMBERSHIP.—

(A) IN GENERAL.—The members of the Committee shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Committee.

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

(i) 5 shall be chosen to represent practicing physicians, 2 of whom shall be gerontologists; and

(ii) 2 shall be chosen to represent practicing nurse practitioners;

(iii) 4 shall be chosen to represent practicing pharmacists;

(iv) 1 shall be chosen to represent the Centers for Medicare & Medicaid Services;

(v) 4 shall be chosen to represent actuaries, biostatisticians, researchers, and other appropriate experts;

(vi) 1 shall be chosen to represent emerging medicine technologies;

(vii) 1 shall be chosen to represent the Food and Drug Administration; and

(viii) 1 shall be chosen to represent individuals enrolled under this part.

(B) CONFERING AMENDMENTS.—Each member of the Committee shall serve for a term determined appropriate by the Secretary. The terms of service of the members initially appointed shall begin on January 1, 2005.

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

(D) COMMITTEE PERSONNEL MATTERS.—

(i) COMPENSATION.—Each member of the Committee who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule in section 5305 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Committee.

(ii) Consultation.—The members of the Committee who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

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

(iv) STAFF.—The Committee may appoint and may act as its executive officer.

(g) OPERATION OF THE COMMITTEE.—

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

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

(h) FEDERAL ADVISORY COMMITTEE ACT.—

(1) AUTHORIZATION OF APPROPRIATIONS.—For purposes of conducting business.

(2) TRANSFER OF PERSONNEL, RESOURCES, AND ASSETS.—For purposes of carrying out its duties, the Secretary may, in his discretion, transfer to the Committee any personnel, resources, and assets of the Department in carrying out this title, as the Committee requires.

(3) AUTHORIZATION OF APPROPRIATIONS.—For purposes of conducting business.

(i) APPLICATION OF GENERAL EXCLUSIONS FROM COVERAGE.—

(A) APPLICABLE TO MEDICARE—a prescription medicine benefit described in section 1851(a)(2)(A) shall be a reference to the Federal Medicare Prescription Medicine Trust Fund.

(B) APPLICATION OF QUALITY STANDARDS.—

(i) APPLICABLE TO MEDICARE—a prescription medicine benefit described in section 1851(a)(2)(A) shall be a reference to the Federal Medicare Prescription Medicine Trust Fund.

(j) AVAILABILITY OF PRESCRIPTION MEDICINE COVERAGE OPTION.—

(1) IN GENERAL.—In the case of a Medicare+Choice eligible individual who is enrolled under part D, the benefits described in paragraph (1) shall be treated in the same manner as benefits described in section 1858(e)(4) for purposes of coverage and payment and any reference in this section to the Federal Supplemental Medical Insurance Trust Fund shall be deemed, with respect to such benefits, to be a reference to the Federal Medicare Prescription Medicine Trust Fund.

(2) TREATMENT OF PRESCRIPTION MEDICINE ENROLLEES.—In the case of a Medicare+Choice eligible individual who is enrolled under part D, the benefits described in paragraph (1) shall be treated in the same manner as benefits described in section 1858(e)(4) for purposes of coverage and payment and any reference in this section to the Federal Supplemental Medical Insurance Trust Fund shall be deemed, with respect to such benefits, to be a reference to the Federal Medicare Prescription Medicine Trust Fund.

(k) AVAILABILITY OF PRESCRIPTION MEDICINE COVERED MEDICATIONS.—

(1) IN GENERAL.—In the case of a Medicare+Choice plan that provides prescription medication benefits described in section 1851(a)(2)(A) the amount of loan otherwise made available under section 1859(b) for the offering the plan shall be increased by the amount otherwise paid, but such amount shall be payable from the Federal Medicare Prescription Medicine Trust Fund.

(l) AMOUNT.—The amount described in the preceding subparagraph is the amount of the contribution amount computed under section 1859(c)(2)(B), subject to adjustment under paragraph (3). Such amount shall be determined by the Secretary of Health and Human Services.
vide and ensuring that policies providing coverage of Medicare+Choice organizations deter-mining whether such policies providing for the amendment made by subsection (a) shall take effect on January 1, 2006.

(c) For the purpose of carrying out section 1854(e) (42 U.S.C. 1395w–24(e)) is amended by adding at the end the following:

(i) LIMITATION ON COST-SHARING.—In no event may a Medicare+Choice organization include a requirement that an enrollee pay cost-sharing in excess of the cost-sharing described in section 1813(f)(1) (42 U.S.C. 1395w–22(f)(1)) is amended by adding at the end the following new paragraph:

(5) LIMITATION ON COST-SHARING.—In no event may a Medicare+Choice organization include a requirement that an enrollee pay cost-sharing in excess of the cost-sharing otherwise permitted under part D.

SEC. 103. MEDIQAP REVISIONS.

(a) Required Coverage of Covered Out-patient Prescription Medicines.—Section 1822(p)(2)(B) (42 U.S.C. 1395s(p)(2)(B)) is amended by inserting before “and” at the end the following:

“increased by the amount specified in subparagraph (C) of section 1902(a)(10)(E)(v) (other than for individuals described in section 1905(p)(1)(B))”.

(b) Treatment of Territories.—Section 1905(p)(2) (42 U.S.C. 1396d(p)(2)) is amended—

(1) by redesignating paragraphs (5) and (6) as paragraphs (6) and (7), respectively; and

(2) by inserting after paragraph (4) the following new paragraph:

(c) Federal Financing.—The third sentence of section 1905(b) (42 U.S.C. 1396d(b)) is amended by inserting the following at the end:

“Federal Financing.—The 1991 NAIC Model Regulation, as subsequently revised regulation incorporating the modific-

ations to conform its regulatory program to the requirements of this section (in this subsection referred to as the “NAIC”) modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the “NAIC”) modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4), the following:

(i) provides medical assistance with respect to the provision of covered outpatient drug benefits (as defined in this section) for individuals (other than qualified medicare beneficiaries) that is enrolled under part D of title XVIII and are described in section 1905(p)(1)(B) or would be so described but for the fact that their income exceeds 100 percent but is less than 175 percent of the official poverty line (referred to in such section) for a family of the size involved;

(ii) subject to section 1905(p)(4), for individuals (other than qualified medicare beneficiaries) that is enrolled under part D of title XVIII and would be so described but for the fact that their income exceeds 150 percent, but is less than 175 percent, of the official poverty line (referred to in such section) for a family of the size in- volved; and

(iii) subject to section 1905(p)(4), for individuals (other than qualified medicare beneficiaries) that is enrolled under part D of title XVIII and would be so described but for the fact that their income exceeds 150 percent, but is less than 175 percent, of the official poverty line (referred to in such section) for a family of the size involved;

(iv) subject to section 1905(p)(4), for individuals (other than qualified medicare beneficiaries) that is enrolled under part D of title XVIII and would be so described but for the fact that their income exceeds 150 percent, but is less than 175 percent, of the official poverty line (referred to in such section) for a family of the size involved;

(i) providing medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(iii) and medicare cost-sharing described in section 1905(p)(3)(B) to low-income medicare beneficiaries, the amount otherwise determined under section 1905(p)(3)(C) but only insofar as it relates to benefits provided under part D of title XVIII, for the year 2004 and with respect to amounts expended that are attributable to section 1902(10)(E)(v) (other than for individuals described in section 1905(p)(1)(B)).

(B) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—Section 1905(p)(2) (42 U.S.C. 1396d(p)(2)) is amended—

(A) by redesignating paragraphs (5) and (6) as paragraphs (6) and (7), respectively; and

(B) by inserting after paragraph (4) the following new paragraph:

(C) by striking “and” at the end of clause (iv); and

(D) by adding “and” at the end of clause (iv);

(E) by adding “and” at the end of clause (iv);

(F) by adding “and” at the end of clause (iv);

(G) by adding “and” at the end of clause (iv);

(H) by adding “and” at the end of clause (iv);

(I) by adding “and” at the end of clause (iv);

(J) by adding “and” at the end of clause (iv);

(K) by adding “and” at the end of clause (iv);

(L) by adding “and” at the end of clause (iv);

(M) by adding “and” at the end of clause (iv);

(N) by adding “and” at the end of clause (iv);

(O) by adding “and” at the end of clause (iv);

(P) by adding “and” at the end of clause (iv).

SEC. 104. TRANSITIONAL ASSISTANCE FOR LOW INCOME BENEFICIARIES.

(a) QMB Coverage of Prescriptions and Cost-Sharing.—Section 1905(p)(3) (42 U.S.C. 1395m(d)(3)) is amended—

(1) in subparagraph (A),

(i) by striking “and” at the end of clause (i) and

(ii) by adding “and” at the end of clause (i) (as defined in section 1905(p)(3)(C));

(b) Expanded SLMB Eligibility.—Section 1902(a)(10)(E) (42 U.S.C. 1396d(a)(10)(E)) is amended—

(1) by striking “and” at the end of clause (iii); and

(2) by adding “and” at the end of clause (iv); and

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

(iv) for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(iii) and medicare cost-sharing described in section 1905(p)(3)(B) to low-income medicare beneficiaries, the amount otherwise determined under section 1905(p)(3)(C) but only insofar as it relates to benefits provided under part D of title XVIII, for the year 2004 and with respect to amounts expended that are attributable to section 1902(10)(E)(v) (other than for individuals described in section 1905(p)(1)(B)).
SEC. 105. STATE PHARMACEUTICAL ASSISTANCE TRANSITION COMMISSION.

(a) Establishment.—

(i) The aggregate amount specified in this clause for—

(ii) A subsequent year, is equal to $25,000,000 or

(ii) The aggregate amount specified in this clause for the previous year increased by annual percentage increase specified in section 1855(c)(5)(A)(ii) after "Subject to subsection (g)":

(b) Report.—

(i) The Secretary shall submit to Congress a report on the application of this paragraph and may include in the report such recommendations as the Secretary deems appropriate.

(c) Effective Date.—The provisions made by this section to apply to medical assistance for premiums and cost-sharing incurred on or after January 1, 2006, with respect to whether regulations to implement such amendments are promulgated by such date.

SEC. 165. EXPANSION OF DUTIES OF MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) Expansion of Membership.—

(i) In general.—Section 1805(c) (42 U.S.C. 1395b–6(c)) is amended—

(ii) Inserting "and section 1905(p)(5)(A)(ii)" after "Subject to subsection (g)":

(iii) In paragraph (1), by striking "17" and inserting "19":

(iv) In paragraph (2), by inserting "experts in the area of pharmacology and prescription medicine benefit programs," after "other professionals":

(b) Initial Terms of Additional Members.—

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

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

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

(c) Commencement of Terms.—Such terms shall begin on January 1, 2004.

SEC. 176. REVISION OF BLEND.—

(a) Reapportioning.—

(i) For each year before 2004, the Secretary shall establish a blend of amounts—

(ii) Which is based on a blend of each State's percentage, described in paragraph (6) for the previous year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6) for that succeeding year, but not taking into account any adjustment under paragraph (6)(C) for a year before 2004.

(b) Reapportioning.—

(i) The aggregate amount specified in this clause for—

(ii) The aggregate amount specified in this clause for the previous year increased by annual percentage increase specified in section 1855(c)(5)(A)(ii) after "Subject to subsection (g)":

(iii) In paragraph (1), by striking "17" and inserting "19":

(iv) In paragraph (2), by inserting "experts in the area of pharmacology and prescription medicine benefit programs," after "other professionals":

(v) In paragraph (3), by inserting "other health professionals":

(vi) In paragraph (4), by inserting "the Secretary identifies have in operation other State pharmaceutical assistance programs, as appointed by the Secretary":

(vii) The Secretary shall designate a member to serve as chair of the Commission and the Commission shall meet at the call of the chair.

(b) Protection of the financial and flexibility interests of States so that States are not disrupted to such participants and that includes a single point of contact for enrollment and program services necessary for the Commission to carry out its responsibilities under this section.

(f) Termination.—The Commission shall terminate 30 days after the date of submission of the report under subsection (d).

SEC. 201. MEDICARE+CHOICE IMPROVEMENTS.

(a) Equalizing Payments with Fee-For-Service.—

(i) In General.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended by adding at the end the following:

"(D) Based on 100 percent of fee-for-service costs.

(ii) In General.—For 2004, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for a Medicare+Choice payment area for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare+Choice under this paragraph for the year involved, is equal to the amount attributable to payments under subsection 1896(h).

(iii) Inclusion of Costs of VA and DOD Military Facility Services to Medicare-Eligible Beneficiaries.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.

(b) Conforming Amendments.—

(i) Section 1805(b)(2) (42 U.S.C. 1395b–6(b)(2)) is amended by inserting "and section 1905(p)(5)(A)(ii)" after "Subject to subsection (g)":

(ii) In (a) the term "pharmaceutical assistance program" means a program (other than the Medicaid program) that is Federally approved with a State that provides as of the date of the enactment of this Act assistance to low-income Medicare beneficiaries for the purchase of prescription drugs.

(b) Program Participant.—The term "program participant" means a low-income Medicare beneficiary who is a participant in a State pharmaceutical assistance program.

(c) Composition.—The Commission shall include the following:

(i) A representative of each governor of each State who the Secretary identifies as operating on a statewide basis a State pharmaceutical assistance program that provides, for eligibility and benefits that are comparable or more generous than the low-income assistance eligibility and benefits offered under part D of title XVIII of the Social Security Act.

(ii) Representatives from other States that the Secretary identifies have in operation other State pharmaceutical assistance programs, as appointed by the Secretary.

(iii) A single representative selected by the Secretary but not to exceed the number of representatives as appointed under paragraphs (1) and (2).

(iv) Representatives of Medicare+Choice organizations and other private health insurance plans, as appointed by the Secretary.

(v) The Secretary (or the Secretary's designate) and such other members as the Secretary may specify.

The Secretary shall designate a member to serve as chair of the Commission and the Commission shall meet at the call of the chair.

(c) Development of Proposal.—The Commission shall develop the proposal described in subsection (a) in a manner consistent with the following principles:

(i) Protection of the interests of program participants in a manner that is the least disruptive to such participants and that includes a single point of contact for enrollment and program services necessary for the Commission to carry out its responsibilities under this section.

(ii) Protection of the financial and flexibility interests of States so that States are not financially worse off as a result of the enactment of this Act.

(iii) Principles of Medicare modernization provided under title II of this Act.

(d) Report.—By not later than January 1, 2003, the Commission shall submit to the President and the Congress a report that contains a detailed proposal (including specific legislative or administrative recommendations, if any) and such other recommendations as the Commission deems appropriate.

(e) Support.—The Secretary shall provide the Commission with the administrative support services necessary for the Commission to carry out its responsibilities under this section.

(f) Termination.—The Commission shall terminate 30 days after the date of submission of the report under subsection (d).

(e) Inclusion of Costs of DOD and VA Military Facility Services to Medicare-Eligible Beneficiaries.—In determining the adjusted average per capita cost under clause (ii) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.
SEC. 202. MAKING PERMANENT CHANGE IN MEDICARE+CHOICE PLAN DEADLINES AND ANNUAL COORDINATION PERIOD.

(a) CHANGE IN REPORTING DEADLINE.—Section 1854(a)(1)(B) (42 U.S.C. 1395w–24(a)(1)), as amended by section 532(d)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended by striking "2002, 2003, and 2004 (or July 1 of each other year)" and inserting "2002 and each subsequent year".

(b) DELAY IN ANNUAL, COORDINATED ELECTION PERIOD.—Section 1851(b)(2) (42 U.S.C. 1395w–22(b)(2)), as amended by section 532(c)(1)(A) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended—

(1) by striking "after 2005"; and
(2) by striking "2004, and 2005" and inserting "and any subsequent year".

(c) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—Section 1853(b)(3) (42 U.S.C. 1395w–23(b)(3)), as amended by section 532(d)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended—

(1) by striking "after 2005"; and
(2) by striking "and 2005" and inserting "and each subsequent year".

SEC. 203. INPATIENT HOSPITAL STAYS TO REHABILITATION FACILITIES.

(a) TREATMENT AS COORDINATED CARE PLAN.—Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is amended by adding at the end the following new paragraph:

"(f) RESTRICTION ON ENROLLMENT FOR SPECIAL NEEDS BENEFICIARIES.—

(A) in subparagraph (A)(ii), by striking
(ii) for any period beginning on or after January 1, 2007, the plan to individuals who are within one or more classes of special needs beneficiaries, as defined in subparagraph (B)."

(b) SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—

(A) TREATMENT AS COORDINATED CARE PLAN.—Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is amended by adding at the end the following new paragraph:

"(g) REPORT ON IMPACT OF INCREASED FINANCIAL ASSISTANCE TO MEDICARE+CHOICE PLANS.—Not later than July 1, 2006, the Medicare Administrator shall submit to Congress a report that describes the impact of additional funding provided under this Act and other Acts (including the Medicare, Medicaid, and SCHIP Balanced Budget Reconciliation Act of 1999 and BIPA) on the availability of Medicare+Choice plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

(h) LIMITATION ON APPLICATION TO 2004 AND 2005.—Notwithstanding any other provision of law, the amendments made by this section shall only apply to payment rates for 2004 and 2005 and for subsequent years the payment rates under the plan to individuals who are within one or more classes of special needs beneficiaries under the plan to individuals who are within one or more classes of special needs beneficiaries under the plan to individuals who are within one or more classes of special needs beneficiaries under the plan to individuals who are within one or more classes of special needs beneficiaries under the plan to individuals who are within one or more classes of special needs beneficiaries under the plan to individuals who are within one or more classes of special needs beneficiaries under the plan to individuals who are within one or more classes of special needs beneficiaries under the plan to individuals who are within one or more classes of special needs beneficiaries under the plan to individuals who are within one or more classes of special needs beneficiaries under the plan to individuals who are within one or more classes of special needs beneficiaries.

(i) REPORT TO CONGRESS.—Not later than December 31, 2005, the Medicare Benefits Administrator shall submit to Congress a report that assesses the impact of specialized Medicare+Choice plans for special needs beneficiaries on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the Medicare program as a result of amendments made by subsections (a), (b), and (c) of section 202.
reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be treated as made on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Reconciliation Amendments of 1984 (Public Law 98-362).

(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395w(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: “An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.”

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: “A primary plan, and an entity responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to such item or service. A primary plan’s responsibility (described in paragraph (2) may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insurer, or by other means.);” and

(B) in the final sentence, by striking “on the date such notice or other information is received and inserting “on the date notice of, or information related to, a primary plan’s responsibility for such payment or other information is received”; and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: “In order to recover payment made under this title, the Secretary, when establishing a rate for such services, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan’s payment to any entity.”.

(d) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395w–3) is amended to read as follows:

"COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES."—

"SEC. 1847. (a) ESTABLISHMENT OF COMPETITIVE ACQUISITION PROGRAMS.—

(1) IMPLEMENTATION.—(A) IN GENERAL.—The Secretary shall establish and implement programs under which competitive acquisition areas are established throughout the United States for the furnishing of items and services under this part of competitively priced items and services (described in paragraph (2) for which payment is made under this part. Such areas may differ for different items and services.

(B) PHASED-IN IMPLEMENTATION.—The programs shall be—

(i) among competitive acquisition areas over a period of not longer than 3 years in a manner so that the competition under the programs occurs—

(I) at least 1/3 of such areas in 2009; and

(II) at least 1/3 of such areas in 2010; and

(ii) among items and services in a manner such that the programs apply to the highest cost and highest volume items and services first.

(C) WAIVER OF CERTAIN PROVISIONS.—In carrying out the programs, the Secretary may waive any Federal Acquisition Regulation as necessary for the efficient implementation of this section, provided that such waiver is consistent with the availability of information and other provisions as the Secretary determines appropriate.

(2) ITEMS AND SERVICES.—The items and services referred to in paragraph (1) are the following:

(A) DURABLE MEDICAL EQUIPMENT AND MEDICAL SUPPLIES.—Covered items (as defined in section 1834(a)(13)) for which payment is otherwise made under section 1834(a), including items used in infusion and surgical procedures, used in conjunction with durable medical equipment, but excluding class III devices under the Federal Food, Drug, and Cosmetic Act.

(B) OTHER EQUIPMENT AND SUPPLIES.—Items, equipment, and supplies (as described in section 1842(s)(2)(D) other than enteral nutrients).

(C) OFF-THE-SHELF ORTHOTICS.—Orthotics (described in section 1861(s)(9)) for which payment is otherwise made under section 1834(a), including items used in infusion and surgical procedures, used in conjunction with durable medical equipment, but excluding class III devices under the Federal Food, Drug, and Cosmetic Act.

(D) MEDICAL SUPPLIES.—Covered items (as described in section 1842(s)(2)(D)).

(E) PHARMACEUTICALS.—Drugs (as described in section 1861(s)(9)) for which payment is otherwise made under section 1834(a), including items used in infusion and surgical procedures, used in conjunction with durable medical equipment, but excluding class III devices under the Federal Food, Drug, and Cosmetic Act.

(F) OTHER ITEMS AND SERVICES.—Items and services that are described in section 1842(s)(2)(D) other than enteral nutrients.

(G) PHASED-IN IMPLEMENTATION.—The programs established under this section shall be effective as if included in the enactment of title III of the Medicare and Medicaid Reconciliation Amendments of 1984 (Public Law 98-362).

(h) PROGRAM REQUIREMENTS.—

(1) IN GENERAL.—The Secretary shall establish and maintain a program for the furnishing of items and services described in subsection (a)(2)(A) for each competitive acquisition area in which the program is implemented under this subsection (a) with respect to such items and services.

(2) CONDITIONS FOR AWARDING CONTRACT.—

(A) IN GENERAL.—The Secretary may not enter into a contract to furnish such items or services unless the Secretary finds all of the following:

(I) The entity meets quality and financial standards specified by the Secretary and otherwise agrees to terms and conditions that the Secretary determines are reasonable for such competitive acquisition area and any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may recover under this section for the item may be considered to be less than the quality standards that would otherwise apply if this section did not apply and shall include consumer services standards.

(II) Beneficiary access to a choice of multiple suppliers in the area is maintained.

(III) Beneficiary liability is limited to 20 percent of the applicable contract award price.

(iv) Beneficiary access to a choice of multiple suppliers in the area is maintained.

(2) CONTENTS.—(A) IN GENERAL.—The contract shall include the following:

(I) The contract described in paragraph (1) shall be subject to the same terms and conditions that the Secretary determines to be necessary for the efficient implementation of this subsection.

(II) The items or services covered under this section for the item may be considered to be less than the quality standards that would otherwise apply if this section did not apply and shall include consumer services standards.

(3) LIMIT ON NUMBER OF CONTRACTORS.—

(A) IN GENERAL.—The Secretary may enter into contracts with no more than three suppliers in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In determining the number of suppliers, the Secretary shall take into account the ability of bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of beneficiaries for such items and services in the geographic area covered under the contract on a timely basis.
"(B) MULTIPLE WINNERS.—The Secretary shall award contracts to multiple entities submitting bids in each area for an item or service.

"(2) PAYMENT.—Payment under this part for competitively priced items and services described in subsection (a)(2) shall be based on the bids submitted and accepted under this section for such items and services.

"(3) PARTICIPATING CONTRACTORS.—Payment shall not be made for items and services described in subsection (a)(2) furnished by a contractor and for which competition is conducted under this section unless—

"(A) the contractor has submitted a bid for such items and services under this section; and

"(B) the Secretary has awarded a contract to the contractor for such items and services under this section.

In this section, the term 'bid' means a request for a proposal for an item or service that includes the cost of the item or service, and where appropriate, any services that are attendant to the provision of the item or service.

"(7) CONSIDERATION IN DETERMINING CATEGORIES FOR BIDS.—The Secretary shall consider the similarity of the clinical efficiency and value of specific codes and products, including products that may provide a therapeutic advantage to beneficiaries, before determining appropriate payment for the drugs and biologicals in products that will be subject to bidding.

"(8) AUTHORITY TO CONTRACT FOR EDUCATION, MONITORING, OUTREACH AND CLAIMANT SERVICES.—The Secretary may enter into a contract with an appropriate entity to address complaints from beneficiaries who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to beneficiaries and monitoring quality of services with respect to the products and services.

"(C) PROGRAM ADVISORY AND OVERSIGHT COMMITTEE.—

"(1) ESTABLISHMENT.—There is established a Program Advisory and Oversight Committee (hereinafter in this section referred to as the 'Committee').

"(2) MEMBERSHIP; TERMS.—The Committee shall consist of the Secretary and such other members as the Secretary may appoint who shall serve for such term or terms as the Secretary may specify.

"(3) DUTIES.—

"(A) TECHNICAL ASSISTANCE.—The Committee shall provide advice and technical assistance to the Secretary with respect to the following functions:

"(i) Development of the program under this section.

"(ii) The establishment of requirements for collection of data.

"(iii) The development of proposals for efficient interaction among manufacturers and distributors of the items and services and providers and beneficiaries.

"(B) MEETINGS.—The Committee shall meet at least quarterly. The Secretary shall give reasonable notice of the meetings.

"(C) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual report on the programs under this section. Each such report shall include information on savings, reductions in beneficiary cost-sharing and quality of life, reductions in beneficiary complaints, and beneficiary satisfaction.

"(D) DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

"(1) AUTHORITY.—The Secretary shall conduct a demonstration project on the application of competitive acquisition under this section to clinical diagnostic laboratory tests—

"(A) for which payment is otherwise made under section 1833(h) or 1834(i)(1) relating to competitive acquisition tests; and

"(B) which are furnished by entities that did not have a face-to-face encounter with the individual.

"(2) TERMS AND CONDITIONS.—Such project shall be under the same conditions as are applicable to items and services described in subsection (a)(2).

"(3) REPORT.—The Secretary shall submit to Congress—

"(A) an initial report on the project not later than December 31, 2008; and

"(B) such progress and final reports on the project after such date as the Secretary determines appropriate.

"(D) DATA-RELATED EXCEPTION.—If the Secretary determines that there is insufficient data available with respect to compute an appropriate payment for the drug or biological for a quarter or that, because of a significant change in price from quarter-to-quarter, the available data on the average acquisition price does not reflect the actual, current acquisition cost for the drug or biological, the Secretary may substitute for the quarters involved an appropriate average acquisition price for such average acquisition price.

"(E) APPLICATION OF NDC CODES.—In the case of a drug or biological that is not a single-source drug under section 1847(a)(3)(B) of the Social Security Act, as amended by title XXVII of the Balanced Budget Act of 1997 (42 U.S.C. 1395w-106(o)), the Secretary may modify the rate otherwise applicable in order to assure access to necessary drugs and biologicals in the case of sole community providers in rural and other areas where the providers are not reasonably able to obtain the drugs and biologicals at the payment rates otherwise applicable. Such modification shall not result in a change of more than 15 percent of the rate otherwise applicable.

"(F) ACCESS EXCEPTION.—The Secretary may provide additional assistance to a contract or other suppliers of drugs and biologicals for a drug or biological covered under the single-source code (BRAND) DRUGS AND BIOLOGICALS. In the case of a drug or biological that meets the requirements for a multi-source drug under subsection (a)(2), the Secretary may modify the rate otherwise applicable in order to assure access to necessary drugs and biologicals in the case of sole community providers in rural and other areas where the providers are not reasonably able to obtain the drugs and biologicals at the payment rates otherwise applicable. Such modification shall not result in a change of more than 15 percent of the rate otherwise applicable.

"(2) DEFINITION OF AVERAGE ACQUISITION PRICE.—In general.—For purposes of this section, the term 'average acquisition price' means, with respect to a drug or biological and with respect to each dosage form and strength, the average acquisition price of the drug or biological product (without regard to any special packaging, labeling, or identifying on the dosage form or
product or package), the average of all final sales prices charged by the manufacturer of the drug or biological product in the United States, excluding sales exempt from inclusion by reason of subparagraph (ii) of section 1927(c)(3)(C) (other than under clause (ii)(III) of such section) and excluding sales subject to a rebate under section 1927, as reported to the Secretary under this subsection.

(B) NET PRICE.—Such average acquisition price shall be calculated net of all of the following, as required by the Secretary:

(i) the sum of all final sales prices charged by the manufacturer of the drug or biological products under clause (i) of such section to $10,000 is deemed to
(ii) the sum of all final prices charged by the manufacturer attesting to the accuracy of
(iii) the sum of all final prices, even if there is no payment for the drug or biological involvement under this part.
(iv) Free goods and services.
(v) Rebates.
(vi) All other service concessions provided by the drug manufacturer.

The Secretary may make subsequent adjustments in such average acquisition price to take into account updated information and differences between the price previously estimated and the actual average acquisition price.

(C) WEIGHTING.—The average of all final sales prices described in subparagraph (A) shall be determined by dividing—

(i) the sum of all final prices charged by the manufacturer of the drug or biological products under subparagraph (B) for sales in
(ii) the total number of units of such sales in

(D) DISTRIBUTION OF REPORTS.—The Secretary shall promptly distribute applicable payments to contractors that make payment for drugs and biologicals under this section in order to apply the uniform reimbursement rate under this section.

(3) PRICE REPORTING REQUIREMENT.—

(A) IN GENERAL.—As a condition for payment for any drug or biological of a manufacturer under this subsection, the manufacturer of the drug or biological shall—

(i) report, on a quarterly basis, to the Secretary's database and the manufacturer's average acquisition price and the information required under subparagraph (C) for all drugs and biologicals of the manufacturer's National Drug Code (NDC); and

(ii) maintain such records (in written or electronic form) regarding such sales and prices for all such drugs and biologicals as may be necessary to audit information so reported or required to be reported, and

(iii) provide the Secretary with access to such records in order to permit the Secretary to audit information so reported or required to be reported.

(B) PENALTIES.—The provisions of section 1927(b)(3)(C) shall apply with respect to the reporting of information under subparagraph (A) in the same manner as it applies to the reporting of information under section 1927(b)(3)(A), except that the reference in clause (i) of such section to $10,000 is deemed to refer to $100,000 and any reference to a suspension of an agreement is deemed a reference to a suspension of payment for the drug or biological product except that the suspension under this paragraph.

The Secretary shall promptly refer to the Inspector General of the Department of Health and Human Services and, if appropriate, to appropriate officials in the Department of Justice in cases in which the Secretary becomes aware of a false price representation made in the information submitted under this subsection.

(C) FORM OF REPORTING.—Information required to be reported under subparagraph (A) shall be reported in a form and manner specified by the Secretary.

The information required to be reported shall include the identification of the generic name of the drug or biological (or its chemical name, if any), the national drug code (NDC) and the HCPCS code assigned to the drug or biological, the dosage form, strength, volume, and unit of measure, the information for a quarter shall be submitted not later than 30 days after the end of the quarter. The information shall be accompanied by a written statement or certification of the manufacturer attesting to the accuracy of it.

The Secretary shall audit information so reported or such records in order to permit the Secretary to determine whether any such information is false or misleading.

The Secretary may conduct such independent price gathering activities, such as surveys and review of published catalog information, information or other transactional information or other independent price gathering activities, such as surveys and review of published catalog information, information or other transactional information or other independent price gathering activities, such as surveys and review of published catalog information, information or other transactional information, such as surveys and review of published catalog information, information or other transactional information.

The Secretary may establish the payment for drug or biological products approved to be reimbursed by the Secretary under this part, the Secretary may require that the payment be subject to adjustment from year to year on the basis of changes in consumer price index over time and may be adjusted as the Secretary determines to be appropriate to reflect differences in the costs of dispensing different drugs.

(5) PAYMENT REQUIRED ON AN ASSIGNMENT-BASED RELATION.—

(A) IN GENERAL.—Payment for any drug or biological for which payment may be made under this part may be made only on an assignment-based basis.

(B) APPLICABILITY OF ENFORCEMENT PROVISIONS.—The provisions of subsection (b)(18)(B) shall apply to charges for such drugs or biologicals in the same manner as they apply to charges for such drugs or biologicals under subsection (b)(18)(C).

(6) MULTIPLE PUSHES.—In establishing the payment amounts under this subsection, the Secretary shall establish the payment for drug administration by push technique based on the payment that was determined under section 1848 of the Social Security Act (42 U.S.C. 1395w-4). The payment for each drug administration by push technique during the same encounter, except that the payment of the drug administration, in the amount of the drug administration services, shall be in effect for the physician fee schedule amount paid for drug administration services under section 1848 of the Social Security Act (42 U.S.C. 1395w-4).

(7) UPDATE.—For years after 2005, the relative value determined under paragraph (4) term "chemotherapy support services" shall be updated to reflect changes in prices since the date of such data.

(8) CONVERSION TO RELATIVE VALUE UNITS.—

The Secretary shall convert the total practice expenses determined under paragraph (3) to practice expense relative value units for chemotherapy support services by dividing the total practice expenses determined under section 1848 of the Social Security Act (42 U.S.C. 1395w-4) for chemotherapy support services for years beginning prior to the year 2005 by the conversion factor that will be in effect for the physician fee schedule for 2005.
revisions are consistent with the methodology set forth in this subsection.

(d) CANCER THERAPY MANAGEMENT SERVICES.—Beginning in 2005, the Secretary shall recognize and pay a payment amount for the service of cancer therapy management to account for the greater pre-service and post-service work associated with these services. Cancer therapy management services shall be furnished by physicians treating cancer patients compared to typical visits and consultations. The payment amount reflects the level and type of the related visit or consultation.

(e) OTHER SERVICES WITHOUT PHYSICIAN WORK RELATIVE VALUE UNITS.—Beginning in 2005, the Secretary shall develop a revised methodology for determining the payment amounts for services that are paid under the fee schedule by section 1848 of the Social Security Act (42 U.S.C. 1395w-4) and that do not have physician work relative value units, including radiation oncology services. Such methodology shall result in payment amounts that fully cover the costs of furnishing such services. Until such time as the methodology for such services is revised and implemented, all such services shall be protected from further payment cuts due to factors such as shifts in utilization or removal of specialty’s services that are paid under the fee schedule established by such section 1848 and that do not have physician work relative value units.

(f) IN GENERAL.—Not later than April 1, 2004, the Secretary shall submit to Congress a report on the payment amounts that may be necessary to provide for payment for cancer patients in the various treatment settings.

(g) INSTITUTE OF MEDICINE STUDY.—(1) GENERAL.—The Secretary shall request the Institute of Medicine to conduct the study described in this subsection.

(b) SCOPE AND DURATION.—The first phase of the study shall include the following objectives:

(A) To the extent to which the current medicare payment system, prior to implementation of the amendments made by this section, facilitates appropriate access to care for cancer patients in the various treatment settings;

(B) To the identification of the comprehensive range of services furnished to cancer patients in the various treatment settings;

(C) A discussion of the practice standards necessary to assure the safe provision of services to cancer patients;

(D) An analysis of the extent to which the current medicare payment system supports the role of nurses in the provision of oncology services and recommendations for any necessary improvements in the payment system in that respect;

(E) The development of a framework for assessing how the amendments made by this act affect the provision of care to medicare patients with cancer; and

(F) CONSULTATION.—The Institute of Medicine shall consult with the National Cancer Policy Board and organizations representing cancer patients and survivors, oncologists, oncology nurses, cancer centers, and other healthcare professionals who treat cancer patients in planning and carrying out this study.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under this section (in this section referred to as the "project") to demonstrate the viability of Medicare coverage for blood clotting factors and other biologicals under part B of title XVIII of the Social Security Act. Not later than 9 months after the date of enactment of this Act, the Secretary shall submit to Congress a report on the project—(1) payment may be made to such a contractor on a contingent basis;

(2) a percentage of the amount recovered may be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services;

(3) the Secretary shall examine the efficacy of the methodology for determining the payment amount for services that are paid under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the medicare program for services for which payment is made under part A or part B of title XVIII of the Social Security Act. Under the project—(1) payment may be made to such a contractor on a contingent basis;

(2) a percentage of the amount recovered may be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) the Secretary shall examine the efficacy of the methodology for determining the payment amount, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION.—(1) SCOPE.—The project shall cover at least 2 States that are among the States with—

(A) the highest per capita utilization rates of Medicare benefits for Medicare patients with cancer;

(B) at least 3 contractors.

(2) DURATION.—The project shall last for not longer than 3 years.

(c) WAIVER.—(1) WAIVER.—The Secretary of Health and Human Services shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services furnished under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS.—(1) IN GENERAL.—The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has—

(A) the appropriate clinical knowledge and experience with the payment rules and regulations under the medicare program or the entity has or will contract with another entity that has such knowledge and experience; and

(B) INELIGIBILITY.—The Secretary shall not enter into a recovery audit contract under this section with an entity only if the entity has been determined, effective October 1, 2004, either (I) by inserting "and after October 1, 2004," after "April 1, 2001,''; or (II) by inserting or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (iv),'' after "clause (iv)'' in the matter preceding subclause (I).

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED EXPERIENCE WITH PRIVATE INSURERS.—In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated experience with medicare payment policies in which accurate payments arise.

(e) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD.—A recovery of an overpayment to a provider by a recovery audit contractor shall not be treated as prohibited by the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

SEC. 401. FAIRNESS IN THE MEDICARE DISPROPORTIONATE SHARING HOSPITALS (DSH) ADJUSTMENT FOR RURAL HOSPITALS.

(a) EQUALIZING DSH PAYMENT AMOUNTS.—(1) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by inserting "and, and after October 1, 2004, for any other fiscal year described in clause (iii),'' after "clause (iv)'' in the matter preceding subclause (I).

(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in clause (iv)—

(i) in subclause (ii) —

(i) by inserting "before October 1, 2004,''; and

(ii) by inserting "and before October 1, 2004," after "April 1, 2001,''; and

(B) by inserting or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (iv),'' after "clause (iv)'' in the matter preceding subclause (I).

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED EXPERIENCE WITH PRIVATE INSURERS.—In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated experience with medicare payment policies in which inaccurate payments arise.

(f) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the medicare program and recommendations on the cost-effectiveness of extending or expanding the project.

TITLE IV—RURAL HEALTH CARE IMPROVEMENTS.

SEC. 401. FAIRNESS IN THE MEDICARE DISPROPORTIONATE SHARING HOSPITALS (DSH) ADJUSTMENT FOR RURAL HOSPITALS.

(a) EQUALIZING DSH PAYMENT AMOUNTS.—(1) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by inserting "and, and after October 1, 2004, for any other fiscal year described in clause (iii),'' after "clause (iv)'' in the matter preceding subclause (I).

(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in clause (iv)—

(i) in subclause (ii) —

(i) by inserting "and before October 1, 2004,''; and

(ii) by inserting "and before October 1, 2004," after "April 1, 2001,''; and

(ii) by inserting or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (iv),'' after "clause (iv)'' in the matter preceding subclause (I).

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED EXPERIENCE WITH PRIVATE INSURERS.—In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated experience with medicare payment policies in which inaccurate payments arise.

(f) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the medicare program and recommendations on the cost-effectiveness of extending or expanding the project.

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(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in clause (iv)—

(i) in subclause (ii) —

(i) by inserting "and before October 1, 2004,''; and

(ii) by inserting "and before October 1, 2004," after "April 1, 2001,''; and

(ii) by inserting or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (iv),'' after "clause (iv)'' in the matter preceding subclause (I).

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED EXPERIENCE WITH PRIVATE INSURERS.—In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated experience with medicare payment policies in which inaccurate payments arise.

(f) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the medicare program and recommendations on the cost-effectiveness of extending or expanding the project.
(B) in clause (viii), by striking "The formula" and inserting "For discharges occurring before October 1, 2004, the formula"; and (C) in each of clauses (x), (xi), (xii), and (xiii), by striking "appearing before October 1, 2004," as inserted under paragraph (4)(B)) for that diagnosis and adjusting or reinserting "With respect to discharges occurring before October 1, 2004, for purposes".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2004.

SEC. 402. IMMEDIATE ESTABLISHMENT OF UNIFORM STANDARDIZED AMOUNT IN RURAL AND SMALL URBAN AREAS.

(a) IN GENERAL.—Section 1886(d)(3)(A) (42 U.S.C. 1395ww(d)(3)(A)) is amended—

(i) in the heading, by inserting "in fiscal years before fiscal year 2003, for hospitals located in all areas, is amended—

(ii) by redesignating clauses (v) and (vi) as clauses (vi) and (vii), respectively, and inserting after clause (vi) the following new clause:

(vi) for discharges occurring in the fiscal year beginning on October 1, 2003, the average standardized amount for hospitals located in areas other than a large urban area shall be equal to the average standardized amount for hospitals located in a large urban area.

(b) CONFORMING AMENDMENTS.—

(1) AMENDING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking "in different fiscal years before fiscal year 2004, before "for hospitals"; and

(B) in the matter preceding clause (i), by striking "for fiscal years before fiscal year 2004," before "for hospitals"; and

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(ii) in subclause (I), by striking "and" after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(ii) in subclause (I), by striking the period at the end and inserting "; and"

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

"(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—"

(I) the average standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year;

(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group;

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by striking "for fiscal years before fiscal year 1997," before "a regional adjusted DRG prospective payment rate"; and

(B) in subparagraph (D), in the matter preceding the matter following "for fiscal years before fiscal year 1997," before "a regional DRG prospective payment rate for each region,"

(3) QUALITY CARE.—The hospital inpatient score for quality of care is not less than the median hospital score for quality of care for hospitals in the State, as established under standards of the utilization and quality control peer review organization under part B of title XI or other quality standards recognized by the Secretary.

(4) ALLOCATE SWING BEDS AND ACUTE CARE INPATIENT BEDS SUBJECT TO A TOTAL LIMIT OF 25 BEDS.—

"(B) SPECIAL RULE FOR ESSENTIAL RURAL HOSPITALS.—In the case of a hospital classified as an essential rural hospital under section 1886(c)(18), the payment under this subsection for covered OPD services during the period shall be based on 102 percent of the reasonable costs for such services. Nothing in this subparagraph shall be construed as affecting the application or amount of deductibles or copayments otherwise applicable to such services under part A or as waiving any requirement for billing for such services."

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 2004.

SEC. 404. MORE FREQUENT UPDATE IN WEEIGHTS USED IN HOSPITAL MARKET BASKET.

(a) MORE FREQUENT UPDATES IN WEEIGHTS.—

(A) IN GENERAL.—Sections 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary shall establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every 5 years.

(b) REPORT.—Not later than October 1, 2004, the Secretary shall submit a report to Congress on the frequency established under section (a), including an explanation of the reasons for, and options considered, in determining such frequency.

SEC. 405. IMPROVEMENT TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) INCREASE IN PAYMENT AMOUNTS.—

(1) IN GENERAL.—Sections 1886(e)(1), 1896(e)(1), and 1896g(b)(3) (42 U.S.C. 1395ww(e)(1), 1395wwgg(b)(3)) each are amended by inserting "equal to 102 percent of" before "the reasonable cost".

(b) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to payments for services furnished during cost reporting periods beginning on or after October 1, 2003.

(b) COVERAGE OF COSTS FOR CERTAIN EMERGENCY ROOM ON-CALL PROVIDERS.—

(1) IN GENERAL.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended—

(A) in the heading—

(i) by inserting "CERTAIN BEFORE "EMERGENCY"

(ii) by striking "PHYSICIANS" and inserting "PROVIDERS";

(2) BY striking "emergency room physicians who are on-call (as defined by the Secretary) to provide emergency services"; and

(C) by striking "physicians' services and inserting "services covered under this title".

(3) BY striking "emergency room physicians who are on-call (as defined by the Secretary) to provide emergency services"; and

(b) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply with respect to costs incurred for services provided on or after January 1, 2004.

(b) BY striking "ACUTE CARE INPATIENT BEDS SUBJECT TO A TOTAL LIMIT OF 25 BEDS.—"
(1) IN GENERAL.—Section 1820(e)(2)(B)(iii) (42 U.S.C. 1395f–4(c)(2)(B)(iii)) is amended to read as follows:

"(iii) provides not more than a total of 25 emergency inpatient services beds (pursuant to an agreement under subsection (f)) and acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient services during a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;';

(2) CONFORMING AMENDMENT.—Section 1820(f)(2) (42 U.S.C. 1395f–4(f)) is amended by striking ‘‘and the number of beds used at any time for acute care inpatient services does not exceed 15 beds’’.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on or after October 1, 2004.

(4) ELIMINATION OF THE ISOLATION TEST FOR COST-BASED CAH AMBULANCE SERVICES.—

(A) IN GENERAL.—Section 1894(i)(8) (42 U.S.C. 1395m(i)(8)), as added by section 205(a) of BIPA (114 Stat. 2763A–482), is amended by striking the comma at the end of subparagraph (B) and all that follows and inserting a period.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to services furnished on or after January 1, 2005.

(2) DEVELOPMENT OF ALTERNATIVE METHODS OF PERIODIC INTERIM PAYMENT (PIP).—

(A) IN GENERAL.—Section 1815(e)(2) (42 U.S.C. 1395m(e)(2)) is amended—

"(A) in the matter before subparagraph (A), by inserting ‘‘, in the cases described in subparagraphs (A) through (D)’’ after ‘‘1986’’; and

(B) by striking ‘‘and’’ at the end of subparagraph (C); and

(C) by adding ‘‘and’’ at the end of subparagraph (D); and

(D) by inserting after subparagraph (D) the following new subparagraph:

‘‘(E) inpatient critical access hospital services.’’

(3) REIMSTATEMENT OF PERIODIC INTERIM PAYMENT PROCEDURAL CORRECTION.—

Section 1815(e)(2) (42 U.S.C. 1395m(e)(2)) is amended—

"(A) in the matter before subparagraph (A), by inserting ‘‘, in the cases described in subparagraphs (A) through (D)’’ after ‘‘1986’’; and

(B) by striking ‘‘and’’ at the end of subparagraph (C); and

(C) by adding ‘‘and’’ at the end of subparagraph (D); and

(D) by inserting after subparagraph (D) the following new subparagraph:

‘‘(E) inpatient critical access hospital services.’’

(4) DEVELOPMENT OF ALTERNATIVE METHODS OF PERIODIC INTERIM PAYMENTS.—With respect to critical access hospitals for which the Secretary established alternative methods for such payments that are based on expenditures of the hospital.

(5) REIMSTATEMENT OF PIP.—The amendments made by paragraph (1) shall apply to payments made on or after January 1, 2004.

(6) CONDITION FOR APPLICATION OF SPECIAL PAYMENT SYSTEM FOR CRITICAL ACCESS HOSPITALS.—

(A) IN GENERAL.—Section 1834(g)(2) (42 U.S.C. 1395gg(g)(2)) is amended by adding after and before subparagraph (B) the following:

"The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician providing professional services in the hospital in any calendar year is billing at billing rates with respect to such services, except that such subparagraph shall not apply to those physicians who have not assigned such billing rights.

(B) EFFECTIVE DATE.—The amendment made by paragraph (1) shall be effective if included in the enactment of section 403 of the Medicare and SCHIP Benefits Act and section 1002 of the Budget Reform Act of 1999 (113 Stat. 1501A–371).

(7) ADDITIONAL 5-YEAR PERIOD OF FUNDING FOR GRANT PROGRAM.—

(A) IN GENERAL.—Section 1820(g) (42 U.S.C. 1395f–4(g)) is amended by adding at the end of such section the following new paragraph:

"(4) FUNDING.—

‘‘(A) IN GENERAL.—Subject to subparagraph (B), payment for grants made under this subsection for fiscal year 2004 through 2008 shall be made from the Federal Hospital Insurance Trust Fund.

‘‘(B) ANNUAL AGGREGATE LIMITATION.—In no case may the amount of payment provided for under subparagraph (A) for a fiscal year exceed $25,000,000.''

(2) CONFORMING AMENDMENT.—Section 1820 (42 U.S.C. 1395f–4) is amended by striking subsection (j).

SEC. 406. REDESIGNATION OF UNRELATED RESIDENT POSITIONS.

(a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended—

"(1) in subparagraph (f), by inserting ‘‘subject to subparagraph (I),’’ after ‘‘October 1, 1997;’’.

(2) in subparagraph (h)(i), by inserting ‘‘subject to subparagraph (I),’’ after ‘‘paragraphs (F) and (G)’’;

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

‘‘(I) REDISTRIBUTION OF UNRELATED RESIDENT POSITIONS.—

‘‘(I) REDUCTION IN LIMIT BASED ON UNRELATED RESIDENT POSITIONS.—

‘‘(I) IN GENERAL.—If a hospital’s resident level (as defined in clause (iii)(ii)) is less than the otherwise applicable resident limit (as defined in clause (iii)(i)) for each of the reference periods (as defined in clause (iii)(ii)), effective for cost reporting periods beginning on or after January 1, 2004, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in clause (iii) (or clause (iv) if applicable).

‘‘(II) REFERENCE PERIODS DEFINED.—In this clause, the term ‘reference periods’ means, for a hospital, the 3 most recent consecutive cost reporting periods for which cost reports have been settled (or, if not submitted, on or before September 30, 2002).

‘‘(III) REFERENCE RESIDENT LEVEL.—Subject to clause (iv), the reference resident level specified in this clause for a hospital is the highest resident level for the hospital during any reference periods.

‘‘(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the resident level for a hospital for the fiscal year following the fiscal year for which the cost reporting period that includes July 1, 2003.

‘‘(V) AFFILIATION.—With respect to hospitals with at least 3 affiliated groups (as defined by the Secretary under paragraph (H)(iii)), the provisions of this section shall be applied with respect to such an affiliation by deemining the affiliated group to be a single hospital.

‘‘(VI) REDISTRIBUTION.—

‘‘(I) in general.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in resident level for which the hospital is subject to such clause (ii) (without taking into account any adjustment under clause (IV) of such clause).

‘‘(II) EFFECTIVE DATE.—No increase under subparagraph (I) shall be effective if not taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2004, or before the date of the hospital’s application for approval under such clause for this clause.

No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2005.

‘‘(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in resident positions, the otherwise applicable resident limit is provided under clause (i), the Secretary shall take into account the need for such an increase by specialty and location.

‘‘(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under clause (i), the Secretary shall first distribute the increase to programs of hospitals located in rural areas and urban areas that are not large urban areas (as defined for purposes of subsection (d) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

‘‘(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount shall be equitably adjusted national average per resident amount computed under subparagraph (E) for that hospital.

‘‘(VI) CONSTRUCTION.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (d) to be equitably adjusted national average per resident amount computed under subparagraph (E) for that hospital.

‘‘(VII) ADDITIONAL 5-YEAR PERIOD OF FUNDING UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2005, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident positions under this section.

‘‘(VIII) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term ‘otherwise applicable resident limit’ means, with respect to a hospital, the total number of full-time equivalent resident positions, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

‘‘(IX) ADDITIONAL 5-YEAR PERIOD OF FUNDING UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2005, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident positions under this section.

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2005, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident positions under this section.

SEC. 410. YEAR TWO EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS UNDER PROGRESSIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) HOLD HARMLESS PROVISIONS.—

(1) IN GENERAL.—Section 1833(t)(7)(D)(I) (42 U.S.C. 1395t(7)(D)(I)) is amended—
(A) in the heading, by striking "small" and inserting "certain";

(B) by inserting "or a sole community hospital (as defined in section 1886(d)(2)(D)(iii)) located in an area that is in the lowest three quartiles of all rural county populations."

Januarv 1, 2004, for which the transportation originates in a qualified rural area (as defined in subparagraph (B)), the Secretary shall provide for an increase in the base rate of the fee schedule for mileage for a trip established under this subsection. In establishing such increase, the Secretary shall, based on the relationship of cost and volume, consider the increase in cost per trip for such services as compared with the cost per trip for the average ambulance service.

(ii) Qualified rural area defined.—For purposes of subparagraph (A), the term 'qualified rural area' is a rural area (as defined in subsection (r)(1)) with a population density of Medicare beneficiaries residing in the area that is in the lowest three quartiles of all rural county populations.

SEC. 411. TWO-YEAR INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA. (a) In general.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)(i)) during the period January 1, 2004, the Secretary shall increase the payment amount otherwise made under section 1905 of such Act (42 U.S.C. 1395f(f)) for such services by 10 percent.

(b) Waiver of applicability.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1833(t) of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of paragraph (a).

SEC. 412. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT ENHANCE UNDERSERVED POPULATIONS. (a) In general.—Section 1128(b)(3) (42 U.S.C. 1320a–7(b)(3)) is amended—

(d) FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Services described in this clause are—

(i) rural health clinic services (as defined in paragraph (2) of section 1861(aa)); and

(ii) services furnished by a federal qualified health center services (as defined in paragraph (3) of such section); that would be described in clause (ii) if such services were not furnished by an individual affiliated with a rural health clinic or a Federally qualified health center.

(e) EFFECTIVE DATE.—The amendments made by subsection (b) shall apply to cost reporting periods under paragraph (1)(B). Such rule shall be effective and final immediately on an interim final rule for an applicable base cost reporting period.

(b) Rulemaking for exception for health center entity arrangements.—

(i) Establishment.—(A) In general.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall establish, by regulation, any exceptions to the rules relating to the exception described in section 1128(b)(3)(G) of the Social Security Act, as added by subsection (a), for health center entity arrangements to the antikickback penalties. (B) Factors to consider.—The Secretary shall consider the following factors, among others, in establishing any exceptions relating to the exception for health center entity arrangements under subparagraph (A):

(i) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

(ii) Whether the arrangement between the health center entity and the other party restricts or limits a patient's freedom of choice.

(iii) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

INTERIM E F F E C TIVE DATE.—Not later than 180 days after the date of enactment of this Act, the Secretary shall publish a rule in the Federal Register consistent with the factors under paragraph (1)(B) that will be effective and final immediately on an interim basis, subject to such change and revision, after public notice and opportunity (for a period not more than 60 days) for public comment, as is consistent with this subsection.

SEC. 413. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIAN SERVICES. (a) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule established under section 1895 of the Social Security Act (42 U.S.C. 1395ww–4) for physicians' services in different geographic areas. Such study shall include—

(B) any remuneration between a public or nonprofit private health center entity and another public or nonprofit private health center entity that is consistent with this subsection.

ii) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

(b) Rulemaking for exception for health center entity arrangements.—

(i) Establishment.—(A) In general.—The Secretary of Health and Human Services (in this subsection referred to as the "Secretary") shall establish, by regulation, any exceptions to the rules relating to the exception described in section 1128(b)(3)(G) of the Social Security Act, as added by subsection (a), for health center entity arrangements to the antikickback penalties. (B) Factors to consider.—The Secretary shall consider the following factors, among others, in establishing any exceptions relating to the exception for health center entity arrangements under subparagraph (A):

(i) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

(ii) Whether the arrangement between the health center entity and the other party restricts or limits a patient's freedom of choice.
SEC. 416. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED WAGE INDEX.

(a) In General.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(1) WAGE LEVELS.—The Secretary and inserting "WAGE LEVELS.—"

(ii) in GENERAL.—Except as provided in clause (ii), the Secretary; and

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

(iii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2004.—

(II) HOLD HARMLESS FOR CERTAIN HOSPITALS.—If the application of clause (I) would result in lower payments to a hospital under this section for any period as if the clause had not been enacted.

(b) Waiving Budget Neutrality.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (I) the following new sentence: The Secretary shall apply the payment adjustments for any period as if the amendments made by section 402(a) of the Medicare Prescription Drug and Modernization Act of 2003 had not been enacted.

SEC. 417. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS FOR PHYSICIAN SCARCITY.

(a) ADDITIONAL BONUS PAYMENT FOR CERTAIN PHYSICIAN SCARCITY AREAS.—

(1) In General.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

(II) INCOME PAYMENTS FOR PHYSICIANS.—

(A) WAGE LEVELS.—The wage level for a physician defined under paragraph (I) for any year shall be the wage level for the physicians in the area determined under subparagraph (B) as if the wage level adjustment determined under subparagraph (C) were not in effect.

(B) INCOME PAYMENTS.—In the case of physicians who furnish services during any year as defined under paragraph (I) for a professional fee medical community defined under paragraphs (E), (F), and (G), the Secretary shall pay, for each year as defined under paragraph (I), a payment determined under subparagraph (C) equal to the product of the wage level for the area determined under subparagraph (B) and the number of hours in the year of services furnished by the physician.

(C) WAGE LEVEL.—The Secretary shall determine, for each year as defined under paragraph (I), the wage level for the area determined under subparagraph (B) for the professional fee medical community defined under paragraphs (E), (F), and (G).

(b) Waiving Budget Neutrality.—Section 1833 (42 U.S.C. 1395l) and section 1834(d)(1) of such Act (42 U.S.C. 1395l(d)(1)) are amended by striking "(A) PAYMENT ADJUSTMENT.—" and inserting "(A) PAYMENT ADJUSTMENT.—" in order to apply the incentive payments determined under subparagraph (C) to the professional fee medical community defined under paragraphs (E), (F), and (G) for the year as defined under paragraph (I)

SEC. 418. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(e) (42 U.S.C. 1395ww(d)(w)) is amended by adding at the end the following new paragraph:

(ii) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

(A) PAYMENT ADJUSTMENT.—

(I) in GENERAL.—Notwithstanding any other provision of this section, for each cost reporting period (beginning with the cost reporting period that begins in fiscal year 2004), the Secretary shall provide for an additional payment to each low-volume hospital as defined under paragraph (III) for discharges occurring during that cost reporting period which is equal to the applicable percentage increase (determined under clause (II)) in the amount paid to such hospital under this section for such discharges.

(iII) APPLICABLE PERCENTAGE INCREASE.—

The Secretary shall determine a percentage increase applicable under this paragraph that ensures that—

(1) no percentage increase in payments under this paragraph exceeds 25 percent of the amount (determined under this paragraph) otherwise be made to a low-volume hospital under this section for each discharge;

(2) low-volume hospitals that have the lowest number of discharges during a cost reporting period receive the highest percentage increases in payments due to the applicable percentage increase under this paragraph;

(3) the percentage increase in payments to any low-volume hospital due to the application of this paragraph is reduced as the number of discharges per cost reporting period increases.

(iII) LOW-VOLUME HOSPITAL DEFINED.—For purposes of this paragraph, a low-volume hospital means a hospital that, for the cost reporting period, a subsection (d) hospital (as defined in paragraph (1)(B)) other than a critical access hospital (as defined in section 1861(mm)(1)).

(I) LOCATED AT LEAST 15 MILES FROM A HOSPITAL (OR IS DEEMED BY THE SECRETARY TO BE SO BY REASON OF THE NATURE OF THE SERVICES PROVIDED) THAT THE SECRETARY DETERMINES APPROPRIATE, INCLUDING THE TIME REQUIRED FOR AN INDIVIDUAL TO TRAVEL TO THE NEAREST ALTERNATIVE SOURCE OF APPROPRIATE INPATIENT CARE (AFTER TAKING INTO ACCOUNT THE LOCATION OF THE NEAREST ALTERNATIVE SOURCE OF INPATIENT CARE AND ANY WEATHER OR TRAVEL CONDITIONS THAT MAY AFFECT SUCH TRAVEL TIME).

(ii) EXHIBITING CERTAIN REDUCTIONS.—

Notwithstanding subsection (e), the Secretary shall not reduce the payment amounts under this section to offset the incentive payments referred to in subparagraph (A)

SEC. 419. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A SOLE COMMUNITY HOSPITAL.

Notwithstanding subsections (a), (b), and (c) of section 1888(d) (42 U.S.C. 1395ww(d)(w)) of such Act (42 U.S.C. 1395ww(d)(w)) and section 1834(d)(1) of such Act (42 U.S.C. 1395ww(d)(w)) and section 1834(d)(1) of such Act (42 U.S.C. 1395ww(d)(w)) and section 1834(d)(1) of such Act (42 U.S.C. 1395ww(d)(w)) and section 1834(d)(1) of such Act (42 U.S.C. 1395ww(d)(w)) and section 1834(d)(1) of such Act (42 U.S.C. 1395ww(d)(w)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act (42 U.S.C. 1395ww(d)(w)) that is furnished in 2004 or 2005 by a sole community hospital (as defined in section 1861(mm)(1)(B)), the hospital shall be treated as if the test is furnished to the nearest alternative source of such services for purposes of this title.
(1) Payment based on reasonable costs.—The amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.
(2) Secretary cost-sharing.—Notwithstanding section 342, no coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under such part B shall apply with respect to such test.

SEC. 420. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC ADJUSTMENTS OF PAYMENTS FOR PHYSICIANS' SERVICES.
Section 1848(e)(3) (42 U.S.C. 1395ww(e)(3)) is amended—

(1) in subparagraph (A), by striking “subparagraphs (B) and (C) and inserting “subparagraphs (B) and (E);” and
(2) by adding at the end the following new subparagraphs:

(E) Floor for geographic indices.—

(i) In general.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2008, after calculating the work geographic indices in subparagraph (A) and (ii) of subparagraph (A), the Secretary shall increase the work floor index to the work floor index for any locality for which such geographic index is less than the work floor index.

(ii) Work floor index.—For purposes of clause (i), the term ‘work floor index’ means—

(I) 0.980 with respect to services furnished during 2004; and

(II) 0.950 for services furnished during 2005, 2006, and 2007.

(F) Floor for practice expense and malpractice geographic indices.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2008, after calculating the practice expense and malpractice indices in clauses (I) and (ii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.

SEC. 421. AMBULANCE PAYMENT RATES.
Section 1886(e)(1) (42 U.S.C. 1395ww(e)(1)) is amended to read as follows:

(3) Payment rates.—

(A) In general.—Subject to any adjustment under subparagraph (B) and paragraph (9) and the full payment of a national mileage rate pursuant to subparagraph (2)(E), in establishing such fee schedule, the following rules shall apply:

(i) Payment rates in 2003.—

(I) Ground ambulance services furnished under this part in 2000, the Secretary shall set the payment rates under the fee schedule for such services at a rate based on the average costs (as determined by the Secretary on the basis of the most recent and reliable information available) incurred by full cost ambulance suppliers in providing non-emergency ambulance support, ambulance services covered under this title, with adjustments to the rates for other ground ambulance service levels to be determined based on the rule established under paragraph (1). For the purposes of the preceding sentence, the term ‘full cost ambulance supplier’ means a supplier for which volunteers or other unpaid staff comprise less than 20 percent of the supplier’s total staff and which receives less than 20 percent of space and other capital assets free of charge.

(II) Ambulance services.—In the case of ambulance services not described in subparagraph (i) that are furnished under this part in 2003, the Secretary shall set the payment rates for the fee schedule for such services based on the rule established under paragraph (1).

(iii) Payment rates in subsequent years for all ambulance services.—In the case of any ambulance service furnished under this part in 2004 or any subsequent year, the Secretary shall set the payment rates under the fee schedule for such service at amounts equal to the payment rate under the fee schedule for that service furnished during the previous year in accordance with the percent-age increase in the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the preceding year. For years beginning with 2004, the Secretary may adjust the payment rates pursuant to subparagraph (2)(E), in the report submitted under section 221(b)(3) (the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000), shall adjust the fee schedule to such rates that would otherwise apply under this subsection for ambulance services provided in low density rural areas based on the increased cost (if any) of providing such services in such areas.

(b) Confirming amendment.—Section 221(c) of BIPA is repealed.

V. PROVISIONS RELATING TO PART B

Subtitle A—Inpatient Hospital Services

SEC. 501. ADJUSTMENT FOR INDIRECT COSTS OF MEDICAL EDUCATION (IME).
Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended by adding at the end the following new clause:

(VII) The Secretary shall periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

(c) Preference for use of DRG adjustment.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended by paragraph (1), is further amended by adding at the end the following new clause:

(VIII) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether the service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries.

(V) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

(VI) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, health services suppliers, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether the service or technology represents a substantial improvement.

(VI) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, health services suppliers, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether the service or technology represents a substantial improvement.

(VII) During each of fiscal years 2004 and 2005, ‘c’ is equal to 1.35.

SEC. 502. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PART B PS.

(a) Improving timeliness of data collection.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)), as amended by paragraph (1), is further amended by adding at the end the following new clause:

(VIII) The Secretary shall periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

(V) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

(VI) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, health services suppliers, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether the service or technology represents a substantial improvement.

(VII) During each of fiscal years 2004 and 2005, ‘c’ is equal to 1.35.
a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. In such cases, the new technology would no longer be considered an item of service or technology unless it was demonstrated that the costs of care using the new technology were greater than 75 percent of the standard deviation for the diagnosis-related group involved under clause (ii)(I). No add-on payment under this subparagraph need be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).''.

(b) IMPROVEMENT IN PAYMENT FOR NEW TECHNOLOGY—(1) IN GENERAL.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended by inserting after ‘‘the estimated average cost of such service or technology’’ the following: ‘‘(based on the marginal rate applied to costs of such service or technology) the following:’’.

(2) PERIOD.—This subsection shall be effective for a period of 12 months beginning October 1, 2003.

SEC. 504. WAGE INDEX ADJUSTMENT RECLASSIFICATION REFORM.

(a) IN GENERAL.—Section 1886(d)(3)(A) is amended by adding at the end of such section the following:

‘‘(11)(A) In order to recognize commuting patterns among Metropolitan Statistical Areas and between such areas and rural areas, the Secretary shall establish a process, upon application of a subsection (d) hospital that establishes that it is a qualifying hospital described in subparagraph (B), for an increase of the wage index applied under paragraph (3)(E) for the hospital in the amount computed under paragraph (D).’’.

(b) QUALIFYING HOSPITAL DESCRIBED IN THIS SUBPARAGRAPH.—(i) the average wages of which exceed the average wages in an area in which the hospital is located and

(ii) which has at least 10 percent of its employees who reside in one or more higher wage index areas.

(C) For purposes of this paragraph, the term ‘‘higher wage index area’’ means, with respect to a hospital, an area with a wage index that exceeds that of the area in which the hospital is located.

(D) The increase in the wage index under subparagraph (A) shall be equal to the percentage of the employees of the hospital that resides in any higher wage index area multiplied by the sum of the products, for each such area—

(i) the difference between (I) the wage index for such area, and (II) the wage index of the area in which the hospital is located (before the application of this paragraph); and

(ii) the number of employees of the hospital that reside in such higher wage index area divided by the total number of such employees that reside in all high wage index areas.

(E) The process under this paragraph shall be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10) with respect to geographic reclassification.

(F) A reclassification under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may request such a reclassification before the end of such period.

(G) A hospital that is reclassified under this paragraph for a period is not eligible for reclassification under paragraphs (8) or (10) for a period of 36 months.

(H) Any increase in a wage index under this paragraph for a hospital shall not be taken into account for purposes of—

(i) computing the wage index for the area in which the hospital is located or any other area; or

(ii) applying any budget neutrality adjustment with respect to such index under paragraph (8)(D).

(b) EFFECTIVE DATE.—The amendment made by this subparagraph is effective on and after such date as the Secretary determines.

(c) EFFECTIVE DATE.—(1) IN GENERAL.—The Secretary shall automatically reclassify any hospital that is a non-federal hospital on or after such date as the Secretary determines that such hospital meets the qualifications for such reclassification.

(2) EXCEPTION.—No reclassification under this paragraph shall apply on and after such date as the Secretary determines that such a hospital is not a non-federal hospital.

SEC. 505. CLARIFICATIONS TO CERTAIN EXEMPTIONS TO MEDICARE Geographic Classification Board Review.

(a) IN GENERAL.—Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended by adding at the end of such section the following:

‘‘(1) I N GENERAL.—The Secretary shall automatically reclassify the hospital as an application for a classification of the service or technology shall be extended by 12 months beginning October 1, 1997.

(b) PERIOD.—This subsection shall be effective for a period of 12 months beginning October 1, 1997.

SEC. 506. INCREASE IN FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

Section 1886(d)(9)(B) (42 U.S.C. 1395ww(d)(9)(B)) is amended—

(1) by striking on or after October 1, 1997, 50 percent (and for discharges beginning in a fiscal year beginning on or after such date, 50 percent (and for discharges beginning in a fiscal year beginning on or after such date, 50 percent (and for discharges between October 1, 1997, and December 30, 1997, 75 percent)’’.

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

‘‘(E) For purposes of subparagraph (A), ‘‘discharge occurring’’ shall mean discharges occurring—

(i) on or after October 1, 1997, and before October 1, 1998, 50 percent (and for discharges between October 1, 1997, and December 30, 1997, 75 percent)’’.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply on and after such date as the Secretary determines.

(1) IN GENERAL.—Section 1886(d)(9)(B) (42 U.S.C. 1395ww(d)(9)(B)) is amended by striking on or after such date, 50 percent (and for discharges beginning in a fiscal year beginning on or after such date, 50 percent (and for discharges beginning in a fiscal year beginning on or after such date, 50 percent (and for discharges between October 1, 1997, and December 30, 1997, 75 percent)’’ and inserting in lieu thereof the following:

‘‘(2) IN GENERAL.—The Secretary shall extend the application of paragraph (4)(C)(iii).’’.

(b) EFFECTIVE DATE.—This subsection shall apply to referrals made for dates of services beginning on or after such date as the Secretary determines.

SEC. 507. TEMPORARY GROWTH CORRECTION.

(a) IN GENERAL.—Section 1886(d)(9)(B) (42 U.S.C. 1395ww(d)(9)(B)) is amended by adding at the end of such section the following:

‘‘(2) IN GENERAL.—For purposes of this section, except as provided in paragraph (B), the term ‘specialty hospital’ means a hospital that is primarily or exclusively engaged in the care and treatment of one of the following:

(i) patients with a cardiac condition;

(ii) patients with an orthopedic condition; or

(iii) patients receiving a surgical procedure;

(iv) any other specialized category of patients or cases that the Secretary designates as consistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

(b) EXCEPTION.—For purposes of this section, the term ‘specialty hospital’ does not include any hospital—

(i) determined by the Secretary—

(ii) to be in operation before June 12, 2003; or

(iii) under development as of such date;

(iv) for which the number of beds and the number of physician investors at any time on or after such date is no greater than the number of such beds or investors as of such date; and

(v) that meets such other requirements as the Secretary may specify.’’.

(b) EFFECTIVE DATE.—Subject to subsection (c), the amendments made by this section shall apply to referrals made for designated health services on or after January 1, 2004.

(c) APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT.—In the case of section 1877(h)(7)(B)(iii)(I) of the Social Security Act, as added by subsection (a)(2), in determining whether a hospital is under development as of such date, the Secretary shall consider—

(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

Subtitle B—Other Provisions

SEC. 511. PAYMENT FOR COVERED SKILLED NURSING FACILITY SERVICES.

(a) ADJUSTMENT TO RESIDENTS.—(1) IN GENERAL.—Section 1877(h)(42 U.S.C. 1395yy(e)) is amended to read as follows:

‘‘(4) E STABLISHMENT OF NEW FUNDING FOR HOSPITAL INPATIENT TECHNOLOGY.—Section 1886(d)(5)(K)(ii)(ii) (42 U.S.C. 1395ww(d)(5)(K)(ii)(ii)) is amended by inserting after ‘‘the applicable Federal percentage is 67 percent;’’ the following:

‘‘(iii) that meets such other requirements as the Secretary may specify.’’.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to referrals made for designated health services on or after January 1, 2004.

(c) APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT.—In the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable shall be increased by 128 percent of such per diem amount as increased costs associated with such residents.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to services furnished on or after October 1, 2003.

SEC. 512. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 1886(d)(5)(K)(ii)(ii) (42 U.S.C. 1395yy(e)) is amended to read as follows:

‘‘(ii) that meets such other requirements as the Secretary may specify.’’.
(2) by striking the period at the end of paragraph (4) and inserting ‘‘; and’’; and
(3) by inserting after paragraph (4) the following new paragraph:
‘‘(5) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this part shall be equal to the amount attributable to the practice expense component.’’.

(c) Conforming Amendment.—Section 1812(a)(2)(A)(i) (42 U.S.C. 1395w–4(f)(2)(A)(i)) is amended by adding at the end the following new paragraph:
‘‘(4) The effect of such refinements on access to medical care beneficiaries to physicians’ services may have improved, remained constant, or deteriorated over time.

(d) Effective Date.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2004.

Title VI—Provisions Relating to Part B

Subtitle A—Physicians’ Services

Sec. 601. Revision of Updates for Physicians’ Services

(a) Update for 2004 and 2005.—

(1) In General.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

‘‘(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by the individual, physician, or other qualified personal who is either the medical director or an employee of a hospice program and that consist of—

(A) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the medicare program;

(B) an examination of changes in the use by beneficiaries of physicians’ services over time;

(C) an examination of the extent to which physicians are not accepting new medicare beneficiaries as patients.

(2) Report.—Not later than 8 months after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include a determination of whether—

(A) data from claims submitted by physicians under part B of the medicare program indicate potential access problems for medicare beneficiaries in certain geographic areas; and

(B) access by medicare beneficiaries to physicians’ services may have improved, remained constant, or deteriorated over time.

(b) Study and Report on Supply of Physicians.—

(1) Study.—The Comptroller General shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on the adequacy of the supply of physicians (including specialists) in the United States and the factors that affect such supply.

(2) Report to Congress.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the results of the study described in paragraph (1), including any recommendations for legislation.

(c) GAO Study of Medicare Payment for Inpatient Services.—

(1) Study.—The Comptroller General of the United States shall conduct a study to examine the adequacy of current reimbursements for inhalation therapy under the medicare program.

(2) Report.—Not later than May 1, 2004, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

Sec. 602. Medpac Report on Payment for Physicians’ Services

(a) Practice Expense Component.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the following:

(1) An analysis of the effect on payment for physicians’ services, after the transition to a prospective payment system, of refinements to the practice expense component of payments for physicians’ services, after the transition to a prospective payment system that are included in section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)).

(b) Use of Fiscal Year Rolling Average in Computing Gross Domestic Product.—

(1) In General.—Section 1848(f)(2)(C) (42 U.S.C. 1395w–4(f)(2)(C)) is amended by inserting at the end the following:

‘‘(2) In the case of a fiscal year, the term ‘average annual growth rate’ means the percentage of change in the gross domestic product of the United States in the case of a fiscal year, adjusted for changes in the consumer price index for all urban consumers’.’’.

Sec. 603. Medpac Report on Payment for Physicians’ Services

(a) Volume of Physician Services.—The Medicare Payment Advisory Commission shall conduct a study to examine the extent to which increases in the volume of physicians’ services under part B of the medicare program are a result of care that is provided to Medicare beneficiaries.

(b) Study and Report on Supply of Physicians.—

(1) Study.—The Comptroller General shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on the adequacy of the supply of physicians (including specialists) in the United States and the factors that affect such supply.

(2) Report to Congress.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the results of the study described in paragraph (1), including any recommendations for legislation.

Sec. 604. GAO Study of Medicare Payment for Inpatient Services

(a) Study.—The Comptroller General shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on the adequacy of current reimbursements for inhalation therapy under the medicare program.

(b) Report to Congress.—Not later than May 1, 2004, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

Sec. 605. Medpac Report on Payment for Physicians’ Services

(a) Practice Expense Component.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the following:

(1) An analysis of the effect on payment for physicians’ services, after the transition to a prospective payment system, of refinements to the practice expense component of payments for physicians’ services, after the transition to a prospective payment system that are included in section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)).

(b) Use of Fiscal Year Rolling Average in Computing Gross Domestic Product.—

(1) In General.—Section 1848(f)(2)(C) (42 U.S.C. 1395w–4(f)(2)(C)) is amended by inserting at the end the following:

‘‘(2) In the case of a fiscal year, the term ‘average annual growth rate’ means the percentage of change in the gross domestic product of the United States in the case of a fiscal year, adjusted for changes in the consumer price index for all urban consumers.’’.

Sec. 606. GAO Study of Medicare Payment for Inpatient Services

(a) Study.—The Comptroller General shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on the adequacy of current reimbursements for inhalation therapy under the medicare program.

(b) Report to Congress.—Not later than May 1, 2004, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

Sec. 607. Medpac Report on Payment for Physicians’ Services

(a) Volume of Physician Services.—The Medicare Payment Advisory Commission shall conduct a study to examine the extent to which increases in the volume of physicians’ services under part B of the medicare program are a result of care that is provided to Medicare beneficiaries.

(b) Study and Report on Supply of Physicians.—

(1) Study.—The Comptroller General shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on the adequacy of the supply of physicians (including specialists) in the United States and the factors that affect such supply.

(2) Report to Congress.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the results of the study described in paragraph (1), including any recommendations for legislation.

Sec. 608. GAO Study of Medicare Payment for Inpatient Services

(a) Study.—The Comptroller General shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on the adequacy of current reimbursements for inhalation therapy under the medicare program.

(b) Report to Congress.—Not later than May 1, 2004, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

Sec. 609. Medpac Report on Payment for Physicians’ Services

(a) Practice Expense Component.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the following:

(1) An analysis of the effect on payment for physicians’ services, after the transition to a prospective payment system, of refinements to the practice expense component of payments for physicians’ services, after the transition to a prospective payment system that are included in section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)). Such report shall examine the following matters by physician specialty:

(A) the effect of such refinements on payment for physicians’ services;

(B) the interaction of the practice expense component with other components of adjustment for physicians’ services under such section.

(2) Appropriateness of the Amount of Compensation by Reason of Such Refinements.—The effect of such refinements on access to care by medicare beneficiaries to physicians’ services.

(3) The effect of such refinements on physician participation under the medicare program.

Sec. 610. Medpac Report on Payment for Physicians’ Services

(a) Volume of Physician Services.—The Medicare Payment Advisory Commission shall conduct a study to examine the extent to which increases in the volume of physicians’ services under part B of the medicare program are a result of care that is provided to Medicare beneficiaries.

(b) Study and Report on Supply of Physicians.—

(1) Study.—The Comptroller General shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on the adequacy of the supply of physicians (including specialists) in the United States and the factors that affect such supply.

(2) Report to Congress.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the results of the study described in paragraph (1), including any recommendations for legislation.

Sec. 611. Coverage of an Initial Preventive Physical Examination

(a) Coverage.—Section 1861(s)(2)(C) (42 U.S.C. 1395w–4(s)(2)(C)) is amended by adding at the end the following:

‘‘(1) STUDY.—The Comptroller General shall submit to Congress a report on the results of the study described in paragraph (1), including any recommendations for legislation.

(c) Waiver of Deductible and Coinsurance.—

(1) Deductible.—The first sentence of section 1833(b) (42 U.S.C. 1395f–1(b)) is amended by adding at the end the following:

‘‘(2) In the case of an initial preventive physical examination, has affected the volume of physicians’ services consisting of a physical examination with the goal of health promotion and disease detection and includes items and services (excluding clinical laboratory tests), as determined by the Secretary, consistent with the recommendations of the United States Preventive Services Task Force.’’.

(b) Services Described.—Section 1861 (42 U.S.C. 1395w–1) is amended by adding at the end the following new subsection:

‘‘(ww) ‘‘Initial Preventive Physical Examination’’ means the term ‘initial preventive physical examination’ means physicians’ services consisting of a physical examination with the goal of health promotion and disease detection and includes items and services (excluding clinical laboratory tests), as determined by the Secretary, consistent with the recommendations of the United States Preventive Services Task Force.’’.

Sec. 612. Conformance to the SGR Act

(a) Initial Preventive Physical Examination.—

(1) In General.—Section 1833(b) (42 U.S.C. 1395f–1(b)) is amended by adding at the end the following:

(2) Effective Date.—The amendment made by paragraph (1) shall apply to services provided under the medicare program for years beginning on or after January 1, 2004.
not later than 6 months after the date the individual's first coverage period begins under part B; and

2. (in paragraph (7), by striking "or (H)" and inserting "or (i)"

(f) Effective Date.—The amendments made by this section shall apply to services furnished on or after January 1, 2004, but only after the end of the coverage period begins on or after such date.

SEA. 6. COVERAGE OF CHOLESTEROL AND BLOOD LIPID SCREENING.

(a) Coverage.—Section 1861(s)(2)(D) (42 U.S.C. 1395(s)(2)), as amended by section 611(a), is amended—

1. in subparagraph (V), by striking "and" at the end; and

2. by adding at the end the following new subparagraph:

"(X) cholesterol and other blood lipid screening tests (as defined in subsection (XXI));"

(b) Services Described.—Section 1861 (42 U.S.C. 1395s), as amended by section 611(b), is amended by adding at the end the following new subsection:

"Cholesterol and Other Blood Lipid Screening Test" "(XXI) The term 'cholesterol and other blood lipid screening test' means diagnostic testing of cholesterol and other lipid levels of the blood, and the purpose of early detection of abnormal cholesterol and other lipid levels.

(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cholesterol and other blood lipid screening tests, except that such frequency may not be more than once every 2 years.

(c) Frequency.—Section 1862(a)(1) (42 U.S.C. 1395s(a)(1)), as amended by section 613(e), is amended—

1. by striking "and" at the end of subparagraph (I);

2. by adding at the end of subparagraph (J) and inserting "and"; and

3. by adding at the end the following new subparagraph:

"(K) in the case of a cholesterol and other blood lipid screening test (as defined in section 1862(a)(1)), which is performed more frequently than is covered under section 1861(xx)(2);"

(d) Effective Date.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEA. 6. WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS.

(a) In General.—The first sentence of section 1863(b) (42 U.S.C. 1395b(b)), as amended by section 613(c)(1), is amended—

1. by striking "and" before "(7);" and

2. by inserting before the period at the end the following: 

"and (8) such deductible shall and be equal to the average wholesale price for the drug, or"

(b) Conforming Amendments.—Paragraphs (2)(C)(ii) and (3)(C)(ii) of section 1834(d) (42 U.S.C. 1395t(d)) are each amended—

1. by striking "DEDUCTIBLE AND" in the heading; and

2. by striking clause (I), by striking "deductible or" each place it appears.

(c) Effective Date.—The amendment made by this section shall apply to items and services furnished on or after January 1, 2004.

SEA. 6. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) Exclusion from OPD Fee Schedule.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395t(1)(B)(iv)) is amended by inserting before the period at the end the following: 

"and does not include screening mammography (as defined in section 1861(j)) and unilateral and bilateral diagnostic mammography." 

(b) Adjustment to Technical Component.—For diagnostic mammography performed on or after January 1, 2004, for which payment is made under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w-4), the Secretary, based on the most recent cost data available, shall provide for an appropriate adjustment in the payment amount for the technical component of the diagnostic mammography.

(c) Effective Date.—The amendment made by subsection (a) shall apply to mammography performed on or after January 1, 2004.

Subtitle C—Other Services

SEA. 6. HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT REFORM.

(a) Payment for Drugs.—

(1) Modification of Ambulatory Payment Classification (APC) Groups.—Section 1833(t) (42 U.S.C. 1395t) is amended—

1. by redesigning paragraph (13) as paragraph (14); and

2. by inserting after paragraph (12) the following new subparagraph:

"(13) Drug APC Payment Rates.—

(A) In General.—With respect to payment for covered OPD services furnished on or after January 1, 2004, the Secretary shall provide for an appropriate adjustment in the payment amount for such drug under the payment system under this subsection for services furnished in—

(i) 2004, 2005, or 2006, shall in no case—

1. exceed 35 percent of the average wholesale price for such drug; or

2. be less than the transition percentage (under subparagraph (C)) of the average wholesale price for the drug.

(B) A subsequent year, shall be equal to the average price for the drug for that area and year established under the competitive acquisition program under section 1947A as calculated and applied by the Secretary for purposes of this paragraph.

(C) Specified Covered Outpatient Drug Defined.—

(i) In General.—In this paragraph, the term 'specified covered outpatient drug' means, subject to clause (ii), a covered outpatient drug (as defined in 1927(k)(2)), that is—

1. a radiopharmaceutical; or

2. a drug or biological for which payment was made under paragraph (6) (relating to pass-through payments) on or before December 31, 2002.

(ii) Exception.—Such term does not include—

1. a drug for which payment is first made on or after January 1, 2003, under paragraph (6); or

2. a drug for which a temporary HCPCS code has not been assigned.

(iii) Transition Towards Historical Average Acquisition Cost.—The transition percentage under this paragraph for drugs furnished in a year is determined in accordance with the following table:

The transition percentage—

For the year— Single source drugs are—

Innovator multiple source drugs are—

Generic multiple source drugs are—

2004 83% 81.5% 46% 79% 77% 46% 2005 83% 81.5% 46% 79% 77% 46% 2006 83% 81.5% 46% 79% 77% 46%

(b) Payment for New Drugs Until Temporary HCPCS Code is Assigned.—With respect to payment for covered OPD services that includes a covered outpatient drug (as defined in 1927(k)(2)) for which a temporary HCPCS code has not been assigned, the amount provided for payment for such drug under the payment system under this subsection shall be equal to 83 percent of the average wholesale price for the drug.

(c) Classes of Drugs.—For purposes of this paragraph, each of the following shall be treated as a separate drug:

(1) Sole Source Drug.—A sole source drug which for purposes of this paragraph means a drug biologic that is not a multiple source drug (as defined in section 1927(k)(1)(A)(i) and (ii) of section 1927(k)(1)(A)(ii)) and is not a drug approved under an abbreviated new drug application under section 505(i) of the Federal Food, Drug, and Cosmetic Act.

(2) Innovator Multiple Source Drugs.—Innovator multiple source drugs (as defined in section 1927(k)(1)(A)(iii)).

(3) Noninnovator Multiple Source Drugs.—Noninnovator multiple source drugs (as defined in section 1927(k)(1)(A)(iii)).

(d) Inapplicability of Expenditures in Determining Conversion Factors.—Additional expenditures resulting from this paragraph and paragraph (14)(C) in a year shall not be taken into account in establishing the conversion factor for that year.

(2) Reduction in Threshold for Separate APCs for Drugs.—Section 1833(t)(14), as redesignated by paragraph (13), is amended by inserting at the end the following new subparagraph:

"(A) Threshold for Establishment of Separate APCs for Drugs.—The Secretary shall reduce the threshold for the establishment of separate ambulatory procedure classification groups (APCs) with respect to drugs to $50 per administration.

(3) Exclusion of Separate Drug APCs from Outlier Payments.—Section 1833(t)(5) is amended by adding at the end the following new subparagraph:

"(E) Exclusion of Separate Drug APCs from Outlier Payments.—No additional payment shall be made under subparagraph (A) in the case of ambulatory procedure codes established separately for drugs.

(4) Payment for Pass Through Drugs.—Section 1833(t)(6)(D) (42 U.S.C. 1395t(6)(D)) is amended by inserting after "under section 1842(o)" the following: "(or if the drug is covered under a competitive acquisition contract for an area, an amount determined by the Secretary equal to the average price for the drug for that area and year established under such contract as calculated by the Secretary for purposes of this paragraph)"

(e) Effective Date.—The amendments made by this subsection shall apply to services furnished on or after January 1, 2004.

(b) Special Payment for Brachytherapy.—

In General.—Section 1833(t)(14), as so redesignated and amended by subsection (a), is amended by adding at the end the following new subparagraph:

"(C) Payment Devices of Brachytherapy at Charges Adjusted to Cost.—Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy furnished on or after January 1, 2004, and before January 1, 2007, the payment basis for the device under this subsection shall be equal to the hospital's charges for such device furnished, adjusted to cost."
"(H) with respect to devices of brachytherapy, the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate categories for palladium-103 and iodine-125 devices.

(3) GAO REPORT.—The Comptroller General of the United States shall conduct a study to determine what payment adjustments, if any, are made to hospitals by Medicare for which payment is made under section 1833(t)(13)(B) of the Social Security Act, as added by paragraph (1), for devices of brachytherapy. Not later than January 1, 2005, the Comptroller General shall submit to Congress and the Secretary a report on the study conducted under this paragraph, and shall include specific recommendations for appropriate payments for such devices.

(c) APPLICATION OF FUNCTIONAL EQUIVALENCE TEST.—

(1) IN GENERAL.—Section 1833(t)(6) (42 U.S.C. 1395(t)(6)) is amended by adding at the end the following new subparagraph:

"(F) LIMITATION ON APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—The Secretary may not apply a functional equivalence standard (including such standard promulgated on November 1, 2002) or any other similar standard in order to deem a particular drug or biological to be identical to another drug or biological with respect to its mechanism of action or clinical effect to deny pass-through payment adjustments and the same relative value units as used in the fee schedule under such paragraph unless

"(i) the Secretary develops by regulation (after providing notice and a period for public comment) criteria for the application of such standard; and

"(ii) such criteria provide for coordination with the Federal Food and Drug Administration and require scientific studies that show the clinical relationship between the drugs or biologicals treated as functionally equivalent.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of enactment of this Act.

(d) HOSPITAL ACQUISITION COST STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study on the costs incurred by hospitals in acquiring covered outpatient drugs for which payment is made under section 1833(t) of the Social Security Act (42 U.S.C. 1395(t))

(2) DRUGS COVERED.—The study in paragraph (1) shall not include those drugs for which the acquisition costs is less than $50 per administration.

(3) REPRESENTATIVE SAMPLE OF HOSPITALS.—In conducting the study under paragraph (1), the Secretary shall select from the universe of hospitals with an urban/rural stratification.

(4) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the study conducted under paragraph (3), and shall include recommendations with respect to the following:

(A) Whether the study should be repeated, and if so, how frequently.

(B) Whether the study produced useful data on hospital acquisition cost.

(C) Whether data produced in the study is appropriate for making adjustments to payments for drugs and biologicals under section 1847A of the Social Security Act.

(D) Whether separate estimates can made of overhead costs, including handling and administering costs for drugs.

SEC. 622. PAYMENT FOR AMBULANCE SERVICES.

(a) HOSPITAL ACQUISITION COST STUDY.—

(1) IN GENERAL.—For using blend of fee schedule and regional fee schedules.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 413(a), is amended—

(1) in paragraph (2)(E), by inserting "consistent with paragraph (1)" after "in an efficient and fair manner"; and

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

"(1) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 413(a), is amended—

(1) in paragraph (2)(E), by inserting "consistent with paragraph (1)" after "in an efficient and fair manner"; and

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

"(11) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of service furnished in a year, the portion of the payment amount that is based on the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

"(A) Fee payment the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

"(B) For 2005, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

"(C) For 2006, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

"(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

"(E) For 2010 and subsequent years, the blended rate shall be based 100 percent on the fee schedule under paragraph (1)."

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the 9 Census divisions using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional relative value unit.

"(12) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—Section 1834(l), as amended by subsection (a), is further amended by adding at the end the following new subparagraph:

"(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—The term 'pediatric facility' means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.

"(13) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)), as amended by subsection (b), is further amended by striking "Until" and inserting "Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2003, and until".

(c) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES Furnished in 2004.—Notwithstanding any other provision of law, with respect to payment for part B of title XVIII of the Social Security Act for renal dialysis services furnished in 2004, the composite payment rate otherwise established under section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)) shall be increased by 1.6 percent.

SEC. 624. ONE-YEAR MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO REPORTS.

(a) YEAR MORATORIUM ON THERAPY CAPS.—

(1) IN GENERAL.—Section 1833(q)(4) (42 U.S.C. 1395(q)(4)) is amended by striking "and 2002" and inserting "2002, and 2004".

(b) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES.—Not later than December 31, 2003, the Secretary shall submit to Congress the reports required under section 1833(q)(4) and insert in the Balanced Budget Act of 1997 (relating to alternatives to a single annual dollar cap on outpatient therapy) and...
under section 221(d) of the Medicare, Med-
icaid, and SCHIP Balanced Budget Refine-
ment Act of 1999 (relating to utilization pat-
terns for outpatient care).
(c) IDENTIFICATION OF CONDITIONS AND DISEASES JUDGING WAIVER OF THERAPY CAP.—
(1) STUDY.—The Secretary shall request the Institute of Medicine of the National Acad-
emy of Sciences to identify conditions or diseases that should justify conducting an
assessment of the need to waive the therapy caps under section 1834(h) of the Social
Security Act (42 U.S.C. 1395f(h)(4)(A)).
(2) REPORTS TO CONGRESS.—
(A) PRELIMINARY REPORT.—Not later than July 1, 2003, the Secretary shall submit to
Congress a preliminary report on the con-
ditions and diseases identified under paragraph (1).
(B) FINAL REPORT.—Not later than Sep-
tember 1, 2004, the Secretary shall submit to
Congress a final report on such conditions and
diseases.
(C) RECOMMENDATIONS.—Not later than Oc-
tober 1, 2004, the Secretary shall submit to
Congress a recommendation of criteria, with respect to such conditions and disease,
under which a waiver of the therapy caps would apply.
(d) GAO STUDY OF PATIENT ACCESS TO
PHYSICAL THERAPIST SERVICES.—
(1) STUDY.—The Comptroller General of the
United States shall conduct a study on ac-
cess to physical therapist services in States
authorizing such services without a physi-
cian referral and in States that require such
a physician referral. The study shall—
(A) examine the use of and referral pat-
terns for physical therapist services for pa-
tients who are Medicare beneficiaries;
(B) examine the potential effect of prohib-
ing a physician from referring patients to
physical therapy services owned by the phy-
sician and provided in the physician's office;
(C) examine the delivery of physical ther-
aists' services within the facilities of De-
partment of Defense; and
(D) analyze the potential impact on medi-
care beneficiaries and on expenditures under the medi-
care program of eliminating the need for a physician referral and physician
registration for physical therapist services
under the medicare program.
(2) COMPTROLLER GENERAL TO SUBMIT REPORT.—
The Comptroller General shall submit to Congress a final report on the study
conducted under paragraph (1) by not later than 1 year after the date of the enact-
ment of this Act.
SEC. 625. ADJUSTMENT TO PAYMENTS FOR SERV-
ICES FURNISHED IN AMBULATORY SURGICAL
CENTERS.
Section 1833(i)(2)(C) (42 U.S.C. 1395b(i)(2)(C))
is amended in the last sentence by inserting "and each of fiscal years 2004 through 2008" after "in each of the fiscal years 1998 through 2002".
SEC. 626. PAYMENT FOR CERTAIN SHOES AND IN-
serts.—(A) COVERAGE FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLL-
MENT PERIOD.—
(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C.
1395x), as amended by sections 611 and 612, is amended by adding at the end the following new subsection:
"(yy) The term 'diabetes screening tests' means diagnostic testing furnished to an individual at risk for diabetes (as defined in subsection (W)) for the purpose of early detec-
tion of diabetes, including—
(1) a fasting plasma glucose test; and
(2) other tests, and modifications to tests, as the Secretary determines appro-
ropriate, in consultation with appropriate or-
ganizations.
"(yy) The term 'diabetes screening tests' means diagnostic testing furnished to an individ-
ual at risk for diabetes (as defined in subsection (W)); and
(1) by striking "and" at the end of paragraph (2); and
(2) by adding at the end the following new sub-
paragraph:
"(yy) The term 'diabetes screening tests' means diagnostic testing furnished to an
individual at risk for diabetes (as defined in subsection (W)), for the purpose of early
detection of diabetes, including—
(1) a fasting plasma glucose test; and
(2) other tests, and modifications to tests, as the Secretary determines appro-
ropriate, in consultation with appropriate or-
ganizations.
"(yy) The term 'diabetes screening tests' means diagnostic testing furnished to an individ-
ual at risk for diabetes (as defined in subsection (W)); and
(1) by striking "and" at the end of paragraph (2); and
(2) by adding at the end the following new sub-
paragraph:
"(yy) The term 'diabetes screening tests' means diagnostic testing furnished to an
individual at risk for diabetes (as defined in subsection (W)), for the purpose of early
detection of diabetes, including—
(1) a fasting plasma glucose test; and
(2) other tests, and modifications to tests, as the Secretary determines appro-
appropriate, in consultation with appropriate or-
ganizations.
"(yy) The term 'diabetes screening tests' means diagnostic testing furnished to an individ-
ual at risk for diabetes (as defined in subsection (W)), for the purpose of early
detection of diabetes, including—
(1) a fasting plasma glucose test; and
(2) other tests, and modifications to tests, as the Secretary determines appro-
appropriate, in consultation with appropriate or-
ganizations.
"(yy) The term 'diabetes screening tests' means diagnostic testing furnished to an individ-
ual at risk for diabetes (as defined in subsection (W)), for the purpose of early
detection of diabetes, including—
(1) a fasting plasma glucose test; and
(2) other tests, and modifications to tests, as the Secretary determines appro-
appropriate, in consultation with appropriate or-
ganizations.
"(l) History of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

(i) Polycystic ovary syndrome.

(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetestesting screens, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test on the individual.

(c) FREQUENCY—The Secretary shall establish, by inserting 'and' at the end of subparagraph (j); (C) by striking 'and' at the end of subparagraph (k) and inserting '; and''; and

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

"(L) in the case of a diabetes screening tests or test (as defined in section 1861(yy)(2)), which is performed more frequently than is covered under section 1861(yy)(3).

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after the date that is 90 days after the date of enactment of this Act.

TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 701. UPDATE IN HOME HEALTH SERVICES.

(a) CHANGE TO CALENDAR YEAR UPDATE.—

(1) IN GENERAL.—Section 1895(f)(2) (42 U.S.C. 1395ff(f)(2)) is amended—

(A) in paragraph (3)(B)(i)—

(i) by striking "each fiscal year (beginning with fiscal year 2002)" and inserting "fiscal year 2002 and for fiscal year 2003 and for each subsequent

(ii) by inserting "or year" after "the fiscal

(iii) by striking (3)(B)(ii) and inserting "any subsequent fiscal year" and inserting "2004 and any subsequent year";

(C) in paragraph (3)(B)(iii), by striking "or year" after "fiscal year" each place it appears;

(D) in paragraph (3)(B)(iv)—

(i) by inserting "or year" after "fiscal year" each place it appears; and

(ii) by inserting "or year" after "fiscal years"; and

(E) in paragraph (5), by inserting "or year" after "fiscal year" each place it appears.

(b) TRANSITION RULE.—The standard pro-

(2) TERMINOLOGY.—For purposes of this section, the term "chronic care improvement program in a

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICI-

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries to help assess the quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to medicare beneficiaries under the project—

(A) adversely affects the provision of home health services to medicare beneficiaries; or

(B) directly causes an unreasonable increase in expenditures under the medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program; and

(3) specific recommendations to exempt permanently and severely disabled home health beneficiaries from coverage on the length, frequency and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the medicare program.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirement of title XVI of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

Subtitle B—Chronic Care Improvement

SEC. 702. VOLUNTARY CHRONIC CARE IMPROVE-

(a) DEMONSTRATION PROJECT TO CLARIFY—

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Commission shall submit to Congress a report on the study under subsection (a).

(c) APPLICATION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(d) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supple-

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries to help assess the quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to medicare beneficiaries under the project—

(A) adversely affects the provision of home health services to medicare beneficiaries; or

(B) directly causes an unreasonable increase in expenditures under the medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program; and

(3) specific recommendations to exempt permanently and severely disabled home health beneficiaries from coverage on the length, frequency and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the medicare program.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirement of title XVI of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supple-

(j) DEFINITIONS.—In this section—

(1) the term "medicare beneficiary" means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) the term "chronic care improvement program" means a chronic care improvement program in a CCIA region for medicare beneficiaries who are not enrolled under part C and who have certain chronic conditions, such as congestive heart failure, diabetes mellitus, end-stage pulmonary disease (COPD), stroke, prostate and colon cancer, hypertension, or other disease as identified by the Secretary as appropriate for chronic care improvement. Such a program shall begin to be implemented no later than 1 year after the date of the enactment of this Act.

(2) TERMINOLOGY.—For purposes of this section—

(A) CCIA REGION.—The term 'CCIA region' means a chronic care improvement administrative region delineated under subsection (b)(2).

(B) CHRONIC CARE IMPROVEMENT PROGRAM.—The terms 'chronic care improvement program' and 'program' means such a program provided by a contractor under this section.

(C) CONTRACTOR.—The term 'contractor' means an entity with a contract with the Secretary to provide a chronic care improvement program in a CCIA region under this section.

(4) INDIVIDUAL PLAN.—The term 'individual plan' means a chronic care improvement plan established under subsection (c)(5) for an individual.

(5) CONSTRUCTION.—Nothing in this section shall be construed as expanding the amount, duration, or scope of benefits under this title.
entities for chronic care improvement programs for each CCIA region under this section through a competitive bidding process.

(2) PROCESS.—Under such process—

(A) in general.—The Secretary shall delineate the United States into multiple chronic care improvement administrative regions; and

(B) the Secretary shall select at least 2 winning bidders in each CCIA region on the basis of the ability of each bidder to carry out a chronic care improvement program in accordance with this section, in order to achieve improved health and financial outcomes.

(3) ELIGIBLE CONTRACTOR.—A contractor may be designated as a chronic care improvement organization, health insurer, provider organization, or any other legal entity that the Secretary determines appropriate.

(4) CHRONIC CARE IMPROVEMENT PROGRAMS.—

(1) IN GENERAL.—Each contractor under this section shall provide for the operation of a chronic care improvement program by a contractor in a CCIA region consistent with this subsection.

(2) IDENTIFICATION OF PROSPECTIVE PROGRAM PARTICIPANTS.—Each contractor shall have a method for identifying Medicare beneficiaries in the region to whom it will offer services under its program. The contractor shall identify such beneficiaries through claims or other data and other means permitted and consistent with applicable disclosure provisions.

(3) INITIAL CONTACT BY SECRETARY.—The Secretary shall communicate with each beneficiary identified under paragraph (2) as a prospective participant in one or more programs concerning participation in a program. Such communication may be made by the Secretary, or on behalf of the Secretary, and shall include information on the following:

(A) A description of the advantages to the beneficiary in participating in a program.

(B) Notification that the contractor offering a program may contact the beneficiary directly concerning such participation.

(C) Notification that participation in a program is voluntary.

(D) A description of the method for the beneficiary to withdraw from the program, including the method for declining to participate and a method for obtaining additional information concerning the method for withdrawing from the program.

(4) PARTICIPATION.—A Medicare beneficiary may participate in only one program under this section and may terminate participation at any time in a manner specified by the Secretary.

(5) INDIVIDUAL CHRONIC CARE IMPROVEMENT PLANS.—

(A) IN GENERAL.—For each beneficiary participating in a program under this section, the contractor shall develop with the beneficiary an individualized, goal-oriented chronic care improvement plan.

(B) ELEMENTS OF INDIVIDUAL PLAN.—Each individual plan developed under subparagraph (A) shall include a single point of contact to coordinate care and the following, as appropriate:

(i) Self-improvement education for the beneficiary (such as education on management through medical nutrition therapy) and support education for health care providers, primary caregivers, and family members;

(ii) Coordination of health care services, such as application of a prescription drug regimen and home health services;

(iii) With physicians and other providers to enhance communication of relevant clinical information.

(iv) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

(v) The provision of information about hospice care, pain and palliative care, and end-of-life care.

(vi) Coordination of services, such as coordinating with the pharmacy and identifying and monitoring enrollees with chronic conditions.

(C) CONTRACTOR RESPONSIBILITIES.—In establishing and carrying out individual plans under a program, a contractor shall, directly or through subcontractors—

(i) understand the history and life-style of the beneficiary, including all their co-morbidities, and in performing activities as specified under this section, the contractor shall, directly or through subcontractors—

(ii) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

(D) ADDITIONAL REQUIREMENTS.—The Secretary shall establish payment requirements for programs and contractors under this section.

(E) ACCREDITATION.—The Secretary may provide that programs that are accredited by qualified organizations may be deemed to meet such requirements under this section as the Secretary may specify.

(F) CONTRACT TERMS.—

(1) IN GENERAL.—A contract under this section shall contain such terms and conditions as the Secretary specifies consistent with this section. The Secretary may not enter into a contract with an entity under this section unless the entity meets such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the population to be served.

(2) USE OF SUBCONTRACTORS PERMITTED.—A contractor may carry out a program directly or through contracts with subcontractors.

(3) BUDGET NEUTRAL PAYMENT CONDITION.—In entering into a contract with an entity under this subsection, the Secretary shall establish payment rates that assure that there will be no net aggregate increase in payments under this title over any period of 3 years or longer, as agreed to by the Secretary.

(Under section 1832 of this title for a comparable population in the Medicare+Choice program, an enrollee in a Medicare+Choice plan as defined by the Secretary is an enrollee who is enrolled in a Medicare+Choice plan or has been enrolled in a Medicare+Choice organization, an enrollee in a Medicare+Choice organization, an enrollee in a Medicare+Choice plan who has one or more chronic conditions, a chronic care improvement program that is designed to manage the needs of such enrollees and that meets the requirements of this subsection.

(B) ENROLLEE WITH MULTIPLE OR SUFFICIENTLY SEVERE CHRONIC CONDITIONS.—For purposes of this subsection, the term ‘enrollee with multiple or sufficiently severe chronic conditions’ means, with respect to an enrollee in a Medicare+Choice organization, an enrollee in a Medicare+Choice organization, an enrollee in a Medicare+Choice plan who has one or more chronic conditions, such as congestive heart failure, diabetes, dementia, end-stage renal disease, heart attack, stroke, cancer, lung, radiation, or other disease as identified by the organization as appropriate for chronic care improvement.

(C) GENERAL REQUIREMENTS.—

(A) IN GENERAL.—Each chronic care improvement program under this subsection shall be conducted consistent with this subsection.

(B) IDENTIFICATION OF ENROLLEES.—Each such program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet the organization’s criteria for participation under the program.

(D) ELEMENTS OF PLANS.—Each chronic care improvement program under this section shall include a single point of contact to coordinate care and the following, as appropriate:

(i) Self-improvement education for the enrollee (such as education for disease management through medical nutrition therapy)
and support education for health care providers, primary caregivers, and family members.

(iii) Coordination of health care services, such as a plan for the selection of a prescription drug regimen and home health services.

(iv) Collaboration with physicians and other providers to enhance communication of relevant clinical information.

(v) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as a mechanism for automated transfer of information.

(vi) The provision of information about hospice care, pain and palliative care, and end-of-life care.

(EE) Organization responsibilities.—In establishing and carrying out chronic care improvement plans for participants under this paragraph, a Medicare+Choice organization shall, directly or through subcontractors—

(i) guide participants in managing their health, including all their co-morbidities, and in performing the activities as specified under the elements of the plan;

(ii) use decision support tools such as evidence-based interventions and other criteria as determined by the Secretary; and

(iii) develop a clinical information database to track and monitor each participant across the continuum.

(3) Additional requirements.—The Secretary may establish additional requirements for chronic care improvement programs under this section.

(4) Accreditation.—The Secretary may provide that chronic care improvement programs that are accredited by qualified organizations may be deemed to meet such requirements under this subsection as the Secretary may specify.

Subtitle C—Other Provisions

SEC. 724. MDPEPC REPORT.

(a) Examination of Budget Sequences.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–6(b)(2)(B)(i)) is amended by adding at the end the following new paragraph:

"(2) Examination of Budget Sequences.—Before making any recommendations, the Commission shall examine the impact of any budget recommendations, directly or through consultation with appropriate expert entities.".

(b) Consideration of Efficient Provision of Services.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–6(b)(2)(B)(i)) amended by inserting "the efficient provision of" after "expenditures for".

(c) Application of Disclosure Requirements.—(1) In General.—Section 1805(c)(2)(D) (42 U.S.C. 1395b–6(c)(2)(D)) is amended by adding at the end the following:

"(8) Examinations of Budget Sequences.—Before making any recommendations, the Commission shall examine the impact of any budget recommendations, directly or through consultation with appropriate expert entities.".

SEC. 732. DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY CARE SERVICES.

(a) Establishment.—Subject to the succeeding provisions of this section, the Secretary of Health and Human Services shall establish a demonstration project (in this section referred to as the "demonstration project") under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day care facility, to provide medical adult day care services as a substitute for treating illegal aliens.

(b) Duration.—The demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise provide for such home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to reflect any increase in amounts expended from the Trust Funds as a result of the demonstration project conducted under this section.

(c) Demonstration Project Sites.—The project established under this section shall be conducted in not more than 5 States selected by the Secretary that license or certify providers of services that furnish medical adult day care services.

(d) Waiver Authority.—The Secretary may waive such requirements of title XVIII of the Social Security Act as may be necessary for the purposes of carrying out the demonstration project, other than waiving the requirement that an individual be homebound in order to be eligible for benefits for home health services.

(e) Evaluation and Report.—The Secretary shall conduct an evaluation of the clinical and cost effectiveness of the demonstration project. Not later than 18 months after the commencement of the project, the Secretary shall submit a report on the evaluation, and shall include in the report the following:

(1) An analysis of the patient outcomes and costs for furnishing such services to medicare beneficiaries participating in the project as compared to such outcomes and costs to beneficiaries receiving only home health services under the same home health services. 

(2) Such recommendations regarding the extension, expansion, or termination of the
services in the facility; and

such other requirements as the Secretary to assure quality of care and health agency;

The term 'medical adult day care facility' means—

(A) home health service items and services described in paragraphs (1) through (7) of section 1861(m) furnished in a medical adult day care facility;

(B) a program of supervised activities furnished in a group setting in the facility that—

(i) meet such criteria as the Secretary determines appropriate; and

(ii) is designed to promote physical and mental health of the individuals; and

(C) such other services as the Secretary may specify.

(4) MEDICARE BENEFICIARY.—The term 'medicare beneficiary' means an individual entitled to benefits under part A, or enrolled for purposes of part B, of title XVIII of the Social Security Act.

(II) A plan offered by an eligible organization; and

(III) A program of all-inclusive care for the elderly (PACE) under section 1894.

(A) IN GENERAL.—With respect to a request for a national coverage determination, assign or temporary coverage determination, or a final coverage determination, assign or temporary coverage determination, the Secretary shall—

(1) determine appropriate; and

(2) rule of construction.—Nothing in this subsection shall be construed as authorizing or requiring the Secretary to modify the regulations set forth on the date of the enactment of this Act and to items and services furnished on or after such date.

(c) ISSUANCE OF TEMPORARY NATIONAL CODES.—Not later than January 1, 2004, the Secretary shall implement revised procedures for the issuance of temporary national HCPCS codes under part B title XVIII of the Social Security Act.

SEC. 734. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.—

(a) IN GENERAL.—(1) Coverage determination.—The term 'fee-for-service medicare beneficiary' means an individual entitled to benefits under part A, or enrolled for purposes of part B, of title XVIII of the Social Security Act.

(b) DEFINITIONS.—In this paragraph:

(1) Covered hospital.—The term 'covered hospital' means, with respect to a hospital on or after the date referred to in subclause (I) shall not apply to a hospital on or after January 1, 2001, or both, but is not enrolled under this part, or both, but is not enrolled under this part, or both, but is not enrolled under this part.

(2) MEDICARE COVERAGE OF ROUTINE COSTS.—A change in ownership with respect to a hospital on or after the date referred to in subclause (I) shall not affect the determination of whether such hospital is a covered hospital for purposes of such subclause.

(III) A social health maintenance organization (SHMO) demonstration project established under section 4102(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203)."

(b) CONFORMING AMENDMENT.—Section 542 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–550), as enacted into law by section 1(a)(6) of Public Law 106–554, is repealed.

(c) EFFECTIVE DATES.—The amendments made by this section shall take effect as if included in the enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–463), as enacted into law by section 1(a)(6) of Public Law 106–554.
SEC. 715. MEDICARE PANCREATIC ISLET CELL TRANSPLANT DEMONSTRATION PROJECT.

(a) Establishment.—In order to test the appropriateness of pancreatic islet cell transplantation, not later than 120 days after the date of the enactment of this Act, the Secretary shall establish a demonstration project which the Secretary, provides for payment under the Medicare program under title XVIII of the Social Security Act for pancreatic islet cell transplantation and related items and services in the case of Medicare beneficiaries who have type I (juvenile) diabetes and have end stage renal disease.

(b) Term.—The authority of the Secretary to conduct the demonstration project under this section shall terminate on the date that is 5 years after the date of the establishment of the project.

(c) Evaluation and Report.—The Secretary shall conduct an evaluation of the outcomes of the demonstration project. Not later than 120 days after the date of the termination of the demonstration project under subsection (b), the Secretary shall submit to Congress a report on the project, including recommendations for such legislative and administrative action as the Secretary deems appropriate.

(d) Payment Methodology.—The Secretary shall establish an appropriate payment methodology for the provision of items and services under the demonstration project. The methodology must include a payment methodology that bundles, to the maximum extent feasible, payment for all such items and services.

(e) Waiver Authority.—The Secretary may waive compliance with the requirements of this section to the extent that such waiver is necessary to comply with statutory requirements.

TITLE VIII—MEDICAID

SEC. 801. CONTINUATION OF MEDICAID DSH ALLOTMENTS UNDER BIPA 2000.

(a) In General.—Section 1923(f)(4) of the Social Security Act (42 U.S.C. 1396r–4(f)(4))—

(1) in paragraph (2)—

(A) in the heading, by striking "through 2002" and inserting "through 2003";

(B) by striking "ending with fiscal year 2002" and inserting "ending with fiscal year 2003"; and

(C) in the table in such paragraph, by striking the columns labeled "FY 02" and "FY 03";

(2) in paragraph (3)(A), by striking "and inserting "and";

(3) in paragraph (4), as added by section 1923(f)(3) of the Social Security Act (42 U.S.C. 1396r–4(f)(3))—

(A) in the heading, by striking "THROUGH 2002" and inserting "THROUGH 2003"; and

(B) by striking "ending with fiscal year 2002" and inserting "ending with fiscal year 2003"; and

(C) in the table in such paragraph, by striking the columns labeled "FY 02" and "FY 03";

(3) in paragraph (5)(A)(i), by striking "1 percent" and inserting "3 percent";

(4) in paragraph (5)(B)(ii)(I), by striking "3 percent" and inserting "5 percent";

(5) in paragraph (5)(B)(ii)(II), by striking "3 percent" and inserting "5 percent";

(6) in paragraph (5)(C)(ii), by striking "3 percent" and inserting "5 percent";

(7) in paragraph (5)(C)(iii), by striking "3 percent" and inserting "5 percent";

(8) in paragraph (5)(C)(iv), by striking "3 percent" and inserting "5 percent";

(9) in paragraph (5)(D), by striking "3 percent" and inserting "5 percent";

(b) Effective Date.—The amendments made by this section shall apply to DSH allotments for fiscal years beginning with fiscal year 2003 and each fiscal year thereafter.

SEC. 802. INCREASE IN FLOOR FOR TREATMENT AS AN EXTREMELY LOW DSH STATE TO 3 PERCENT IN FISCAL YEAR 2003.

(a) Increase in DSH Floor.—Section 1923(f)(5) of the Social Security Act (42 U.S.C. 1396r–4(f)(5)) is amended—

(1) by striking "fiscal year 1999" and inserting "fiscal year 2003";

(2) by striking "August 31, 2000" and inserting "August 31, 2002";

(3) by striking "1 percent" each place it appears and inserting "3 percent"; and

(4) by striking "fiscal year 2001" and inserting "fiscal year 2003".

(b) Effective Date.—The amendments made by subsection (a) take effect as if enacted on October 1, 2002, and apply to DSH allotments under title XIX of the Social Security Act for fiscal year 2003 and each fiscal year thereafter.

SEC. 803. CLARIFICATION OF INCLUSION OF IN-PATIENT DRUG PRICES CHARGED TO MEDICAID BENEFICIARIES.

(a) In General.—Section 1927(c)(1)(C)(i)(I) of the Social Security Act (42 U.S.C. 1395hh(a)) is amended by adding at the end the following:

""(including inpatient prices charged to hospitals described in section 3408(a)(4)(L) of the Public Health Service Act)"

(b) Effective Date.—The amendment made by this section takes effect as if enacted on the date of the enactment of this Act. The Secretary shall establish a demonstration project to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project.

TITLE IX—REGULATORY REDUCTION AND CONSTRUCTIVE REFORM

Subtitle A—Regulatory Reform

SEC. 901. CONSTRUCTION, DEFINITION OF SUPPLIER.

(a) Construction.—Nothing in this title shall be construed to—

(1) to compromise or affect existing legal remedies for fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 1320a-7b(b)(3)(A) and 1128a(b)(12) of the False Claims Act; or

(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the Medicare program.

(b) Effectiveness of Final Rule.—Nothing in this Act shall be treated as having been extended for 1 additional year.

(c) Effective Date.—The amendments made by this section shall apply to the date of enactment of this Act.

(d) Substantive Change in Regulations.—The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.

(e) Effective Date.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act. The Secretary shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.

(f) Limitations on New Matter in Final Regulations.—The amendment made by paragraph (3) shall apply to final regulations published on or after the date of the enactment of this Act.

SEC. 902. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) No Retroactive Application of Substantive Changes.—In General.—Section 1927(a)(2) of the Social Security Act (42 U.S.C. 1395hh(a)), as amended by subsection (a), is amended by adding at the end the following:

""(4) If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published interim final rule or final rule, such provision shall be treated as having been published as a final regulation and shall not take effect until there is an opportunity for public comment and a publication of the provision again as a final regulation."

(b) Effective Date.—The amendment made by paragraph (3) shall apply to final regulations published on or after the date of the enactment of this Act.

SEC. 903. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) No Retroactive Application of Substantive Changes.—In General.—Section 1927(a)(2) of the Social Security Act (42 U.S.C. 1395hh(a)), as amended by subsection (a), is amended by adding at the end the following:

""(5) Substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by either or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—"";
(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) NOTICE OF SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(6)(A), as added by subsection (a), is amended by adding at the end the following:

"[(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change referred to in paragraph (1).]"

(2) IN GENERAL.—Section 1871(6)(A), as added by subsection (a), is amended by adding at the end of the following new subparagraph:

"[(B)(ii) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation."

(2) IN GENERAL.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

(c) RELIANCE ON GUIDANCE.—

(1) IN GENERAL.—The amendment made by paragraph (A) shall not be construed to require a contract, to secure performance thereof any failure to apply the guidance described in paragraph (4) only if—

"(2) The exporting contractor that has a contract under this title, the Federal Acquisition Regulation applying to such contract, and the Secretary determines appropriate to further reduce such inconsistency or conflict.".

Subtitle B—Contracting Reform

SEC. 911. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

"SEC. 1874A. (a) AUTHORITY.—

"(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with Medicare administrative contractors to perform the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

"(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

"(A) the entity has demonstrated capability to carry out such function; and

"(B) the entity has sufficient assets to financially support the performance of such function; and

"(C) the entity has qualified as a Medicare administrative contractor defined—For purposes of this title and title X.

"(b) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with Medicare administrative contractors in carrying out activities under parts A and B of such title.

"(c) AUTHORITY TO ENTER INTO CONTRACTS.—In entering into contracts under this section, the Secretary shall assure that functions of Medicare administrative contractors are performed in a manner consistent with the requirements of the Federal Acquisition Regulation."

SEC. 904. RESEARCH AND STUDIES RELATING TO REGULATORY REFORM.

(a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary to provide for advisory opinions about appropriate interpretation and application of requirements to carry out the Medicare program under title XVIII of the Social Security Act. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) not later than one year after the date of the enactment of this Act.

(b) RELATIONSHIP TO CURRENT LAW.—The amendment described in the functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and functions relating to services furnished to an individual entitled to benefits under part A or enrolled under part B, both, as follows:

(1) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subsections (b) and (g) of section 1861 of the National Health Insurance Act) the amount payable under part A or under part B, both, as applicable, to Medicare administrative contractors for services furnished to an individual entitled to benefits under part A or enrolled under part B, both, as applicable:

(2) PAYMENT ACTIONS.—Determining (subssections (d) and (g) of section 1861 of the National Health Insurance Act) the amount payable under part A or under part B, both, as applicable, to Medicare administrative contractors for services furnished to an individual entitled to benefits under part A or enrolled under part B, both, as applicable:

(3) PROVIDER PAYMENT RELATED PROVISIONS.—Not later than one year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (2) of this section.
under this section, taking into account performance quality as well as price and other factors.

(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a Medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the Medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contractor for the immediately preceding contract term, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every five years.

(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among Medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the provisions of this title and subpart I applicable to functions described in subsection (a)(4)).

(D) INCENTIVES FOR QUALITY.—The Secretary shall provide incentives for Medicare administrative contractors to provide quality service and to promote efficiency.

(E) UPHOLDING REQUIREMENTS.—No contract under this section shall be entered into with any Medicare administrative contractor unless the Secretary finds that such Medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal standards, service standards and other matters as the Secretary finds pertinent.

(F) PERFORMANCE REQUIREMENTS.—(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—In developing contract performance requirements, the Secretary shall develop performance requirements applicable to functions described in subsection (a)(4).

(B) CONSULTATION.—In developing such requirements, the Secretary may consult with the representatives of organizations representing individuals entitled to benefits under part A or enrolled under part B and with representatives of other organizations representing individuals entitled to benefits under part A or enrolled under part B, including providers and suppliers, and such organizations representing individuals entitled to benefits under part A or enrolled under part B.

(C) CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate Medicare administrative contractor. Such performance requirements—

(i) shall reflect the performance requirements developed under subparagraph (A), but may include additional performance requirements;

(ii) shall be used for evaluating contractor performance under the contract; and

(iii) shall be consistent with the written statement of work provided under the contract.

(D) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a Medicare administrative contractor under this section unless the contractor agrees—

(A) to furnish to the Secretary such timely and accurate information and reports as the Secretary determines to be appropriate and necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

(B) to limit liability for conduct that would constitute fraud the United States.

(C) to furnish to the Secretary such timely and accurate information and reports as the Secretary determines to be appropriate and necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

(D) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Aid to States program.

(4) INFORMATION REQUIREMENTS.—The Secretary may transfer functions among Medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the provisions of this title and subpart I applicable to functions described in subsection (a)(4)).

(5) INCLUSION IN CONTRACTS.—All contracts with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary to ensure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

(6) SUBORDINATION OF CONTRACTUAL RIGHTS.—(A) The administration of this part shall be conducted through contracts with Medicare administrative contractors under section 1874A.

(B) To the extent the Medicare administrative contractor has met or exceeded the performance requirements under this contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the Medicare administrative contractor match data obtained other than in its activities under this title with data administered under the Medicare program, and no performance requirements under this contract may require the Medicare administrative contractor to do so.

(3) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

(A) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (3) of this subsection.

(B) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (3) of this subsection.

(4) INDEMNIFICATION.—

(A) IN GENERAL.—No Medicare administrative contractor shall be liable to the Secretary for a payment by a certifying officer under this section, the Secretary for a payment by a certifying officer under this section, or the Secretary for the payment of such a payment by a certifying officer, if the Secretary determines to be appropriate and necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

(B) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of section 3726 or section 3731 of title 18, United States Code (commonly known as the 'False Claims Act').

(1) INDEMNIFICATION BY SECRETARY.—

(A) IN GENERAL.—Subject to subparagraphs (B) and (D), in the case of a Medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from any aspect of the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title, provide indemnification to the contractor, indemnify the contractor and such persons.

(B) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the Medicare administrative contractor match data obtained other than in its activities under this title with data administered under the Medicare program, and no performance requirements under this contract may require the Medicare administrative contractor to do so.

(C) RELATING TO FISCAL INTERMEDIARIES.—

Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

``PROVISIONS RELATING TO THE ADMINISTRATION OF PART A'';

(2) Subsection (a) is amended to read as follows:

``(a) The administration of this part shall be conducted through contracts with Medicare administrative contractors under section 1874A. . .''

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking "agreement under this section" and inserting "contract under section 1874A that provides for making payments under this part".

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking "an agreement with an agency or organization under this section" and inserting "a contract with a Medicare administrative contractor under section 1874A with respect to the administration of this part"; and

(B) the Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to conduct that is determined by the Secretary to be criminal in nature, fraudulent, or grossly negligent, then such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2)(A) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations by the Secretary that certain cases should be reviewed by hearing officers), as such sections were in effect before the date of the enactment of this Act.

(3) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

``PROVISIONS RELATING TO THE ADMINISTRATION OF PART A''.

(2) Subsection (a) is amended to read as follows:

``(a) The administration of this part shall be conducted through contracts with Medicare administrative contractors under section 1874A. . .''

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking "agreement under this section" and inserting "contract under section 1874A that provides for making payments under this part".

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking "an agreement with an agency or organization under this section" and inserting "a contract with a Medicare administrative contractor under section 1874A with respect to the administration of this part''; and

(B) the Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to conduct that is determined by the Secretary to be criminal in nature, fraudulent, or grossly negligent, then such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.
(B) by striking “such agency or organization” and inserting “such Medicare administrative contractor” each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE ADMINISTRATION OF PART B’’.

(2) Subsection (a) is amended to read as follows:

‘‘The administration of this part shall be conducted through contracts with Medicare administrative contractors under section 1851(a).’’

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking ‘‘carriers’’ and inserting ‘‘Medicare administrative contractors’’;

and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before paragraph (A), by striking ‘‘by Medicare administrative contractors’’; and

(ii) in the manner before clause (i), by striking ‘‘by Medicare administrative contractors’’ and inserting ‘‘the Secretary’’ each place it appears.

(4) Subsection (c) is amended—

(A) in paragraph (1), by striking ‘‘Each carrier’’ and inserting ‘‘The Secretary’’;

(B) in paragraph (2), by striking ‘‘such carrier’’ and inserting ‘‘the Secretary’’.

(5) Subsection (d) is amended—

(A) in paragraph (1), by striking ‘‘Each carrier having an agreement with the Secretary under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in subparagraphs (A) and (B) of such section’’ and inserting ‘‘the Secretary’’;

(B) in paragraph (2), by striking ‘‘such carrier’’ and inserting ‘‘the Secretary’’.

(6) Subsection (e) is amended—

(A) in paragraph (2)—

(i) by striking ‘‘Each carrier having an agreement with the Secretary under section 1874A, as inserted by subsection (a)(1), that continues the activities referred to in subparagraphs (A) and (B) of such section’’ and inserting ‘‘The Secretary’’;

and

(ii) by striking ‘‘Each such carrier’’ and inserting ‘‘The Secretary’’;

(B) in paragraph (3)—

(i) by striking ‘‘Each carrier having an agreement with the Secretary under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in subparagraphs (A) and (B) of such section’’ and inserting ‘‘the Secretary’’;

and

(ii) by striking ‘‘such carrier’’ and inserting ‘‘the Secretary’’.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking ‘‘Each carrier having an agreement with the Secretary under section 1874A, as inserted by subsection (a)(1), that continues the activities referred to in subparagraphs (A) and (B) of such section’’ and inserting ‘‘The Secretary’’; and

(ii) by striking ‘‘Each such carrier’’ and inserting ‘‘The Secretary’’;

(B) in paragraph (3) (i) by striking ‘‘a carrier having an agreement with the Secretary under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in subparagraphs (A) and (B) of such section’’ and inserting ‘‘the Secretary’’;

and

(ii) by striking ‘‘such carrier’’ and inserting ‘‘the Secretary’’.

(8) Subsection (i) is amended—

(A) in paragraph (1)(A)(ii), by striking ‘‘carrier’’ and inserting ‘‘Medicare administrative contractor’’;

and

(B) in paragraph (2), by striking ‘‘carrier’’ and inserting ‘‘Medicare administrative contractor’’.

(9) Subsection (j)(3)(A) is amended by striking ‘‘carriers’’ and inserting ‘‘Medicare administrative contractors’’.

(10) Subsection (q)(1)(A) is amended by striking ‘‘carriers’’ and inserting ‘‘Medicare administrative contractors’’.

(11) Subsection (q)(1)(A) is amended by striking ‘‘carrier’’ and inserting ‘‘Medicare administrative contractor’’.

(D) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified in subparagraph (A) that continue to apply on a timely basis.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall provide for the letting of competitive bids for contracts for annual contract periods that begin on or after October 1, 2010.

(D) Waiver of Provider Nomination Provisions During Transition.—During the period beginning on the enactment of this Act and before the date specified under subparagraph (A) that continue to apply on a timely basis to the extent provided in paragraph (1) without regard to any of the provider nomination provisions of such section.

(E) GENERAL TRANSITION RULES.—The Secretary shall take such steps, consistent with paragraphs (1) and (1)(C), as are necessary to provide for an appropriate transition from contracts under section 1816 and section 1942 of the Social Security Act (42 U.S.C. 1395m, 1395xx) to contracts under section 1874A, as added by subsection (a)(1).

(F) AUTHORIZING CONTINUATION OF MIP FUNCTION WITH RESPECT TO CONTRACTS AND AGREEMENTS AND UNDER ROLLOVER CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall apply notwithstanding the amendments made by this section, and any reference in such provision to a fiscal intermediary or carrier shall be deemed a reference to a Medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(G) REPORTS ON IMPLEMENTATION.—

(1) PLAN FOR IMPLEMENTATION.—By not later than October 1, 2004, the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report any recommendations to the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2005, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of Medicare contractors to adapt to full competition.

SEC. 912. REQUIREMENTS FOR INFORMATION SECURITY FOR MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 911(a)(1), is amended by adding at the end the following new subsection:

"(3) REQUIREMENTS FOR INFORMATION SECURITY.—

‘‘(A) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A Medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a) shall develop and maintain an information security program that, in the judgment of the Secretary, is adequate to provide for information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under paragraphs (1) through (7) of section 44 of title 44, United States Code (other than the requirements under paragraphs (2)(D)(i), (5)(A), and (6)(B) of such section).

(B) INDEPENDENT AUDITS.—

‘‘(A) PERFORMANCE OF ANNUAL EVALUATIONS.—Each year a Medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a) shall undergo an evaluation of the information security of the contractor and of the information security program, to determine whether the contractor is meeting the requirements for information security programs imposed on Federal agencies under paragraphs (1) through (7) of section 44 of title 44, United States Code (other than the requirements under paragraphs (2)(D)(i), (5)(A), and (6)(B) of such section).

(B) REFERENCES.—

‘‘(A) MEASURES RELATING TO COMPLIANCE.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall apply notwithstanding the amendments made by this section, and any reference in such provision to a fiscal intermediary or carrier shall be deemed a reference to a Medicare administrative contractor (as provided under section 1874A of the Social Security Act)."""
"(ii) test the effectiveness of information security control techniques of an appropriate subset of the contractor's information systems (as defined in section 3502(b) of title 44, United States Code), and in addition to the evaluations under that title and an assessment of compliance with the requirements of this subsection and related information security policies, standards, and guidelines, including policies and procedures as may be prescribed by the Director of the Office of Management and Budget and applicable industry standards promulgated under section 11311 of title 40, United States Code.

(B) DEADLINE FOR INITIAL EVALUATION.—

(i) NEW CONTRACTORS.—In the case of a Medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant to such subparagraph (A) shall be completed prior to commencing such functions.

(ii) Ongoing Contractors.—In the case of a Medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted under subparagraph (A) or (B) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

(C) REPORTS AND EVALUATIONS.—

(i) TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services and to the Secretary.

(ii) TO CONGRESS.—The Inspector General of the Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations, including assessments of the scope and sufficiency of such evaluations.

(iii) AGENCY REPORTING.—The Secretary shall address the results of such evaluations in reports required under section 3546(c) of title 44, United States Code.

(b) APPLICATION OF REQUIREMENTS TO FISCAL INTERMEDIARIES AND CARRIERS.—

(1) IN GENERAL.—The provisions of section 1874A, as added by subparagraph (B), shall apply to each fiscal intermediary and carrier under section 1816 of the Social Security Act (42 U.S.C. 1395m) and each carrier under section 1842 of such Act (42 U.S.C. 1395ll) in the same manner as they apply to Medicare administrative contractors under such provisions.

(2) EFFECTIVE DATE.—The amendment made by this subsection takes effect on the date of the enactment of this Act.

(c) REPORTS ON EVALUATIONS.—The Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the evaluation and oversight, including whether to use such methodology as coding, claims, coverage, and other appropriate information under this title.

(d) MONITORING OF CONTRACTOR RESPONSES.—

(1) IN GENERAL.—Each Medicare administrative contractor shall, consistent with standards developed by the Secretary under subsection (a)(7), maintain a system for identifying who may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

(2) DEVELOPMENT OF STANDARDS.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

(3) MONITORING.—In conducting evaluations of individual Medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) (taking into account as performance requirements the standards established under clause (i)). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

(4) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

(5) EFFECTIVE DATE.—The amendment made by paragraph (1) takes effect October 1, 2004.

(6) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A, as added by paragraph (1), shall apply to each fiscal intermediary and carrier under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395ll) in the same manner as they apply to Medicare administrative contractors under such provisions.

1874A(f)(2)(A) of the Social Security Act, as added by paragraph (1), and a companion report on the adequacy of methodology under section 1874A(f)(3) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

(4) REPORT ON USE OF METHODOLOGY IN ASSESSING CONTRACTOR PERFORMANCE.—Not later than October 1, 2004, the Comptroller General of the United States shall submit to Congress a report on the adequacy of the methodology for assessing the performance of Medicare administrative contractors under section 1874A(f), including whether to use such methodology as a basis for performance bonuses. The report shall include an analysis of the sources of identified errors and potential changes in systems of contractors and rules of the Secretary that could reduce claims error rates.

(5) PROVISION OF ACCESS TO AND PROMPT RESPONSES FROM MEDICARE ADMINISTRATIVE CONTRACTORS.—

(1) IN GENERAL.—Section 1874A, as added by section 911(a)(1) and as amended by section 912(a) and subsection (b), is amended by adding at the end the following new subsection:

"(i) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(A) IN GENERAL.—Section 1874A, as added by section 911(a)(1) and as amended by section 912(a), is amended by adding at the end the following new subsection:

"(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

"(i) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—

"(A) PROVIDER EDUCATION.—There are authorized to be used for education and training to providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, an amount for such purposes as may be necessary to carry out the purposes of section 1874A(f)(1) of the Social Security Act, as amended by paragraph (1), and a companion report on the adequacy of methodology under section 1874A(f)(2)(A) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

"(B) PROVIDER EDUCATION.—There are authorized to be used for education and training to providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, an amount for such purposes as may be necessary to carry out the purposes of section 1874A(f)(1) of the Social Security Act, as amended by paragraph (1), and a companion report on the adequacy of methodology under section 1874A(f)(2)(A) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

"(C) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—

"(A) PROVIDER EDUCATION.—There are authorized to be used for education and training to providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, an amount for such purposes as may be necessary to carry out the purposes of section 1874A(f)(1) of the Social Security Act, as amended by paragraph (1), and a companion report on the adequacy of methodology under section 1874A(f)(2)(A) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

"(B) PROVIDER EDUCATION.—There are authorized to be used for education and training to providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, an amount for such purposes as may be necessary to carry out the purposes of section 1874A(f)(1) of the Social Security Act, as amended by paragraph (1), and a companion report on the adequacy of methodology under section 1874A(f)(2)(A) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

"(C) PROVIDER EDUCATION.—There are authorized to be used for education and training to providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, an amount for such purposes as may be necessary to carry out the purposes of section 1874A(f)(1) of the Social Security Act, as amended by paragraph (1), and a companion report on the adequacy of methodology under section 1874A(f)(2)(A) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

SEC. 912. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

The Secretary shall coordinate the educational activities provided through Medicare contractors (as defined in subsection (g), including under section 1839) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers under part A.
Supplementary Medical Insurance Trust Fund) $25,000,000 for each of fiscal years 2005 and 2006 and such sums as may be necessary for succeeding fiscal years.

(2) The funds made available under paragraph (1) shall be used to increase the conduct by Medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

(c) Tailoring Education and Training Activities for Small Providers or Suppliers.—

(1) IN GENERAL.—Insofar as a Medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)).

(2) SMALL PROVIDER OF SERVICES OR SUPPLIERS.—In this subsection, the term 'small provider of services or suppliers' means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(e) Requirement To Maintain Internet Sites.—

(1) IN GENERAL.—Section 1889, as added by subsection (a), is further amended by adding at the end the following new subsection:

(d) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1899, as added by subsection (a), is further amended by adding at the end the following new subsection:

(e) Encouragement of Participation in Education Program Activities.—A Medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

[f) Construction.—Nothing in this section or section 1899(g) shall be construed as providing for disclosure by a Medicare contractor of any information, regardless of whether that information compromises pending law enforcement activities or reveal findings of law enforcement-related audits.

[g) Definitions.—For purposes of this section, the term 'Medicare contractor' includes the following:

(1) Persons who are a Medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary under section 1816 and a carrier under section 1851.

(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier that has no authority under this title or title XI with respect to such activities and such provider of services or supplier.

(2) Effective Date.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

SEC. 922. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the "demonstration program") under which assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under Medicare under title XVIII of the Social Security Act (including provisions of title XI of such Act insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

(2) FORM AND CONTENT OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph—

(A) evaluation and recommendations regarding billing systems, and

(B) information and assistance regarding policies and procedures under the Medicare program, including coding and reimbursement.

(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term "small provider of services or suppliers" means—

(A) a provider with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(4) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary shall enter into contracts with qualified organizations (such as peer review organizations or entities described in section 1899A(g)(2) of the Social Security Act, as inserted by section 5(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

(c) FINANCIAL PARTICIPATION BY PROVIDERS.—(1) IN GENERAL.—The Secretary shall enter into contracts with qualified organizations (such as peer review organizations or entities described in section 1899A(g)(2) of the Social Security Act, as inserted by section 5(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

(2) AVAILABILITY OF RECOVERY ACTIONS FOR PROBLEMS IDENTIFIED AS CORRECTED.—The Secretary shall have the authority to pursue recovery actions for fraud and notwithstanding any other provision of law, any errors found in a compliance review for a small provider of services or supplier under the demonstration program shall not be subject to recovery action if the technical assistance personnel under the program determine that—

(1) the problem that is the subject of the compliance review has been corrected to its satisfaction within 30 days of the date provided to the small provider of services or supplier; and

(2) such problem remains corrected for such period as is appropriate.

(3) The preceding provisions apply only to claims filed as part of the demonstration program and lasts only for the duration of such program and only as long as the small provider of services or supplier is a participant in such program.

(d) GAO EVALUATION.—Not later than 2 years after the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether claims error rates are reduced for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

(e) Financial Participation by Providers.—The provision of technical assistance to a small provider of services or supplier under the demonstration program is conditioned upon the small provider of services or supplier paying an amount estimated and disclosed in advance of a provider's or supplier's participation (and specified to be equal to at least 25 percent of the cost of the technical assistance.

(f) Authorization of Appropriations.—There is authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the demonstration program—

(1) for fiscal year 2005, $1,000,000, and

(2) for fiscal year 2006, $6,000,000.

SEC. 923. MEDICARE PROVIDER OMBUDSMAN. MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1886(42 U.S.C. 1395w-23) is amended—

(1) by inserting at the end of the heading the following: "MEDICARE PROVIDER OMBUDSMAN" after "OMBUDSMAN";

(2) in section (b), as so redesignated, by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

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

(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Provider Ombudsman. The Ombudsman shall—

(1) provide assistance, on a confidential basis, to providers of services and suppliers, including small providers of services and suppliers, with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to such title and are not administered by the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and Medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

(2) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations to resolve suspending regulations and policies where there is widespread confusion in program administration), and
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(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and supplies. The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

(b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII, as previously amended, is amended by inserting after section 1809 the following new section:

"MEDICARE BENEFICIARY OMBUDSMAN

"Sec. 1810. (a) IN GENERAL.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

(b) Duties.—The Medicare Beneficiary Ombudsman shall:

(1) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any Medicare program;

(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including:

(A) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a Fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary;

(B) assistance to such individuals with any problems arising from disenrollment from a Medicare+Choice plan under part C, and

(C) assistance to such individuals in presenting information under section 1862–2(b) of this title;

(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

The Ombudsman shall not serve as an advocate for increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

(c) Working with Health Insurance Counseling Programs.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 4360 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding Medicare+Choice plans and changes to those plans. Nothing in this subsection shall preclude further collaboration between the Ombudsman programs.

(d) Deadline for Appointment.—The Secretary shall appoint the Medicare Provider Ombudsman and the Medicare Beneficiary Ombudsman, under the amendments made by subsections (a) and (b), respectively, by not later than 1 year after the date of the enactment of this Act.

(e) Funding.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Fund of the Federal Supplemental Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1866 of the Social Security Act (relating to the Medicare Ombudsman), as added by subsection (a)(5) and section 1807 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

(f) Use of Toll-Free Number 1–800–MEDICARE.—

(1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—Section 1809(o)(2)(B) of title XVIII of the Social Security Act (42 U.S.C. 1395p–2(b)) is amended by adding at the end the following:

"The Secretary shall provide, through the toll-free number 1–800–MEDICARE, for a toll-free number to be used by individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.”

(2) Monitoring Accuracy.—

(A) Study.—The Comptroller General of the United States shall conduct a study to monitor the accuracy and consistency of information provided to individuals entitled to benefits under title XVIII of the Social Security Act, or enrolled under part B of such title, or both, through the toll-free number 1–800–MEDICARE, including an assessment of whether the information provided is sufficient to identify problems for individuals. In conducting the study, the Comptroller General shall examine the education and training of the individuals providing information through such number.

(B) Report.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A).

Sec. 924. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) In General.—The Secretary shall establish a demonstration program (in this section referred to as the “demonstration program”) under which Medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both, regarding the Medicare program at the location of existing local offices of the Social Security Administration.

(b) Locations.—

(1) In General.—The demonstration program shall be conducted in at least 6 offices in 2 or more areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by individuals referred to in subsection (a).

(2) Assistance for Rural Beneficiaries.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program in such rural areas, the Secretary shall provide for Medicare specialists to travel among local offices in a rural area.

(c) Duration.—The demonstration program shall be conducted over a 3-year period.

(d) Evaluation.—

(1) In General.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and satisfaction with, such programs; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing Medicare specialists at local offices of the Social Security Administration.

(2) Report.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing Medicare specialists at local offices of the Social Security Administration.

Sec. 925. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY BENEFITS

(a) In General.—The Secretary shall provide that in Medicare beneficiary notices provided (under section 1806A(3) of the Social Security Act) with respect to the provision of post-hospital extended care services under part A of title XVIII of the Social Security Act, there shall be included information to the number of days of coverage of such services remaining under such part for the Medicare beneficiary and any problems arising from disenrollment from Medicare+Choice plans and changes to those plans.

(b) Effective Date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

Sec. 926. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS

(a) Availability of Data.—The Secretary shall publicly provide information that enables hospital discharge planners, Medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the Medicare program.

(b) Inclusion of Information in Certain Hospital Discharge Plans.

(1) In General.—Section 1816(ee)(2)(D) of title XVIII of the Social Security Act (42 U.S.C. 1395xv(ee)(2)(D)) is amended—

(A) by striking “hospice services” and inserting “‘hospice care’ and ‘post-hospital extended care services’”; and

(B) by inserting before the period at the end of the following:

“and this information through such number.”

(2) Effective Date.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a).

Subtitle D—Appeals and Recovery

Sec. 931. TRANSFER OF RESPONSIBILITY FOR MEDICAID APPEALS.

(a) Transition Plan.—

(1) In General.—Not later than October 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the respective Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(b) Transfer of Jurisdiction.—

(1) In General.—Not earlier than July 1, 2005, and not later than October 1, 2005, the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described
(b) by striking "PROCEEDING" and all that follows through "DETERMINATION" and inserting "DETERMINATIONS AND RECONSIDERATIONS"; and

(c) by redesignating clauses (i) and (ii) as clauses (i) and (ii) and by moving the indentation of such subclauses (and the matter that follows) 2 ems to the left; and

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

"(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or the entity in the administrative appeals process, which has the authority to decide the question of law or regulation or the matter in controversy and that there is no material issue of fact in dispute, may request the Secretary to expedite the review. The Secretary may make such request only once with respect to the same question of law or regulation in a case of an appeal.

(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for a hearing under subparagraph (A), the Secretary determines that there is no material issue of fact in dispute and that such request is accompanied by the documents and materials required, the Secretary may expedite the review and make a determination on the request in writing within 60 days after the date such request is received by the Secretary. Such determination shall be final and not subject to review by the Secretary.

(C) ACCESS TO JUDICIAL REVIEW.—

(i) IN GENERAL.—If the appropriate review panel determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that no review panel has the authority to decide; or

(ii) fails to make such determination within the period provided under subparagraph (B); then the appellant may bring a civil action described in this subparagraph.

(iii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in (i), within 60 days after the date of the determination described in such subparagraph; or

(iv) clause (iii), within 60 days of the end of the period provided under subparagraph (B) for the determination.

(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

(iv) INTEREST ON AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is a judicial review pursuant to this paragraph, the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the date of the action described pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund and by the Federal Supplemental Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income for the purposes of reimbursing due providers of services or suppliers under this Act.

(D) REVIEW PANELS.—For purposes of this subsection, a ‘review panel’ consisting of 3 members (who shall be administrative law judges, members of the Departmental Appeals Board, or qualified individuals designated by the Secretary for purposes of making determinations under this paragraph).

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting "(A)" after "(h)(1)"); and

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

"(B) An institution or agency described in subparagraph (A) that requests a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers under section 1862(a)(2) subject to the requirements of this subsection."
"(3) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE BY PROVIDERS.—A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented in the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 28, 2003.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended by BIPA, is amended by adding at the end the following new paragraph:

"(4) RECEPTION.—Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, and shall include—

(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

(B) the procedures for obtaining additional information concerning the decision; and

(C) notification of the right of the appeal or instructions on how to initiate such appeal under this section;".

(4) SUBMISSION OF RECORD FOR APPEAL.—Section 1869(c)(3)(C)(i) (42 U.S.C. 1395ff(c)(3)(C)(i)) by striking "prepare" and by inserting "submit" and by striking "with respect to" and all that follows through "and relevant policies".

(d) QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is amended—

(A) in subparagraph (A), by striking "sufficient medical, legal, and other expertise" and inserting "sufficient medical, legal, and other expertise (including knowledge of the program and the evidence used in making the determination);"

(B) in paragraph (4) and, where a claim is regarding a review by a panel described in paragraph (3), by striking "(c)(3)(E)" and inserting "(c)(3)(D)";

(C) in clause (i), by striking "submit" and by inserting "be submitted"; and

(D) by adding the following new paragraph:

"(3) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(3)(D) (42 U.S.C. 1395ff(c)(3)(D)), as amended by BIPA, is amended—

(A) in subparagraph (A), by striking "is not a related party (as defined in subsection (g)(3));"

(B) by adding the following new paragraph:

"(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be licensed to practice medicine in the case of a review by a panel described in paragraph (3) and has medical expertise in the field of practice that is appropriate for such items or services;".

(2) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is amended—

(A) by inserting "be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate) after "in writing",; and

(B) by adding the following new paragraph:

"(9) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with reviews under this section shall not be contingent on any decision rendered by the reviewer or by any reviewing professional.".

(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with reviews under this section shall not be contingent on any decision rendered by the reviewer or by any reviewing professional.

(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall—

(A) be a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services to individuals with such a disability; and

(B) has medical expertise in the field of practice that is appropriate for the items or services at issue; or

(C) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue to individuals with such a disability.
(S) Related party defined.—For purposes of this section, the term ‘related party’ means, with respect to a case under this title involving a specific individual entitled to benefits or services or deemed to be under part B or B, or both, any of the following:;

(A) The Secretary, the Medicare administrative contractor involved, or any fiduciary, officer, or employee thereof of the Department of Health and Human Services, or of such contractor.

(B) The individual (or authorized representative) at which the items or services involved in the case were provided.

(C) The health care professional that provides the items or services involved in the case.

(D) The institution at which the items or services (or treatment) involved in the case were provided.

(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

(F) Any other party determined under any regulations to have a substantial interest in the case involved.

(3) Reducing minimum number of qualified independent contractors.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking ‘‘not fewer than 12 qualified independent contractors under this subsection’’ and inserting ‘‘with a sufficient number of qualified independent contractors (but not fewer than 12) as the Secretary determines to be necessary in the circumstances’’.

(4) Effective date.—The amendments made by paragraphs (1) and (2) shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, (114 Stat. 2763A–534).

SEC. 934. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 912 of the Social Security Act (42 U.S.C. 1395u), and section 1816 of the Social Security Act (42 U.S.C. 1395w–11), is amended by inserting ‘‘(a) IN GENERAL.—Section 1874A, as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395w–11) and each carrier under section 1842 of such Act (42 U.S.C. 1395u).’’

(b) RECOVERY OF OVERPAYMENTS.—

(a) IN GENERAL.—Section 1893 (42 U.S.C. 1395dd) is amended by adding at the end the following new subsection:

‘‘(f) Recovery of Overpayments.—

‘‘(1) Use of repayment plans.—

‘‘(A) IN GENERAL.—If the repayment, within 30 days by a provider of services or supplier, of any overpayment under this title would constitute a hardship (as defined in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months to a maximum of 5 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

‘‘(B) Hardship.—For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if it is not possible for the provider of services that files report costs, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

‘‘(C) Exceptions.—Subparagraph (A) shall not apply if—

(i) in the case of a provider of services that files report costs, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year;

(ii) RULE OF APPLICATION.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this title during the previous year or was paid under this title only during a portion of the previous year."

(iii) Treatment of previous overpayments.—If a provider of services or supplier has entered into a repayment plan under this paragraph (A) with a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

(i) there is a bill that the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the Medicare program under this title;

(ii) there is an indication of fraud or abuse committed against the program.

(b) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

(c) RELATION TO NO FAULT PROVISION.—Nothing in this payment plan shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the case of certain overpayments).

(d) LIMITATION ON RECUPERATION.—

(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action against the provider of services or supplier that will authorize any other person, including any Medicare contractor, as defined in subparagraph (C), to recuperate the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is adverse to the provider of services or supplier, the Secretary may award interest on the overpayment accruing on and after the date of the original notice of overpayment. Insofar as such determination is adverse to the provider of services or supplier, and such determination is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term ‘‘Medicare contractor’’ (as defined by the Secretary) means—

(1) a person or entity designated by the Secretary to perform any or all of the administrative functions performed under this Act; and

(2) a person or entity designated by the Secretary to perform any or all of the functions performed under the Medicare program.

(D) PROVISION OF SUPPORTING DOCUMENTATION.—In the case of a provider of services or supplier with respect to which amounts were determined to be overpaid, the Secretary may request the periodic production of records or supporting documentation for a...
limited sample of submitted claims to ensure that the previous practice is not continuing.

"(5) Consent settlement reforms.—

"(A) In general.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a project overpayment. 

"(B) Opportunity to submit additional information before consent settlement offer.—If, after giving a provider of services or supplier a consent settlement, the Secretary shall—

"(i) communicate to the provider of services or supplier—

"(I) that, based on a review of the medical records requested by the Secretary, a pre-limiting sample of those records indicates that there would be an overpayment;

"(II) the nature of the problems identified in such evaluation; and

"(ii) the steps that the provider of services or supplier should take to address the problems; and

"(iii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

"(C) Consent settlement offer.—The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

"(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

"(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

"(I) the opportunity for a statistically valid random sample; or

"(II) a consent settlement.

The opportunity provided under clause (I)(i) does not waive any appeal rights with respect to the alleged overpayment involved.

"(D) Consent settlement defined.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than 100% of valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

"(6) Notice of over-utilization of codes.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified significant over-utilization of billing codes by that class of providers of services or suppliers under the programs under this title that is more than 1 year after the date of the enactment of this Act.

"(A) In general.—The Secretary shall establish a standard methodology for probe sampling. The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

"(B) Effective dates and deadlines.—

"(1) Use of repayment plans.—Section 1866[(l)(1)(A)(i)(I)] of the Social Security Act, as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act.

"(2) Limitation on recoupment.—Section 1893[(i)(2)] of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

"(3) Use of extrapolation.—Section 1893[(j)(3)] of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

"(4) Provision of supporting documentation.—Section 1893[(f)(4)(A)] of the Social Security Act, as added by subsection (a), shall take effect on the date of the enactment of this Act.

"(5) Consent settlement.—Section 1893[(j)(5)] of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

"(6) Notice of overutilization.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish by regulation a process for the establishment of billing codes under section 1893[(f)(6)] of the Social Security Act, as added by subsection (a).

"(7) Payment audits.—Section 1893[(f)(7)] of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

"(8) Standard for abnormal billing patterns.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall establish a standard methodology for selecting claims for abnormal billing patterns under section 1893[(f)(8)] of the Social Security Act, as added by subsection (a).

SEC. 936. PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.

(a) In general.—Section 1886[(d)(10)(D)(vi)] (42 U.S.C. 1395ww(d)(10)(D)(vi)) is amended by adding after subclause (II) at the end the following:

"(B) Deadlines.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment and, if applicable, renewal of enforcement. The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

"(C) Consultation.—The Secretary shall consult with providers of services and suppliers before making changes in the procedures for enrollment for the purposes of this subparagraph.

"(D) Consent settlement offer.—The Secretary shall consult with providers of services and suppliers to be eligible to submit claims for which payment may be made under this title.

"(D) Consent settlement defined.—For purposes of paragraph (1), the term 'consent settlement offer' means an agreement by the Secretary to settle a projected overpayment.

"(E) Effective dates.—

"(1) Enrollment process.—The Secretary shall provide for the establishment of the enrollment process under section 1866[(l)(1)(A)] of the Social Security Act, as added by subsection (a)(2), within 6 months after the date of the enactment of this Act.

"(2) Consultation.—Section 1866[(i)(1)(C)] of the Social Security Act, as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made or after January 1, 2004.

"(F) Hearing rights in cases of denial or non-renewal.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.''.

"(b) Effective dates.—

"(1) Enrollment process.—The Secretary shall provide for the establishment of the enrollment process under section 1866[(l)(1)(A)] of the Social Security Act, as added by subsection (a)(2), within 6 months after the date of the enactment of this Act.

"(2) Consultation.—Section 1866[(i)(1)(C)] of the Social Security Act, as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made or after January 1, 2004.

"(3) Hearing rights.—Section 1866[(j)(2)] of the Social Security Act, as added by subsection (a)(2), shall apply to denial occurring on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary specifies.

SEC. 937. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS WITHOUT PURSUING APPEALS PROCESS.

(a) Claims.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1899(g) of the Social Security Act, as inserted by section 301(a)(1)) and representatives of providers of services and suppliers, a process under which the Secretary, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under this title, may give the provider of services or supplier a determination by the Secretary without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

"(b) Permitted use of corrected and supplementary data.—

"(1) In general.—Section 1896[(d)(10)(D)(vi)] (42 U.S.C. 1395ww(d)(10)(D)(vi)) is amended by adding after subclause (II) at the end the following:

"(A) In general.—Notwithstanding any other provision of this title or other provision of law, a hospital may submit (or resubmit) an application for a change described in section 1886[(d)(10)(C)(ii)(I)](I) of the Social Security Act for fiscal year 2004 if the hospital demonstrates to the satisfaction of the Secretary that the use of corrected or supplementary data under
the amendment made by paragraph (1) would materially affect the approval of such an application.

(b) Application of Budget Neutrality.—If one or more of the hospital's applications are approved as a result of paragraph (1) and subparagraph (A) for fiscal year 2004, the Secretary shall make a proportional adjustment in the standard amounts determined under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) for fiscal year 2004 to assure that approval of such application does not result in aggregate payments under section 1886(d) of such Act that are greater or less than those that would have been paid if paragraph (1) and subparagraph (A) did not apply.

SEC. 918. PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES: ADAPTATION OF BIPA.

(a) In General.—Section 1886(h)(2) of the Social Security Act (as added by sections 521 and 522 of BIPA and amended by section 935[a] of the Medicare and Medicaid Revenue Act of 2003), as amended by section 1211 of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, is further amended by adding at the end the following new subsection:

"(h) PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.—

"(1) Establishment of process.—

"(A) In general.—With respect to a Medicare administrative contractor that has a contract with the Secretary, the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor to the medical necessity for the item or service, administrative costs and burdens, amount involved with respect to the item or service, and any other appropriate documentation to make a coverage determination.

"(B) No prior determination after receipt of Services.—Once an individual is provided items and services, there shall be no prior determination under this subsection with respect to such items or services.

"(B) Effective Date; Transition.—

"(1) PRIOR DETERMINATION PROCESS.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall establish the prior determination process under the amendment made by subsection (a) in such a manner as to provide for the acceptance of requests for determinations under such process filed not later than 18 months after the date of the enactment of the Act.

"(2) TRANSITION.—During the period in which the amendment made by subsection (a) has become effective but contracts are not provided under section 1874A of the Social Security Act with Medicare administrative contractors, any reference in section 1886(g) of such Act (as added by such amendment) to a reference to a fiscal intermediary or carrier with an agreement under section 1816, or contract under section 1822, respectively, of such Act.

(c) Limitation on application to SGR.—For purposes of applying section 1869(g)(1)(D)(i)(II) of the Social Security Act (as added by subsection (a)), the amendment made by subsection (a) shall not be considered to be a change in law or regulation.

(d) Provisions Relative to Advance Beneficiary Notices: Report on Prior Determination Process.—

"(1) Data Collection.—The Secretary shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (2)) has been provided and in instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

"(2) Outreach and Education.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the Medicare program.

"(3) GAO Report Report on Use of Advance Beneficiary Notices: Report on Prior Determination Process.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices.

"(d) GAO Report on Use of Prior Determination Process.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include information concerning the types of procedures for which a prior determination has been sought, determinations made under such procedure, and determinations made under procedures resulting from the application of such process; and
(B) an evaluation of whether the process was useful for physicians (and other suppliers) and beneficiaries, whether it was timely, and whether the amount of information necessary for visits is burdensome to physicians and beneficiaries.

(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term ‘‘advance beneficiary notice’’ means a written notice or written messages as defined in section 1395ww(d)(2)(D) of title XVIII of such Act filed as part of the pilot project and lasts only for the duration of the pilot project and only as long as the provider is a participant in the pilot project.

(6) STUDY OF IMPACT.—Each pilot project shall examine the effect of the new evaluation and management documentation guidelines.

(a) In General.—The Secretary shall examine the effect of the new evaluation and management documentation guidelines; and the Secretary shall consult with practicing physicians, in- cluding both generalists and specialists, for the purposes of determining whether the guidelines will be met in the implementation of such guidelines; and that includes appropriate outreach.

(b) Study.—The Secretary shall carry out a study of the matters described in paragraph (a) as part of the pilot project.

(c) Matters Described.—The matters referred to in paragraph (a) are—

(1) the development of a simpler, alter- native methods for coding, and
(2) the costs of the activities, including coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

(4) EXECUTIVE COORDINATOR FOR TECH- NOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132a(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and beneficiaries regarding coding, and payment processes under this title.

(b) Methods for Determining Payment Basis for New Lab Tests.—Section 1863(h) (42 U.S.C. 1320a(2)(h)) is amended by adding at the end the following:

(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or sub- stitution for a new test code (as defined in section 1861(s)(2)) is added to the list of tests for which payments are made under title XVIII of such Act, by determining the applicable payment amount under this subsection for establishing payment amounts for the tests on such list;


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(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in the payment for the services that are being proposed to be billed under this subparagraph, receive such comments and recommendations (and data on which the recommendations are based);

(iv) after such public comment, receive such public comment, receive such comments and recommendations (and accompanying data) received at such meeting, develop, and make available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection as the Secretary deems appropriate.

(c) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

(i) set forth the criteria for making determinations under subparagraph (A); and

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(D) The Secretary may convene such further public meetings to receive public comments and recommendations from hospitals, physicians, and the public.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to items or services as such a standard.
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(f) Waiver of Administrative Limitation.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory group members or the subject matter of the advisory group (within the Department of Health and Human Services or otherwise).

SEC. 946. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) In General.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

"(D) A hospital program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a professional nature not provided non-routinely and so infrequently that the provision of such services directly would be impracticable and prohibitively expensive.";

(b) Conforming Payment Provision.—Section 1886(c)(3)(ii) (42 U.S.C. 1395ff(c)(3)(ii)), as amended by section 521 of BIPA, is amended by adding at the end the following new paragraph:

"(I) In the case of hospice care provided by a hospice program under arrangements under section 1886(d)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.

(c) Effective Date.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 947. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) In General.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (R), by striking "and"

and adding at the end the following:

"(j) The Secretary shall, in consultation with the Secretary of Labor, establish such regulations as the Secretary determines to be appropriate,";

and

(2) adding at the end of subsection (b) the following new paragraph:

"(4)(A) A hospital that fails to comply with the requirement of subsection (a)(3)(T) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is subject to termination of an agreement under this section and the right to be paid under such agreement.

(2) The amount referred to in subparagraph (A) is an amount that is subject to the amount civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in paragraph (1) (as defined in section 1128(f) (f) that determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.";

SEC. 950. TREATMENT OF CERTAIN DENTAL SERVICES.

(a) In General.—Section 1862 (42 U.S.C. 1395y) is amended by adding after subsection (g) the following new subsection:

"(h) Subject to paragraph (2), a group health plan (as defined in section 1311 of the Patient Protection and Affordable Care Act) shall provide coverage for such services provided by a supplier ofChoose from: A. other hospitals to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such services, and inserting "or (ii) where the service was provided under a contractual arrangement between such physician or other person and an entity (as defined by the Secretary), to the entity if, under the contractual arrangement, the entity submits the bill for such services, and inserting "except to an employer, entity, or other person"; and

(c) Effective Date.—The amendments made by this section shall apply to payments made on or after the date of the enactment of this Act.
the enactment of this Act, the Comptroller General shall submit to Congress a report on all aspects of physician compensation for services furnished under title XVIII of the Social Security Act and how those payments interact and the effect on appropriate compensation for physician services. Such report shall review alternatives for the physician fee schedule under section 1848 of such title (42 U.S.C. 1395w–4).

(b) Annual Publication of List of National Coverage Determinations.—The Secretary, in an annual publication available to the public, a list of national coverage determinations made under section 1861(s)(1) of the Social Security Act in the previous year and information on how to get more information with respect to such determinations.

(c) Flexibility in Applying Home Health Conditions of Participation to Patients Who Are Not Medicare Beneficiaries.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the implications if there were flexibility in the application of the Medicare conditions of participation for home health agencies with respect to groups or types of patients who are not Medicare beneficiaries. The report shall include an analysis of the potential impact of such flexible application on clinical operations and the recipients of such services and an analysis of the means for monitoring the quality of care provided to such recipients.

(d) OIG Report on Notices Relating to Use of Hospital Lifetime Reserve Days.—Not later than 1 year after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall submit a report to Congress on—

(1) the extent to which hospitals provide notice to Medicare beneficiaries in accordance with applicable requirements before they use the 60 lifetime reserve days described in section 1812(a)(1) of the Social Security Act (42 U.S.C. 1395k(a)(1)); and

(2) the appropriateness and feasibility of hospitals providing a notice to such beneficiaries before they completely exhausting such lifetime reserve days.

SEC. 1001. Importation of Prescription Drugs.

(a) In General.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 384 and inserting the following:

"SEC. 384. Importation of prescription drugs.

"(a) Definitions.—In this section:

"(1) Importer.—The term 'importer' means a pharmacist or wholesaler.

"(2) Pharmacist.—The term 'pharmacist' means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.

"(3) Prescription drug.—The term 'prescription drug' means a drug subject to section 303(b), other than—

"(A) an uncontrolled substance (as defined in section 810 of the Controlled Substances Act (21 U.S.C. 802));

"(B) a biological product (as defined in section 351 of the Public Health Service Act (42 U.S.C. 262));

"(C) a product in an intravenous solution; and

"(D) an infused drug (including a peritoneal dialysis solution).

"(4) Qualifying Laboratory.—The term 'qualifying laboratory' means a laboratory in the United States that has been approved by the Secretary for the purposes of this section.

"(5) Wholesaler.—

"(A) In general.—The term 'wholesaler' means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 303(a)(2)(A).

"(B) Exclusion.—The term 'wholesaler' does not include a person authorized to import drugs under section 301(d)(1).

(b) Regulations for Importing Prescription Drugs.—

(1) Definitions.—The Secretary, after consultation with the United States Trade Representative and the Commissioner of Customs, shall promulgate regulations permitting pharmacists and wholesalers to import prescription drugs from Canada into the United States.

(2) Limitation.—The regulations under subsection (b) shall—

"(D) require that safeguards be in place to ensure that each prescription drug imported under the regulations complies with section 506 (including with respect to being safe and effective for the intended use of the prescription drug), with sections 501 and 502, and with other applicable requirements of this Act;

"(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e); and

"(3) contain any additional provisions determined by the Secretary to be appropriate as a safeguard to protect the public health or as a means to facilitate the importation of prescription drugs.

(g) Information and Records.—

(1) In General.—The regulations under subsection (b) shall require—

"(A) the name and quantity of the active ingredient of the prescription drug;

"(B) a description of the dosage form of the prescription drug; and

"(C) the date on which the prescription drug is shipped.

(f) The quantity of the prescription drug that is shipped.

(e) The point of origin and destination of the prescription drug.

(f) The price paid by the importer for the prescription drug.

(g) Documentation from the foreign seller specifying—

"(i) the original source of the prescription drug; and

"(ii) the quantity of each lot of the prescription drug actually received by the seller from that source.

(h) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

(i) The name, address, telephone number, and professional license number (if any) of the importer.

(j) In the case of a prescription drug that is shipped directly from the first foreign recipient of the prescription drug from the manufacturer—

"(1) documentation demonstrating that the prescription drug was received by the recipient from the manufacturer and subsequently shipped by the first foreign recipient to the importer;

"(2) documentation of the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient;

"(3) documentation of the quantity of each lot of the prescription drug received by the unauthorized recipient demonstrating that the quantity being imported into the United States was statistically sampled; and

"(4) the amount and type of testing conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory.

(k) Certification from the importer or manufacturer of the prescription drug that the prescription drug—

"(i) is approved for marketing in the United States; and

"(ii) meets all labeling requirements under this Act.

(l) Laboratory records, including complete data derived from all tests necessary to ensure that the prescription drug is in compliance with established specifications and standards.

(m) Documentation demonstrating that the testing required by subparagraphs (j) and (l) was conducted at a qualifying laboratory.

(n) Any other information that the Secretary determines is necessary to ensure the protection of the public health.

(2) Maintenance by the Secretary.—The Secretary shall maintain information and documentation submitted under paragraph (1) for such period of time as the Secretary determines to be necessary.

(e) Testing.—The regulations under subsection (b) shall require—

"(1) that testing, described in subparagraphs (j) and (l) of subsection (d)(1) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory;

"(2) if the tests are conducted by the importer—

"(A) that information needed to—

"(i) authenticate the prescription drug being tested; and

"(ii) confirm that the labeling of the prescription drug complies with labeling requirements under this Act;

"(B) that the information supplied under subparagraph (A) be kept in strict confidence and used only for purposes of testing or otherwise complying with this Act; and

"(C) that the information may include such additional provisions as the Secretary determines to be appropriate to provide for the protection of trade secrets and commercial or financial information that is privileged or confidential;

"(f) Registration of Foreign Sellers.—Any establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment.

(f) Payment of Importation.—The Secretary shall require that importations of a specific prescription drug or importations by a specific importer under subsection (b) be immediately suspended on discovery of a pattern of importation of that specific prescription drug or by that specific importer of drugs that are counterfeit or in violation of any requirement under this section, until an investigation is completed and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported under subsection (b).

(h) Approved Labeling.—The manufacturer of a prescription drug shall provide an importer with written assurance that the importer to use, at no cost, the approved labeling for the prescription drug.
"(i) Prohibition of Discrimination.—

"(1) IN GENERAL.—It shall be unlawful for a manufacturer of a prescription drug to discriminate against, or cause any other person to discriminate against, a pharmacy or pharmacy wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

"(2) Discrimination.—For the purposes of paragraph (1), a manufacturer of a prescription drug who distributes a prescription drug by means of, or in connection with, a pharmacy or pharmacy wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

(3) Waiver Authority for Importation by Individuals.—

(1) IN GENERAL.—The Secretary may grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition on importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate.

(2) By the Comptroller General.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study to determine the effect of this section on the price of prescription drugs sold to consumers at retail.

(B) REPORT.—Not later than 18 months after the effective date of the regulations under subsection (b), the Comptroller General shall submit to Congress a report describing the findings of the study under subparagraph (A).

(m) Construction.—Nothing in this section shall be construed to permit any person to discriminate against a pharmacist or pharmacy wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6), by striking "covered product pursuant to section 804(b)" and inserting "covered product in violation of section 804; and"

(p) Conditions.—This section shall be- come effective only if the Secretary certifies to the Congress that implementation of this section will—

(ii) identically the same or in circumstances in which

(i) the importation is clearly for personal use; and

(ii) the prescription drug or device imported does not appear to present an unreasonable risk to the individual.

(3) Drugs Imported from Canada.—In particular, the Secretary shall by regulation authorize a waiver to permit individuals to import into the United States a prescription drug that—

(A) is imported from a licensed pharmacy for personal use by an individual, not for resale, in quantities that do not exceed a 90-day supply;

(B) is accompanied by a copy of a valid prescription; and

(C) is imported from Canada, from a seller registered with the Secretary;

(4) In General.—The Secretary shall publish, and update as necessary, guidance that accurately describes circumstances in which—

(i) the importation is clearly for personal use; and

(ii) the prescription drug or device imported does not appear to present an unreasonable risk to the individual.

(5) Declaration.—

(1) IN GENERAL.—The Secretary may grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition on importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate.

(2) Case-by-Case Waivers.—

The Secretary shall publish, and update as necessary, guidance that accurately describes circumstances in which the Secretary will consider granting waivers on a case-by-case basis under subparagraph (A), so that individuals may know with the greatest practicable degree of certainty whether a particular importation for personal use will be permitted.

(3) Drugs Imported from Canada.—In particular, the Secretary shall by regulation authorize a waiver to permit individuals to import into the United States a prescription drug that—

(A) is imported from a licensed pharmacy for personal use by an individual, not for resale, in quantities that do not exceed a 90-day supply;

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(C) is imported from Canada, from a seller registered with the Secretary;

(4) Prohibition of Discrimination.—

(1) IN GENERAL.—It shall be unlawful for a manufacturer of a prescription drug to discriminate against, or cause any other person to discriminate against, a pharmacy or pharmacy wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

(2) Discrimination.—For the purposes of paragraph (1), a manufacturer of a prescription drug who distributes a prescription drug by means of, or in connection with, a pharmacy or pharmacy wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

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(1) IN GENERAL.—The Secretary may grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition on importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate.

(2) By the Comptroller General.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study to determine the effect of this section on the price of prescription drugs sold to consumers at retail.

(B) REPORT.—Not later than 18 months after the effective date of the regulations under subsection (b), the Comptroller General shall submit to Congress a report describing the findings of the study under subparagraph (A).

(m) Construction.—Nothing in this section shall be construed to permit any person to discriminate against a pharmacist or pharmacy wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6), by striking "covered product pursuant to section 804(b)" and inserting "covered product in violation of section 804; and"

(p) Conditions.—This section shall be- come effective only if the Secretary certifies to the Congress that implementation of this section will—

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(A) is imported from a licensed pharmacy for personal use by an individual, not for resale, in quantities that do not exceed a 90-day supply;

(B) is accompanied by a copy of a valid prescription; and

(C) is imported from Canada, from a seller registered with the Secretary;
whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(iii) RECPIENTS OF NOTICE.—An applicant required under this subparagraph to give notice shall give notice to—

"(I) in the case of a patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

"(II) the holder designated to receive such a notice); and

"(iii) of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(iv) CONTENTS OF NOTICE.—A notice required under this subparagraph shall—

"(I) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, sale, or distribution of the drug before the expiration of the patent referred to in the certification; and

"(II) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed.

(2) in paragraph (5)—

(A) in subparagraph (B)—

"(bb) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;";

and

(bb) if the expiration of such period the district court decides that the patent has been infringed, the approval shall be made effective as provided in subclause (I);",;

(B) redesignating subparagraphs (C) and (D) as subparagraphs (E) and (F), respectively; and

(C) by inserting after subparagraph (B) the following:

"(C) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

"(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—An owner of the patent that is the subject of the certification and for which information was submitted to the Secretary under subsection (b)(1) or (c)(2) before the date on which the application (excluding an amendment or supplement to the application), which the Secretary later determines to be substantially complete, was submitted;"; and

(II) in clause (iii)—

(a) by striking clause (I) and inserting the following:

"(I) in the first sentence, by striking "unless" and all that follows and inserting "unless, before the expiration of 45 days after the date on which the notice described in paragraph (2)(A) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under subsection (b)(1) or (c)(2) before the date on which the application (excluding an amendment or supplement to the application), which the Secretary later determines to be substantially complete, was submitted;"; and

(ii) the holder of the approved application under this subsection for the drug that is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(D) CONTENTS OF NOTICE.—A notice required under this paragraph shall—

"(I) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, sale, or distribution of the drug before the expiration of the patent referred to in the certification; and

"(II) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed.

"(E) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent (or a use of which is claimed by the patent) brings a civil action against another person for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under subsection (b) for the drug that is the subject of the certification, the approval shall be made effective on—

"(aa) the drug for which the application was approved; or

"(bb) an approved method of using the drug.

"(F) NO INDEPENDENT CAUSE OF ACTION.—

Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action for infringement of another patent than that which is the subject of the certification and for which information was submitted to the Secretary under subsection (b) for the drug that is the subject of the certification.

"(G) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action against another person for infringement of the patent that is the subject of the certification.

(b) in subsection (c)(3)—

"(I) by striking "paragraph (3)(B)" and inserting "paragraph (3)(B)"; and

"(II) by striking clause (i) and inserting the following:

"(i) the date on which the court enters judgment reflecting the decision; or

"(ii) the date of a settlement order or consent decree signed and entered by the court stating that the patent is the subject of the certification is invalid or not infringed;";

and

(ii) the holder of the approved application under this subsection for the drug that is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(H) TIMING OF NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall give notice as required under this paragraph—

"(i) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, or requests of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(ii) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, or requests of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(C) RECPIENTS OF NOTICE.—An applicant required under this paragraph to give notice shall give notice to—

"(i) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

"(ii) the holder of the approved application under this subsection for the drug that is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(D) CONTENTS OF NOTICE.—A notice required under this paragraph shall—

"(I) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, sale, or distribution of the drug before the expiration of the patent referred to in the certification; and

"(II) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed.

"(E) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent (or a use of which is claimed by the patent) brings a civil action against another person for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under subsection (b) for the drug that is the subject of the certification, the approval shall be made effective on—

"(aa) the drug for which the application was approved; or

"(bb) an approved method of using the drug.

"(F) NO INDEPENDENT CAUSE OF ACTION.—

Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action for infringement of another patent than that which is the subject of the certification and for which information was submitted to the Secretary under subsection (b) for the drug that is the subject of the certification.

"(G) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action against another person for infringement of the patent that is the subject of the certification.

"(H) TIMING OF NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall give notice as required under this paragraph—

"(i) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, or requests of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(ii) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, or requests of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

"(C) RECPIENTS OF NOTICE.—An applicant required under this paragraph to give notice shall give notice to—

"(i) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

"(ii) the holder of the approved application under this subsection for the drug that is claimed by the patent (or a representative of the holder designated to receive such a notice).

"(D) CONTENTS OF NOTICE.—A notice required under this paragraph shall—

"(I) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, sale, or distribution of the drug before the expiration of the patent referred to in the certification; and

"(II) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed.

(2) in subsection (c)(3)—

(A) in the first sentence, by striking "under the following" and inserting "by applying the following to each certification made under paragraph (2)(A)(iv)";

(B) in subparagraph (C)—

(i) by striking "under the following" and inserting "by applying the following to each certification made under paragraph (2)(A)(iv)";

(ii) by striking "paragraph (3)(B)" and in-
be entitled to damages in a civil action against that applicant, unless any owner or holder that has brought such a counterclaim described in subclause (I).

(2) In an infringement action or a declaratory judgment action brought by the holder under subsection (b) or this subsection that on its face is sufficiently complete to permit a substantive review and determination by the Secretary that the application does not meet the requirements for approval under paragraph (2)(A) or (B), cannot receive effective approval because the application contains a certification described in paragraphs (2)(A)(v) and (B)(B), the application is not an approved drug and shall not have an effective approval until the Secretary issues an approval for a declaratory judgment action described in paragraphs (2)(A)(vii) and (B)(B).

(3) EFFECTIVE DATE OF APPROVAL.—The term 'forfeiture period' means—

(a) the date on which the court of appeals, in a court order under section 271(e)(1)(A) of title 35, United States Code, orders the holder to pay damages to the owner or holder that has brought such a civil action against the applicant for infringement of a patent that is the subject of the certification before the expiration of 45 days after the date on which the notice given under subsection (b)(3)(A) to the holder of the approved application is received, that is pending on or after the date of enactment of this Act, and has commenced.

(b) the earliest of the date on which the approval of the application of the first applicant is made effective under subparagraph (A) or (B) of section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) (as amended by section 1102), the approval after any necessary additional review of the application by the Secretary required by section 505(a) of such Act, or the date on which the Secretary issues an approval under paragraph (2)(A).
to which that applicant submitted a certifica-
tion qualifying the applicant for the 180-
day exclusivity period.

"(IV) FAILURE TO OBTAIN TENTATIVE AP-
PROVAL. —If a drug application holder fails to
submit tentative approval of the application within
30 months after the date on which the appli-
cation is filed, unless the failure is caused by a
change in the requirements of the requirements
for approval of the application imposed after the
date on which the application is filed.

"(V) AGREEMENT WITH ANOTHER APPLICANT.
The United States shall, if requested by an appli-
cant, enter into an agreement with another appli-
cant under this subsection for the drug, the hold-
er of which is the subject of the certification
under paragraph (II) of this subsection.

"The first applicant and the other applicant shall
be treated as though they were one applicant for
purposes of this Act and for which neither of the
events described in subclause (I) or (II) of section
505(j)(2)(B)(i)(IV) of that Act that occurred before the date of enactment of this Act has occurred or on or after the date of enactment of this Act for a listed drug for which a certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act for a listed drug was made.

"DECISION OF A COURT WHEN THE 180-DAY
EXCLUSIVITY PERIOD HAS NOT BEEN TRIG-
GERED. —With respect to an application filed
before, on, or after the date of enactment of this
Act for a listed drug for which a certification
under section 505(j)(2)(A)(vii)(IV) of that Act
was made before the date of enactment of this
Act and for which neither of the events described in subclause (I) or (II) of section 505(j)(2)(B)(iv) of that Act (as in ef-
fact on or after the date of enactment of this Act) has occurred or on or after the date of enactment of this Act, the term "de-
cision of a court" as used in clause (iv) of section
505(j)(2)(B)(iv) of this Act means the final deci-
sion of a court from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken.

SEC. 1104. BIOAVAILABILITY AND BIOEQUIVA-
LENCE.

(a) In General. —Section 505(j)(8) of the Federal
Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(8)) is amended —

"(1) by striking subparagraph (A) and in-
serting the following:

"(A)(i) The term 'bioavailability' means the rate and extent to which the active in-
gredient or therapeutic ingredient is ab-
sorbed from a drug and becomes available at the site of drug action.

"(ii) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may decide by regulation that biovalid measurements intended to reflect the rate and extent to which the active ingredi-
ent or therapeutic ingredient becomes available at the site of drug action.

(2) by adding at the end the following:

"(C) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may establish alternative, scientifically valid methods to show bioequivalence if the alternative methods are expected to detect a significant difference between the drug and the listed drug in safety and therapeu-
tic effect.''.

(b) EFFECT OF AMENDMENT. —The amend-
ment made by subsection (a) does not alter the standards under subsection (d) under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

SEC. 1105. REMEDIES FOR INFRINGEMENT.

Section 329 of title 33 United States Code, is amended by adding at the end the fol-
lowing:

"(d) CONSIDERATION.—In making a deter-
nement that a violation of this Act has occurred brought in infringement of a patent that claims a drug or a method or using a drug, the court shall consid-
er whether information on the patent was fre-
ely available at the site of drug action.''; and

"(II) failure to obtain tentative approval of the application imposed after the date on which the application is filed, unless the failure is caused by a change in the requirements of the requirements for approval of the application imposed after the date on which the application is filed.

"(V) AGREEMENT WITH ANOTHER APPLICANT.
The United States shall, if requested by an appli-
cant, enter into an agreement with another appli-
cant under this subsection for the drug, the hold-
er of which is the subject of the certification
under paragraph (II) of this subsection.

"The first applicant and the other applicant shall
be treated as though they were one applicant for
purposes of this Act and for which neither of the
events described in subclause (I) or (II) of section
505(j)(2)(B)(i)(IV) of that Act that occurred before the date of enactment of this Act for a listed drug was made.

"DECISION OF A COURT WHEN THE 180-DAY
EXCLUSIVITY PERIOD HAS NOT BEEN TRIG-
GERED. —With respect to an application filed
before, on, or after the date of enactment of this
Act for a listed drug for which a certification
under section 505(j)(2)(A)(vii)(IV) of that Act
was made before the date of enactment of this
Act and for which neither of the events described in subclause (I) or (II) of section
505(j)(2)(B)(iv) of that Act (as in ef-
fact on or after the date of enactment of this Act) has occurred or on or after the date of enactment of this Act, the term "de-
cision of a court" as used in clause (iv) of section
505(j)(2)(B)(iv) of this Act means the final deci-
sion of a court from which no appeal (other than a petition to the Supreme Court
who loved and respected him. He was our living legend. Strom's life was dedicated to achieving peace through strength, as shown by his military service in liberating Europe from Nazi fascists, his tireless work in fighting the defense of the Congress which ultimately led to the defeat of Soviet communism.

He pioneered the development of the South Carolina Republican Party from effective nonexistence in the 1960s to majority status by the end of the century. He has been a role model of service to South Carolina's young people and our family has had three generations on his staff: my wife's two uncles were staff attorneys, my wife and I were interns, and our three oldest sons were pages. A distinguished highlight for our family was to host Senator Strom Thurmond and his family before his last election in 1996 at the First Presbyterian Church in Columbia.

The legacy of Strom Thurmond will always be felt in South Carolina because of his steadfast integrity and the thoughtful constituent service. He was my personal hero, and I will miss him dearly.

Mr. Speaker, I yield myself such time as I may consume. Let me join in expressing the sorrow of the folks in Louisiana for your loss. Mr. WILSON of South Carolina. Mr. Speaker, I yield myself 3 minutes.

Mr. WILSON of South Carolina. Mr. Speaker, it is with great sadness tonight that I announce that Senator Strom Thurmond passed away at 9:45. I was a former staff member of Senator Thurmond, my wife was a staff person for Senator Thurmond, and our three sons have been pages with his office. With the death of Strom Thurmond, South Carolina has lost its greatest statesman of the 20th century, just as John C. Calhoun was the most impressive statesman of the 19th century. Strom Thurmond will never be replaced in the countless hearts of those who loved and respected him.

The entire Wilson family mourns this profound loss and we extend our sympathy to the Thurmond family.

Senator Strom Thurmond will endure as the leading example of a public servant due to his love and devotion to all the people of South Carolina regardless of status, race, politics or region. He was the leading example of a public servant as the most powerful statesman of the 20th century, just as John C. Calhoun was the most impressive statesman of the 19th century. Strom Thurmond will never be replaced in the countless hearts of those who loved and respected him.

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until you have got $5,100. They are going to privatize your Medicare in the year 2010. That is pretty bad.

But it is followed by other things: massive subsidies to the insurance companies which commence in 2 years, in 2006, not all of them. We guarantee as to what it costs you in terms of what you have to pay in the way of premiums, no assurance that you will get any particular level of benefits. The only person who is going to cut the fat hog out of this deal are those good-hearted, flinty-hearted, cold-hearted folk in the insurance business who are going to all of a sudden get a key to the United States Treasury, the right to collect any amount of money they want and to sicken the Secretary of HHS any old way they are minded and to walk home and to pay the money perhaps to the senior citizens but possibly to their shareholders or in dividends or perhaps to pay it in salaries or in bonuses to their corporate officers. That is what you get under the Republican plan. And privatization of Social Security as you know it today.

The Republicans have said that they intend to do away with Social Security. Well, this is what is happening here. The Democratic plan compels the drug houses to negotiate with the Federal Government and the Secretary. The Republicans preclude him by absolute authority from doing what he would do for the senior citizens and not the fat cats that my Republican colleagues and friends look after.

Vote for the Democratic plan. Vote down the Republican plan. Let us take care of the senior citizens. It is the right thing to do.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let us look at the facts behind the rhetoric here. What is going to be the impact of this Democratic substitute on seniors? My colleague from Louisiana just reminded us that 100 percent of employers are going to drop their plans. There is no choice for my senior citizens and not the fat cats that my Republican colleagues and friends look after.

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Vote for the Democratic plan. Vote down the Republican plan. Let us take care of the senior citizens. It is the right thing to do.
Let us look at Lipitor. An awful lot of Americans take Lipitor every day to keep their cholesterol down. It does. It costs $108.65 today because for 40 years the Democrats did not do anything about prescription drugs and for 4 years President Clinton did not do anything about prescription drugs. But under our plan Lipitor goes down to $86.92 because of our purchasing power, but the beneficiary pays $13.00 for a month's supply and if they are a poor senior citizen, $5, $5, down from $86.28.

Zoloft, 100 milligrams, 30 tabs for a month, it is an antidepressant. A lot of elderly suffer from depression, unfortunately, at their age in part because they do not have good health care. We bring the price down to $63.17. The beneficiary pays $12.63 a month and if she is poor, she is in a similar situation.

This chart is pretty straightforward and pretty simple. This demonstrates what happens when good-minded people and pretty simple. This demonstrates what happens when good-minded people get the job done for the elderly, a job that is important, at their age in part because they do not have good health care. We bring the price down to $63.17. The beneficiary pays $12.63 a month and if she is poor, she is in a similar situation.

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The Republican bill fails all of these tests. It requires everyone to pay for the drug, the benefit that the beneficiary pays $13.00 for a month's supply and if they are a poor senior citizen, $5, $5, down from $86.28.

Mr. Speaker, I yield myself 15 seconds.

I hope my colleagues look at that chart because it has the same actual value as Alice in Wonderland. There is no requirement that any of those drugs be made available. There is no requirement that they be made available at a particular price or that they have to be made available under the plan at any particular price because of cost sharing with the insurance.

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We give them $430 million, twice what CMS estimates they ought to get. So we get rid of this stinky system that is charging American seniors 20 percent of phoney prices and costing the government Medicare system tens of billions of dollars every year costing the doctors, and we replace it with a rational, a rational reimbursement system.

Now, the Democrats try to settle that system too. Let me tell my colleagues what they do in their substitute. They substitute this average wholesale price system with a system of reimbursement that, according to CBO estimates, is going to cost $34 billion over 10 years; and it is going to cost seniors another $8 billion of copays. We ought to reject that solution.

Mr. DINGELL. Mr. Speaker, I yield to the distinguished gentleman from New Jersey (Mr. Pallone).

Mr. PALLONE. Mr. Speaker, the only thing that stinks here is the Republican bill, and it stinks for a lot of reasons.

First of all, because it is not going to give the seniors any benefit. They are not going to have really any drug benefit whatsoever. It is going to force them into an HMO. They will not have any choice of doctors. And fundamentally, in the end what the Republican bill does is by setting up a voucher system so we do not even have traditional Medicare. I am sick and tired of hearing my Republican colleagues on the other side criticize traditional Medicare. Medicare is a good program. Do not tell me that Medicare is broke or Medicare needs to be fixed. And I say to the gentlwoman from Connecticut, do not insult me and Medicare. Do not insult us as Democrats. We have been there protecting it for years.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I want to calm down a little bit. There has been a lot of shouting around here, a lot of heated rhetoric, a lot of hyperbole. Let us just look at a couple of facts.

It is a fact that the Medicare actuaries are telling us that Medicare is going insolvent in 13 years. The entire system goes broke. It is a fact that if we add more money on top of Medicare without doing any reforms, you are going to accelerate the insolvency of Medicare. We can try and speak those facts away, but the fact remains that those are facts.

Now, what this Democrat substitute does is it costs over $1 trillion. It accelerates the bankruptcy of Medicare. The basic assumption in this CBO estimate is that every employer providing private drug coverage for the retirees is going to drop it. And why would they not? Why would they not drop it if the Federal Government is going to pay for it all?
What the facts are is that this plan is going to accelerate the bankruptcy of Medicare.

Now, what are we trying to achieve with the Republican bill? Mr. Speaker, there are parts of this bill that none of us who care about our own health. But what we are trying to achieve is not only modernizing this program so it works for today’s seniors by giving them cheaper drugs and coverage of drugs, but we are also trying to modernize this program and save it for the baby boom generation.

We have 77 million retirees coming in this country starting in 15 years; and if we accelerate the bankruptcy of this program as the Democrats are proposing to do, it is not going to be there for them.

So what we are doing with these market-based reforms and giving seniors more choices? We are giving them the chance that this program will be solvent for the boomers when they retire. That is what we are trying to do here. The responsible thing is to make it work for today’s seniors, make it modern, make it comprehensive, work on prescription drug prices, work on prescription drug coverage, but give seniors more choices, use competition, use the things that have worked in the past so we can save this program for the baby boomers. That is what the Republican bill does.

Mr. STARK. Mr. Speaker, I yield myself self 30 seconds for a couple of housekeeping things.

In 13 years, the revenues start to decline, but it does not go insolvent for 24 years. And I say to the gentleman from Ohio (Mr. NUSSELE), if he has indeed the same letter that we are informed we have from CBO dated June 26, it says nothing in there about employers turning back Medicare, so he either misspoke or made it up, which, in my State, we call telling a lie. Unless he has a different letter, which I am assured by CBO he does not, then he made that up.

Mr. Speaker, I yield 1 minute to the gentleman from New Jersey (Mr. MENENDEZ).

Mr. MENENDEZ. Mr. Speaker, I rise on behalf of my 84-year-old mother and millions like her across this country. She worked her entire life in the factories of New Jersey. Today she has Alzheimer’s and spends over half of her social security check on prescription drugs. If it was not for my sister and me, she would not be able to live with the dignity she deserves.

Now, this Republican package is wrapped in a label that says, “I care,” but when you open it up, it contains nothing more than an empty promise.

Under this Republican plan, which lacks the compassion promised by the President and expected from our doctors, millions of seniors who want to stay in traditional Medicare will be forced into HMOs, and millions like her across this country. Instead of helping seniors with their prescription drug plan, the Republican plan subsidizes private insurance companies. This plan tends to bribe private insurance companies to provide service in rural districts like mine. These insurance companies have come before our Committee on Energy and Commerce and have testified that they will not be providing the service, and the Republican plan just will not work.

If insurance companies do change their minds, there is nothing in this bill that will prevent them from shifting the added costs to our seniors. I had an amendment in the Committee on Energy and Commerce that would have prevented increases in the monthly premiums for seniors where they live. But unfortunately, it was voted down on a party line vote.

The GOP plan has a huge gap in coverage and does nothing to reduce the inflated prices big drug companies are charging for prescription drugs. In fact, the Republican plan has a noninterference clause that says the Health and Human Services Secretary will not, will not be allowed to negotiate lower prices for Americans.

The Rangel-Dingell bill will ensure that every senior, regardless of where they live, will be able to obtain the prescription drugs and the quality of health care they require to live a healthy life. This coverage will be provided through Medicare. Democrats are working to strengthen this program, not to do away with it, as the gentleman from California (Mr. THOMAS) called for when he said, and I quote him, “To those who say the GOP bill will end Medicare as we know it, our answer is: We certainly hope no.” Thus, the real motive behind the GOP plan is to do away with Medicare. Democrats proudly stand behind Medicare. Support the Rangel-Dingell substitute.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2 minutes to the gentleman from Arizona (Mr. HAYWORTH), a member of the Committee on Ways and Means.

Mr. HAYWORTH. Mr. Speaker, I thank my friend from Connecticut, and she has visited the same pharmacy as I do, and I know that the hour grows late and the debate grows heated and sometimes well-intentioned efforts from some are thrown in the confusion.

Mr. Speaker, I rise to urge this House to reject the Democratic substitute and to vote “yes” for H.R. 1 for reasonable, rational, clear-cut reform of Medicare that will bring Medicare into the 21st century with prescription drug coverage.
Seniors are crying out for help, but their pleas are drowned out by the cash registers humming away at the majority party headquarters, while insurance and pharmaceutical company lobbyists rush to the great Medicare sellout of all time. Senior citizens are being asked to pay for Medicare and the Administration mortgage the future of the working families that my friends purport to support.

People of good will can have different opinions, and we certainly have them here. But that is our privilege. The question often comes down to this, when is enough enough? With the left it is never enough. With the right it is never enough enough? With the left it is never enough enough? With the right it is never enough.
trillion dollars would provide coverage for those who do not even need it. It sounds like what they accuse Republicans of.

I was really interested to see, when you look at page 12 of the Democrat bill, there is all sorts of things to interesting. They say we do not provide guaranteed access. We do provide guaranteed access. The government actually steps in when there are not plans available, negotiates down the risk which reduces coverage.

If you look at page 12, what does the Democrat plan do? It says, "The Secretary shall develop procedures to ensure coverage." That will give you some comfort. I can see why they are not talking about their legislation. I would not either. Vote for the underlying bill. Vote down this substitute that they will not talk about.

Mr. STARK. Mr. Speaker, I yield myself 1 1/2 minutes.

Mr. Speaker, just to straighten out some of the figures, the Republicans do indeed add $26.7 billion for rural providers and $1 billion for rural providers. That is $2.5 billion more, and I would hope that the Republicans are not lying to the seniors.

You can lie to us because we are used to it. The White House has set the tone for that. But do not lie to the seniors.

There is nothing in your bill. I say to the gentleman from Ohio (Mr. PORTMAN), there is nothing in your bill that guarantees anything, and to say that to the seniors is lying to the seniors.

There is nothing in your bill that guarantees a thing to the seniors and you know it. And if you do not know it, read it again. Otherwise, you are lying to the seniors.

Our bill provides a Medicare benefit which is definable. Yours does not. You do not require any benefits if no insurance company steps up to the plate and there is nothing that requires it. There is not one line in your bill that requires any company to provide anything. So it is all a fantasy. At least we are requiring the government to provide a benefit to the seniors in the same manner they are now familiar, under Medicare with a determined premium, a determined deductible, determined benefits, the same across the country. None of that is available through the Republican bill. To tell the seniors otherwise is lying. You have lied to us tonight and stop lying to the seniors. To support our substitute and vote down the great Republican lie.

Mr. DINGELL. Mr. Speaker, I have an inquiry as to time first before I yield the balance of my time. I believe the gentlewoman from Illinois (Ms. SCHAKOWSKY) did not get the full 2 1/4 minutes that I yielded to her. I would like to know how much time I have left and how much I can properly yield the gentlewoman from Illinois.

The SPEAKER pro tempore. The gentleman from Michigan has 3 minutes remaining.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, I thank the gentleman from Michigan (Mr. DINGELL) for yielding me time.

Again, this is just a warning, a friendly warning to you that if you pass H.R. 1 tonight, you better also go out and get your running shoes because the seniors are too smart to be fooled by your proposal. And you can trash Medicare all you want. You can call it an outdated program, antiquated; but I do not know you and I do not call them enough. You do not go to senior centers enough. Not the ones I have gone to in my 5 years as director of the State Council of Senior Citizens. Seniors love their Medicare. The only thing they do not like is that it does not cover prescription drugs. And that is why if you are smart or out of shape and not able to be chased by seniors, you will vote for the Rangel-Dingell substitute.

The Democratic substitute is what seniors have been asking for and what every politician has been promising them, an understandable, defined, dependable Medicare prescription drug benefit. It has all the features of Medicare that our seniors know and love, a set premium, no copayments. Vote for the substitute or start running.

Mrs. J. JOHNSON of Connecticut. Mr. Speaker, I yield 1 1/2 minutes to the gentleman from Virginia (Mr. TOM DAVIS).

Mr. TOM DAVIS of Virginia. Mr. Speaker, I would like to engage in a colloquy with my colleague.

Can she confirm that the language in H.R. 1 includes plans under the Federal Employee Retirement Plan as an employment base plan?

Mr. Speaker, will the gentleman yield?

Mr. TOM DAVIS of Virginia. I yield to the gentlewoman from Connecticut.

Mrs. J. JOHNSON of Connecticut. Mr. Speaker, yes, that is correct.

Mr. TOM DAVIS of Virginia. This will allow OPM to take advantage of the subsidies in the bill just as other employees and unions will.

Mrs. J. JOHNSON of Connecticut. That is correct.

Mr. TOM DAVIS of Virginia. Mr. Speaker, I appreciate the gentlewoman's and the chairman's willingness to work with us on this issue. I think that allowing the subsidies H.R. 1 provides for will result in lower premiums and improved benefits for all FEHBP enrollees.

Mrs. J. JOHNSON of Connecticut. I thank the gentleman, and I look forward to working with the gentleman on this issue as the bill moves to conference.

Mr. TOM DAVIS of Virginia. Mr. Speaker, as I said, I appreciate the willingness of the gentlewoman to clarify that.

I have another concern, that Federal employees are often treated differently from current Federal employees in ways that are not always equitable. Retirees are different from current Federal employees. For example, current Federal employees may pay their health insurance premiums from pre-tax dollars. Federal retirees are not.

FEHBP currently does not provide different benefits for retirees and current employees. One is simply a member of FEHBP. I think it is important that this dynamic remain once a Medicare prescription drug benefit is put into place, whichever plan passes.

As chairman of the Committee on Government Reform, I look at this from an employer's perspective. We do not want private employers to drop the prescription drug coverage they provide for their retirees. H.R. 1 provides incentives so that they will not do so, but we as the Federal Government have to lead by example.

I have introduced legislation that simply states that Federal retirees will continue to be treated on par with current Federal employees when it comes to prescription benefits. I regret we were unable to include this language in H.R. 1, but I am grateful to have the commitment of the Speaker and the majority leader to bring this bill to the floor as soon as we return from recess.

Mr. TAUSIN. Mr. Speaker, may I inquire how many minutes it will take for each one of the four who have allocated time.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Connecticut (Mr. STARK) has 1 minute remaining.

The SPEAKER pro tempore. The gentleman from California (Mr. STARK) has 1 minute remaining.

Mrs. J. JOHNSON of Connecticut. Mr. Speaker, will the gentleman yield?

Mr. TOM DAVIS of Virginia. I yield to the gentlewoman from Connecticut.

Mrs. J. JOHNSON of Connecticut. Mr. Speaker, yes, that is correct.

The SPEAKER pro tempore. The gentleman from Michigan (Mr. DINGELL) has 2 minutes remaining.

Mr. TAUSIN. Mr. Speaker, we reserve the balance of our time. If anyone wants to use some more time at this time would be a good time to do it.

Mr. DINGELL. Mr. Speaker, I reserve the balance of my time, and I want to yield it to our leader.

Mrs. J. JOHNSON of Connecticut. Mr. Speaker, I yield myself 30 seconds.

This is a historic evening. It is our opportunity tonight to provide prescription drugs to all seniors under Medicare as an entitlement and to do it in a way that is fair, simple and generous and sustainable. It is our opportunity tonight to modernize the benefit program under Medicare to deal with chronic care for our seniors, a big concern for them, and to structure Medicare in such a way that it will be sustainable, the dollars will be there and Medicare will be able to provide the health retirement security in the future that it has in the past.

I urge support of H.R. 1 and defeat of the substitute.
The SPEAKER pro tempore. The call was taken by electronic device, and the following Members responded to their names:

Mr. TAUZIN. Mr. Speaker, I move a postponement of the vote). There are 2 minutes remaining in this vote. (Roll No. 329)

Mr. Speaker, these founding truths were forged by a firm commitment from our Founding Fathers, the last sentence in the Declaration of Independence. It says: In support of this declaration, with a firm reliance on the protection of Divine Providence, we mutually pledge to each other our lives, our fortunes, and our sacred honor.

Mr. Speaker, I think that those men would be heartbroken to see what happens here this evening. As I said earlier, the Republicans are in charge. We recognize that. You can do what you want to do. You do, and you give me credit, for publicly acknowledging that you want to destroy Medicare. You do, and I give you credit, for some of your leaders publicly acknowledging that you would put us into bankruptcy just so we can make the government smaller. So we can do away with certain social programs that you do not like. And I give you credit for that. In fact, I think some of you, and I have seen it, have publicly proclaimed you are proud of it.

My dilemma is, why would you want to do what you are trying to do tonight to the greatest generation, the men and women that went through the Depression, fought World War II, and then built this great Nation into what it is today and turned it over to my generation?

I had a little cute remark in there, but I am not going to use it because I think this is far too serious a business we take up this evening. A government should not make poor people poorer, rich people richer. It should not create a situation where no one has to be responsible, and it should not make it possible for a group of people to be able to take advantage of others because of an act of that government.

If you do what you are talking about doing, you will make that exact thing possible. You will make it possible for insurance companies and pharmaceutical companies to rob the senior citizens of this country.

The SPEAKER pro tempore. The gentleman from Michigan (Mr. DINGELL) is recognized.

Mr. DINGELL. Mr. Speaker, I yield the balance of my time to the distinguished gentleman from Arkansas (Mr. BERRY).

The SPEAKER pro tempore. The gentleman from Arkansas is recognized for 2 minutes.

Mr. BERRY. Mr. Speaker, we are here this evening on a very serious matter. It can literally mean life or death for many of our elderly citizens. Our great Nation was founded, and has so far been successful, based on the self-evident truth in the Declaration of Independence that all men are created equal. They are endowed by their Creator with certain inalienable rights, and that among these are life, liberty, and the pursuit of happiness.

The SPEAKER pro tempore. An ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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If you do what you are talking about doing, you will make that exact thing possible. You will make it possible for insurance companies and pharmaceutical companies to rob the senior citizens of this country.
Mr. Speaker, the gentleman from California (Mr. Thomas), the gentleman from Connecticut (Mrs. Johnson), the gentleman from Louisiana (Mr. Tauzin), the members of the Committee on Ways and Means, members of the Committee on Unfunded and Commer., Members know this is incredibly important. The future of our seniors, the future of our children are at stake.

We have been spending $267-plus billion a year on Medicare. Payroll taxes only pay 57 percent of that, general revenue and other funds cover the rest. In less than 20 years, the payroll taxes will only cover 30 percent, the rest will come from our children and their incomes. That is on top of the fact that there is over $550 billion on the Medicare debt. In just 5 years, we will be spending over $400 billion per year on Medicare. Now some on my side of the aisle think $400 billion is a lot of money over 10 years, and giving this benefit is really expensive.

But at the same time what are we getting for this system that has been designed to bankrupt this country? What are we getting is doctors refusing to take seniors as patients. We have hospitals closing. We have costs escalating through the roof. Medicare is driving other health care costs through the roof. Seniors are having to make spending decisions based upon the cost of their health care or their drugs. This is the system they want to preserve. This is the system that they want to see continue. But many of us, both Democrats and Republicans, think that this is a time that we have an incredible opportunity.

I came here to make a difference; and, frankly, since this Republican Congress has been in the majority we have made an incredible difference. Some Members wanted to preserve the old welfare system. We reformed welfare. Some of our Members have commented over the last few days that entitlements are forever. No, they are not. Welfare was an entitlement, and we closed up the lines and took the responsibility to do so. Tax relief, tax reform, paying down the debt, not one time in 40 years did the other side of the aisle balance the budget, we did. They spent 40 years and gave us this opportunity to lead; and in leadership, responsibility has to be there. We are ready to stand up and lead, and it is our job to seize that opportunity today. I just ask Members, I implore Members to vote for Medicare, vote for our seniors, vote yes for this bill.

Mr. Speaker, the American people have asked us for this. They sent us here to do this, and they deserve this approach. It is the right thing to do, it is the right time to do it, and if we fail to act now, we may never have another chance to make it right. The American people have given us this opportunity to lead; and in leadership, responsibility has to be there. We are ready to stand up and lead, and it is our job to seize that opportunity today. I just ask Members, I implore Members to vote for Medicare, vote for our seniors, vote yes for this bill.

Ms. Pelosi. Mr. Speaker, the distinguished majority leader who just spoke said something that I agree with. He said that this issue that we are voting on tonight is probably one of the most important issues we will vote on in our career. Mr. Leader, the larger point is that it is the right thing to do.

Mr. Speaker, that is why it is hard to understand why we are taking up this debate in the dark of night when the Senate has taken up the bill for 2 weeks without allowing their amendments, to have a free and open exchange of ideas about this most important issue in our careers. And when the bill was sent to the floor in this House of Representatives for this most important issue, it passed with 100 percent of the Democratic votes and not one Republican vote.

But after hearing my colleagues talk about fiscal responsibility, I cannot resist the opportunity to state the facts because it is one of the mysteries of this floor, that Members can come to the floor and misrepresent the facts, and that is in order, but to call them on it is out of order. But I am going to take that risk.

The fact is that under the Clinton administration and the legislation passed in this House with 100 percent of the Democratic votes and not one Republican vote, coming out of the Clinton years we were on a path of $5.6 trillion in surplus. In surplus. In the 2½ years in the Bush administration, we are now on a path going to $3 trillion in deficit, a swing of over $8 trillion onto the national debt, and they call that fiscally sound, as they give away huge tax cuts to the 200,000 wealthiest families in America, and many of us in this room are part of that and would benefit, but not in the enlightened self-interest of this country. But for that same money.
Mr. Speaker, I urge my colleagues on both sides of the aisle to support this bill. This is a defining moment for this Congress. It is too late for obstruction. It is too late for nit-picking. It is too late for all the lame excuses that we hear the gentleman from Louisiana (Mr. TAUZIN). I am grateful for their philosophical beliefs. But this bill extends the best of times and the worst of times when it comes to health care choices throughout his whole working career will feel comfortable shopping around for the best health care plan for his individual needs when he qualifies for Medicare. 

Ladies and gentlemen, not many times in this great hall do we have a piece of legislation when all the forces come together and we have an opportunity to make real change. We have that opportunity tonight. I ask you to provide for our citizens with a better Medicare system and a real prescription drug benefit.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). All time for debate has expired. Pursuant to House Resolution 299, the previous question is ordered on the bill and on the amendment in the nature of a substitute offered by the gentleman from New York (Mr. RANGEL).

The question is on the amendment in the nature of a substitute offered by the gentleman from New York (Mr. RANGEL). The question was taken; and the Speaker pro tempore announced that the noes appeared to have it.

RECORDED VOTE

Mr. RANGEL. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered. The vote was taken by electronic device, and there were—aye 175, noes 255, answered “present” 1, not voting 4, as follows:

- A recorded vote was ordered.
- The vote was taken by electronic device.
- There were 175 ayes, 255 noes, and 1 “present.”
The Clerk read as follows:

**MOTION TO RECOMMEND WITH INSTRUCTIONS**

Mr. THOMPSON of California moves to recommit the bill H.R. 1 jointly to the Committee on Ways and Means and the Committee on Energy and Commerce with instructions to report the same back to the House promptly with the following amendments:

Strike all after the enacting clause and insert the following:

**SECTION 1—SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.**

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

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

(c) **BIPA; SECRETARY.**—In this Act:

(1) **BIPA.**—The term "BIPA" means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2003, as amended into law by section 3(a)(6) of Public Law 106-556.

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

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

Sec. 1. Short title; amendments to Social Security Act; references to BIPA and Secretary; table of contents.

**TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT**

Subtitle A—Medicare Voluntary Prescription Drug Delivery Program

Sec. 101. Medicare voluntary prescription drug delivery program.

PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

Sec. 106. Definitions; treatment of references to provisions in Medicare Advantage program.

Sec. 107. Establishment of voluntary prescription drug delivery program.

Sec. 108. Enrollment under program.

Sec. 109. Election of a Medicare Prescription Drug plan.

Sec. 110. Providing information to beneficiaries.

Sec. 111. Beneficiary protections.

Sec. 112. Prescription drug benefits.

Sec. 113. Requirements for entities offering Medicare Prescription Drug plans; establishment of standards.

**SUBTITLE B—PRESCRIPTION DRUG DELIVERY SYSTEM**

Sec. 120. Establishment of service areas.

Sec. 121. Authorization of a prescription drug delivery system.

Sec. 122. Submission of bids for proposed Medicare Prescription Drug plans; references to other programs.

Sec. 123. Approval of proposed Medicare Prescription Drug plans.

Sec. 124. Computation of monthly standard prescription drug coverage premiums.
Sec. 104. Medicaid and other amendments
Sec. 105. Expansion of membership and duty
Sec. 106. Payments to eligible entities
Sec. 107. Computation of monthly benefit obligation
Sec. 108. Collection of monthly beneficiary obligation
Sec. 109. Premium and cost-sharing subsidies for low-income individuals
Sec. 110. Reinsurance payments for expenses incurred in providing prescription drug coverage above the annual out-of-pocket threshold
Sec. 111. Direct subsidy for sponsor of a qualified retiree prescription drug plan for plan enrollees eligible for, but not enrolled in, this part.
Subpart 3—Miscellaneous Provisions
Sec. 112. Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund
Sec. 113. Related other provisions.
Sec. 114. Study and report on permitting of Medicare Payment Advisory Commission (MedPAC).
Sec. 115. Study regarding variations in spending and drug utilization.
Subtitle B—Preferred Provider Organizations
Sec. 116. Medicare Prescription Drug Discount Card and Transitional Assistance for Low-Income Beneficiaries
Sec. 117. Medicare prescription drug discount card and transitional assistance for low-income beneficiaries.
Subtitle C—Standards for Electronic Prescribing
Sec. 118. Standards for electronic prescribing.
TITLE II—MEDICAREADVANTAGE
Subtitle A—Medicare Advantage Competition
Sec. 119. Eligibility, election, and enrollment.
Sec. 120. Benefits and beneficiary protections.
Sec. 121. Payments to Medicare Advantage organizations.
Sec. 122. Submission of bids; premiums.
Sec. 123. Special rules for prescription drug benefits.
Sec. 124.Facilitating employer participation.
Sec. 125. Administration by the Center for Medicare Choices.
Sec. 126. Conforming amendments.
Sec. 127. Effective date.
Subtitle B—Preferred Provider Organizations
Sec. 128. Establishment of Medicare Advantage preferred provider program option.
Subtitle C—Other Managed Care Reforms
Sec. 129. Extension of reasonable cost contains.
Sec. 130. Specialized Medicare Choice plans for special needs beneficiaries.
Sec. 131. Payment by PACE providers for medicare and medicaid services furnished by noncontract providers.
Sec. 132. Institute of Medicine evaluation and report on health care performance measures.
Sec. 133. Expanding the work of Medicare quality initiative to organize to include parts C and D.
TITLE III—CENTER FOR MEDICARE CHOICES
Sec. 134. Establishment of the Center for Medicare Choices.
Sec. 135. Miscellaneous administrative provisions.
TITLE IV—MEDICARE FEE-FOR-SERVICE
Subtitle A—Medicare Fee-for-Service Improvements
Sec. 136. Provisions Relating to Part A
Sec. 137. Equalizing urban and rural standardized payment amounts under the Medicare Inpatient Hospital Prospective Payment System.
Sec. 138. Adjustment to the Medicare Inpatient Hospital PPS wage index to reflect the labor-related share of such index.
Sec. 139. Medicare Inpatient Hospital Payment Adjustment for Low Volume Hospitals.
Sec. 140. Fairness in the Medicare Disproportionate Share Hospital (DSH) adjustment for Rural Hospitals.
Sec. 141. Critical Access Hospital (CAH) Improvements.
Sec. 142. Authorizing use of arrangements to provide posthospital services to low-income beneficiaries.
Sec. 143. Services provided to hospice patients by nurse practitioners, clinical nurse specialists, and physician assistants.
Sec. 144. Authority to include costs of training of psychologists in payments to hospitals under Medicare.
Sec. 145. Revision of Federal rate for hospital outpatient department.
Sec. 146. Authority regarding geriatric fellowships.
Sec. 147. Clarification of congressional intent relating to the counting of residents in a nonprovider setting and a technical amendment regarding the 3-year rolling average and the IPE ratio.
Sec. 148. Limitation on charges for inpatient hospital services.
Sec. 149. Medicare fee-for-service care coordination demonstration program.
Sec. 150. GAO study of geographic differences in payments for physicians' services.
Subtitle C—Provisions Relating to Parts A and B
Sec. 151. Increase for home health services furnished in a rural area.
Sec. 152. Limitation on reduction in area wage adjustment factors under the prospective payment system for home health services.
Sec. 153. Clarifications to certain exceptions to Medicaid limits on physician referrals policies.
Sec. 154. Demonstration program for substitute adult day services.
Sec. 155. Medicare secondary payor (MSP) demonstration projects.
TITLE V—MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS
Subtitle A—Regulatory Reform
Sec. 156. Rules for the publication of a final regulation based on the previous publication of an interim final regulation.
Sec. 157. Compliance with changes in regulations related to Medicare.
Sec. 158. Report on legal and regulatory inconsistencies.
TITLE VI—OTHER PROVISIONS

Sec. 601. Increase in medicaid DSH allotments for fiscal years 2004 and 2005.

Sec. 602. Increase in floor for treatment as an extremely low DSH State under the medicaid program for fiscal years 2004 and 2005.

Sec. 603. Increased reporting requirements to include the age appropriateness of payment adjustments to disproportionate share hospitals under the medicaid program.

Sec. 604. Clarification of inclusion of inpatient drug prices charged to certain public hospitals in the best price exemptions for the medicaid drug rebate program.

Sec. 605. Assistance with coverage of legal immigrants under the medicaid program and SCHIP.

Sec. 606. Establishment of consumer ombudsman account.

Sec. 607. GAO study regarding impact of asset test for low-income beneficiaries.

Sec. 608. Health care infrastructure improvements.

Sec. 609. Capital infrastructure revolving loan program.

Sec. 610. Federal reimbursement of emergency health services furnished to undocumented aliens.

Sec. 611. Increase in appropriation to the health care fraud and abuse control account.

Sec. 612. Increase in civil penalties under the False Claims Act.

Sec. 613. Increase in civil monetary penalties under the Social Security Act.

Sec. 614. Extension of customs user fees.

Sec. 615. Increased flexibility in medicaid administration.

Sec. 616. Reception, recovery, and enforcement reform.

Sec. 617. Provider access to review of local coverage determinations.

Subtitle C—Contracting Reform

Sec. 511. Submission of plan for transfer of responsibility for medicaid appeals.

Sec. 512. Expedited review of appeals.

Sec. 513. Expedited review of certain provider agreement determinations.

Sec. 514. Revisions to medicaid appeals process.

Sec. 515. Hearing rights related to decisions by the Secretary to deny or not renew a medicaid enrollment agreement; consultation before changing provider enrollment forms.

Sec. 516. Appeals provisions when there is no other party available.

Sec. 517. Provider access to review of local coverage determinations.

Subtitle D—Education and Outreach

Sec. 521. Increase in medicaid DSH allotments for fiscal years 2004 and 2005.

Sec. 522. Increase in floor for treatment as an extremely low DSH State under the medicaid program for fiscal years 2004 and 2005.

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Sec. 612. Increase in civil penalties under the False Claims Act.

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Sec. 614. Extension of customs user fees.
each eligible beneficiary enrolled under this part shall be provided with access to qualified prescription drug coverage as follows:

(a) MedicareAdvantage enrollees receive coverage through MedicareAdvantage plan.

(i) In general.—Except as provided in clause (ii), an eligible beneficiary who is enrolled in a MedicareAdvantage plan offered by a Medicare Advantage organization may make an election to enroll under this part. Such process shall be similar to the process for enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides. For purposes of this part, the term ‘Medicare Advantage plan’ has the meaning given such term in section 1859(b)(3).

(ii) Exception for enrollees in Medicare Advantage MSA plans.—An eligible beneficiary who is enrolled in a Medicare Advantage plan that is offered in the same geographic area in which the beneficiary resides.

(ii) Exception for enrollees in Medicare Advantage private fee-for-service plans.—An eligible beneficiary who is enrolled in a Medicare Advantage plan and enrolled in a private fee-for-service plan under part C shall receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides. For purposes of this part, the term ‘private fee-for-service plan’ has the meaning given such term in section 1859(b)(2).

(ii) Exception for Medicare Advantage MSA plans.—An eligible beneficiary who is enrolled under this part but is not enrolled in a Medicare Advantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) shall receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides.

(2) Voluntary nature of program.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

(3) Scope of benefits.—Pursuant to section 1860D–6(b)(3)(C), the program established under this part shall provide for coverage of all therapeutic categories and classes of covered drugs (although not necessarily for all drugs within such categories and classes).

(4) Program to begin in 2006.—The Administrator shall establish the program under this part in a manner so that benefits are first provided beginning on January 1, 2006.

(b) Access to alternative prescription drug coverage.—An eligible beneficiary who has creditable prescription drug coverage (as defined in section 1860D–2(b)(3)(F)), such beneficiary:

(i) May continue to receive such coverage and not enroll under this part; and

(ii) Pursuant to section 1860D–2(b)(3)(C), is permitted to subsequently enroll under this part without any penalty and obtain access to qualified prescription drug coverage in the manner described in subsection (a) if the beneficiary involuntarily loses such coverage.

(c) Financing.—The costs of providing benefits under this part shall be payable from the Program Account.

(1) Enrollment under program.

Sec. 1860D–2. Establishment of enrollment process.

(i) Process similar to part B enrollment.—The Administrator shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare Advantage plan offered by a Medicare Advantage organization) may make an election to enroll under this part. Such process shall be similar to the process for enrollment in part B under section 1837, including the deeming provisions of such section.

(ii) Condition of enrollment.—An eligible beneficiary shall enroll under this part in order to be eligible to receive access to qualified prescription drug coverage.

(iii) Special enrollment procedures.—(A) Late enrollment.

(1) Increase in monthly beneficiary obligation.—Subject to the succeeding provisions of this paragraph, in the case of an eligible beneficiary whose coverage period under this part began pursuant to an enrollment in part B determined pursuant to section 1837(d) and not pursuant to the open enrollment period described in paragraph (2), the Administrator shall establish procedures for increasing the amount of the monthly beneficiary obligation under section 1837(e) that the administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under this part but was not so enrolled.

(B) Periods taken into account.—For purposes of calculating any 12-month period under subparagraph (A), there shall be taken into account:

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

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

(C) Periods not taken into account.—In determining any 12-month period under subparagraph (A), subject to clause (ii), there shall not be taken into account months for which the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the beneficiary had creditable prescription drug coverage (as defined in subparagraph (F)).

(D) Beneficiary must involuntarily lose coverage.—Clause (i) shall only apply with respect to coverage—

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

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

(E) Continuous period of eligibility.—

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

(ii) Separate period.—Any period during all of which an eligible beneficiary is enrolled under subparagraph (1) of section 1836 and which terminated in or before the month preceding the month in which the beneficiary attained 65 shall be considered a separate ‘continuous period of eligibility’ with respect to the beneficiary (and each such period which terminates shall be deemed not to have existed for purposes of subparagraph (i)).

(F) Creditable prescription drug coverage defined.—Subject to subparagraph (G), for purposes of this part, the term ‘creditable prescription drug coverage’ means any of the following:

(i) Drug-only coverage under Medicare.—Coverage of covered outpatient drugs (as defined in section 1905) through a waiver under 1115 where covered outpatient drugs are the sole medical assistance benefit.

(ii) Prescription drug coverage under a group health plan.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under chapter 89 of title 5, United States Code (commonly known as the Federal employees health benefits program), and a qualified retiree prescription drug plan (as defined in section 1860D–20(c)(4)).

(iii) State pharmaceutical assistance program.—Coverage of prescription drugs under a State pharmaceutical assistance program.

(iv) Veterans’ coverage of prescription drugs.—Coverage of prescription drugs for veterans, and survivors and dependents of veterans, under chapter 17 of title 38, United States Code.

(v) Prescription drug coverage under Medicare advantage plans.—Coverage under a Medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(d)(1)).

(G) Requirement for creditable coverage.—Coverage described in clauses (i) through (v) of subparagraph (F) shall not be considered to be creditable under this part unless the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)).

(H) Disclosure.—An entity that offers coverage of the type described in clause (i), (iii), (iv), or (v) of subparagraph (F) shall disclose standards established by the Administrator, of whether the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)).

(I) Waiver of limitations.—An individual may apply to the Administrator to waive the application of subparagraph (G) if the individual establishes that the individual was not adequately informed that the coverage the beneficiary was enrolled in did not provide the level of benefits required in order for the coverage to be considered creditable under subparagraph (F).

(2) Initial election period.
''(A) OPEN ENROLLMENT PERIOD FOR CURRENT BENEFICIARIES IN WHICH LATE ENROLLMENT PROCEDURES DO NOT APPLY.—In the case of an individual who is an eligible beneficiary after November 1, 2005, there shall be an open enrollment period of 6 months beginning on that date under which such beneficiary may enroll under this part without regard to any applicable late enrollment procedures established under paragraph (1)(A).

''(B) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who becomes an eligible beneficiary after November 1, 2005, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

''(C) SPECIAL ENROLLMENT PERIOD FOR BENEFICIARIES WHO INVolUNTARILY LOSE CREDitable PRESCRIPTION DRUG COVERAGE.—

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

''(B) SPECIAL OPEN ENROLLMENT PERIOD.—The special open enrollment period described in this subparagraph is the 63-day period that begins on the first day of the month following the month in which:

(i) the case of a beneficiary with coverage described in clause (ii) of paragraph (1)(F), the latter of the date on which the plan terminates, ceases to provide, or substantially reduces the coverage or the date the beneficiary is provided with notice of such termination or reduction;

(ii) in the case of a beneficiary with coverage described in clause (i), (iii), or (iv) of paragraph (1)(F), the latter of the date on which the beneficiary is involuntarily disenrolled or becomes ineligible for such coverage or the date the beneficiary is provided with notice of such loss of eligibility; or

(iii) in the case of a beneficiary with coverage described in clause (v) of paragraph (1)(F), the latter of the date on which the beneficiary is involuntarily disenrolled under the policy or the date the beneficiary is provided with notice of such termination.

''(c) PERIOD OF COVERAGE.—

''(1) GENERAL.—Except as provided in paragraph (2) and subject to paragraph (3), an eligible beneficiary’s coverage under the program under this part shall be effective for the period beginning January 1, 2006, as if that section applicable to the program under this part, was applied to the program under this part pursuant to subsection (b)(2) shall be entitled to the benefits under this part beginning on January 1, 2006.

''(B) SPECIAL ENROLLMENT.—Subject to paragraph (3), an eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(2) shall be entitled to the benefits under this part beginning on January 1, 2006.

''(d) TERMINATION.—

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

''(2) Coverage Terminated by Termination of Coverage Under Part A or B.—

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

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

''(3) Procedures Regarding Termination of a Beneficiary Under a Plan.—The Administrator shall establish procedures for determining the eligibility of an eligible beneficiary’s enrollment under this part if the beneficiary’s enrollment in a Medicare Prescription Drug plan offered by an eligible entity is terminated by the entity for cause (pursuant to procedures established by the Administrator under section 1860D–3(a)(3)).

''ELECTION OF A MEDICARE PRESCRIPTION DRUG PLAN

''SEC. 1860D–3. (a) IN GENERAL.—

''(1) Process.—

''(A) Election.—

''(i) IN GENERAL.—The administrator shall establish a process through which an eligible beneficiary who is enrolled under this part and enrolled in a Medicare Advantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) offered by a Medicare Advantage organization—

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

(iii) may make an annual election to change the election described in clause (ii).

''(B) Clarification Regarding Enrollment.—The process established under clause (i) shall include, in the case of an eligible beneficiary who is enrolled under this part but who has failed to make an election of a Medicare Prescription Drug plan in an area, for the enrollment in any Medicare Prescription Drug plan offered by an eligible entity in the area. The Administrator shall establish a process for designating a plan or plans in order to carry out the preceding sentence.

''(2) Requirements for Process.—In establishing the process under subparagraph (A), the Administrator shall—

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

(II) may make an annual election to change the selection made under subsection (I);

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

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

(ii) provide comparative information comparing the plans offered by eligible entities under this part that are available to eligible beneficiaries residing in an area.

''(3) Procedures Regarding Termination.—The process developed under paragraph (1) shall ensure that eligibility of beneficiaries who enroll under this part during the open enrollment period under section 1860D–3(a)(1) is maintained.

''(b) Requirement for Conversion to Medicare Advantage Plan.—

''(1) IN GENERAL.—An eligible beneficiary who is enrolled under this part and enrolled in a Medicare Advantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) offered by a Medicare Advantage organization shall receive access to such coverage under this part.

''(2) Rules.—Enrollment in a Medicare Advantage plan is subject to the rules for enrollment in such plan under section 1852.

''(3) Information to Enrollees.—Notwithstanding any other provision of law, the Administrator shall, in each contract under this part, provide such information about eligible beneficiaries as the Administrator determines to be necessary to facilitate efficient enrollment by such beneficiaries with such entities. The Administrator may provide such information only so long as and to the extent necessary to carry out such objective.

''Providing Information to Beneficiaries

SEC. 1860D–4. (a) Activities.—

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

''(2) Special Rule for First Enrollment Under the Program.—The activities described in paragraph (1) shall ensure that eligible beneficiaries are provided with such information at least 30 days prior to the first enrollment period described in section 1860D–3(a)(2).

(b) Requirements.—

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

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

(ii) be coordinated with the activities performed by—

(A) the Administrator under such section; and

(B) the entity under this part.

''(2) COMPARATIVE INFORMATION.—The comparative information described in paragraph (3)(C) shall include a comparison of the following:

(A) BENEFITS.—The benefits provided under the plan and the plans and grievance and appeals processes under the plan.

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

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

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

(E) CONSUMER SATISFACTION SURVEYS.—The results of consumer satisfaction surveys regarding the plan and the eligible entity offering such plan (conducted pursuant to section 1860D–5(4)).

(F) ADDITIONAL INFORMATION.—Such additional information as the Administrator may prescribe.
(D) Grievance and appeals processes.

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

(2) ACKNOWLEDGMENT UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll in a Medicare Prescription Drug plan, an eligible entity offering such plan shall provide information similar (as determined by the Administrator) to the information described in subparagraphs (A), (B), and (C) of section 1927(c)(2) to such individual.

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

(4) CLAIMS INFORMATION.—An eligible entity offering a Medicare Prescription Drug plan must furnish to enrolled individuals in a form easily understandable to such individuals—

(A) an explanation of benefits (in accordance with section 1980(a) or in a comparable manner); and

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

(5) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The provisions of section 1927(h) shall apply to marketing material and application forms under this part in the same manner as such provisions apply to marketing material and application forms under part C.

(p) ACCESS TO COVERED DRUGS.—

(1) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—An eligible entity offering a Medicare Prescription Drug plan shall have in place procedures to ensure that beneficiaries are not charged more than the negotiated price of a covered drug. Such procedures shall include the issuance of a card (or other means) to beneficiaries or enrolled beneficiaries for the purchase of prescription drugs for which coverage is not otherwise provided under the Medicare Prescription Drug plan.

(2) ASSURING PHARMACY ACCESS.—

(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access.

(B) USE OF POINT-OF-SERVICE SYSTEM.—

An eligible entity offering a Medicare Prescription Drug plan shall establish an optional point-of-service method of operation under which—

(i) the plan provides access to any or all pharmacies that are not participating pharmacies for the duration of the plan;

(ii) the plan may charge beneficiaries through adjustments in copayments any additional costs associated with the point-of-service option.

The additional copayments so charged shall not count toward the application of section 1906(d)(1).

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

(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

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

(ii) COMPOSITION.—A pharmacy and therapeutic committee shall include at least one academic expert, at least one practicing physician, and at least one practicing pharmacist, all of whom will represent the care of elderly or disabled persons, and a majority of the members of such committee shall consist of individuals who are a practicing physician or a practicing pharmacist (or both).

(B) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, and such other information as the committee determines to be appropriate.

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

(i) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered drugs (as defined by the Administrator) in a manner that ensures that all drugs within such categories and classes.

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

(B) quality assurance measures to reduce costs when appropriate.

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

(D) CONSIDERATIONS IN PHARMACY FEES.—

The eligible entity offering a Medicare Prescription Drug plan shall take into account the costs of providing services under the medication therapy management program, the resources and time used in implementing the program.

(E) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—The eligible entity offering a Medicare Prescription Drug plan shall provide the price of any pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

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

(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan shall provide meaningful procedures for hearing and resolving grievances between the eligible entity (including any entity or individual through which the plan provides covered benefits) and enrollees with Medicare Prescription Drug plans of the eligible entity under this part in accordance with section 1927(f).

(B) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—The requirements of paragraphs (1) through (3) of section 1927(c) shall apply to an eligible entity with respect to covered benefits under the Medicare Prescription Drug plan it offers under this part in the same manner as such requirements apply to a plan under the Medicare program with respect to benefits it offers under a Medicare Advantage plan under part C.

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

(1) IN GENERAL.—Subject to paragraph (2), the requirements of paragraphs (4) and (5) of section 1852(g) shall apply to an eligible entity with respect to covered drugs not included on a Medicare Advantage plan formulary in a manner that is similar (as determined by the Administrator) to the manner that such requirements apply to a Medicare Advantage organization with respect to benefits it offers under a Medicare Advantage plan under part C.

(2) FORMULARY DETERMINATIONS.—An eligible entity shall ensure that the formulary in a Medicare Advantage plan offered by an eligible entity may appear to obtain coverage for a covered drug that is not on a formulary of the entity's. An applicable plan formulary and the prescribing physician determines that the formulary for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

(f) Privacy, Confidentiality, and Accuracy of Enrollee Records.—Insofar as an eligible entity maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in a Medicare Prescription Drug plan offered by the entity, the entity shall have in place procedures to—

(1) safeguard the privacy of any individually identifiable beneficiary information in a manner that is consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996;

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

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

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

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

(h) Consumer Satisfaction Surveys.—An eligible entity shall conduct consumer satisfaction surveys with respect to the plan and the entity. The Administrator shall establish uniform requirements for such surveys.

"Prescription Drug Benefits "

Sec. 18001 - 6. (a) Requirements.—

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

(A) STANDARD PRESCRIPTION DRUG COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard prescription drug coverage (as defined in subparagraph (c)) and access to negotiated prices under subparagraph (e).

(B) ACTUARILY EQUIVALENT PRESCRIPTION DRUG COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of drugs which meets the alternative coverage requirements of subparagraph (d) and access to negotiated prices under subparagraph (e).

(2) PERMITTING ADDITIONAL PRESCRIPTION DRUG COVERAGE.—

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

(B) REQUIREMENT.—An eligible entity may offer an individual a Medicare Prescription Drug plan that provides additional benefits pursuant to subparagraph (A) in an area unless the eligible entity offering such plan also offers a Medicare Prescription Drug plan in the area that only provides the coverage of prescription drugs that is required under paragraphs (1) and (2) of section 1852(g).

(3) CONTROL MECHANISMS.—In providing qualified prescription drug coverage, the entity offering the Medicare Prescription Drug plan may use a variety of cost control mechanisms, including the use of formularies, tiered copayments, selective contracting with providers of prescription drugs, and mail order pharmacies.

(4) LIMITS ON COST-SHARING.—The coverage has cost-sharing (for costs above the annual deductible) under paragraph (1) and up to the initial coverage limit under paragraph (3) that is equal to 25 percent or that is actuarially equivalent to an initial coverage limit under the provisions of section (f).

(5) ANNUAL PERCENTAGE INCREASE.—For purposes of this part and part C, the term ‘standard prescription drug coverage’ means coverage of covered drugs that meets the following requirements:

(I) DEDUCTIBLE.—

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

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

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

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

(II) LIMITS ON COST-SHARING.—The coverage has cost-sharing (for costs above the annual deductible) under paragraph (1) and up to the initial coverage limit under paragraph (3) that is equal to 25 percent or that is actuarially equivalent to an initial coverage limit under the provisions of section (f) with an average expected payment of 50 percent of such costs.

(III) INITIAL COVERAGE LIMIT.—

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

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

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

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

(IV) APPLICABLE PERCENT DEFINED.—

(I) IN GENERAL.—For purposes of subparagraph (C)(ii), but subject to clause (ii), the applicable percent specified in this subparagraph—

(i) for years before 2010, 20 percent; and

(ii) for any year thereafter, 100 percent.

(II) SECRETARIAL LIMITATION ON TOTAL EXPENDITURES.—The Secretary, in consultation with the Office of Management and Budget, shall estimate at the time of enactment of this part, the aggregate budget outlays that will result during the 10-Fiscal-year period beginning with the current fiscal year that are associated with the Prescription Drug and Medicare Improvement Act of 2003. If such estimate exceeds $393,000,000,000, the Secretary shall provide for such proportional reductions in the percentages specified in clause (ii) as the Secretary determines to be necessary to assure that such aggregate budget outlays during such period do not exceed such amount.

(III) INFORMATION REGARDING THIRD-PARTY REIMBURSEMENT.—In order to ensure compliance with the requirements of subparagraph (C)(ii), the Administrator is authorized to establish procedures, in coordination with the Secretary of Treasury and the Secretary of Labor, for determining whether costs for individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement, and for assuring the entity whether the individuals are enrolled about such reimbursement arrangements. An entity with a contract under this part may periodically ask individuals enrolled by the entity the information described in the preceding sentence by an individual (as defined in standards set by the Administrator and determined through a process established by the Administrator) shall constitute grounds for termination of enrolment under section 1860d-2.

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

(6) ALTERNATIVE COVERAGE REQUIREMENTS.—A Medicare Prescription Drug plan that offers individuals an alternative prescription drug benefit design from the standard prescription drug coverage described in section (c) so long as the Alternative Coverage determines (based on an actuarial analysis by the Administrator) that the following requirements are met and the plan...
apply for, and receives, the approval of the Administrator for such benefit design;—

"(1) ASSURING AT LEAST ACTUARILY EQUVALENT PRESCRIPTION DRUG COVERAGE.—

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

(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard prescription drug coverage. For purposes of this subparagraph, the actuarial value of the coverage (as determined under subsection (f)) exceeds the actuarial value of the amounts associated with the application of section 1900D–20(e)(4) and reinsurance payments under section 1906O–20 with respect to such coverage.

(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (f)), to provide for the payment, with respect to costs included that are equal to the initial coverage limit under subsection (c)(3), of an amount equal to at least the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (c)(3), of an amount equal to at least the payment, with respect to costs incurred that are equal to the initial coverage limit.

(iii) the percentage specified in subsection (c)(2).

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

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

(e) ACCESS TO NEGOTIATED PRICES.—

(A) IN GENERAL.—Under qualified prescription drug coverage offered by an eligible entity or a Medicare Advantage organization, the entity or organization shall provide beneficiaries with access to negotiated prices for payment for covered drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs.

(B) SECRETARIAL NEGOTIATED PRICE.—Notwithstanding any other provision of this part, the Secretary shall, in consultation with the Administrator, establish the best price under section 1802(c)(1) that is equal to the initial coverage limit under subsection (c)(3) for the year. For purposes of this paragraph, the term ‘negotiated price’ means the price at which an eligible entity or a Medicare Advantage organization offering a Medicare Prescription Drug plan and that is not covered under section 1906O–20, enters into a contract under this subsection and that entity or organization shall provide the Administrator with a report of any negotiations and an offer of a contract, the terms of which do not include the application of the requirements of section 1906O–20. Such a contract with an entity or an organization shall provide the Administrator with a report of any negotiations and an offer of a contract, the terms of which do not include the application of the requirements of section 1906O–20, unless the Administrator has determined that the entity or organization is not able to meet the requirements.

(f) AUDITS AND REPORTS.—To protect against fraud and abuse and to ensure proper disclosures and accounting under this part, in addition to any protections against fraud and abuse provided under section 1927(c)(1), the Administrator may periodically audit the financial statements and records of an eligible entity offering a Medicare Prescription Drug plan and a Medicare Advantage organization offering a Medicare Advantage plan.

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

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

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

(i) an actuarial valuation of standard prescription drug coverage, and

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

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

Such processes shall take into account any effect that providing actuarially equivalent coverage in lieu of standard prescription drug coverage has on drug utilization.
subsection to Medicare Prescription Drug plans and eligible entities—

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

"(B) any reference to solvency standards were treated as a reference to solvency standards established under subsection (a) of paragraph (2).

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

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

(2) COMPLIANCE WITH STANDARDS.—An eligible entity that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Administrator shall establish certification procedures for such eligible entity with respect to such solvency standards in the same manner described in section 1855(c)(2).

(3) INDICATORS OF FINANCIAL STABILITY.—The Administrator may not establish the service areas under subsection (a) consistent with the following:

(A) the Administrator shall establish the service areas under subsection (a) in a manner that—

(1) maximizes the availability of Medicare Prescription Drug plans to eligible beneficiaries; and

(2) minimizes the ability of eligible entities offering such plans to favorably select eligible beneficiaries.

(B) the Administrator shall establish the service areas under subsection (a) in a manner that—

(1) in general—

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

(B) Each service area must include at least 10 service areas.

(C) Each service area must include at least 1 State.

(D) The Administrator may not divide States so that portions of the States are in different service areas.

(E) To the extent possible, the Administrator shall include multistate metropolitan statistical areas in service areas.

(F) The Administrator shall establish the service areas consistent with the following:

(1) There shall be at least 10 service areas.

(2) Each service area must include at least 1 State.

(3) The Administrator may not divide States so that portions of the States are in different service areas.

"(2) PROCEDURES FOR TERMINATION.—Section 1857(g), except that in applying such section—

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

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

"(3) PERIODIC REVIEW AND REVISION OF STANDARDS.—

(1) IN GENERAL.—Subject to paragraph (2), the Administrator shall periodically review the standards established under this section and, based on such review, may revise such standards in the same manner as the Administrator determines necessary.

(2) PROVISION OF MPPS.—The Administrator shall provide information as the Administrator may specify, such information as the Administrator may require, including the information described in subsection (b) and—

(1) ANNUAL SUBMISSION.—An eligible entity shall submit the information required under paragraph (1) with respect to a Medicare Advantage plan, which the entity intends to offer on an annual basis.

(2) INFORMATION DESCRIBED.—The information described in this subsection includes information on each of the following:

(A) The benefits under the plan (as required under section 1860–6).

(B) The actuarial value of the qualified prescription drug coverage.

(C) The amount of the monthly plan premium under the plan, including an actuarial certification of—

(1) the actuarial basis for such monthly plan premium;

(2) the portion of such monthly plan premium attributable to standard prescription drug coverage and, if applicable, to benefits that are in addition to such coverage; and

(3) the reduction in such monthly plan premium resulting from the payments provided under section 1860–20.

(4) The service area for the plan.

(5) Whether the entity intends to use any funds in the plan stabilization reserve fund in the Prescription Drug Account that are attributable to standard prescription drug coverage or actuarially equivalent prescription drug coverage.

"(2) REQUIREMENTS FOR ESTABLISHMENT OF SERVICE AREAS.—

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

(A) maximizes the availability of Medicare Prescription Drug plans to eligible beneficiaries; and

(B) minimizes the ability of eligible entities offering such plans to favorably select eligible beneficiaries.

(2) ADDITIONAL REQUIREMENTS.—The Administrator shall establish the service areas under subsection (a) in a manner that—

(A) maximizes the availability of Medicare Prescription Drug plans to eligible beneficiaries; and

(B) minimizes the ability of eligible entities offering such plans to favorably select eligible beneficiaries.

"(3) MAY CONFORM TO MEDICAREADVANTAGE PREPARED PROVIDER REGIONS.—The Administrator may conform the service areas established under this section to the preferred provider regions established under section 1883(a)(3).

"(4) EFFECT OF PROVISION.—The provisions of this section shall be applied in a manner consistent with the following:

(A) The Administrator shall conform the service areas established under this section and, based on such review, may revise such service areas if the Administrator determines such revision to be appropriate.

(B) All entities that are licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Administrator shall establish certification procedures for such eligible entity with respect to such solvency standards in the same manner described in section 1855(c)(2).

(5) Whether the entity plans to use any funds in the plan stabilization reserve fund in the Prescription Drug Account that are attributable to standard prescription drug coverage or actuarially equivalent prescription drug coverage.
available to the entity to stabilize or reduce the monthly plan premium submitted under paragraph (3), and if so, the amount in such reserve fund that is to be used.

(6) Subparagraph (b) of this paragraph may be applied for 2006 and each subsequent year if the Administrator determines, with respect to an area, that the access required under paragraph (d)(2) is going to be provided in the area during the subsequent year.

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

(3) FAVORABLE SELECTION OF ELIGIBLE BENEFICIARIES.—The Administrator may not enter into a contract with an entity under subparagraph (B) (i) if the number of beneficiaries in the service area for which the contract is entered into exceeds the number of beneficiaries in the service area that would have been included if the Administrator had not applied such adjustment. If the number of beneficiaries in the service area for which the contract is entered into exceeds the number of beneficiaries in the service area that would have been included if the Administrator had not applied such adjustment, the contract may be entered into only if such contract in each such area.

(2) AUTHORITY TO REDUCE RISK TO ENSURE ACCESS.—

(a) IN GENERAL.—Subject to subparagraph (B), if the Administrator determines, with respect to an area, that the access required under paragraph (d)(2) is going to be provided in the area during the subsequent year, the Administrator shall—

(i) adjust the percent specified in paragraph (2) and (4) of section 1860–16(b) in an area in a year if 2 or more qualified bids are submitted under paragraph (d) for the entity to offer a Medicare Prescription Drug plan in the area for the year after the Administrator has exercised the authority under subsection (d)(2) in the area for the year;

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

The administrator shall exercise the authority under the preceding sentence only as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

(b) REQUIREMENTS FOR USE OF AUTHORITY.—In exercising authority under subparagraph (A), the Administrator—

(i) shall not provide for any underwriting of financial risk for any eligible entity;

(ii) shall not provide for any underwriting of financial risk for a public eligible entity with respect to a Medicare Advantage or a Medicare Advantage and Medicare Prescription Drug plan; and

(iii) shall seek to maximize the assumption of financial risk by eligible entities to ensure fair competition among Medicare Prescription Drug plans.

(c) REQUIREMENT TO ACCEPT 2 FULL-RISK QUALIFIED BIDS BEFORE EXERCISING AUTHORITY.—The Administrator shall exercise the authority under paragraph (A) with respect to an area and year if 2 or more qualified bids are submitted by eligible entities to offer a Medicare Prescription Drug plan in the area for the year under paragraph (1) before the application of subparagraph (A).

(d) REPORTS.—The Administrator, in each annual report to Congress under section 1808(c)(1)(D), shall include information on the exercise of authority under subparagraph (A) and any methodology used to arrive at such recommendations as may be appropriate to limit the exercise of such authority.

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

(A) DETERMINATION.—Not later than September 1 of each year (beginning in 2005) and for each area (established under section 1860–10), the Administrator shall make a determination as to whether the access required under subsection (d)(2) is going to be provided in the area during the subsequent year. Such determination shall be made on the basis provided under section 1860–10, the Administrator shall take the following steps:

(A) DETERMINATION.—Not later than September 1 of each year (beginning in 2005) and for each area (established under section 1860–10), the Administrator shall make a determination as to whether the access required under subsection (d)(2) is going to be provided in the area during the subsequent year. Such determination shall be made on the basis provided under section 1860–10, the Administrator shall take the following steps:

(B) CONTRACT WITH AN ENTITY TO PROVIDE COVERAGE.—The Administrator may enter into a contract under this paragraph for 2006 and each subsequent year if the Administrator determines, with respect to an area, that the access required under paragraph (d)(2) is going to be provided in the area during the subsequent year. Such determination shall be made on the basis provided under section 1860–10, the Administrator shall take the following steps:

(ii) payment for the negotiated costs of covered drugs provided to eligible beneficiaries enrolled with the entity; and

(iii) payment of prescription management fees that are tied to performance requirements established by the Administrator for the management, administration, and delivery of the benefits under the contract.

(B) PERFORMANCE REQUIREMENTS.—The performance requirements established by the Administrator pursuant to subparagraph (A)(ii) shall include the following:

(i) The entity contains costs to the Prescription Drug Plan for all qualified beneficiaries enrolled under this part and with the entity.

(ii) The entity contains costs to the Prescription Drug Plan for all qualified beneficiaries enrolled under this part and with the entity.

(iii) The entity contains costs to the Prescription Drug Plan for all qualified beneficiaries enrolled under this part and with the entity.

(iii) The entity contains costs to the Prescription Drug Plan for all qualified beneficiaries enrolled under this part and with the entity.

(iv) The entity contains costs to the Prescription Drug Plan for all qualified beneficiaries enrolled under this part and with the entity.

(v) The entity contains costs to the Prescription Drug Plan for all qualified beneficiaries enrolled under this part and with the entity.

(vi) The entity contains costs to the Prescription Drug Plan for all qualified beneficiaries enrolled under this part and with the entity.

(vii) The entity contains costs to the Prescription Drug Plan for all qualified beneficiaries enrolled under this part and with the entity.

(viii) The entity contains costs to the Prescription Drug Plan for all qualified beneficiaries enrolled under this part and with the entity.

(ix) The entity contains costs to the Prescription Drug Plan for all qualified beneficiaries enrolled under this part and with the entity.

(x) The entity contains costs to the Prescription Drug Plan for all qualified beneficiaries enrolled under this part and with the entity.

(x) The entity contains costs to the Prescription Drug Plan for all qualified beneficiaries enrolled under this part and with the entity.
"(ii) The entity provides such beneficiaries with quality clinical care.

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

(C) Activities Required at the Extent to the Extent of the Fees Tied to Performance Requirements.—An entity with a contract under paragraph (1)(B) shall only be at risk for the provisions under the contract, and the extent that the management fees paid to the entity are tied to performance requirements under subparagraph (A)(ii).

(4) District or area not eligible to be awarded the contract.—An eligible entity that submitted a bid to offer a Medicare Prescription Drug Plan for a year under section 1860D–12, including a bid submitted after the Administrator has exercised the authority under subsection (d)(2), may not be awarded a contract under paragraph (1)(B) for that area and year. The previous sentence shall apply to an entity that was awarded a contract under paragraph (1)(B) for the area in the previous year and submitted such a bid under section 1860D–12 for the year.

(5) Contract to be available in designated area for 2 years.—Notwithstanding paragraph (1), if the Administrator enters into a contract with an entity with respect to an area designated under paragraph (B) of the previous sentence, the following rules shall apply:

(A) The contract shall be for a 2-year period.

(B) The Secretary is not required to make the determination under paragraph (1)(A) with respect to the second year of the contract for the area.

(C) Effective for the second year of the contract, an entity may be designated under paragraph (B) of the previous sentence, in the case of an area where (before the application of this section for 2006) the Administrator shall compute a monthly standard plan premium approved for the plan under section 1860D–6(a)(2) for a Medicare Prescription Drug plan that is available in the area.

(6) Entity not permitted to market or brand the contract.—An entity with a contract under paragraph (1)(B) may not engage in any marketing or branding of such contract.

(7) Rules for areas where only 1 competitively bid plan was approved.—In the case of any area before the application of this subsection (and pursuant to section 1860D–6(e)) under such contract or through any Medicare Prescription Drug plan that is available in the area.

(8) Plan premium for each covered drug that constitutes a portion of such amount;

(9) The negotiated price for the eligible entity offering such a plan.

(10) The number of prescriptions; and

(11) The average beneficiary copayment rate for each covered drug that constitutes a portion of such amount.

(12) Certain expenses not included.—The amounts under clauses (i) and (ii) of subparagraph (A) may not include:

(A) Administrative expenses incurred in providing the coverage described in subparagraph (A)(i);

(B) Amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6a(2); or

(C) Amounts expended for which the entity is subsequently provided with reinsurance payments under section 1860D–20.

(2) Adjusting payment.—

(A) No adjustment if allowable costs within upper limit of risk corridor.—If the allowable costs (specified in paragraph (3) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (4)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (4)(A)(ii)) for the plan for the year, then no additional payments shall be made by the Administrator and no payments shall be made by (or collected from) the eligible entity offering the plan.

(B) Increase in payment if allowable costs above upper limit of risk corridor.—

(I) In general.—If the allowable costs for the plan for the year are more than the first threshold upper limit of the risk corridor (specified in paragraph (4)(A)(ii)) for the plan for the year, then the Administrator shall increase the total of the monthly payments made to the entity offering the plan by an amount equal to the sum of—

(1) the applicable percent (as defined in subparagraph (D)) of such allowable costs that are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (4)(A)(iii)); and

(2) 90 percent of such allowable costs which are more than such second threshold upper limit of the risk corridor.

(C) Special transitional corridor for 2006 and 2007.—If the Administrator determines with respect to 2006 or 2007 that at least 60 percent of Medicare Prescription Drug plans and Medicare Advantage Plans (excluding MSA plans or private fee-for-service plans that do not provide qualified prescription drug coverage) have allowable costs (as defined under paragraph (2)) that are more than the first threshold upper limit of the risk corridor for the plan for the year and that such plans represent at least 60 percent of the total national allowable costs as determined under this part, clause (ii)(B) shall be applied by substituting ‘90 percent’ for ‘applicable percent’.

"(d) Portion of total payments of monthly plan premiums subject to risk.—

(1) Notification of spending under the plan.—

In general.—For each year (beginning in 2007), the eligible entity offering a Medicare Prescription Drug plan shall notify the Administrator of the following:

(I) The total amount of costs that the entity incurred in providing standard prescription drug coverage (or prescription drug coverage that is actuarially equivalent pursuant to section 1860D–6a(1)(B)) for an enrollee under the plan in the previous year.

(II) Actual costs for specific drugs.—With respect to the total amount under clause (i) for the year, a breakdown of—

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

(2) the negotiated price for the eligible entity offering such a plan.

(III) the number of prescriptions; and

(IV) the average beneficiary copayment rate for each covered drug that constitutes a portion of such amount.

(2) Adjustment of payment.—

(A) No adjustment if allowable costs within upper limit of risk corridor.—If the allowable costs (specified in paragraph (3) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (4)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (4)(A)(ii)) for the plan for the year, then no additional payments shall be made by the Administrator and no payments shall be made by (or collected from) the eligible entity offering the plan.

(B) Increase in payment if allowable costs above upper limit of risk corridor.—

(I) In general.—If the allowable costs for the plan for the year are more than the first threshold upper limit of the risk corridor (specified in paragraph (4)(A)(ii)) for the plan for the year, then the Administrator shall increase the total of the monthly payments made to the entity offering the plan by an amount equal to the sum of—

(1) the applicable percent (as defined in subparagraph (D)) of such allowable costs that are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (4)(A)(iii)); and

(2) 90 percent of such allowable costs which are more than such second threshold upper limit of the risk corridor.

(C) Special transitional corridor for 2006 and 2007.—If the Administrator determines with respect to 2006 or 2007 that at least 60 percent of Medicare Prescription Drug plans and Medicare Advantage Plans (excluding MSA plans or private fee-for-service plans that do not provide qualified prescription drug coverage) have allowable costs (as defined under paragraph (2)) that are more than the first threshold upper limit of the risk corridor for the plan for the year and that such plans represent at least 60 percent of the total national allowable costs as determined under this part, clause (ii)(B) shall be applied by substituting ‘90 percent’ for ‘applicable percent’.

"(e) Determination of monthly plan premiums.—For each year (beginning with 2006), the Administrator shall determine the monthly plan premium for each Medicare Prescription Drug plan approved under section 1860D–13 and for each Medicare Advantage plan.

(1) In general.—The monthly standard prescription drug coverage premium for a plan for a year shall be equal to—

(I) in the case of a plan offered by an eligible entity or Medicare Advantage organization that provides standard prescription drug coverage or an actuarially equivalent prescription drug coverage that is not provided as additional prescription drug coverage pursuant to section 1860D–6a(2), the monthly plan premium approved for the plan under section 1860D–6a(2); and

(II) in the case of a plan offered by an eligible entity or Medicare Advantage organization that provides additional prescription drug coverage pursuant to section 1860D–6a(2)—

(A) an amount that reflects only the actuarial value of the standard prescription drug coverage under the plan, or

(B) if determined appropriate by the Administrator, the monthly plan premium approved under section 1860D–13 for the year by the Medicaid and Medicare Improvement Act of 2003 for the year.

(2) Weighted average.—The monthly national average premium computed under paragraph (1) shall be a weighted average, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the previous year.

(B) Geographic Adjustment.—The Administrator shall establish an appropriate methodology for adjusting the monthly national average premium computed under paragraph (1) for the year to take into account differences in prices for covered drugs among different areas.

(3) In general.—The Administrator shall compute a monthly plan premium for each Medicare Prescription Drug plan and each Medicare Advantage plan (as computed under section 1860D–14) such premium may be adjusted pursuant to any methodology determined under subsection (b), as determined appropriate by the Administrator.

(C) Special Rule for 2006.—For purposes of applying this section for 2006, the Administrator shall establish an appropriate methodology for determining the monthly plan premium pursuant to any methodology determined under subsection (a) for the year to take into account differences in prices for covered drugs among different areas.

(D) In general.—For each year (beginning with 2006), the Administrator shall compute a monthly standard prescription drug coverage premium for each Medicare Prescription Drug plan approved under section 1860D–3a(1)(A)(ii), such plan shall be the plan designated in the area under such section.

(2) Two-Year Contracts.—Except for a contract under paragraph (1)(B), a contract approved under this part, clause (i) for the year after the plan for the year, then the Administrator shall establish procedures for determining the monthly plan premium average under subsection (a)(ii) for 2005.

(3) Payments to eligible entities.—

(1) In general.—For each year (beginning with 2006), the Administrator shall pay to each entity offering a Medicare Prescription Drug plan in which an eligible beneficiary is enrolled an amount equal to the full amount of the monthly plan premium approved for the plan under section 1860D–13 on behalf of each eligible beneficiary enrolled in such plan for the year, as adjusted using the risk corridor and risk adjustment (under rules applicable to such plans under section 1860D–6(e)) under such plan.

(2) Payment for services furnished prescription drug coverage through enrollment in the plan or with an entity with a contract under paragraph (1)(B); and

(3) For purposes of applying section 1860D–3a(1)(A)(ii), such plan shall be the plan designated in the area under such section.

(4) In general.—For each year (beginning with 2006), the Administrator shall compute a monthly standard prescription drug coverage premium for each Medicare Prescription Drug plan approved under section 1860D–13 and for each Medicare Advantage plan.
(C) Plan Payment If Allowable Costs Below Lower Limit of Risk Corridor.—If the allowable costs for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the entity offering the plan shall make a payment to the Administrator of an amount (or the Administrator shall otherwise recover from the plan an amount) equal to—

(i) the applicable percent (as so defined) of such allowable costs which are less than such first threshold lower limit of the risk corridor.

(D) Applicable Percent Defined.—For purposes of this paragraph, the term ‘applicable percent’ means—

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

(ii) for 2008 and subsequent years, 50 percent.

(3) Establishment of Allowable Costs.—

(A) In General.—For each year, the Administrator shall establish the allowable costs for each Medicare Prescription Drug plan for the year. The allowable costs for a plan for a year shall be equal to the amount described in paragraph (1)(A) for the plan for the year, adjusted under subparagraph (B)(i).

(B) Repricing of Costs.—

(i) Calculation of Average Plan Cost.—Utilizing the information obtained under paragraph (3)(A)(ii) and section 1860D–2(b), for each year (beginning with 2006), the Administrator shall establish an average negotiated price with respect to all Medicare Prescription Drug plans for each covered drug.

(ii) Adjustment If Actual Costs Exceed Average Costs.—With respect to a Medicare Prescription Drug plan for a year, the Administrator shall reduce the amount described in paragraph (1)(A)(i) for the plan for the year to the extent such amount is based on costs of specific covered drugs furnished under the plan in the year (as defined under subparagraph (1)(A)(iii)) for which the negotiated prices are greater than the average negotiated price with respect to all covered drugs for the year (as determined under clause (i)).

(4) Establishment of Risk Corridors.—

(A) In General.—For each year (beginning in 2006), the Administrator shall establish a risk corridor for each Medicare Prescription Drug plan. The risk corridor for a plan for a year shall be equal to a range as follows:

(i) First Threshold Lower Limit.—The first threshold lower limit of such corridor shall be equal to—

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

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

(ii) Second Threshold Lower Limit.—The second threshold lower limit of such corridor shall be equal to—

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

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

(iii) First Threshold Upper Limit.—The first threshold upper limit of such corridor shall be equal to—

(A) the target amount described in subparagraph (B) for the plan; plus

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

(iv) Second Threshold Upper Limit.—The second threshold upper limit of such corridor shall be equal to the sum of—

(A) such target amount; and

(B) the amount described in clause (ii)(i).

(5) Target Amount Described.—The target amount described in this paragraph is the amount negotiated for the Medicare Prescription Drug plan offered by an eligible entity in a year—

(i) in the case of a plan offered by an eligible entity that provides standard prescription drug coverage or actuarially equivalent prescription drug coverage and does not provide additional prescription drug coverage pursuant to section 1860D–6(a)(2), an amount equal to the total of the monthly premium payments paid to such entity for the year pursuant to subsection (a), reduced by the percentage specified in subparagraph (D); and

(ii) in the case of a plan offered by an eligible entity that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2), an amount equal to the total of the monthly premium payments paid to such entity for the year pursuant to subsection (a), reduced by the percentage specified in subparagraph (D).

(D) Target Amount Not to Include Administrative Expenses Negotiated Between the Administrator and the Entity Offering the Plan.—For purposes of clause (i), and to the extent that an entity is the entity offering the plan (as determined under subparagraph (A)(ii)) for which the negotiated price is—

(i) the applicable percent (as so defined) of such allowable costs which are less than such second threshold lower limit of the risk corridor.

(6) Stabilization Reserve Fund.—

(A) In General.—Each contract under this part shall provide that—

(i) the entity offering a Medicare Prescription Drug plan shall provide the Administrator with such information as the Administrator determines is necessary to carry out this section; and

(ii) the Administrator shall have the right to inspect and to request and review any books and records of the entity that pertain to the information regarding costs provided to the Administrator under paragraph (3).

(B) Restriction on Use of Information.—Information disclosed or obtained pursuant to the provisions of this section may be used by officers and employees of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

(C) Stabilization Reserve Fund.—

(1) Establishment.—

(A) In General.—There is established, with respect to each Medicare Prescription Drug Account, a stabilization reserve fund in which the Administrator shall deposit amounts on behalf of eligible entities in accordance with paragraph (2) to—

(i) pay amounts on behalf of an entity that is not an eligible entity as of the date referred to in section 1860D–17 for any year; or

(ii) make payments on behalf of an eligible entity that is less than the first threshold lower limit of such corridor.

(B) Reversion of Unused Amounts.—Any amount in the stabilization reserve fund established under subparagraph (A) that is not deposited for the use of an eligible entity in accordance with paragraph (3) (or that was deposited for the use of an eligible entity that no longer has a contract under this part shall revert for use of the Medicare Prescription Drug Account.

(2) Deposit of Amounts for 5 Years.—

(A) In General.—If the target amount for a Medicare Prescription Drug plan for 2006, 2007, 2008, 2009, or 2010 (as determined under subsection (b)(4)(B)) exceeds the applicable costs for the plan for the year by more than 3 percent, then—

(i) the entity offering the plan shall make a payment to the Administrator of an amount (or the Administrator shall otherwise recover from the plan an amount) equal to the portion of such excess that is in excess of 3 percent of the target amount.

(ii) the Administrator shall deposit an amount equal to the amount collected or otherwise recovered under clause (i) in the stabilization reserve fund on behalf of the eligible entity offering such plan.

(B) Applicable Costs.—For purposes of subparagraph (A), the term ‘applicable costs’ means, with respect to a Medicare Prescription Drug plan for a year, the amount described in clause (i)(III) of section 1860D–17 for the year in which such change in payments is made.

(7) Disclosure of Information.—

(A) In General.—Each contract under this part shall provide that—

(i) the entity offering a Medicare Prescription Drug plan shall provide the Administrator with such information as the Administrator determines is necessary to carry out this section; and

(ii) the Administrator shall have the right to inspect and to request and review any books and records of the entity that pertain to the information regarding costs provided to the Administrator under paragraph (3).

(B) Restriction on Use of Information.—Information disclosed or obtained pursuant to the provisions of this section may be used by officers and employees of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

(8) Procedures.—The Administrator shall establish procedures for—
(i) reducing monthly plan premiums submitted under section 1860D–12(b)(3) pursuant to subparagraph (A); and

(ii) making payments from the plan stabilization fund in the Prescription Drug Account to eligible entities that inform the Secretary under section 1860D–12(b)(5) of the entity’s intent to use funds in such reserve fund to reduce such premiums.

(d) PORTION OF PAYMENTS OF MONTHLY PLAN PREMIUMS ATTRIBUTABLE TO ADMINISTRATIVE EXPENSES TIED TO PERFORMANCE REQUIREMENTS.—

(1) IN GENERAL.—The Administrator shall establish procedures to adjust the portion of the payments of monthly plan premiums made under section (a) that are attributable to administrative expenses (as determined pursuant to subsection (b)(4)(D)) to ensure that the entity meets the performance requirements described in clauses (ii) and (iii) of section 1860D–13(e)(4)(B).

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

(e) PAYMENT TERMS.—

(1) ADMINISTRATOR PAYMENTS.—Payments to an entity under a Medicare Prescription Drug plan under this section shall be made in a manner determined by the Administrator and based upon the manner in which payments under section 1858A(c) (relating to payments to Medicare Advantage organizations).

(2) PLAN PAYMENTS.—The Administrator shall establish a process for collecting (or other otherwise recovering) amounts that an entity offering a Medicare Prescription Drug plan is required to make to the Administrator under this section.

(f) PAYMENTS TO MEDICAREADVANTAGE PLANS.—For provisions related to payments to Medicare Advantage organizations offering Medicare Advantage plans for qualified prescription drug coverage made available under the plan, see section 1858A(c).

(g) SECONDARY PAYOR PROVISIONS.—The provisions of section 1860B(c) shall apply to the benefits provided under this part.

(1) COMPUTATION OF MONTHLY BENEFICIARY OBLIGATION—

SEC. 1860D–17. (a) BENEFICIARIES ENROLLED IN A MEDICARE PRESCRIPTION DRUG PLAN.—In the case of an eligible beneficiary enrolled under this part and in a Medicare Prescription Drug plan, the monthly beneficiary obligation for enrollment in such plan for the year is equal to the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation for the eligible beneficiary in that year shall be an amount equal to—

(A) the applicable percent of the amount of such monthly national average premium; plus

(B) the amount by which such monthly national average premium exceeds the amount of the monthly plan premium approved by the Administrator for the plan.

(2) PLAN PREMIUM EXCEEDS MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year exceeds the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to—

(A) the applicable percent of the amount of such monthly national average premium; minus

(B) the amount by which such monthly national average premium exceeds the amount of the monthly plan premium approved by the Administrator for the plan.

(3) MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator for the plan exceeds the amount of the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to—

(A) the applicable percent of the amount of such monthly national average premium; plus

(B) the amount by which such monthly national average premium exceeds the amount of the monthly plan premium approved by the Administrator for the plan.

(4) APPLICABLE PERCENT.—For purposes of this section, except as provided in section 1860D–19 (relating to premium subsidies for low-income individuals), the applicable percent for any year is the percentage equal to a fraction—

(1) the numerator of which is 27.5 percent; and

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

(A) the total reinsurance payments which the Administrator will be made under section 1860D–20 to qualify entities described in subsection (c) of such section during the year, divided by

(B) the sum of—

(i) the amount estimated under subparagraph (A) for the year; and

(ii) the total payments which the Administrator estimates will be made under sections 1860D–16 and 1858A(c) during the year that relate to standard prescription drug coverage (or actuarially equivalent prescription drug coverage) for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides for the amount of such monthly national average premium, but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as determined under section 1860D–15) for the area for the year;

(5) LOW-INCOME INDIVIDUALS.—Subject to paragraph (2), the applicable percent that would otherwise apply under such subsection; and

(6) IN SUBSECTION (a)(3)(B), BY SUBSTITUTING ‘2.5 PERCENT’ FOR ‘10 PERCENT’ —

(i) in subsection (c), by substituting ‘0 percent’ for the applicable percent that would otherwise apply under such subsection; and

(ii) in subsection (a)(3)(B), by substituting ‘the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides for the amount of such monthly national average premium, but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as determined under section 1860D–15) for the area for the year;’ for ‘the amount of the monthly plan premium attributable to qualified low-income individuals (as defined in paragraph (4)(B)) or a qualifying individual (as defined in paragraph (4)(C))—

(A) the applicable percent that would otherwise apply under such subsection; and

(B) the amount by which such monthly national average premium exceeds the amount of the monthly plan premium attributable to qualified low-income individuals (as defined in paragraph (4)(B)) or a qualifying individual (as defined in paragraph (4)(C))—

(1) subject to paragraph (2), by substituting ‘2.5 percent’ for ‘10 percent’ in such subsection; and

(2) subject to paragraph (2), by substituting ‘25 percent’ for ‘50 percent’.

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

(2) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR QUALIFIED MEDICARE BENEFICIARIES.—In the case of a qualified medicare beneficiary (as defined in paragraph (4)(A)—

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

(ii) in section 1860D–6(c)(1) in a year shall be reduced to 0.

(C) COLLECTION FOR BENEFICIARIES ENROLLED IN A MEDICAREADVANTAGE PLAN.—In the case of an eligible beneficiary enrolled in a Medicare Advantage plan, the monthly beneficiary obligation for qualified prescription drug coverage under a Medicare Advantage plan, see section 1860D–19.

(3) PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS

SEC. 1860D–19. (a) AMOUNT OF SUBSIDIES.—

(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR QUALIFIED MEDICARE BENEFICIARIES.—In the case of a qualified medicare beneficiary (as defined in paragraph (4)(A)—

(A) in section 1860D–19 shall be applied—

(ii) in subsection (c), by substituting ‘0 percent’ for the applicable percent that would otherwise apply under such subsection;

(B) the annual deductible applicable under section 1860D–6(c)(1) in a year shall be reduced to 0.

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

(D) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the annual out-of-pocket limit described in section 1860D–6(c)(3)) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A), this is equal to 5.0 percent.

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

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

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

(A) section 1860D–17 shall be applied—

(i) in subsection (c), by substituting ‘0 percent’ for the applicable percent that would otherwise apply under such subsection; and

(ii) in subsection (a)(3)(B), by substituting ‘the amount of the monthly plan premium attributable to qualified low-income individuals (as defined in paragraph (4)(B)) or a qualifying individual (as defined in paragraph (4)(C))—

(A) the applicable percent that would otherwise apply under such subsection; and

(B) the amount by which such monthly national average premium exceeds the amount of the monthly plan premium attributable to the beneficiary under this part directly to the beneficiary.

(3) INFORMATION NECESSARY FOR COLLECTION.—In order to carry out subsection (a), the Administrator shall transmit to the Commissioner of Social Security—

(1) by the beginning of each year, the name, social security account number, monthly beneficiary obligation for Medicare Prescription Drug plan for each month during the year, and other information determined appropriate by the Administrator; and

(2) periodically throughout the year, information to update the information previously transmitted under this paragraph for the Medicare Prescription Drug plan offered in the area in which the individual resides that has a
monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year;

“(B) if the deductible applicable under section 1860D–6(c)(1) in a year shall be reduced to 50 percent by

“(c) section 1860D–6(c)(2) shall be applied by substituting '2.5 percent' for '10 percent' each place it appears;

“(D) such individual shall be responsible for cost-sharing for the amount that is equal to or less than the monthly national average premium, but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides; and

“(E) section 1860D–6(c)(4)(A) shall be applied by substituting '2.5 percent' for '10 percent'.

In no case may the application of subparagraph (A), (B), and (C) of section 1860D–6(c)(4)(A) for a coverage year:

“(i) reduce the amount specified in section 1860D–6(a)(2) for the year involved.

“(ii) reduce the amount specified in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)(ii), that is equal to 10.0 percent; and

“(iii) reduce the amount specified in section 1860D–6(c)(4)(A)(ii) for the year involved.

“(B) in paragraphs (A) and (B) of section 1860D–6(c)(5), by substituting the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides for the amount of such monthly national average premium, but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year; and

“(i) 2005, shall be reduced to $50, and

“(ii) for a subsequent year, shall be reduced to the amount specified under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers for the month of October of the previous year for the area involved.

“(iii) such individual shall be responsible for cost-sharing for the amount of the deductible applicable under section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)(ii), that is equal to 10.0 percent; and

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

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

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

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

“(ii) the highest percentage that would otherwise apply under section 1860D–17 in the service area in which the subsidy-eligible individual resides, in the case of a subsidy-eligible individual residing, in the case of a subsidy-eligible individual residing in the State whose income equals 160 percent of the poverty line;

“(A) QUALIFIED MEDICARE BENEFICIARY.— Subject to subparagraph (H), the term 'qualified medicare beneficiary' means an individual who:

“(i) is enrolled under this part, including an individual who is enrolled under a Medicare Advantage plan; and

“(ii) whose income is less than 160 percent of the poverty line; and

“(B) SUBSIDY PERCENT DEFINED.—Subject to subparagraph (H), the term 'subsidy-eligible individual' means an individual—

“(i) who is enrolled under this part, including an individual who is enrolled under a Medicare Advantage plan; and

“(ii) whose income is less than 160 percent of the poverty line; to

“(ii) whose income is less than 160 percent of the poverty line; and

“(iii) the number of prescriptions; and

“(B) RULES IN APPLYING COST-SHARING SUBSIDIES.—Nothing in this section shall be construed as preventing an eligible entity offering a Medicare Advantage plan or a Medicare Advantage organization offering a Medicare Advantage plan from waiving or reducing the amount of the deductible or other cost-sharing applicable pursuant to section 1860D–6(a)(2).

“(C) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator shall establish the process whereby, in the case of an individual eligible for a cost-sharing subsidy under subsection (a) who is enrolled in a Medicare Prescription Drug plan or a Medicare Advantage plan, the Administrator shall provide in accordance with this section for payment to a qualifying entity of the reinsurance payment amount (as specified in subsection (c)(1)) for costs incurred by the entity in providing prescription drug coverage for a qualifying covered individual after the individual has reached the annual out-of-pocket threshold specified in section 1860D–6(c)(4)(B) for the year involved.

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

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

“(1) IN GENERAL.—Subject to section 1860D–21(b), the Administrator shall provide in accordance with this section for payment to a qualifying entity of the reinsurance payment amount (as specified in subsection (c)(1)) for costs incurred by the entity in providing prescription drug coverage for a qualifying covered individual after the individual has reached the annual out-of-pocket threshold specified in section 1860D–6(c)(4)(B) for the year involved.

“(2) ACTUAL COSTS FOR SPECIFIC DRUGS.—With respect to the total amount of reinsurance payments under this section for a qualifying covered individual for a coverage year:

“(a) TOTAL ACTUAL COSTS.—The total amount (if any) of costs that the qualifying entity incurred in providing prescription drug coverage for the individual in the year involved that had reduced the annual out-of-pocket threshold specified in section 1860D–6(c)(4)(B) for the year involved.

“(B) actual costs for a specific drug amounting to section 1860D–6(c)(4)(B) for the year involved.

“(B) actual costs for a specific drug amounting to section 1860D–6(c)(4)(B) for the year involved.

“(a) FOR EACH DRUG.—With respect to the total amount of reinsurance payments under this section for a qualifying covered individual for a coverage year:

“(i) each covered drug that constitutes a portion of such amount;

“(ii) the negotiated price for the qualifying entity for each such drug;

“(iii) the number of prescriptions; and

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

“(2) CERTAIN EXPENSES NOT INCLUDED.—The amounts under subparagraphs (A) and (B) of paragraph (1) may also include—

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

“(B) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2).
(3) RESTRICTION ON USE OF INFORMATION.—

The restriction specified in section 1860D–16(b)(7)(B) shall apply to information disclosed or obtained pursuant to the provisions of this section.

(c) REINSURANCE PAYMENT AMOUNT.—

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

(2) ALLOWABLE COSTS.—

(A) IN GENERAL.—In the case of a qualifying covered individual for a coverage year, the Administrator shall establish the allowable costs for the individual and year. Such allowable costs shall be equal to the amount described in such subsection for the individual and year, adjusted under subsection (a).

(B) REPRICING OF COSTS IF ACTUAL COSTS EXCEED AVERAGE COSTS.—The Administrator shall reduce the amount described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year to the extent such amount is based on costs of specific claims incurred under the plan in the year (as specified under subsection (b)(1)(B)) that are greater than the average cost for the covered drug for the year (as determined under section 1860D–16(b)(3)(A)).

(d) PAYMENT METHODS.—

(I) IN GENERAL.—Payments under this section shall be made by the Prescription Drug Account.

(e) DEFINITIONS.—In this section—

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

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

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

(B) is enrolled in this part and in a Medicare Advantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage); or

(C) is eligible for, but not enrolled in, the program that is part, and is covered under a qualified retiree prescription drug plan.

(3) QUALIFYING ENTITY.—The term ‘qualifying entity’ means any of the following entities that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

(A) An eligible entity offering a Medicare Prescription Drug plan under this part.

(B) A Medicare Advantage organization offering a Medicare Advantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage).

(C) An entity with a qualified retiree prescription drug plan.

(4) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—

(I) IN GENERAL.—The term ‘qualified retiree prescription drug plan’ means employment-based retiree health coverage if, with respect to a qualifying covered individual who is covered under the plan, the following requirements are met:

(ii) ASSURANCE.—The sponsor of the plan shall assure the Administrator that it will provide such assurances as the Administrator may require, that the coverage meets or exceeds the requirements for qualified prescription drug coverage described in clauses (i) and (ii) of section 1860D–16(b)(7)(A).

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

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

DIRECT SUBSIDY FOR SPONSOR OF A QUALIFIED RETIREE PRESCRIPTION DRUG PLAN FOR PLAN ENROLLEES ELIGIBLE FOR, BUT NOT ENROLLED IN, THIS PART.—SEC. 1860D–26. (a) RESTRICTION ON ENROLLMENT IN A MEDICARE PRESCRIPTION DRUG PLAN OFFERED BY A SPONSOR OF EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—(1) IN GENERAL.—The sponsor of the employment-based retiree health coverage described in paragraph (2) to coordinate the prescription drug coverage described in such paragraph may not offer enrollment in the Medicare Prescription Drug plan described in such paragraph based on the health status of eligible beneficiaries enrolled under this part to eligible beneficiaries who are enrolled in such coverage.

ASSESSMENT FUND.—SEC. 1860D–25. (a) ESTABLISHMENT.—(1) IN GENERAL.—There is hereby created in the Federal Supplementary Medical Insurance Trust Fund the Medicare Prescription Drug Account established by section 1841 to account for, and for the use, of amounts that will be payable after obtaining all of the information.

(b) SOURCE PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

ASSESSMENT FUND.—SEC. 1860D–25. (a) ESTABLISHMENT.—(1) IN GENERAL.—There is hereby created in the Federal Supplementary Medical Insurance Trust Fund the Medicare Prescription Drug Account established by section 1841 to account for, and for the use, of amounts that will be payable after obtaining all of the information.

(b) SOURCE PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

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(c) REGULATIONS TO CARRY OUT THIS PART.—

(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.
"(1) Authority for interim final regulations.—The Secretary may promulgate initial regulations implementing this part in interim final form without prior opportunity for public comment. Such regulations may be promulgated under paragraph (1) of section 1860D–19 of the Social Security Act (42 U.S.C. 1395rr) to participate as an eligible entity under part D of such Act, as added by section 101, as a condition for issuing such policy.

(2) Prohibition on state requirement.—A State may not require an issuer of a medicare supplemental policy under section 1858A(e) of the Social Security Act (42 U.S.C. 1395rr) to participate as an eligible entity under part D of such Act, as added by section 101, as a condition for issuing such policy.

(3) Agreement to establish information and enrollment sites at social security offices.—The Secretary shall enter into an agreement with the Social Security Administration to establish information and enrollment sites at public offices of the Social Security Administration.

(a) Determinations of eligibility for low-income subsidies.—Section 1902(a)(42 U.S.C. 1396a(a)) is amended—

(i) by striking "and" before "such amounts"; and

(ii) by inserting after "1940D" the following: "and sections 1860D–18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account established by section 1860D–25); in subsection (g), by inserting after "1940D" the following: "and sections 1860D–18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account established by section 1860D–25); (2) in subsection (g), by inserting after "by" the following: "the payments provided for under part D (in which case the payments may be provided from the Prescription Drug Account in the Trust Fund);";

(3) in subsection (h), by inserting after "1940D" the following: "and sections 1860D–18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account established by section 1860D–25);";

(4) in subsection (i), by inserting after "1940D" the following: "and sections 1860D–18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account established by section 1860D–25);"

(b) Conforming amendments to federal supplemental medical insurance trust fund.—Section 1841 (42 U.S.C. 1396a) is amended—

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

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

(B) by inserting before the period the following: "and such amounts as may be deposited in the Federal supplemental medical insurance trust fund as authorized under section 1860D–25;";

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

(3) in subsection (h), by inserting after "1940D" the following: "and sections 1860D–18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account established by section 1860D–25);";

(4) in subsection (i), by inserting after "1940D" the following: "and sections 1860D–18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account established by section 1860D–25);"

(c) Conforming references to previous part D.—Any reference in law (in effect before such date) to title (as in effect after such date). The Act is deemed a reference to part F of such title (as so added).

(d) Submission of legislative proposal.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this Act.
inserting “twice the total number of individuals described in section 1902(a)(10)(E)(i) in the State; to”; to (d) OUTREACH BY THE COMMISSIONER OF SOCIAL SECURITY.—Section 1144 (42 U.S.C. 1320e-14) is amended—

(1) in the section heading, by inserting “AND INCOME INDIVIDUALS UNDER TITLE XVIII” after “COST-SHARING”;

(2) in subsection (a)—

(A) in paragraph (1),

(i) in subparagraph (A), by inserting “for the transitional prescription drug assistance program under section 1807A, or for premium and cost-sharing subsidies under section 1860D–19;” after “medicare cost-sharing under the medicaid program, and subsidies” after “medical assistance”;

(ii) in subparagraph (B), by inserting “, program, and subsidies” after “medical assistance”;

(B) in paragraph (2),

(i) in the matter preceding subparagraph (A), by inserting “, the transitional prescription drug assistance program under section 1807A, or premium and cost-sharing subsidies under section 1860D–19’’ after “assistance’’;

(ii) in subparagraph (A), by striking “such eligibility and inserting “eligibility for medicare cost-sharing under the medicaid program’’; and

(iii) in subsection (b),

(A) in paragraph (1), by inserting “, for the transitional prescription drug assistance program under section 1807A, or for premium and cost-sharing subsidies for low-income individuals under section 1860D–19 after ‘1933’’;

(B) in paragraph (2), by inserting “, program, and subsidies” after “medical assistance”.

SEC. 105. EXPANSION OF MEMBERSHIP AND DUTIES OF MEDICARE PAYMENT ADVISORY COUNCIL ON DRUGS AND ENROLLMENT FEES.—

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1506 the following new sections:

“B” the transitional prescription drug assistance program under section 1807A, or premium and cost-sharing subsidies under section 1860D–19’’ after “assistance’’;

and

(ii) in subparagraph (B), by inserting “, program, and subsidies” after “medical assistance”.

(b) EXPANSION OF MEMBERSHIP.—

(1) IN GENERAL.—Section 1805(c) (42 U.S.C. 1395b–8(c)) is amended—

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

and

(B) in paragraph (2), by inserting “, the area of pharmacy and prescription drug benefit programs, after “other health professionals’’.

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(A) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act, and the initial terms of the 2 additional members of the Commission provided for by the amendment under paragraph (1)(A) are as follows—

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

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

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

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

“D” VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.—Specifically, the Commission shall require, in a manner that the Secretary determines is consistent with the Federal regulations concerning the privacy of individually identifiable health information promulgated under section 262 of the Health Insurance Portability and Accountability Act of 1996.

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

(c) CONFIDENTIALITY OF ELECTRONIC RECORDS.—Notwithstanding any other provision of law, a prescription drug card sponsor maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in a prescription drug discount card program endorsed under this section other than an enrollment fee charged for the receipt and response to inquiries and complaints concerning the medicare prescription drug discount card endorsement program established in this section and prescription drug discount card programs endorsed under such program.

(d) BENEFICIARY PROTECTIONS.—

(A) MONEY BACK GUARANTEE.—A prescription drug card sponsor shall make available to each eligible beneficiary under a prescription drug discount card program endorsed by the Secretary the ability to demand a refund of the enrollment fee charged under such program at any time.

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

(A) RELATION TO OTHER FEDERAL LAWS.—Insofar as a prescription drug card sponsor maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in a prescription drug discount card program endorsed under this section, the prescription drug card sponsor shall have in place procedures to safeguard the privacy of any individually identifiable beneficiary information in a manner that the Secretary determines is consistent with the Federal regulations concerning the privacy of individually identifiable health information promulgated under section 262 of the Health Insurance Portability and Accountability Act of 1996.

(3) NO OTHER FEES.—A prescription drug card sponsor may not charge any fee to an eligible beneficiary under a prescription drug discount card program endorsed under this section other than an enrollment fee charged under such program.

(c) PRICES.—

(A) AVOIDANCE OF HIGH PRICED DRUGS.—A prescription drug card sponsor shall ensure that the enrollment fee for a prescription drug discount card program endorsed under this section is not charged more than the lower of the negotiated price or the usual and customary charge.

(2) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the 1-800-MEDICARE toll-free number for the receipt and response to inquiries and complaints concerning the medicare prescription drug discount card endorsement program established in this section and prescription drug discount card programs endorsed under such program.

(d) BENEFICIARY PROTECTIONS.—

(A) MONEY BACK GUARANTEE.—A prescription drug card sponsor shall make available to each eligible beneficiary under a prescription drug discount card program endorsed by the Secretary the ability to demand a refund of the enrollment fee charged under such program at any time.

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

(A) RELATION TO OTHER FEDERAL LAWS.—Insofar as a prescription drug card sponsor maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in a prescription drug discount card program endorsed under this section, the prescription drug card sponsor shall have in place procedures to safeguard the privacy of any individually identifiable beneficiary information in a manner that the Secretary determines is consistent with the Federal regulations concerning the privacy of individually identifiable health information promulgated under section 262 of the Health Insurance Portability and Accountability Act of 1996.

(3) NO OTHER FEES.—A prescription drug card sponsor may not charge any fee to an eligible beneficiary under a prescription drug discount card program endorsed under this section other than an enrollment fee charged under such program.

(c) PRICES.—

(A) AVOIDANCE OF HIGH PRICED DRUGS.—A prescription drug card sponsor shall ensure that the enrollment fee for a prescription drug discount card program endorsed under this section is not charged more than the lower of the negotiated price or the usual and customary charge.

(2) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the 1-800-MEDICARE toll-free number for the receipt and response to inquiries and complaints concerning the medicare prescription drug discount card endorsement program established in this section and prescription drug discount card programs endorsed under such program.

(d) BENEFICIARY PROTECTIONS.—

(A) MONEY BACK GUARANTEE.—A prescription drug card sponsor shall make available to each eligible beneficiary under a prescription drug discount card program endorsed by the Secretary the ability to demand a refund of the enrollment fee charged under such program at any time.

(3) QUALITY ASSURANCE.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall have in place adequate procedures for assuring that quality service is provided to beneficiaries enrolled in a prescription drug discount card program offered by such sponsor.
a prescription drug discount card program endorsed under this section may not change more frequently than once every 60 days.

(E) PRESCRIPTION DRUG BENEFITS.—

(1) IN GENERAL.—Subject to subparagraph (D), each prescription drug card sponsor shall provide benefits to individuals enrolled under the prescription drug discount card program endorsed under this section.

(2) SAVINGS TO ELIGIBLE BENEFICIARIES.—

(A) IN GENERAL.—A sponsor that engages in the sale or distribution of prescription drugs under a formulary, the following requirements must be considered under a prescription drug discount card program if the program excludes the categories of covered outpatient drugs and services as the Secretary may specify. The Secretary shall use the compendia referred to in section 1927(g)(1)(B)(i) or other recognized sources for categorizing drug therapeutics.

(B) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible beneficiary that would otherwise be covered under a formulary section shall not be considered under a prescription drug discount card program if the program excludes the categories of covered outpatient drugs and services as the Secretary may specify. The Secretary shall use the compendia referred to in section 1927(g)(1)(B)(i) or other recognized sources for categorizing drug therapeutics.

(C) QUALIFIED ACCESS TO NEGOTIATED PRICES.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures under which eligible beneficiaries have access to the negotiated prices for prescription drugs provided under subparagraph (A).

(1) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs as defined by the Secretary, although not necessarily for all drugs within such categories and classes.

(2) REQUIREMENT.—In defining therapeutic categories and classes of covered outpatient drugs pursuant to subparagraph (A), the Secretary shall use the compendia referred to in section 1927(g)(1)(B)(i) or other recognized sources for categorizing drug therapeutics.

(3) DISQUALIFICATION FOR ABUSE PRACTICES.—The Secretary may implement interim corrective sanctions and revoke the endorsement of a program that the Secretary determines no longer meets the requirements of this section or that has engaged in improper activities.

(4) DISCOUNT CARDS.—Each prescription drug card program endorsed under this section shall provide pharmaceutical support services, such as education, counseling, and services to prevent adverse drug interactions.

(5) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and pharmacies.

(F) FRAUD AND ABUSE PREVENTION.—

(1) IN GENERAL.—The Secretary shall provide to the Inspector General to ensure compliance of endorsed programs with the requirements of this section, including verification of the negotiated prices and services provided.

(2) DISCOUNT CARDS.—Each prescription drug card program endorsed under this section shall submit to the Secretary, at such time and in such manner as the Secretary may require, such information as the Secretary may require.

(3) ANNUAL CERTIFICATIONS OF ENFORCEMENT AND APPROVAL.—

(1) SUBMISSION OF APPLICATIONS FOR ENFORCEMENT.—Each prescription drug card program endorsed under this section shall submit to the Secretary, at such time and in such manner as the Secretary may require.

(2) APPROVAL.—The Secretary shall review the information submitted under paragraph (1) and determine whether to endorse the prescription drug discount card program to which such information relates.

(G) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a prescription drug card sponsor offering a prescription drug discount card program uses a formulary, the following requirements must be met:

(1) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

(A) IN GENERAL.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary.

(B) COMPOSITION.—A pharmacy and therapeutic committee shall include at least 1 academic expert, at least 1 practicing physician, and at least 1 practicing pharmacist, all of whom have expertise in the care of elderly or disabled persons, and a majority of the members of such committee shall consist of individuals who are not employees of the pharmacy benefit manager or a practitioner.

(2) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base its clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

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

(A) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs as defined by the Secretary, although not necessarily for all drugs within such categories and classes.

(B) REQUIREMENT.—In defining therapeutic categories and classes of covered outpatient drugs pursuant to subparagraph (A), the Secretary shall use the compendia referred to in section 1927(g)(1)(B)(i) or other recognized sources for categorizing drug therapeutics.

(4) DISQUALIFICATION FOR ABUSE PRACTICES.—The Secretary may implement interim corrective sanctions and revoke the endorsement of a program that the Secretary determines no longer meets the requirements of this section or that has engaged in improper activities.

(5) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries and pharmacies.

(H) FRAUD AND ABUSE PREVENTION.—

(1) IN GENERAL.—The Secretary shall provide to the Inspector General to ensure compliance of endorsed programs with the requirements of this section, including verification of the negotiated prices and services provided.

(2) DISQUALIFICATION FOR ABUSE PRACTICES.—The Secretary may implement interim corrective sanctions and revoke the endorsement of a program that the Secretary determines no longer meets the requirements of this section or that has engaged in improper activities.

(I) IN GENERAL.—The term 'eligible beneficiary' means an individual who—

(i) enrolled under title XIX or under a waiver under section 1115 of the requirements of such title for medical assistance that includes but is limited solely to covered outpatient drugs; and

(ii) is entitled to, or enrolled for, benefits under part A and enrolled under part B.

(ii) ELIGIBILITY, ELECTION OF PROGRAM, AND ENROLLMENT FEES.—

(1) DEFINITIONS.—In this section:

(A) ELIGIBLE BENEFICIARY.—

(i) ELIGIBLE INDIVIDUAL.—

(ii) DUAL ELIGIBLE INDIVIDUAL.—
"(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, the enrollment procedures established under section 1807(b)(2)(A)(ii) shall apply for purposes of this section.

"(B) ENROLLMENT OF ANY ELIGIBLE LOW-INCOME BENEFICIARY.—Each prescription drug card sponsor offering a prescription drug assistance card program under this section shall permit any eligible low-income beneficiary to enroll in such program if it serves the geographic area in which the beneficiary resides.

"(C) SIMULTANEOUS ENROLLMENT IN PRESCRIPTION DRUG DISCOUNT CARD PROGRAM.—An eligible low-income beneficiary who enrolls in a prescription drug discount card program offered by a prescription drug card sponsor under this section shall be simultaneously enrolled in a prescription drug assistance card program offered by such sponsor.

"(D) WAIVER OF ENROLLMENT FEES.—

"(1) IN GENERAL.—A prescription drug card sponsor may not charge an enrollment fee to any eligible low-income beneficiary enrolled in a prescription drug discount card program offered by such sponsor.

"(2) PAYMENT BY SECRETARY.—Under a contract awarded under subsection (f)(2), the Secretary shall pay to each prescription drug card sponsor an amount equal to any enrollment fees收取的可排除在医疗保险报销范围内的费用 shall be excluded in the calculation of the total amount of coverage available under subparagraph (A).

"(E) ADDITIONAL BENEFICIARY PROTECTIONS.—

"(1) PROVIDING INFORMATION TO ELIGIBLE LOW-INCOME BENEFICIARIES.—In addition to the information provided to eligible beneficiaries under section 1807(c), the prescription drug card sponsor shall:

(i) periodically notify each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor of the amount of coverage for prescription drugs remaining under subsection (d)(2)(A); and

(ii) notify each eligible low-income bene-

...
shall perform the functions described in section 1935(a)(1).

(i) Appropriations.—There are appropriated from the Federal Supplementary Medical Insurance Trust Fund under section 1841 such sums as may be necessary to carry out the program under this section.

(ii) Definitions.—In this section:

(1) Eligible beneficiary; negotiated price; prescription drug.—The terms ‘eligible beneficiary’, ‘negotiated price’, and ‘prescription drug’ have the meanings given those terms in section 1807.

(2) Eligible low-income beneficiary.—The term ‘eligible low-income beneficiary’ means an individual who—

(1) is not a dual eligible beneficiary as defined under section 1807(i)(1)(B); and

(2) is not an eligible beneficiary as defined in section 1807(i)(1)(C).

(iii) E xclusion of Prices from Determination of Best Price.—Section 1927(c)(1)(C) (42 U.S.C. 1396r–8(c)(1)(C)) is amended—

(1) by striking ‘‘and’’ at the end of subsection (c)(3); and

(2) by inserting ‘‘with the following:’’ after ‘‘and’’ at the end of subsection (c)(4).

(iv) Exclusion of Prescription Drug Assistance Card Costs From Determination of Best Price.—Section 1927(c)(1)(C) is amended—

(1) by striking ‘‘attributable to the application of section’’ after clause (ii); and

(2) by striking the period at the end of subclause (ii) and inserting ‘‘;’’ and; and

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

(V) any negotiated prices charged under the medicare prescription drug discount card endorsement program under section 1807 or under the transitional prescription drug assistance card program for eligible low-income beneficiaries under section 1807A.

(v) Exemption From the Paperwork Reduction Act.—The Secretary shall ensure that such programs continue to operate under the interim final regulations implementing sections 1807 and 1807A of the Social Security Act. Such transition and discontinuation shall ensure that such programs continuously operate until the date on which the first enrollment period under part D ends.

Subtitle C—Standards for Electronic Prescribing

Title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

PART D—ELECTRONIC PRESCRIBING

‘‘STANDARDS FOR ELECTRONIC PRESCRIBING

‘‘SEC. 1120. (a) Standards.—

(1) Development and Adoption.—

(A) General.—The Secretary shall develop or adopt standards for transactions and data elements for such transactions (in this section referred to as ‘‘standards’’) to enable the electronic transmission of medication history, eligibility, benefit, and other prescription information.

(B) Consultation.—In developing and adopting the standards under subparagraph (A), the Secretary shall consult with representatives of physicians, hospitals, pharmacists, standard setting organizations, pharmaceutical benefit managers, information exchange networks, technology experts, and representatives of the Departments of Veterans Affairs and Defense and other interested parties.

(2) Objective.—Any standards developed or adopted under this part shall be consistent with the objectives of improving—

(i) patient safety;

(ii) the quality of care provided to patients;

(3) Requirements.—Any standards developed or adopted under this part shall comply with the following:

(A) Electronic transmittal of prescriptions.—

(i) In general.—Except as provided in clause (ii), the standards require that prescriptions be written and transmitted electronically.

(ii) Exceptions.—The standards shall not require a prescription to be written and transmitted electronically:

(1) in emergency or other exceptional circumstances recognized by the Administrator; or

(2) if the patient requests that the prescription not be transmitted electronically.

If a patient makes a request under subclause (ii), no additional charges may be imposed on the patient for making such request.

(B) Patient-Specific Medication History, Eligibility, Benefit, and Other Prescription Information.—

(i) In general.—The standards shall accommodate electronic transmission of patient-specific medication history, eligibility, benefit, and other prescription information among prescribing and dispensing professionals at the point of care.

(ii) Exemption.—The information described in clause (i) shall include the following:

(1) covered drug information;

(2) prior authorization information;
(I) Information to the extent available and feasible on the drugs being prescribed for that patient and other information relating to the medication history of the patient that is relevant to the appropriate prescription for that patient.

(II) Cost-effective alternatives (if any) to the drug prescribed.

(III) Information on eligibility and benefits, including the drugs included in the applicable formulary and any requirements for prior authorization.

(IV) Information on potential interactions with drugs listed on the medication history, graded by severity of the potential interaction.

(V) Other information to improve the quality of patient care and to reduce medical errors.

(6) Undue burden.—The standards shall be designed so that, to the extent practicable, the standards do not impose an undue administrative burden on the practice of medicine, pharmacy, or other health professions.

(D) Compatibility with Administrative Simplification and Privacy Laws.—The standards may include requirements that:

(i) consistent with the Federal regulations concerning the privacy of individually identifiable health information promulgated under part C of chapter 117 of title 45, Health Insurance Portability and Accountability Act of 1996;

(ii) appropriate standard data elements needed for the electronic exchange of medication history, eligibility, benefit, and other prescription drug information and other health information determined appropriate in compliance with the standards adopted or modified under this part.

(4) Transfer of Information.—The Secretary shall develop and adopt standards for transferring among prescribing and insurance entities and other necessary entities appropriate standard data elements needed for the electronic exchange of medication history, eligibility, benefit, and other prescription drug information and other health information determined appropriate in compliance with the standards adopted or modified under this part.

(5) Compliance With Standards.—The standards adopted or modified under this part shall supersede any State law or regulations that are inconsistent with the standards adopted or modified under this part.

(b) Application.—No grant may be made under this section except pursuant to a grant application that is submitted in a time, manner, and form approved by the Secretary.

(c) Authorization of Appropriations.—There are authorized to be appropriated from the Treasury of the United States for each of fiscal years 2006, 2007, and 2008, such sums as may be necessary to carry out this section.

TITLE II—MEDICAIDADVANTAGE

Subtitle A—MedicareAdvantage Competition

Sec. 11804. (a) In General.—The Secretary is authorized to make grants to health care providers for the purpose of assisting such entities to implement electronic prescription programs that comply with the standards adopted or modified under this part.

(B) Application.—No grant may be made under this section except pursuant to a grant application that is submitted in a time, manner, and form approved by the Secretary.

(C) Authorization of Appropriations.—There are authorized to be appropriated from the Treasury of the United States for each of fiscal years 2006, 2007, and 2008, such sums as may be necessary to carry out this section.

TITLES OF THE CONGRESSIONAL RECORD

CONGRESSIONAL RECORD—HOUSE

June 26, 2003

H6202

Subtitle A—MedicareAdvantage Competition

Sec. 201. Eligibility, Election, and Enrollment

Section 1551 (42 U.S.C. 1395w-21) is amended to read as follows:

"(A) Eligibility, Election, and Enrollment

"(i) Eligibility, election, and enrollment

"(ii) There is no other MedicareAdvantage plan which provides prescription drug coverage under the plan for the individual, except for a MedicareAdvantage plan that provides prescription drug coverage under the plan for the individual (as defined in paragraph (3)) to the extent available, and subject to reasonable cost-sharing liability in obtaining such benefits.

"(B) Special Rule for Certain Individuals Covered Under FEHBP or Eligible for Veterans or Military Health Benefits

"(i) In general.—An individual who is enrolled in a health benefit plan under chapter 55 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

"(B) VA and DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) to individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

"(C) Limitation on Eligibility of Qualified Medicare Beneficiaries and Other Medicare Beneficiaries to Enroll in an MSA Plan

"(i) In general.—An individual who is an eligible Medicare beneficiary (as defined in section 1905(f)(1)), a qualified disabled and working
individual (described in section 1905(s)), an individual described in section 1922(a)(10)(E)(iii), or otherwise entitled to Medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

(4) Coverage under MSA Plans on a Demonstration Basis.—

(A) Initial Election.—An individual is not eligible to enroll in an MSA plan under this part—

(i) on or after January 1, 2004, unless the enrollee is an individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

(ii) the individual changes the election under this section; or

(iii) the MedicareAdvantage plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(3)(B), no longer serves the area in which the individual resides.

(B) Providing Information To Promote Informed Choice.—

(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to Medicare beneficiaries (including prospective Medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

(2) Provision of Notice.—

(A) OPEN SEASON NOTIFICATION.—At least 45 days before the beginning of each annual enrollment period for an individual described in subsection (e)(3)(B), the Secretary shall mail to each MedicareAdvantage eligible individual residing in an area the following:

(i) GENERAL INFORMATION.—The general information described in paragraph (3).

(ii) LIST OF PLANS AND COMPARISON OF PLANS.—(A) The information required by paragraph (3)(C) shall be presented in a comparative form.

(iii) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

(B) NOTIFICATION TO NEWLY ELIGIBLE MEDICAREADVANTAGE ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial MedicareAdvantage enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by Medicare beneficiaries.

(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of MedicareAdvantage plans, the benefits under such plans, and the MedicareAdvantage monthly basic beneficiary premium, MedicareAdvantage monthly beneficiary premiums, and MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage for such plans.

(3) General Information.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

(A) BENEFITS UNDER THE ORIGINAL MEDICARE-FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered under parts A and B of the original Medicare fee-for-service program.

(i) covered items and services;

(ii) beneficiary cost-sharing, such as deductibles, coinsurance, and copayment amounts;

(iii) any beneficiary liability for balance billing.

(B) CATASROPHE COVERAGE AND COMBINED DEDUCTIBLE.—A description of the catastrophic coverage and unified deductible applicable under the plan.

(C) OUTPATIENT PRESCRIPTION DRUG COVERAGE BENEFITS.—The information required under section 1860D-4 with respect to coverage for prescription drugs under the plan.

(D) QUALITY AND PERFORMANCE.—Information and instructions on how to exercise election options under this section.

(4) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a MedicareAdvantage organization refuses to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, may have on individuals enrolled with the MedicareAdvantage plan under this part.

(5) Information Comparing Plan Options.—Information comparing the benefits, enrollment rights, and other requirements applicable to Medicare supplemental policies under section 1882 and private fee-for-service plans described in section 1882(t).

(6) Rights.—A general description of procedures and rights (including grievance and appeals procedures) of benefits under the original Medicare fee-for-service program (including such rights under part D) and the MedicareAdvantage program and the right to be reenrolled against disqualification based on health status-related factors under section 1852(b).

(7) Information on Medicare and Medicaid Select.—A general description of the benefits, enrollment rights, and other requirements applicable to Medicare supplemental policies under section 1882 and private fee-for-service plans described in section 1882(t).

(8) Coordination Through MedicareAdvantage Organizations.—

(A) Enrollment.—Such process shall permit an individual who wishes to elect a MedicareAdvantage plan offered by a MedicareAdvantage organization to make such election through the filing of an appropriate election form with the organization.

(B) disenrollment.—Such process shall permit an individual who has elected a MedicareAdvantage plan offered by a MedicareAdvantage organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

(3) Default.—

(A) Initial Election.—

(i) Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the original medicare fee-for-service program option.

(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a Medicare+Choice plan or another health plan (other than a MedicareAdvantage plan) offered by a MedicareAdvantage organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the Medicare+Choice plan offered by the organization (or, if the organization offers more than 1 such plan, such plan or plans as the Secretary identifies under such procedures).

(B) Continuing Periods.—An individual who has made (or is deemed to have made)
benefits under the plan (and how such indicators compare to quality and performance indicators under the original Medicare fee-for-service program under parts A and B and under the organization’s drug delivery program under part D in the area involved), including—

(i) disenrollment rates for Medicare enrollees, and the plan’s ability to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan’s service area);

(ii) information on Medicare enrollee satisfaction;

(iii) information on health outcomes; and

(iv) information regarding the operation of this part in all areas in which Medicare Advantage plans are offered and an Internet site through which individuals may electronically obtain information on such options and Medicare Advantage plans.

(g) FEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

(h) DISCLOSURE OF INFORMATION.—A Medicare Advantage organization shall provide the Secretary with such information on the organization and each Medicare Advantage plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

(1) COVERAGE PERIODS.—

(I) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICAIDADVANTAGE PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual eligible to elect to receive benefits under part B or D (whichever is later), there is 1 or more Medicare Advantage plans offered in the area in which the individual resides, the individual may change the election under this section during a period specified by the Secretary, and the individual may elect under subsection (a)(1)—

(A) to enroll in a Medicare Advantage plan; or

(B) to change the Medicare Advantage plan in which the individual is enrolled.

(II) SPECIAL ELECTION PERIODS.—Effective on and after January 1, 2006, an individual who, upon first becoming eligible for Medicare Advantage (including enrollment for) benefits under part A, enrolls in a Medicare Advantage plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

(II) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

(A) IN GENERAL.—Subject to paragraph (5), during the period beginning on November 15, 2005, and ending on December 31 of the year before such period, and with respect to a year before 2003 and after 2006, the period beginning on November 15 and ending on December 31 of the year before such period.

(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a year before 2003 and after 2006, the period beginning on November 15, 2005, and ending on December 31 of the year before such period.

(C) MEDICAIDADVANTAGE HEALTH INFORMATION FAIRS.—During the fall season of each year (beginning with 2006), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform Medicare Advantage eligible individuals about Medicare Advantage plans, and艇 relationships under the plan.

(D) SPECIAL INFORMATION CAMPAIGN.—During the period beginning on November 15, 2005, and ending on December 31, 2005, the Secretary shall provide for an educational and publicity campaign to inform Medicare Advantage eligible individuals about the availability of Medicare Advantage plans, and eligible organizations with risk-sharing contracts under section 1876, offered in different areas, of the election process provided under this section.

(E) SPECIAL ELECTION PERIODS.—Effective on and after January 1, 2006, an individual may elect under subsection (a) of this section, an individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

(i) to enroll in a Medicare Advantage plan; or

(ii) to change the Medicare Advantage plan in which the individual is enrolled.

(F) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

(1) DURING INITIAL COVERAGE ELECTION PERIODS.—Subject to paragraph (3), an election or change of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to or enrolled for) benefits under part B, and

(2) DURING CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect during the 12-month period beginning on the date the election or change is made.
"(3) ANNUAL, COORDINATED ELECTION PE-
RIOD.—An election or change of coverage made
during an annual, coordinated election period
(as defined in subsection (e)(3)(B)) in a year
furnished as of the first day of the following
year.

"(4) OTHER PERIODS.—An election or
change of coverage made during any other
period under section (e) shall take ef-
faction in such manner as the Secretary pro-
vides in a manner consistent (to the extent practicable)
with protecting continuity of health
coverage.

"(g) GUARANTEED ISSUE AND RENEWAL.

I. IN GENERAL.—Except as provided in
this subsection, a MedicareAdvantage orga-
nization (or agent of such organization) shall be
required to accept all individuals who elect to
enroll in such plan, or who elect to change
their enrollment to such plan, and shall be
required to provide such individuals with
coverage under such plan as of the first day
of the month next following the month in
which such election was made.

II. REGULATIONS.—In this subsection the
Secretary shall promulgate regulations to im-
plement this section.

"(h) GUARANTEED ISSUE AND RENEWAL.

I. IN GENERAL.—Except as provided in
this subsection, a MedicareAdvantage orga-
nization (or agent of such organization) shall be
required to accept all individuals who elect to
enroll in such plan, or who elect to change
their enrollment to such plan, and shall be
required to provide such individuals with
coverage under such plan as of the first day
of the month next following the month in
which such election was made.

II. REGULATIONS.—In this subsection the
Secretary shall promulgate regulations to im-
plement this section.

"(i) CERTIFICATION.—Except as provided in
this subsection, each MedicareAdvantage
organization shall certify to the Secretary
that it will accept all individuals who elect to
enroll in such plan, or who elect to change
their enrollment to such plan, for the period
of the contract.

III. ENROLLMENT IN A MEDICAREADVANTAGE PLAN.

I. IN GENERAL.—Each MedicareAdvantage
organization shall register to accept
enrollment in such plan, or to change
their enrollment to such plan, for the period
of the contract.

II. CERTIFICATION.—In implementing this
section, the Secretary shall promulgate
regulations to implement this section.

"(j) MEDICAREADVANTAGE PLAN OPTION.—

I. IN GENERAL.—A MedicareAdvantage
organization shall be entitled to pay
MedicareAdvantage monthly beneficiary pre-
mum for a MedicareAdvantage plan that
is furnished to the Secretary under this
title for services furnished to the individual.

II. ONLY ORGANIZATION ENTITLED TO PAY-
MENT.—Subject to sections 1853(f), 1853(h),
and 1853(i), all MedicareAdvantage
organizations shall be entitled to receive payments from
such plan for services furnished to the individual.

SEC. 202. BENEFITS AND BENEFICIARY PROTEC-
TIONS.

Section 1852 (42 U.S.C. 1395w–22) is amended as
follows:

"(b) BENEFITS AND BENEFICIARY PROTECTIONS.—

"(1) IN GENERAL.—Except as provided in
section 1859(b)(3) for MSA plans, each
MedicareAdvantage plan shall provide to
members enrolled under this plan, through
providers and other persons that meet the
applicable requirements of this title and part
A of title XI—

(A) those items and services (other than
hospice care) for which benefits are available
under parts A and B to individuals residing in
the area served by the plan;

(B) except as provided in subsection (2)(D),
qualified prescription drug coverage under part
D to individuals residing in the area served by
the plan;

(C) a maximum limitation on out-of
pocket expenses and a uniform deductible;

(D) additional benefits required under
section 1854(d)(1).

"(2) SATISFACTION OF REQUIREMENT.—

(A) IN GENERAL.—A MedicareAdvantage
plan that offers a MedicareAdvantage plan
shall be entitled to receive payments for
services furnished to the individual.

"(3) ENROLLEES.—If a beneficiary enrolls in a plan
that offers a MedicareAdvantage plan, the
MedicareAdvantage organization shall pro-
vide to the individual the benefits and cov-
erage described in subsection (b)(1).

"(4) BENEFITS AND BENEFICIARY PROTECTIONS.

I. IN GENERAL.—A MedicareAdvantage
organization shall provide to the
individual the benefits and coverage described in
section 1854(d)(1).

II. LIMITATION ON TERMINATION OF ELEC-
TION.—A MedicareAdvantage organization
shall not terminate or limit the benefits and cov-
erage provided to an individual unless the
Secretary has agreed in writing to such
limitation or termination.

III. MEDICAL ADVICE.—A MedicareAdvantage
organization shall not terminate or limit the
benefits and coverage provided to an individual
unless the Secretary has agreed in writing to such
limitation or termination.

"(5) SPECIAL TREATMENT OF MARKETING
MATERIAL FOLLOWING MODEL MARKETING LAN-
UAGE.—In the case of marketing material of
a MedicareAdvantage organization that uses, without modifi-
cation, a model marketing form or other
marketing material that is developed
by the plan and organization except with re-
spect to the portion of such material or
form that is specific to an area involved.

"(6) OTHER REQUISITES.—Each MedicareAdvantage
organization shall conform to the applicable
standards, in relation to MedicareAdvantage
organizations for non-
covered items and services as would other-
wise be authorized under parts A and B (in-
cluding any balance billing permitted under
such parts).

"(7) ELECTION OF UNIFORM COVERAGE POL-
ICY.—In the case of a MedicareAdvantage
organization that offers a MedicareAdvantage
plan in an area in which local coverage policy appli-
cable requirements of this title and part
D to individuals residing in the area served by
the plan.

"(8) SPECIAL TREATMENT OF MARKETING
MATERIAL FOLLOWING MODEL MARKETING LAN-
UAGE.—In the case of marketing material of
an organization that uses, without modifica-
tion, proposed model language specified by
the Secretary, the period specified in para-
graph (1)(A) shall be reduced from 45 days to
10 days.

"(9) EFFECT OF ELECTION OF
MEDICAREADVANTAGE PLAN OPTION.—

I. PAYMENTS TO ORGANIZATIONS.—Subject to
subsections (a)(3), (a)(4), (a)(5), (a)(6)
and (a)(7), a MedicareAdvantage organization
shall be entitled to receive payments from
such plan for services furnished to the individual.

II. AVAILABILITY OF DRUG COVERAGE
FOR ENROLLEES.—If a beneficiary enrolls in a plan
making the election described in clause (i),
the beneficiary may enroll for drug coverage under part D with an eligible entity under such part.

(3) ENSHRINED MEDICAL BENEFITS.—

(a) Benefits included subject to Secretary’s approval.—Each Medicare Advantage organization may provide to individuals enrolled under this part, other than under an MSA plan, medical benefits that the Secretary may approve. The Secretary shall approve any such enhanced medical benefits unless the Secretary determines that including such enhanced medical benefits would unreasonably discriminate enrollment by Medicare Advantage eligible individuals with the organization.

(b) At enrollment option.—A Medicare Advantage organization may not provide, under an MSA plan, enhanced medical benefits that cover the deductible described in section 1859(b)(2)(B). In applying the previous sentence, health benefits described in section 1822(u)(2)(B) shall not be treated as covering such deductible.

(c) Application to Medicare Advantage private fee-for-service plans.—Notwithstanding the preceding provisions of this paragraph, the Secretary may not approve any enhanced medical benefit that provides for the coverage of any prescription drug (other than falling within the scope of the provider’s license or certification under applicable State law, solely on the basis of such license or certification). The provision in the previous sentence shall not be construed as requiring a Medicare Advantage organization to enroll individuals who are determined to have end-stage renal disease.

(d) Antidiscrimination.—

(i) in general.—A Medicare Advantage organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

(ii) exceptions.—(A) The organization makes such benefits available consistent with section 1851(d)(2)(A).

(iii) the plan provides for reimbursement of any costs otherwise incurred by the enrollee that are not covered under the plan, or that are required by law, if the enrollee incurs those costs as a result of a decision of the organization to deny, limit, or condition the coverage or provision of benefits, or to otherwise fail to comply with this paragraph.

(e) Enhanced medical benefits.—

(i) in general.—A Medicare Advantage organization may offer an enhanced medical benefit that provides for the coverage of additional benefits under this part for an individual who is determined to have end-stage renal disease.

(ii) limitations.—(A) Subject to clause (ii), paragraph (c)(2)(i) of section 1833(b) shall not be construed as requiring a Medicare Advantage organization to enroll individuals who are determined to have end-stage renal disease.

(f) Enhancing covered items and services.—(1) IN GENERAL.—A Medicare Advantage organization may provide an additional medical benefit that provides for the coverage of additional items and services (as defined in paragraph (3)), but—

(a) such determination or legislative change in benefits shall not apply to contracts entered into before the first anniversary date of the contract year that begins after the end of such period; and

(b) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1851(l)(2) shall not apply to such additional benefits or coverage under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based by the Secretary of the actuarial costs associated with the coverage determination or legislative change in benefits.

(g) Application to prohibit risk selection.—The Secretary shall have the authority to prohibit any Medicare Advantage plan that the Secretary determines is designed to attract an enrollee that is healthier than the average population residing in the service area of the plan.

(h) Unified deductible defined.—In this paragraph, the term ‘unified deductible’ means an annual deductible amount that is applied in lieu of the inpatient hospital deductible under section 1833(b) and the deductible under section 1859(b). Nothing in this part shall be construed as preventing a Medicare Advantage organization from reducing coinsurance or copayment for inpatient hospital services. A Medicare Advantage organization may not deny, limit, or condition the coverage, or provision of benefits in the service areas of the plan.

(i) enhanced medical benefits available from the organization offering the plan, including—

(A) whether the enhanced medical benefits are external;

(B) the enhanced medical benefits covered; and

(C) the Medicare Advantage monthly premium for enhanced medical benefits.

(g) Prior authorization rules.—Rules regarding prior authorization or other requirements that could result in non-payment.

(h) Plan grievance and appeals procedures.—All plan appeal or grievance rights and procedures.

(i) Quality assurance program.—A description of the organization’s quality assurance program under subsection (e).
In this subsection—

**ICE PLANS.**—In addition to any other requirements under this part, each Medicare Advantage plan must have written protocols for utilization review, base such protocols on current standards of medical practice and using the criteria specified in section 1865(b)(2), establish quality review and improvement organizations for the purpose of carrying out the requirements in such clause.

**OF POST-STABILIZATION CARE.**—A Medicare Advantage plan that elects to provide coverage for emergency medical services shall—

(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition; and

(ii) it was not reasonable given the circumstances to obtain the services through the organization.

**emergency care provider's contractual arrangement.**—With respect to any specific clause of subparagraph (A), the Secretary may not deny the application of the requirements under this paragraph if the Secretary has determined assures the continued operation of the organization and using the criteria specified in section 1865(b)(2), whether the process of the review of quality complaints and improvement organization approved by the Secretary to perform functions of the type described in paragraphs (xii) and (xiii) of section 1873(p) that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

**QUALITY ASSURANCE PROGRAM.—**

**IN GENERAL.**—Each Medicare Advantage plan must have an agreement with an independent quality review and improvement organization that the Secretary has determined assures the continued operation of the organization. The Secretary may not deny such an agreement on the basis of any specific clause of subparagraph (A) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1866 to carry out the requirements of this part.

**NONDUPLICATION OF ACCREDITATION.**—

**IN GENERAL.**—Each Medicare Advantage plan shall have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in paragraphs (xii) and (xiii) of section 1873(p) that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

**TREATMENT OF ACCREDITATION.**—

**IN GENERAL.**—The Secretary shall provide that a Medicare Advantage organization that meets all the requirements described in this subparagraph (relating to quality assurance programs) and the requirements described in this subparagraph (relating to quality assurance programs) has an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in paragraphs (xii) and (xiii) of section 1873(p) that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

**ASSURING ACCESS TO SERVICES IN MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—**

**SMALL MEDICAL OFFICE PRACTICE.**—Each Medicare Advantage plan that elects to provide coverage for emergency medical services shall—

(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition; and

(ii) it was not reasonable given the circumstances to obtain the services through the organization.

**EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.**—The term ‘emergency medical condition’ means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the health of the woman or her unborn child to result in—

(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

(ii) serious impairment to bodily functions; or

(iii) serious dysfunction of any bodily organ or part.

**ASSURING ACCESS TO SERVICES IN MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—**In addition to any other requirements under this part, the Secretary may not deny the application of the requirements in such clause if the Secretary has determined assures the continued operation of the organization.

**ELEMENTS OF PROGRAM.—**

**IN GENERAL.**—The quality assurance program of an organization with respect to a Medicare Advantage plan (other than a nonnetwork MSA plan) shall—

(i) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality assurance program that the Secretary recognizes that will permit measurement of outcomes and other indices of the quality of Medicare Advantage plans and organizations;

(ii) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions; by physicians and other health care professionals of the process followed in the provision of such health care services;

(iii) provide access to disease management and chronic care services;

(iv) provide access to preventive benefits and information for enrollees on such benefits;

(v) evaluate the continuity and coordination of care that enrollees receive;

(vi) be evaluated on an ongoing basis as to its effectiveness;

(vii) include measures of consumer satisfaction;

(viii) provide the Secretary with such information and data (in accordance with a quality assurance program that the Secretary has determined assures the continued operation of the organization and using the criteria specified in section 1865(b)(2), whether the process of the review of quality complaints and improvement organization approved by the Secretary to perform functions of the type described in paragraphs (xii) and (xiii) of section 1873(p) that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

**QUALITY ASSURANCE PROGRAM.—**

**IN GENERAL.**—The quality assurance program of an organization with respect to a Medicare Advantage plan (other than a nonnetwork MSA plan) it offers shall—

(i) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition; and

(ii) it was not reasonable given the circumstances to obtain the services through Medicare Advantage plans for which payment is made under this title. The previous sentence shall not apply to a Medicare Advantage private fee-for-service plan or a nonnetwork MSA plan that does not employ utilization review.

**NONDUPLICATION OF ACCREDITATION.**—

**IN GENERAL.**—Each Medicare Advantage organization shall, for each Medicare Advantage plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in paragraphs (xii) and (xiii) of section 1873(p) that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

**TREATMENT OF ACCREDITATION.**—

**IN GENERAL.**—The Secretary shall provide that a Medicare Advantage organization that meets all the requirements described in this subparagraph (relating to quality assurance programs) and the requirements described in this subparagraph (relating to quality assurance programs) has an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in paragraphs (xii) and (xiii) of section 1873(p) that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

**ASSURING ACCESS TO SERVICES IN MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—**In addition to any other requirements under this part, the Secretary may not deny the application of the requirements in such clause if the Secretary has determined assures the continued operation of the organization.
including the authority to terminate contracts with MedicareAdvantage organizations under subsection (c)(2) of this section.

(5) REPORT TO CONGRESS.—

"(A) IN GENERAL.—The Secretary shall report to Congress annually on the implementation of this section, including the extent to which enrollees are able to receive timely and appropriate determinations.

"(B) DETERMINATIONS.—The Secretary shall report to Congress on the determinations regarding enrollees under this part, including the reasons for any delays in making such determinations.

(6) MECHANISM.—Each MedicareAdvantage organization must provide meaningful procedures for hearing and resolving grievances of enrollees, including the following:

"(A) RECEIPT OF REQUESTS.—The Secretary shall ensure that enrollees have a procedure for filing requests for reconsideration of any determination described in this section.

"(B) ORGANIZATION PROCEDURES.—The Secretary shall ensure that MedicareAdvantage organizations have procedures for handling requests for reconsideration, including the following:

"(i) A written request for reconsideration must include the enrollee's name, Medicare number, and the specific determination to be reconsidered.

"(ii) The organization shall provide a written notice of the request for reconsideration, including the date the request was received and the name and contact information of the person to whom the request is being addressed.

"(iii) The organization shall provide a written explanation of the determination, including the reasons for the determination and any other relevant information.

"(iv) The organization shall provide a written decision on the request for reconsideration, including the date the decision was made and the name and contact information of the person who made the decision.

"(C) CONSTRUCTION.—Nothing in subsection (b) shall be construed to limit the Secretary's authority to require MedicareAdvantage organizations to establish additional procedures for handling requests for reconsideration.

(7) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Insofar as a MedicareAdvantage organization deems appropriate, such information shall be made available for public inspection and review.

(8) RULES REGARDING PROVIDER PARTICIPATION.—In all cases in which a provider is required to provide information to MedicareAdvantage organizations, such information shall be provided in a timely manner.

(9) CONSTRUCTION.—Nothing in this section shall be construed to affect the authority of the Secretary to require MedicareAdvantage organizations to establish additional procedures for handling requests for reconsideration.

(10) CONSTRUCTION.—Nothing in this section shall be construed to affect the authority of the Secretary to require MedicareAdvantage organizations to establish additional procedures for handling requests for reconsideration.

(11) CONSTRUCTION.—Nothing in this section shall be construed to affect the authority of the Secretary to require MedicareAdvantage organizations to establish additional procedures for handling requests for reconsideration.

H6208

CONGRESSIONAL RECORD — HOUSE

June 26, 2003
(A) IN GENERAL.—No Medicare Advantage organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:—

(i) The plan is made directly or indirectly under the plan to a physician or professional, or other entity—

(A) providing comprehensive health care services to a specific individual enrolled under the plan; or

(B) conducting periodic surveys of both inpatient and outpatient medical care services provided by the organization and with respect to an individual enrolled with the organization—

(I) provides stop-loss protection for the physician or professional, or other entity furnishing health care services to such an enrollee; and

(ii) conducts periodic surveys of both individual and group practices of individuals previously enrolled with the organization to determine the degree of access of such individuals to health care services.

(B) PHYSICIAN INCENTIVE PLAN DEFINED.—

In this paragraph, the term ‘physician incentive plan’ means any compensation arrangement between a Medicare Advantage organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

(3) LIMITATION ON PROVIDER INDEMNIFICATION.—A Medicare Advantage organization may not provide stop-loss protection for a health care professional, provider of services, or other entity providing health care services or (group of such professionals, providers, or other entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a Medicare Advantage plan with respect to the organization’s denial of medically necessary care.

(4) SPECIAL RULES FOR MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—For purposes of applying this part (including subsection (k)(1)) and section 1861(a)(3), a hospital (or other provider of services or other entity furnishing healthcare services) may not provide stop-loss protection for a health care professional, provider of services, or other entity furnishing health care services to patients if the entity is providing such services through a Medicare Advantage private fee-for-service plan (or it offers such a plan) that would be provided to the enrollee with a Medicare Advantage plan. The Medicare Advantage organization that offers such a plan shall establish procedures, similar to the procedures described in section 1858(a)(1)(A), in order to carry out clause (i).

(5) ASSURING ENFORCEMENT.—If the Medicare Advantage organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1858(g).

(A) E NROLLEE ELECTION.—The enrollee elects to receive such coverage through such facility.

(B) B AKE S AND S OF PAYMENT TO HOME SNF.—

A Medicare Advantage plan may operate any physician incentive plan (as defined in subparagraph (B)) for a home skilled nursing facility consistent with the contract or agreement described in subparagraph (A)(ii), as the case may be.

(6) NO LESS FAVORABLE COVERAGE.—The coverage provided under paragraph (1) (including scope of services, cost-sharing, and coinsurance) for covered post-hospital extended care services (other than otherwise covered under the Medicare Advantage plan)

(7) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to the following:

(i) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for medicare beneficiaries not enrolled in a Medicare Advantage plan.

(ii) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

(8) DEFINITIONS.—In this subsection:

(A) HOME SKILLED NURSING FACILITY.—The term ‘home skilled nursing facility’ means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a Medicare Advantage plan, any of the following skilled nursing facilities:

(i) SNF RESIDENCE AT TIME OF ADMIS- 

(ii) SNF AGREEMENT.—The facility has a

(iii) SNF AGREEMENT.—The facility has a

(iv) SNF AGREEMENT.—The facility has a
"(iii) SNF RESIDENCE OF SPOUSE AT TIME OF DISCHARGE.—The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

"(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate monthly payments under paragraph (a) to Medicare Advantage organizations in accordance with subsection (a) of section 1859(e), as adjusted—

"(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Notwithstanding any other provision of this paragraph, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments made under paragraph (a) of section 1859(e) to Medicare Advantage organizations associated with such rate of the social health maintenance organization end-stage renal disease capitation demonstration program established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 1367(b) of the Omnibus Budget Reconciliation Act of 1993, and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease.

"(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

"(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with a Medicare Advantage plan, with respect to classes of individuals determined to have end-stage renal disease and enrolled in a Medicare Advantage plan of the organization, and the underlying cause of the end-stage renal disease.

"(B) SPECIAL RULE FOR CERTAIN ENROLLMENTS.—

"(B) SPECIAL RULE FOR CERTAIN ENROLLMENTS.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a Medicare Advantage organization under a plan operated, sponsored, or contributed to by the individual's employer (or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 30 days.

"(ii) CANCELLATION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

"(C) EQUALIZATION OF FEDERAL CONTRIBUTION.—In applying subparagraph (A), the Secretary shall ensure that the payment to the Medicare Advantage organization for each individual enrolled with the organization shall equal the Medicare Advantage benchmark amount for the payment area in which that individual resides (as determined under paragraph (4)), as adjusted—

"(C) EQUALIZATION OF FEDERAL CONTRIBUTION.—The Secretary shall ensure that the payment to the Medicare Advantage plan of the organization for each individual enrolled with the organization shall equal the Medicare Advantage benchmark amount for the payment area in which that individual resides (as determined under paragraph (4)), as adjusted—

"(I) by multiplying the benchmark amount determined under subsection (d)(4) by the factor

"(I) by multiplying the benchmark amount determined under subsection (d)(4) by the factor

"(B) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted for that payment area to reflect the number of individuals enrolled in the Medicare Advantage plan of the organization for each month under this part in a Medicare Advantage payment area for each year, the amount of payment described in clause (i) if the hospitals had not been reimbursed under such section.

"(B) IN GENERAL.—The amount of payment described in clause (i) if the hospitals had not been reimbursed under such section for that payment area by the ratio of—

"(B) IN GENERAL.—The amount of payment described in clause (i) if the hospitals had not been reimbursed under such section for that payment area by the ratio of—

"(I) the payment amount determined under subsection (d)(4) to

"(I) the payment amount determined under subsection (d)(4) to

"(II) the weighted service area benchmark amount determined under subsection (d)(2); and

"(II) the weighted service area benchmark amount determined under subsection (d)(2); and

"(III) using such risk adjustment factor as specified by the Secretary under subsection (b)(1)(B).

"(C) EQUALIZATION OF FEDERAL CONTRIBUTION.—In applying subparagraph (A), the Secretary shall ensure that the payment to the Medicare Advantage organization for each individual enrolled under this subsection may be retroactively adjusted methodology described in this subparagraph is the risk adjustment methodology that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

"(C) EQUALIZATION OF FEDERAL CONTRIBUTION.—In applying subparagraph (A), the Secretary shall ensure that the payment to the Medicare Advantage organization for each individual enrolled under this subsection may be retroactively adjusted methodology described in this subparagraph is the risk adjustment methodology that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

"(D) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require Medicare Advantage organizations to submit such data and other information as the Secretary deems necessary.

"(E) IMPROVEMENT OF PAYMENT ACCURACY.—Notwithstanding any other provision of this subparagraph, the Secretary may revise the comprehensive risk adjustment methodology described in this subparagraph for the purpose of improving the accuracy of the payments described in clause (i) for the year.

"(E) IMPROVEMENT OF PAYMENT ACCURACY.—Notwithstanding any other provision of this subparagraph, the Secretary may revise the comprehensive risk adjustment methodology described in this subparagraph for the purpose of improving the accuracy of the payments described in clause (i) for the year.

"(F) ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.—

"(F) ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.—Beginning in 2004, the Secretary shall publish in the Federal Register in the summer of each year the risk adjustment factors for the following year that reflects payments rates payments to hospitals reimbursed under section 1886(d)(5)(B); and

"(F) ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.—Beginning in 2004, the Secretary shall publish in the Federal Register in the summer of each year the risk adjustment factors for the following year that reflects payments rates payments to hospitals reimbursed under section 1886(d)(5)(B); and

"(1) ANNUAL ANNOUNCEMENT.—Beginning in 2004, the Secretary shall publish in the Federal Register in the summer of each year the risk adjustment factors for the following year that reflects payments rates payments to hospitals reimbursed under section 1886(d)(5)(B); and

"(1) ANNUAL ANNOUNCEMENT.—Beginning in 2004, the Secretary shall publish in the Federal Register in the summer of each year the risk adjustment factors for the following year that reflects payments rates payments to hospitals reimbursed under section 1886(d)(5)(B); and

"(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall—

"(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall—

"(A) provide for notice to Medicare Advantage organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement;

"(A) provide for notice to Medicare Advantage organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement;

"(B) provide such organizations with an opportunity to comment on such proposed changes.

"(B) provide such organizations with an opportunity to comment on such proposed changes.

"(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in...
methodology used in the announcement in sufficient detail so that Medicare Advantage organizations can compute each payment factor described in paragraph (1).''

(1) (A) ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

(i) IN GENERAL.—For purposes of making payments under this part for years before 2006 and for calculating annual Medicare+Choice capitation rates under paragraph (7) beginning with such year, subject to subparagraph (B)(i), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area before 2006 or a Medicare Advantage payment area beginning with such year for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), or (C):—

(A) BLENDED CAPITATION RATE.—The sum of—

(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare+Choice capitation rate for the Medicare+Choice payment area, as determined under paragraph (3) for the year; and

(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year, multiplied by the budget neutrality adjustment factor determined under paragraph (5).''

(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

(i) For 1998 and 1999, 109 percent but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area;

(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

(iii)(I) Subject to subparagraph (ii), for 2001, for any area in a Metropolitan Statistical Area with a population of more than 250,000, 125 percent of the amount determined under clause (ii) for such area for 2000.

(ii) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not exceed 125 percent of the amount determined under clause (ii) for such area for 2000.

(iv) For 2002 through 2013, the minimum amount specified in this clause (or clause (iii)(I) for the year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

(v) For 2014 and each succeeding year, the minimum amount specified in this clause (or clause (iv) for the preceding year increased by the percentage increase in the Consumer Price Index (or urban consumers, urban average) for the 12-month period ending with J une of the previous year.

(C) MINIMUM PERCENTAGE INCREASE.—

(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the Medicare+Choice payment area.

(ii) For 1999 and 2000, 10 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

(iv) For 2002 and each succeeding year, 102 percent of the Medicare+Choice capitation rate under this paragraph for the area for the previous year.

(v) For 2003, 103 percent of the Medicare+Choice capitation rate under this paragraph for the area for 2002.

(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

(A) for 1998, the ‘area-specific percentage’ is 90 percent and the ‘national percentage’ is 10 percent;

(B) for 1999, the ‘area-specific percentage’ is 82 percent and the ‘national percentage’ is 18 percent;

(C) for 2000, the ‘area-specific percentage’ is 74 percent and the ‘national percentage’ is 26 percent;

(D) for 2001, the ‘area-specific percentage’ is 66 percent and the ‘national percentage’ is 34 percent;

(E) for 2002, the ‘area-specific percentage’ is 58 percent and the ‘national percentage’ is 42 percent;

(F) for a year after 2002, the ‘area-specific percentage’ is 50 percent and the ‘national percentage’ is 50 percent.

(3) AREASPECIFIC MEDICARE+CHOICE CAPITATION RATE.—

(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraph (B), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (determined under subparagraph (A)); or

(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, multiplied by the national per capita Medicare+Choice growth percentage for such subsequent year.

(B) REMOVAL OF MEDICAL EDUCATION FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

(i) IN GENERAL.—In determining the area-specific Medicare+Choice capitation rate under paragraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (determined under subparagraph (A)); or

(ii) the sum (for all Medicare+Choice payment areas) of the product of—

(A) the annual area-specific Medicare+Choice capitation rate determined for that year for the area under paragraph (3); and

(B) the average number of Medicare beneficiaries residing in that area in that year, divided by the average of the risk factors for beneficiaries in such area, divided by the sum of the products described in clause (i)(I) for all areas for that year.

(4) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE DEFINED.—

(A) IN GENERAL.—In this part, the ‘national standardized annual Medicare+Choice growth percentage’ for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary’s estimate of the projected per capita capitation rate of growth in expenditures under this title for an individual entitled to (or enrolled for) benefits under part A and enrolled under part B, or enrolled under part D, that shall equal the aggregate payments that would have been made under this part if payment was based entirely on area-specific capitation rates.

(B) NATIONAL STANDARDIZED ANNUAL MEDICARE+CHOICE CAPITATION RATE.—In sub-paragraph (A)(i), the ‘national standardized annual Medicare+Choice capitation rate’ for a year is determined by—

(i) the sum (for all Medicare+Choice payment areas) of the products of—

(A) the annual area-specific Medicare+Choice capitation rate determined for that year for the area under paragraph (3); and

(B) the average number of Medicare beneficiaries residing in that area in that year, divided by the average of the risk factors for beneficiaries in such area; divided by the sum of the products described in clause (i)(I) for all areas for that year.

(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (3)(A), for each year, the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iii) and (i)) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

(6) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE DEFINED.—

(A) IN GENERAL.—In this part, the ‘national standardized annual Medicare+Choice growth percentage’ for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary’s estimate of the projected per capita capitation rate of growth in expenditures under this title for an individual entitled to (or enrolled for) benefits under part A and enrolled under part D, or enrolled under part B, that shall equal the aggregate payments that would have been made under this part if payment was based entirely on area-specific capitation rates.
computed rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amounts for the previous year) for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years.

"(7) TRANSITION TO MEDICAREADVANTAGE COMPETITION.—For each year beginning with 2006, the Secretary shall adjust the amounts determined under subsection (a)(3) using the comprehensive risk adjustment methodology applicable under subsection (a)(3).

"(8) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title for which the Secretary is required to be provided under this part that the Secretary projects will result in a significant increase in the costs to MedicareAdvantage organizations, the Secretary shall adjust the benchmark amount for each month for such increased costs (as determined by the Secretary). The Secretary shall make this adjustment in an amount that is no less than the amount that would be required to preserve the value of the benefits under the original Medicare fee-for-service program option, as determined by the Secretary, if the Secretary were to make this adjustment.

"(9) APPLICATION OF COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall adjust the amounts determined under paragraph (a) using the comprehensive risk adjustment methodology applicable under subsection (a)(3).

"(B) CONTINUED CALCULATION OF CAPITATION RATES.—For each year beginning with 2006, the Secretary shall determine the amounts under this paragraph for each Medicare+Choice payment area based on the assumptions described in section 1385(c) to the extent applicable to such year.

"(C) METROPOLITAN BASED SYSTEM.—The Secretary may establish a metropolitan based system described in this section for Medicare+Choice payment areas that consist of a single consolidated metropolitan statistical area, a single metropolitan statistical area within the consolidated metropolitan statistical area, or any area designated as such by the Secretary.

"(D) AREAS.—In paragraph (c), the term 'metropolitan statistical area', 'consolidated metropolitan statistical area', and 'area designated as such by the Secretary' means any area designated as such by the Secretary.
SEC. 204. SUBMISSION OF BIDS; PREMIUMS.

2006 shall be paid on the first business day of October 2006.

(h) [Special Rule for Certain Inpatient Hospital Stays.—In the case of an individual with a Medicare Advantage plan, the individual’s Medicare Advantage organization shall submit to the Secretary, in form and manner as the Secretary may prescribe, for each Medicare Advantage plan that the organization intends to offer in a service area in the following year—

(A) notice of such information and on the service area of the plan; 

(B) the plan type for each plan; 

(C) if the Medicare Advantage plan is a coordinated care plan (as described in section 1851(a)(2)(A) of the original Medicare fee-for-service program) or a Medicare Advantage plan (as described in section 1851(a)(2)(C)), the information described in paragraph (2) with respect to each plan; 

(D) the enrollment capacity (if any) in relation to the plan and each payment area; 

(E) the expected mix, by health status, of enrolled individuals; and 

(F) such other information as the Secretary may specify.

(2) INFORMATION REQUIRED FOR COORDINATED CARE PLANS AND PRIVATE FEES-FOR-SERVICE PLANS.—For a Medicare Advantage plan that is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in this paragraph is as follows:

(A) INFORMATION REQUIRED WITH RESPECT TO BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—Information relating to the coverage of benefits under the original Medicare fee-for-service program option is as follows:

(i) The plan bid, which shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing the benefits under the original Medicare fee-for-service program option to an individual enrolled in the plan that resides in the service area of the plan for a month.

(ii) For the enhanced medical benefits package offered—

(A) the adjusted community rate (as defined in subsection (g)(3)) of the package; 

(B) the portion of the actuarial value of such benefits package (if any) that will be applied toward satisfying the requirements described in subsection (g)(3); 

(C) the Medicare Advantage monthly beneficiary premium for enhanced medical benefits (as described in subsection (b)(1)(A)(i)); 

(D) a description of any cost-sharing; 

(E) a description of whether the amount of the unified deductible has been lowered or increased, or maximum out-of-pocket expenses have been decreased (relative to the levels used in calculating the plan bid); 

(VI) such other information as the Secretary considers appropriate.

(iii) The assumptions that the Medicare Advantage organization used in preparing the plan bid with respect to numbers, in each payment area, of Medicare Advantage monthly basic beneficiary premiums (if any).

(B) INFORMATION REQUIRED WITH RESPECT TO PART D.—The information required to be submitted by an eligible entity under section 1860D-12, including the monthly premiums for standard coverage and any other qualified prescription coverage available to individuals enrolled under part D.

(C) DETERMINING PLAN COSTS INCLUDED IN PLAN BID.—For purposes of submitting its plan bid, each Medicare Advantage organization (or the Medicare Advantage monthly basic beneficiary premium (if any).
(C) MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, means, with respect to a MedicareAdvantage plan, the amount determined under section 1851(a)(1)(A).

(C) MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, means, with respect to a MedicareAdvantage plan, the amount required to be charged under subsection (f)(2) for the plan, in the case of an MSA plan, the amount filed under subsection (a)(3).

(D) MedicareAdvantage monthly MSA premium.—The term ‘MedicareAdvantage monthly MSA premium’ means, with respect to a MedicareAdvantage plan, the amount of such premium filed under subsection (a)(3) for the plan.

Uniform Premium.—The MedicareAdvantage monthly basic beneficiary premium, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, and the MedicareAdvantage monthly MSA premium charged under subsection (b) of a MedicareAdvantage organization under this part may not vary among individuals enrolled in the plan.

(D) Determination of Premium Reductions, Reduced Cost-Sharing, Additional Benefits, and Uniform Premium.—

(1) BIDS BELOW THE BENCHMARK.—If the Secretary determines under section 1853(d)(3) that the weighted service area benchmark amount exceeds the plan bid, the Secretary shall permit the plan to provide additional benefits in accordance with subsection (g).

(2) BIDS ABOVE THE BENCHMARK.—If the Secretary determines under section 1853(d)(3) that the plan bid exceeds the weighted service area benchmark amount (determined under section 1853(d)(2)), the amount of such excess shall be the MedicareAdvantage monthly basic beneficiary premium (as defined in section 1854(b)(2)(A)).

(3) Requirement.—In general.—Each MedicareAdvantage organization shall permit the payment of any MedicareAdvantage monthly basic premium, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits on a monthly basis, may terminate the provision of such benefits in a MedicareAdvantage plan for failure to make premium payments only in accordance with section 1855(g)(3)(B)(i), and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise (other than as an additional benefit described in subsection (g)(3)(C)).

(4) Limitation on Enrollee Liability.—

(1) For Benefits Under the Original Medicare Fee-For-Service Program Option.—The actuarial value of the deductibles, coinsurance, and copayments (determined in the same basis as used in determining the plan’s bid under paragraph (2)(C)) applicable on average to individuals enrolled under this part with a MedicareAdvantage plan described in subparagraph (A) or (C) of section 1855(a)(2) of an organization with respect to required benefits described in section 1855(a)(1) must equal—

(a) the actuarial value of the deductible, coinsurance, and copayments that would be applicable on average to individuals who have the benefits described in the original Medicare fee-for-service program option if such individuals were not members of a MedicareAdvantage organization for the year (adjusted as determined appropriate by the Secretary to account for geographic differences and for plan cost and utilization differences).

(b) For enhanced medical benefits.—If the MedicareAdvantage organization provides to its members enrolled under this part in a MedicareAdvantage plan, in a Medicare Advantage plan, either—

(i) the plan specified under subsection (a)(3); or

(ii) the plan specified under subsection (a)(3)(A).

(2) Determination on Other Basis.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1), the Secretary may determine such amount with respect to all individuals in the same geographic area, the State, or the United States, and the MedicareAdvantage organization involved in this subsection, the organization shall permit the payment of any such benefits pursuant to clause (ii), (iii), or (iv) of subsection (g)(2)(C) that the plan specified under subsection (a)(3)(A) for the plan.

(3) Special Rule for Private Fee-For-Service Plans.—With respect to a MedicareAdvantage private fee-for-service plan (other than a plan that is an MSA plan), in no event may—

(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such plan with respect to required benefits described in subparagraphs (A), (C), and (D) of section 1853(a)(1); exceed the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to (or enrolled for) benefits under part A and enrolled under part B if such individuals were members of a MedicareAdvantage organization for the year.

(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to (or enrolled for) benefits under part A and enrolled under part B if such individuals were members of a MedicareAdvantage organization for the year.

(4) Requirement for Additional Benefits.—

(1) Requirement.—

(A) In general.—Each MedicareAdvantage organization (in relation to a MedicareAdvantage plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits described in subparagraph (C) as the organization may determine (subject to the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (D))).

(B) Excess Amount.—For purposes of this paragraph, the term ‘excess amount’ means, for an organization for a plan, is 100 percent of the amount (if any) by which the weighted service area benchmark amount determined under section 1853(d)(2) exceeds the plan bid (as adjusted under section 1853(d)(1)).

(C) Additional Benefits Described.—The additional benefits described in this subparagraph are as follows:

(i) Subject to subparagraph (F), a monthly part B premium reduction for individuals enrolled in the plan.

(ii) Lowering the amount of the unified deductible and decreasing the maximum limitation on out-of-pocket expenses for individuals enrolled in the plan.

(iii) A reduction in the actuarial value of plan cost-sharing for plan enrollees.

(iv) The amount of any combination of the reductions and benefits described in clauses (i) through (v).

(D) Adjusted Excess Amount.—For purposes of this paragraph, the term ‘adjusted excess amount’ means, for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

(E) Rule for Approval of Medical and Prescription Drug Benefits.—An organization may not specify any additional benefit that provides for the coverage of any prescription drug (other than that relating to prescription drugs covered under the original Medicare fee-for-service program option).

(2) Premium Reductions.—

(i) In general.—Subject to clause (ii), as providing any additional benefits required under subparagraph (A), a MedicareAdvantage organization may make a reduction in its payments under section 1833(a)(3)(A)(ii) with respect to a MedicareAdvantage plan and the Secretary shall apply such reduction to reduce the premium under section 1829 of each enrollee in such plan as provided in section 1840(i).

(ii) Amount of Reduction.—The amount of the reduction under clause (i) with respect to each enrollee in a MedicareAdvantage plan—

(a) may not exceed 125 percent of the premium described under section 1833(a)(3); and

(b) shall apply uniformly to each enrollee of the MedicareAdvantage plan to which such reduction applies.

(3) Uniform Application.—This paragraph shall be applied uniformly for all enrollees for a plan.

(4) Construction.—Nothing in this subsection shall be construed as preventing a MedicareAdvantage organization from providing enhanced medical benefits described in section 1852(a)(1); exceed the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals enrolled under this part with such plan with respect to required benefits described in subparagraphs (A), (C), and (D) of section 1853(a)(1).
"(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicareAdvantage plan under this Part C (or enrolled in a MedicareAdvantage plan under a "community rating system" (as defined in section 1302(b) of the Public Health Service Act, other than subparagraph (C)); or (B) the weightings used to determine the cost-sharing reductions for low-income MedicareAdvantage eligible individuals (as defined in section 1860D–2(b) of the Social Security Act).

SEC. 206. FACILITATING EMPLOYER PARTICIPATION.

(a) General.—The provisions of subsection (b) of section 1819(f) shall apply to the year 2006, and section 1819(f) shall be applied by the Secretaries of Health and Human Services and Labor in the same manner as it would apply to an individual eligible for Medicare under such section if the Secretary determines that the requirements of such provision apply to an individual as described in such section.

(b) Treatment of Reduction for Purposes of Determining Government Contribution Under Part B.—Section 1854(c)(4)(B) of the Social Security Act (42 U.S.C. 1395w–21(c)(4)(B)) is amended by inserting “(including subsection (i) of such section)" after "section 1857."
SEC. 208. CONFORMING AMENDMENTS.

(a) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICAREADVANTAGE ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS.--Section 1855 (42 U.S.C. 1395w–25) is amended--

(1) in subsection (b), in the matter preceding paragraph (1), by inserting "subparagraphs (A), (B), and (D)" after "before "section 1852A(1)";

(2) by striking "Medicare+Choice" and inserting "MedicareAdvantage" each place it appears;

(b) ESTABLISHMENT OF PSO STANDARDS.--Section 1856 (42 U.S.C. 1395w–26) is amended by striking "Medicare+Choice" and inserting "MedicareAdvantage" each place it appears.

(c) CONTRACTS WITH MEDICAREADVANTAGE ORGANIZATIONS.--Section 1857 (42 U.S.C. 1395w–27) is amended--

(1) in subsection (g)(1)—

(A) in subparagraph (B), by striking "amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums" and inserting "amounts of the MedicareAdvantage monthly basic premium and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits";

(B) in subparagraph (F), by striking "or" after the semicolon at the end;

(C) by inserting "MedicareAdvantage" after "Medicare+Choice"; and

(D) by striking after subparagraph (G) the following new subparagraph:

"(H) "Medicare+Choice" each place it appears.

2. DEFINITIONS; MISCELLANEOUS PROVISIONS.

(1) ENSURE MEDICARE ADVANTAGE PRESCRIPTION DRUG COVERAGE.--The term 'MedicareAdvantage' monthly basic and supplemental beneficiary premium for enhanced medical benefits' is defined in section 1852A(3).

(2) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.--The term 'MedicareAdvantage eligible individual' is defined in section 1852(a)(3).

(3) MEDICAREADVANTAGE PAYMENT AREA.--The term 'MedicareAdvantage payment area' is defined in section 1852(a)(3).

(4) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.--The national per capita Medicare+Choice growth percentage is defined in section 1852(c)(6).

(5) MEDICAREADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM; MEDICAREADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM FOR ENHANCED MEDICAL BENEFITS.--The terms 'MedicareAdvantage monthly basic beneficiary premium', 'MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage', and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits' are defined in section 1854(b)(2).
"(b) Eligibility, Election, and Enrollment: Benefits and Beneficiary Protections.—

"(1) In General.—Except as provided in the succeeding paragraphs of this subsection, the provisions of sections 1851 and 1852 that apply with respect to coordinated care plans shall apply to preferred provider organizations offered by a preferred provider organization.

"(2) Service area.—The service area of a preferred provider organization plan shall be a preferred provider region.

"(3) Availability.—Each preferred provider organization plan must be offered to each Medicare Advantage eligible individual who resides in the service area of the plan.

"(4) Authority to prohibit risk selection.—The provisions of section 1852(a)(6) shall apply to preferred provider organization plans.

"(5) Assuring access to services in preferred provider organization plans.—

"(A) In General.—In addition to any other requirements under this section, in the case of a preferred provider organization plan, the organization offering the plan must demonstrate to the Secretary that the organization has a sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan.

"(B) Determination of sufficient access.—The Secretary shall find that an organization has met the requirement under subparagraph (A) with respect to any category of health care professional or provider if, with respect to that category of provider the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan.

"(C) Construction.—Subparagraph (B) shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.

"(6) Payments to preferred provider organizations.—

"(A) Monthly payments.—

"(i) In General.—Under a contract under section 1857 and subject to paragraph (5), subsections (a)(1) and (a)(2) of section 1851, the Secretary shall make, to each preferred provider organization, with respect to an individual for a month under this part in a preferred provider region, separate monthly payments with respect to—

"(I) benefits under the original Medicare fee-for-service program for each Medicare Advantage eligible individual who resides in the service area for the year.

"(II) benefits under the voluntary prescription drug program for each Medicare Advantage eligible individual who resides in the service area for the year.

"(B) Special rule for end-stage renal disease.—The Secretary shall establish separate rates of payment applicable with respect to each class of individuals determined to have end-stage renal disease and enrolled in a preferred provider organization plan under this clause that are similar to the separate rates of payment described in section 1853(a)(1)(B).

"(C) Comprehensive risk adjustment methodology.—The Secretary shall apply the comprehensive risk adjustment methodology specified in section 1853(a)(2) to 100 percent of the amount of payments to plans under paragraph (4)(D)(ii).

"(D) Adjustment for spending variations within a region.—The Secretary shall establish a methodology for adjusting the amount of payments to plans under paragraph (4)(D)(ii) to reflect the plan's experience consistent with the requirements under this part and subject to subparagraph (A) as the adjustment described in paragraph 1853(a)(2)(C).

"(2) Annual calculation of benchmark amounts for preferred provider regions.—For each year (beginning in 2006), the Secretary shall calculate a benchmark amount for each preferred provider region for each month for such year with respect to the amount for plans described in section 1853(d)(6), the Secretary shall adjust the amount of payment to each preferred provider organization plan as follows:

"(I) the payment amount under subparagraph (D); and

"(II) the additional benefits required and Medicare Advantage monthly basic beneficiary premiums.

"(D) Determination of payment amount.—

"(1) In General.—Subject to clause (ii), the Secretary shall determine the amount of total payment to a preferred provider organization for a preferred provider organization plan as follows:

"(I) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the preferred provider regional benchmark amount, the amount of each monthly payment to the plan is determined by subtracting the preferred provider regional benchmark amount from the amount of total payment calculated under subparagraph (A) for the year in which the plan bid is made.

"(II) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the preferred provider regional benchmark amount, the amount of each monthly payment to the plan is determined by multiplying the preferred provider regional benchmark amount reduced by the amount of any premium reduction elected by the Secretary under section 1854(d)(1)(A)(ii).

"(E) Factors used in adjusting bids and benchmarks for preferred provider organizations and in determining enrollee premiums.—Subject to subparagraph (F), in addition to the factors used to adjust payments to plans described in section 1853(d)(6), the Secretary may use the following factors in adjusting bids and benchmarks for preferred provider organizations in the same manner as the Secretary makes payment adjustment for geographic variation within the region established under paragraph (1)(D).

"(F) Adjustment for national coverage determinations and legislative changes in benefits.—The Secretary shall adjust the amounts determined under subparagraph (A) using the factors described in paragraph 1853(d)(1)(F).

"(G) Payments from trust fund.—The payment to a preferred provider organization under this section shall be made from the Medicare Trust Fund in a manner similar to the rules applicable under section 1853(h) but shall apply with respect to preferred provider organizations.

"(H) Submission of bids by PPOS; premium surcharges.—"(A) In General.—For the requirements on submission of bids by Medicare Advantage preferred provider organization plans, see section 1854(a)(1).
"(B) UNIFORM PREMIUMS.—Each bid amount submitted under subparagraph (A) for a preferred provider organization plan in a preferred provider region may not vary among Medicare-eligible individuals residing in such preferred provider region.

"(C) APPLICATION OF FEMP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under subparagraph (A) for a preferred provider organization plan must reasonably and equitably reflect the cost of benefits provided under that plan.

"(D) DISCLOSEMENT.—The Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the Medicare Advantage monthly basic premium and the Medicare Advantage monthly beneficiary premium for enhanced medical benefits filed under this paragraph and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the preferred provider organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

"(E) AUTHORITY TO LIMIT NUMBER OF PLANS IN A REGION.—If there are bids for more than 3 preferred provider organization plans in a preferred provider region, the Secretary shall accept only the 3 lowest-cost credible bids for that region that meet or exceed the quality and minimum standards applicable under this section.

"(2) MONTHLY PREMIUM CHARGED.—The amount of the monthly premium charged to an individual enrolled in a preferred provider organization plan in a preferred provider region, the Secretary shall accept only the 3 lowest-cost credible bids for that region that meet or exceed the quality and minimum standards applicable under this section.

"(3) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—The rules for determining premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums under section 1854(d) shall apply with respect to preferred provider organizations.

"(4) REIMBURSEMENT OF CERTAIN PROVIDER REGIONS.—The Secretary may not permit a preferred provider organization to elect to apply the provisions of this section uniformly to separate segments of a preferred provider region (rather than uniformly to an entire preferred provider region).

"(e) PORTION OF TOTAL PAYMENTS TO AN ELIGIBLE ENTITY.—(A) IN GENERAL.—For 2007 and 2008, the Medicare Advantage monthly basic beneficiary premium, as defined in section 1854(b)(2)(A), if any.

"(B) The Medicare Advantage monthly basic beneficiary premium for an individual enrolled in a preferred provider organization plan in a preferred provider region, shall be equal to—

"(I) 50 percent of the amount of such total costs which are more than such first threshold upper limit of the risk corridor (as specified under paragraph (3)(A)(i)); and

"(II) 90 percent of the amount of such total costs which are more than such first threshold upper limit of the risk corridor.

"(2) ADJUSTMENT OF PAYMENT.—(A) NO REDUCTIONS WHILE PROVIDER ORGANIZATIONS ARE UNDER REVIEW.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then no additional payments shall be made by the Secretary and no reduced payments shall be made to the preferred provider organization offering the plan.

"(B) INCREASE IN PAYMENT IF COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—(i) IN GENERAL.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are more than the first threshold upper limit of the risk corridor (as specified under paragraph (3)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(ii)) for the plan for the year, then no additional payments shall be made to the preferred provider organization offering the plan for the year under subsection (c)(1)(A) by an amount equal to the sum of—

"(I) 50 percent of the amount of such total costs which are more than such first threshold upper limit of the risk corridor and not less than such second threshold upper limit of the risk corridor.

"(ii) 90 percent of the amount of such total costs which are more than such second threshold upper limit of the risk corridor.

"(ii) REDUCTION IN PAYMENT IF COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the Secretary shall reduce the total of the monthly payments made to the preferred provider organization offering the plan for the year under subsection (c)(1)(A) by an amount equal to—

"(I) 50 percent of the amount of such total costs which are less than such first threshold lower limit of the risk corridor and not less than such second threshold lower limit of the risk corridor.

"(ii) 90 percent of the amount of such total costs which are less than such second threshold lower limit of the risk corridor.

"(3) EXECUTIVE ORDER.—The Secretary shall establish a risk corridor for each preferred provider organization plan. The risk corridor for a plan for a year shall be equal to—

"(1) the first threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(ii)); and

"(2) the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(iii)).

"(h) CONTRACTS WITH PREFERRED PROVIDER ORGANIZATIONS.—(1) CONTRACTS.—The provisions of section 1857 shall apply to a preferred provider organization plan offered by a preferred provider organization under this section.

"(1) CONTRACTS WITH PREFERRED PROVIDER ORGANIZATIONS.—(A) CONTRACTS.—The Secretary shall enter into contracts with preferred provider organizations under this section.

"(2) CONTRACTS WITH PREFERRED PROVIDER ORGANIZATIONS.—(A) CONTRACTS.—The Secretary shall enter into contracts with preferred provider organizations under this section.

"(3) ESTABLISHMENT OF ALLOWABLE ADMINISTRATIVE EXPENSES.—(A) IN GENERAL.—For 2006 and 2007, the Secretary shall establish a risk corridor for each preferred provider organization plan. The risk corridor for a plan for a year shall be equal to—

"(i) the target amount described in subparagraph (B) for the plan; minus

"(ii) an amount equal to 5 percent of such target amount.

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

"(i) the target amount described in subparagraph (B) for the plan; minus

"(ii) an amount equal to 10 percent of such target amount.

"(j) CONTRACTORS.—No change in payments made by reason of this subsection shall affect the amount of the Medicare Advantage basic beneficiary premium that a beneficiary is otherwise required to pay for the plan for the year under subsection (d)(2)(A).

"(k) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—The rules for determining premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums under section 1854(d) shall apply with respect to preferred provider organizations.

"(l) EXTENSION OF CONTRACTS.—The provisions of this section shall apply to a preferred provider organization plan offered by a preferred provider organization under this section.
(1) by redesigning paragraph (5) as paragraph (6); and
(2) by inserting after paragraph (4) the following new paragraph:

"(5) the Secretary determines that the organization meets the requirements applicable to such organizations and contracts under this section."

SEC. 222. GENERAL PROVISIONS.

(a) SECURED McARIE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—

(1) TREATMENT OF SECURED COORDINATED CARE PROGRAM.—Section 1851(a)(21)(A) (42 U.S.C. 1395w-21(a)(21)(A)) is amended by striking at the end the following new sentence: "Specialized Medicare+Choice plans for special needs beneficiaries (as defined in section 1395d(4)(A)) may be any type of coordinated care plan.".

(2) SPECIALIZED McARIE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—Section 1851(b) (42 U.S.C. 1395w-28(b)) is amended by adding at the end the following new section:

"(4) SPECIALIZED McARIE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—

(1) IN GENERAL.—The term 'specialized Medicare+Choice plan' means a Medicare+Choice plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

(2) SPECIAL NEEDS BENEFICIARY.—The term 'special needs beneficiary' means a Medicare+Choice eligible individual who:

(i) is institutionalized (as defined by the Secretary);

(ii) is entitled to medical assistance under a State plan or under title XIX; or

(iii) meets such requirements as the Secretary may determine would benefit from enrollment in a specialized Medicare+Choice plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.

(3) RESTRICTION ON ENROLLMENT PERMITTED.—Section 1859 (42 U.S.C. 1395w-28) is amended by adding at the end the following new section:

"(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED McARIE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2006, the plan may restrict the enrollment of individuals under the plan to individuals who are within 1 or more classes of special needs beneficiaries.

(4) REPORT TO CONGRESS.—Not later than December 31, 2006, the Secretary shall submit to Congress a report that assesses the impact of specialized Medicare+Choice plans for special needs beneficiaries on the cost and quality of services provided to enrollees.

(5) EFFECTIVE DATE.—

(A) IN GENERAL.—The amendments made by subsections (a), (b), and (c) shall take effect on the date of enactment of this Act.

(b) MEDICAID SERVICES.—

(1) APPLICATION OF OTHER SECTIC FOR MEDICAID SERVICES FURNISHED BY NONCONTRACT PROVIDERS.—

(a) MEDICAID SERVICES FURNISHED BY NONCONTRACT PROVIDERS.—

(1) IN GENERAL.—The amendments made by subsections (a), (b), and (c) shall take effect on the date of enactment of this Act.

(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Not later than 1 year after the date of enactment of this Act, the Secretary shall issue final regulations to establish requirements for noncontract physicians and other entities under section 1395d(4)(B)(ii) (social Security Act, as added by subsection (b)).

(c) PAYMENT FOR MEDICAID SERVICES FURNISHED BY NONCONTRACT PROVIDERS.—

(1) IN GENERAL.—The amendments made by subsection (a) shall take effect on the date of enactment of this Act.

(2) EFFECTIVE DATE.—

(A) MEDICAID SERVICES FURNISHED BY NONCONTRACT PROVIDERS.—

(a) MEDICAID SERVICES FURNISHED BY NONCONTRACT PROVIDERS.—

(1) IN GENERAL.—The amendments made by subsection (a) shall take effect on the date of enactment of this Act.

(2) EFFECTIVE DATE.—

(A) APPLICATION OF OTHER SECTIC FOR MEDICAID SERVICES FURNISHED BY NONCONTRACT PROVIDERS.—

(a) IN GENERAL.—The amendments made by subsection (a) shall take effect on the date of enactment of this Act.
noncontract physicians and other entities with respect to services covered under title XVIII shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract establishing payment amounts for services furnished to such an individual in the same manner that is applicable to Medicare+Choice organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

(4) Reference to related provision for noncontract providers of services.—For purposes relating to limitations on balance billing against PACE providers for services covered under title XVIII furnished by noncontract providers of services, see section 1866(a)(1)(O).

(5) Reference to related provision for noncontract providers of services.—For provisions relating to limitations on balance billing against PACE providers for services covered under title XVIII furnished by noncontract providers of services, see section 1866(a)(1)(O).

(6) Reference to related provision for noncontract providers of services.—For provisions relating to limitations on balance billing against PACE providers for services covered under title XVIII furnished by noncontract providers of services, see section 1866(a)(1)(O).

(c) Authorization of Appropriations.—There are authorized to be appropriated $1,000,000 for purposes of conducting the evaluation and preparing the report required by this section.

SEC. 225. EXPANDING THE WORK OF MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS TO INCLUDE PARTS C AND D.

(a) Application to Medicare Managed Care and Prescription Drug Coverage.—Section 1154(a)(1)(B) of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) shall apply to Medicare+Choice programs in public or private sector settings;

(b) Catalogue and evaluate the success and utility of alternative performance incentive programs in public or private sector settings; and

(c) Identify and prioritize options to implement policies that align performance with payment under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) Specific matters evaluated.—In conducting the evaluation under paragraph (1), the Institute shall—

(A) prepare, review, and evaluate the validity of leading health care performance measures;

(B) catalogue and evaluate the success and utility of alternative performance incentive programs in public or private sector settings; and

(C) identify and prioritize options to implement policies that align performance with payment under the Medicare program that indicate—

(i) the performance measurement set to be used and how that measurement set will be updated;

(ii) the payment policy that will reward performance;

(iii) the key implementation issues (such as data and information technology requirements) that must be addressed.

(3) Scope of health care performance measures.—The health care performance measures described in paragraph (2)(A) shall encompass a variety of perspectives, including physicians, hospitals, health plans, purchasers, and consumers.

(4) Consultation with MedPAC.—In evaluating the matters described in paragraph (2)(C), the Institute shall consult with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395n–6).

(b) Medicare+Choice program under part C of title XVIII of the Social Security Act, the Medicare+Choice program under part D of title XVIII of the Social Security Act, and Medicare+Choice and Medicare Advantage plans under part C quality improvement assistance pertaining to prescription drug card sponsors and prescription drug card members of such plans, and Medicare+Choice and Medicare Advantage plans under part D.

(c) Effective date.—The amendments made by this section shall apply on and after January 1, 2004.

TITLE III—CENTER FOR MEDICARE CHOICES

SEC. 301. ESTABLISHMENT OF THE CENTER FOR MEDICARE CHOICES.

(a) In general.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 111, is amended by inserting after 1806 the following new section:

"SECTION 1806. Establishment of the Center for Medicare Choices.

(a) In general.—The Secretary shall establish within the Department of Health and Human Services the Center for Medicare Choices, which shall be separate from the Centers for Medicare & Medicaid Services.

(b) Administrator and Deputy Administrator.—

(1) Administrator.—"(A) The Administrator shall be responsible for, and head the Center for Medicare Choices, and shall be responsible for the exercise of all the functions and duties of the Center for Medicare Choices, and shall have authority and control over all personnel and activities thereof.

(2) Deputy Administrator.—"(A) The Deputy Administrator shall assist the Administrator in the performance of the Administrator's duties and shall have such authority, duties, and functions as the Administrator determines necessary or appropriate.

(b) Compensation.—"(A) The Administrator shall be paid at the rate of基本 pay payable for level IV of the Executive Schedule under section 5314 of title 5, United States Code.

(c) Term of office.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of a Administrator's term of office, such file Administrator shall appoint a successor, and the successor shall take office at the time of such appointment. In any case in which a successor does not take office at the end of a Administrator's term of office, such file Administrator shall appoint a successor, and the successor shall take office at the time of such appointment. In any case in which a successor does not take office at the end of a Administrator's term of office, such file Administrator shall appoint a successor, and the successor shall take office at the time of such appointment.

(d) Duties.—The Administrator shall perform such duties and exercise such powers as the Administrator shall delegate, assign, or direct.
offering of Medicare Prescription Drug plans under part D.

(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C, D, or E, including duties relating to—

(i) reasonable cost contracts with eligible organizations under section 1870(h); and

(ii) demonstration projects carried out in part D in such areas, including the demonstration project carried out through a Medicare Advantage (formerly Medicare+Choice) project that demonstrates the application of capitation payment rates for frail elderly Medicare beneficiaries through the use of an interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

(C) NONINTERFERENCE.—In order to promote competition under parts C and D, the Administrator, in carrying out the duties required under this section, may, to the extent possible, interfere in any way with negotiations between eligible entities, Medicare Advantage organizations, hospitals, physicians, other entities or individuals furnishing items and services under this title (including contractors for such items and services), and drug manufacturers, wholesalers, and distributors. The Administrator shall require such organizations and the President to submit to the Congress a report on the administration of the voluntary prescription drug delivery program under this part during the previous fiscal year.

(2) MANAGEMENT STAFF.—

(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, compensate, and remove such management staff as determined appropriate. Any such manager shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in the following areas:

(i) The review, negotiation, and administration of health care contracts.

(ii) The design of health care benefit plans.

(iii) Actuarial sciences.

(iv) Compliance with health plan contracts.

(v) Consumer education and decision making.

(B) COMPENSATION.—

(i) In general.—Subject to clause (ii), the Administrator shall establish the rate of pay for an individual employed under subparagraph (A).

(ii) Minimum rate.—In no case may the rate of compensation determined under clause (i) exceed the highest rate of basic pay for the Senior Executive Service under section 5317 of title 5, United States Code.

(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(A) IN GENERAL.—The Secretary, the Administrator of the Center for Medicare Choices, and the Administrator of the Centers for Medicare & Medicaid Services shall establish a transitional team responsible in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare and Medicaid Services to the Administrator of the Center for Medicare Choices as is appropriate to carry out the purposes of this section.

(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator of the Center for Medicare Choices data and information concerning the performance of the duties described in subparagraph (A).

(4) ADMINISTRATOR.—

(A) IN GENERAL.—The Administrator shall carry out the duties described in paragraph (1).

(B) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Centers for Medicare & Medicaid Services is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Centers for Medicare & Medicaid Services in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

(D) ESTABLISHMENT.—The Secretary shall establish within the Center for Medicare Choices an Office of Beneficiary Assistance to carry out functions relating to Medicare beneficiaries under this title, including making determinations of eligibility of individuals for benefits under this title, providing for enrollment of Medicare beneficiaries under this title, and the functions described in paragraph (2). The Office shall be a separate operating division within the Center for Medicare Choices.

(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to Medicare beneficiaries, by mail, by posting on the Internet site of the Center for Medicare Choices, and by any other means (including toll-free telephone numbers provided for under section 1808(b), information with respect to the following:

(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

(ii) Benefits, and limitations on payment under parts A and B, including information on Medicare supplemental policies under section 1882.

(iii) Other areas determined to be appropriate by the Administrator.

Such information shall be presented in a manner so that Medicare beneficiaries may compare benefits under parts A, B, and D, and Medicare supplemental policies with benefits under Medicare Advantage plans under part C.

(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to Medicare beneficiaries (including Medicare Advantage beneficiaries) of the health plan (right of appeal) (including procedures) of beneficiaries under the original Medicare fee-for-service program under parts A and B, the Medicare Advantage program under part C, and the voluntary prescription drug delivery program under part D.

(3) MEDICARE OMBUDSMAN.—

(A) IN GENERAL.—Within the Office of Beneficiary Assistance, there shall be a Medicare Ombudsman, appointed by the Secretary from among individuals with expertise and experience in the fields of health care and administration of such parts, to carry out the duties described in subparagraph (B).

(B) DUTIES.—The Medicare Ombudsman shall:

(i) receive complaints, grievances, and requests for information submitted by a Medicare beneficiary, with respect to any aspect of coverage, quality, or other matter under parts C and D, and any program, plan, or service furnished to Medicare beneficiaries.

(ii) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

(I) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a health intermediary, carrier, Medicare Advantage organization, an eligible entity, or other entity, and

(II) assistance to such beneficiaries with any problems arising from disenrollment from a Medicare Advantage plan under part C or a prescription drug plan under part D; and

(iii) submit annual reports to Congress, the Secretary, and the Medicare Competitive Policy Advisory Board on the development of such recommendations and such reports submitted to Congress of such recommendations.

(B) OFFICE OF BENEFICIARY ASSISTANCE.—

(1) ESTABLISHMENT.—The Secretary shall establish within the Center for Medicare and Medicaid Services an Office of Medicare Benefits and Appeals Rights, to—

(i) provide information about the Medicare program; and

(ii) conduct outreach to educate Medicare beneficiaries with respect to matters in which problems under the Medicare program may be resolved or avoided.

(E) MEDICARE COMPETITIVE POLICY ADVISORY BOARD.—

(1) ESTABLISHMENT.—There is established within the Center for Medicare Choices the Medicare Competitive Policy Advisory Board (in this section referred to as the "Board").

(2) DUTY OF ADMINISTRATOR.—With respect to matters of the administration of parts C and D, the Administrator shall submit to Congress and to the Secretary any report submitted by the Board appropriate for legislative or administrative changes to improve the administration of such parts, including the stability and solvency of the programs under such parts and topics described in subparagraph (B) of such report. Each such report shall be published in the Federal Register.

(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

(I) FOSTERING COMPETITION.—Recommendations or proposals to increase competition among entities offering Medicare Advantage or Part D prescription drug plans.

(II) EDUCATION AND ENROLLMENT.—Recommendations for the improvement of education and enrollment under parts C and D.

(III) QUALITY.—Recommendations or proposals to improve the quality of benefits or services furnished under parts C and D.

(C) REPORTS.—

(1) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress each report submitted by the Administrator such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the stability and solvency of the programs under such parts and topics described in subparagraph (B) of such report. Each such report shall be published in the Federal Register.

(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

(I) FOSTERING COMPETITION.—Recommendations or proposals to increase competition among entities offering Medicare Advantage or Part D prescription drug plans.

(II) EDUCATION AND ENROLLMENT.—Recommendations for the improvement of education and enrollment under parts C and D.

(III) QUALITY.—Recommendations or proposals to improve the quality of benefits or services furnished under parts C and D.

(C) REPORTS.—

(1) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress each report submitted by the Administrator such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the stability and solvency of the programs under such parts and topics described in subparagraph (B) of such report. Each such report shall be published in the Federal Register.

(4) MEMBERSHIP.—

(A) IN GENERAL.—With respect to any report submitted by the Board under this section, not later than 30 days after the report is submitted, the Administrator shall submit to the Congress of such recommendations and such Board at Congress and to the Secretary and the Medicare Competitive Policy Advisory Board on the development of such recommendations and such Board at Congress and to the Secretary and the Medicare Competitive Policy Advisory Board on the development of such recommendations.

(B) DUTY OF ADMINISTRATOR.—With respect to any report submitted by the Board under this section, not later than 30 days after the report is submitted, the Administrator shall submit to Congress and the President an analysis of recommendations made by the Board at Congress and to the Secretary and the Medicare Competitive Policy Advisory Board on the development of such recommendations shall be published in the Federal Register.
(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of 7 members to be appointed as follows: 

(i) One member shall be appointed by the President. 

(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice and consent of the Senate, and the ranking minority member of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives. 

(iii) One member shall be appointed by the President pro tempore of the Senate with the advice of the chairmen and the ranking minority member of the Committee on Finance of the Senate. 

(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board. 

(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

(D) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the Board, compensation at rates not to exceed the daily equivalent to the amount paid Federal Government employees performing similar duties in the Federal Government. 

(E) TERMS OF OFFICE.—

(A) IN GENERAL.—The term of office of members of the Board shall be 3 years. 

(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

(i) one shall be appointed for a term of 1 year, 

(ii) three shall be appointed for terms of 2 years; and 

(iii) three shall be appointed for terms of 3 years. 

(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years. 

(D) VACANCY.—Any member appointed to fill a vacancy occurring before the expiration of the term of the member for whose predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member’s term until a successor has been elected. 

(E) CHAIR.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

(F) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than 3 times during each fiscal year. 

(G) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its functions under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

(H) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account), such sums as are necessary to carry out this section.

(i) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-MEDICARE).—The Secretary shall provide, through the toll-free number 1-800-MEDICARE, for a method by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annular notice under subsection (a) instead of the listing of numbers of individual contractors.

SEC. 302. MISCELLANEOUS ADMINISTRATIVE PROVISIONS. 

(a) ADMINISTRATOR AS MEMBER AND CO-SECRETARY OF THE TRUSTEES OF THE MEDICARE TRUST FUNDS.—The fifth sentence of sections 1817(b) and 1841(b) (42 U.S.C. 1395(b), 1395b(b)) are each amended by striking "and" and inserting "and the Administrator of the Center for Medicare Choices shall serve as co-secretaries". 

(b) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTER FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—Section 3314 of title 5, United States Code, is amended by adding at the end the following: "Administrator of the Centers for Medicare & Medicaid Services." 

(2) CONFORMING AMENDMENT.—Section 3315 of such title is amended by striking "Administrator of the Health Care Financing Administration." 

(c) EFFECTIVE DATE.—The amendments made by this subsection take effect on March 1, 2004.

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM. 

(a) IN GENERAL.—Section 1886(d)(3)(A) (42 U.S.C. 1395ww(d)(3)(A)) is amended—

(i) by striking "(iv)(I) Subject to the succeeding provisions of this clause, for discharges; and"; and 

(ii) by adding at the end the following new subsections:

(i) For discharges occurring during fiscal year 2004, the standardized amount for hospitals located other than in a large urban area shall be increased by 1/2 of the difference between the operating standardized amount determined under subparagraph (i) for hospitals located in large urban areas for such fiscal year and such amount determined (without regard to this subparagraph) for other hospitals for such fiscal year; 

(ii) For discharges occurring in a fiscal year beginning with fiscal year 2005, the Secretary shall compute an operating standardized amount for hospitals located in any area within the United States and within each region equal to the operating standardized amount computed for the previous fiscal year for hospitals located in a large urban area (or, beginning with fiscal year 2006, applicable for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

(b) CONFORMING AMENDMENTS.

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking "IN DIFFERENT AREAS"; 

(B) in the matter preceding clause (i), by striking "(iv)(I) Subject to the succeeding provisions of this clause, for discharges; and"; 

(C) in clause (i)—

(i) in the matter preceding clause (i), by inserting "for fiscal years before fiscal year 2006" before "for hospitals"; 

(ii) in clause (i), by striking "and" and inserting "or"; 

(iii) in the matter preceding clause (i), by inserting "for fiscal years before fiscal year 2005", before "for hospitals"; and 

(iv) in clause (i), by inserting "for fiscal years before fiscal year 2005", before "for hospitals"; and 

(D) in clause (ii), by adding at the end the following new clause:

(iii) For discharges occurring during fiscal year 2004, the standardized amount for discharges occurring during fiscal year 2004 for hospitals located other than in a large urban area shall be increased by 1/2 of the difference between the operating standardized amount determined under subparagraph (i) for hospitals located in large urban areas for such fiscal year and such amount determined (without regard to this clause) for other hospitals for such fiscal year; 

(ii) For discharges occurring in a fiscal year beginning with fiscal year 2005, the Secretary shall compute an operating standardized amount for hospitals located in any area within the United States and within each region equal to the operating standardized amount computed for the previous fiscal year for hospitals located in a large urban area (or, beginning with fiscal year 2006, applicable for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.

(c) IMPOSSIBLE TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX

(a) IN GENERAL.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(i) by striking "(iv) Subject to the succeeding provisions of this clause, for discharges; and"; and 

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

(i) Alternative proportion to be adjusted beginning in fiscal year 2004. 

(ii) In general.—Except as provided in clause (ii), for discharges occurring on or after October 1, 2003, the Secretary shall substitute 62 percent for the proportion described in the first sentence of clause (i). 

(b) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E)(ii) (42 U.S.C. 1395ww(d)(3)(E)(ii)), as amended by subsection (a), is amended by adding at the end the following new sentence: "The Secretary shall apply the succeeding sentence for any period as if the amendments made by section 402(a) of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted." 

(c) MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS. 

Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended by adding at the end the following new paragraph:
"(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—
"(A) PAYMENT ADJUSTMENT.—
"(i) IN GENERAL.—Notwithstanding any other provision of this section, for each cost reporting period (beginning with the cost reporting period that begins in fiscal year 2004), the Secretary shall provide for an additional payment to each low-volume hospital (as defined in clause (iii)) for discharges occurring during that cost reporting period which is equal to the amount paid to such hospital under this section for such discharges.

(ii) APPLICABLE PERCENTAGE INCREASE.—The Secretary shall determine a percentage increase applicable under this paragraph that ensures that—

(I) no percentage increase in payments under this paragraph exceeds 25 percent of the amount of payment that would (but for this paragraph) otherwise be made to a low-volume hospital under this section for each discharge;

(II) low-volume hospitals that have the lowest number of discharges during a cost reporting period receive the highest percentage increase due to the application of this paragraph; and

(III) the percentage increase in payments to any low-volume hospital due to the application of this paragraph is reduced as the number of discharges per cost reporting period increases.

(iii) LOW-VOLUME HOSPITAL DEFINED.—For purposes of this paragraph, the term "low-volume hospital" means, for a cost reporting period, a subsection (d) hospital (as defined in paragraph (3)(B)(ii) other than a critical access hospital (as defined in section 1861(mm)(1)) that—

(I) the Secretary determines had an average of less than 2,000 discharges (determined in paragraph (3)(B)(ii)) other than a critical access hospital (as defined in section 1861(mm)(1)) that—

(A) in the heading—

(i) by inserting "and before October 1, 2003," after "April 1, 2001;" and

(ii) by inserting "or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii) after "clause (xii);" and

(B) the following new clause:

(II) by inserting "and before October 1, 2003," after "April 1, 2001;" and

(III) by inserting "or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii) after "clause (x) or (xii);"

(iv) in subclause (V)—

(I) by inserting "and before October 1, 2003," after "April 1, 2001;" and

(II) by inserting "or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii) after "clause (x) or (xii);"

SEC. 405. CRITICAL ACCESS HOSPITAL (CAH) IMPROVEMENTS.

(a) PERMITTING CAHS TO ALLOCATE SWING BEDS AND ACUTE CARE INPATIENT BEDS SUBJECT TO A TOTAL LIMIT OF 25 BEDS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395w(d)(2)(B)(iii)) is amended to read as follows:

"(iii) provides not more than a total of 25 extended care service beds (pursuant to an agreement under section (d) and acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined by the Secretary, an annual, average basis, 96 hours per patient;".

(b) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395w(d)(f)) is amended by striking "and the number of beds used at any time for acute care inpatient services does not exceed 15 beds".

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to discharges occurring on or after October 1, 2003.

SEC. 406. CRITICAL ACCESS HOSPITAL (CAH) IMPROVEMENTS.

(a) PERMITTING CAHS TO ALLOCATE SWING BEDS AND ACUTE CARE INPATIENT BEDS SUBJECT TO A TOTAL LIMIT OF 25 BEDS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395w(d)(2)(B)(iii)) is amended to read as follows:

"(iii) provides not more than a total of 25 extended care service beds (pursuant to an agreement under section (d) and acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined by the Secretary, an annual, average basis, 96 hours per patient;".

(b) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395w(d)(f)) is amended by striking "and the number of beds used at any time for acute care inpatient services does not exceed 15 beds".

(c) EFFECTIVE DATE.—The amendments made by this subsection shall apply to discharges occurring on or after October 1, 2003.

SEC. 407. ELIMINATION OF THE ISOLATION TEST FOR COST-BASED CAH AMBULANCE SERVICES.—

(a) ELIMINATION.—In general.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(I) in the heading—

(i) by striking "(C) AMOUNT OF GRANT .—A grant to a hospital under this paragraph may not exceed $50,000."

(II) by inserting after paragraph (3) the following new paragraph:

"(A) GRANTS TO HOSPITALS.—The Secretary shall make grants to hospitals that have submitted applications in accordance with subparagraph (B) to assist eligible rural hospitals (as defined in paragraph (3)(B)) in meeting the costs of reducing medical errors, increasing patient safety, protecting patient privacy, and improving hospital quality and performance.

(B) APPLICATION.—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

(C) AMOUNT OF GRANT.—A grant to a hospital under this paragraph may not exceed $50,000.

(D) USE OF FUNDS.—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff, and obtaining technical assistance.

(E) EFFECTIVE DATE.—Section 1820(c)(2)(B) to assist eligible rural hospitals (as defined in paragraph (3)(B)) in meeting the costs of reducing medical errors, increasing patient safety, protecting patient privacy, and improving hospital quality and performance.

(F) PROVISIONS RELATED TO CERTAIN RURAL GRANTS.—

(1) SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM.—Section 1820(g) (42 U.S.C. 1395g–4(g)) is amended—

(A) by redesignating paragraph (3)(F) of section 1820(g) as paragraph (5) and redesignating and indenting paragraph (5) appropriately; and

(B) by inserting after paragraph (3) the following new paragraph:

"(A) GRANTS TO HOSPITALS.—The Secretary shall make grants to hospitals (as defined in paragraph (3)(B)) that have submitted applications in accordance with subparagraph (B) to assist eligible rural hospitals in meeting the costs of reducing medical errors, increasing patient safety, protecting patient privacy, and improving hospital quality and performance.

(B) APPLICATION.—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

(C) AMOUNT OF GRANT.—A grant to a hospital under this paragraph may not exceed $50,000.

(D) USE OF FUNDS.—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff, and obtaining technical assistance.
(42 U.S.C. 1395w(d)(9)) is amended by adding at the end the following new subparagraph:

"(E) For purposes of subparagraph (A), for discharges occurring—

"(i) between October 1, 1997, and September 30, 1997, the applicable Puerto Rico percentage is 75 percent; and the applicable Federal percentage is 25 percent;

"(ii) on or after October 1, 1997, and before October 1, 2004, the applicable Puerto Rico percentage is 50 percent (and for discharges between October 1, 1997, and September 30, 1997, 75 percent)" and inserting "the applicable Federal percentage (specified in subparagraph (E))"; and

"(2) by adding at the end the following new subparagraph:

"(F) The Secretary shall be defined as the residents' stipends for the training program in that setting. All, or substantially all, of the costs of the training program in that setting shall be defined as the residents' stipends and benefits and other costs, if any, as determined by the Secretary."
an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and
(ii) under a program funded by the Indian Health Service and operated by an Indian Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4) in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services).

(b) Effective Date.—The amendments made by this section shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 6 months after the date of enactment of this Act) to Medicare participation agreements in effect (or entered into) on or after such date.

SEC. 413. GAO STUDY AND REPORT ON APPROPRIATE FLOOR PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES.

(a) Study.—The Comptroller General of the United States, using the most current data available, shall conduct a study to determine—

(1) the appropriate level and distribution of payments in relation to costs under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for inpatient hospital services furnished by subsection (d) hospitals (as defined in subsection (d)(2)(B) of such section); and

(2) a need to adjust such payments under such system to reflect legitimate differences in costs across different geographic areas, kinds of hospitals, and types of cases.

(b) Report.—Not later than 24 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.

Subtitle B—Provisions Relating to Part B

SEC. 421. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC ADJUSTMENTS OF PAYMENTS FOR PHYSICIANS’ SERVICES.

Section 1848(e)(3) (42 U.S.C. 1395ww(e)(3)) is amended—

(1) in subparagraph (A), by striking "subparagraphs (B) and (C)" and inserting "subparagraphs (B)(i) and (C)"; and

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

"(E) FLOOR FOR WORK GEOPGRAPHIC INDICES.—

"(i) In General.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2006, the composite rate for such services shall be increased by 1.6 percent under section 1881(b)(12) of such Act (42 U.S.C. 1395r(b)(12)), as added by section 423(b)(5).

"(ii) Work Floor Index.—For purposes of clause (i), the term ‘composite floor index’ means—

"(I) 0.980 with respect to services furnished during 2004; and


"(iii) FLOOR FOR PRACTICE EXPENSE AND MALPRACTICE GEOGRAPHIC INDICES.—For purposes of payment for services furnished on or after January 1, 2005, and before January 1, 2006, after calculating the practice expense and malpractice indices in clauses (i) and (ii) of paragraph (B)(7)(D)(iii) of section 1886(d)(3)(D)(iii) (42 U.S.C. 1395ww(d)(3)(D)(iii)), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.

SEC. 422. MEDI CARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS.

(a) Procedures for Secretary, and Not Physicians, to Determine When Bonus Payments Under Medicare Incentive Payment Program (or Part B) under Section 1833(m) (42 U.S.C. 1395l(m)) is Amended—

(1) by inserting ‘‘(i)’’ after ‘‘(ii)’’; and

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

‘‘(2) The Secretary shall establish procedures under which the Secretary, and not the physician furnishing the service, is responsible for determining when a payment is required to be made under paragraph (1).’’

(b) Educational Program Regarding the Medicare Incentive Payment Program.—The Secretary shall establish and implement an ongoing educational program to provide education to physicians under the Medicare program on the Medicare incentive payment program:

(1) Ongoing Study.—The Secretary shall conduct an ongoing study on the Medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395l(m)). Such study shall focus on whether such program is achieving the access of medical care to those who reside in a rural area that is designated under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area to physicians’ services under the Medicare program.

(2) Annual Reports.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1) together with recommendations as the Comptroller General considers appropriate.

(c) Ongoing GAO Study and Annual Reports on the Medicare Incentive Payment Program.—

(1) Ongoing Study.—The Comptroller General of the United States shall conduct an ongoing study on the Medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395l(m)). Such study shall focus on such program and report to the Congress annually the results of the study and any recommendations as the Comptroller General determines appropriate.

SEC. 422. INCREASE IN RENAL DIALYSIS COMPENSATION.

Notwithstanding any other provision of law, with respect to payment under part B of title XVIII of the Social Security Act for renal dialysis services furnished in 2005 and 2006, the composite rate for such services shall be increased by 1.6 percent under section 1881(b)(12) of such Act (42 U.S.C. 1395r(b)(12)), as added by section 423(b)(5).

SEC. 424. ESTABLISHMENT OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND TREATMENT OF CERTAIN INPATIENT HOSPITALS TO LIMIT DECLINE IN PAYMENT UNDER THE OPP PS.

(a) SMALL RURAL HOSPITALS.—Section 1833(t)(7)(D) (42 U.S.C. 1395l(t)(7)(D)) is amended by striking ‘‘2004’’ and inserting ‘‘2006’’.

(b) SMALL COMMUNITY HOSPITALS.—Section 1833(t)(7)(B) (42 U.S.C. 1395l(t)(7)(B)) is amended by striking ‘‘January 1, 2004’’ and inserting ‘‘January 1, 2006’’.

SEC. 425. INCREASE IN PAYMENTS FOR CERTAIN SERVICES FURNISHED BY SMALL RURAL AND SOLE COMMUNITY HOSPITALS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) Increase.—

(1) In General.—In the case of an applicable covered OPD service (as defined in paragraph (2) that is furnished in 2005, 2006, and 2007.

(2) In General.—In the case of an applicable covered OPD service (as defined in paragraph (2)(i) that is furnished in 2005, 2006, and 2007.

(3) In General.—In the case of an applicable covered OPD service (as defined in paragraph (2)(i) that is furnished in 2005, 2006, and 2007.

(b) Effective Date.—The amendments made by this section shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 6 months after the date of enactment of this Act) to Medicare participation agreements in effect (or entered into) on or after such date.
such rates otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent.

"(B) APPLICATION OF INCREASED PAYMENTS AFTER 2003.—The payment under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph for a subsequent year.

SEC. 427. ENSURING APPROPRIATE COVERAGE OF AIR AMBULANCE SERVICES UNDER AMBULANCE FEE SCHEDULE.

(a) COVERAGE.—Section 1834(l)(42 U.S.C. 1395m(l)), as amended by section 426, is amended by adding at the end the following new paragraph:

"(1) ENSURING APPROPRIATE COVERAGE OF AIR AMBULANCE SERVICES.—

"(A) IN GENERAL.—The regulations described in section 1881(s)(7) shall ensure that air ambulance services (as defined in subparagraph (C)) are reimbursed under this subsection at the rate of 100 percent of the reasonable costs of the transport; and

"(B) COMPLIES WITH REQUIREMENTS ESTABLISHED BY THE SECRETARY.—For purposes of this paragraph, the term "air ambulance service" means an air ambulance service that—

"(i) is medically necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport;

"(ii) complies with equipment and crew requirements established by the Secretary.

"(C) MEDICALLY NECESSARY.—An air ambulance service shall be considered to be medically necessary for purposes of subparagraph (A)(i) if the service is—

"(i) furnished in 2004 or 2005 by a sole community hospital;

"(ii) furnished on or after January 1, 2004.

"(ii) in subparagraph (F)—

"(3) by adding at the end the following new paragraph:

"(3) in paragraph (2)(A) after "per visit;" and

"(4) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as so defined) applicable to primary care services (as so defined) furnished as of the first day of that year.

SEC. 430. ELIMINATION OF CONSOLIDATED BILLING FOR CERTAIN SERVICES UNDER THE MEDICARE PPS FOR SKILLED NURSING FACILITY SERVICES.

(a) CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Section 1888(e)(42 U.S.C. 1395y(e)) is amended—

"(1) in paragraph (2)(A)(i)(II), by striking "clauses (ii) and (iii)" and inserting "clauses (ii), (iii), and (iv)";

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

"(3) in subparagraph (B)(iii), by striking "a subsequent year" and inserting "2003"; and

"(3) by adding at the end the following new clauses:

"(ix) for each of the years 2004 through 2010—

"(C) MEDICALLY NECESSARY.—An air ambulance service shall be considered to be medically necessary for purposes of subparagraph (A)(i) if the service is—

"(i) furnished in 2004 or 2005 by a sole community hospital;

"(ii) furnished on or after January 1, 2004.

"(ii) in subparagraph (F)—

"(3) by adding at the end the following new paragraph:

"(3) in paragraph (2)(A) after "per visit;" and

"(4) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as so defined) applicable to primary care services (as so defined) furnished as of the first day of that year.

SEC. 431. FREEZE IN PAYMENTS FOR CERTAIN ITEMS OF DURABLE MEDICAL EQUIPMENT.

(a) FREEZE FOR DME.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

"(1) in subparagraph (E), by striking "and" at the end;

"(2) in subparagraph (F)—

"(A) by striking "a subsequent year" and inserting "2003"; and

"(B) by striking "the previous year." and inserting "2002"; and

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

"(G) for each of the years 2004 through 2010—

"(i) in the case of class III medical devices described in section 513(k) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage increase described in subparagraph (B) for the year involved; and

"(ii) in the case of covered items not described in clause (i), 0 percent points; and

"(iii) in the case of covered items described in subparagraph (B) for the year involved.

(b) FREEZE FOR OFF-THE-SHELF ORTHOTICS.—Section 1834(h)(4)(A) of the Social Security Act (42 U.S.C. 1395m(h)(4)(A)) is amended—

"(1) in clause (vii), by striking "and" at the end;

"(2) in clause (viii), by striking "a subsequent year" and inserting "2003"; and

"(3) by adding at the end the following new clauses:

"(ix) for each of the years 2004 through 2010—

"(C) MEDICALLY NECESSARY.—An air ambulance service shall be considered to be medically necessary for purposes of subparagraph (A)(i) if the service is—

"(i) furnished in 2004 or 2005 by a sole community hospital;

"(ii) furnished on or after January 1, 2004.

"(ii) in subparagraph (F)—

"(3) by adding at the end the following new paragraph:

"(3) in paragraph (2)(A) after "per visit;" and

"(4) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as so defined) applicable to primary care services (as so defined) furnished as of the first day of that year.

SEC. 432. IMPROVEMENT IN RURAL HEALTH CLINIC REIMBURSEMENT.

Section 1395ww(d)(5)(D)(iii) is amended—

"(1) in paragraph (3), by striking "and" and at the end inserting a semicolon; and

"(2) in paragraph (4)(A) by striking "in a subsequent year" and inserting "in 1996 through 2003"; and

"(3) by striking the period at the end and inserting "and after that".

SEC. 433. IMPROVEMENT IN RURAL HEALTH CLINIC REIMBURSEMENT.


"(1) by striking "and" and at the end inserting a semicolon; and

"(2) by striking the period at the end and inserting "and after that year".
"(D) Items and Services Described.—The items and services described in this subparagraph are covered items (as defined in paragraph (13)) for which payment may otherwise be made under this subsection. Other than items used in infusion, and inhalation drugs used in conjunction with durable medical equipment, the term ‘drug or biological’ includes any item used to treat a disease or illness and any item used in conjunction with durable medical equipment."

"(E) Phased-in Implementation.—The application of the quality standards described in paragraph (A) shall be phased-in over a period that the Secretary determines appropriate.

SEC. 432. Application of Coinsurance and Deductible for Clinical Diagnostic Laboratory Tests.

(a) Coinsurance.

(1) In general.—Section 1833(a) (42 U.S.C. 1395f(a)) is amended—

(A) in paragraph (2)(D)(i), by striking ‘‘(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis)’’; and

(B) in paragraph (2)(D)(i), by striking ‘‘(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1833(a).’’

(2) Conforming Amendment.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A)) is amended—

(A) in paragraph (4), by striking ‘‘and with respect to clinical diagnostic laboratory tests for which payment is made under part B’’; and

(B) in paragraph (5), by striking ‘‘and with respect to clinical diagnostic laboratory tests for which payment is made under part B’’.

(b) Deductible.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395f(b)) is amended—

(1) in paragraph (1), by striking ‘‘equal to 95 percent of the average wholesale price’’ and inserting ‘‘equal to—

(A) in the case of a drug or biological furnished prior to January 1, 2004, 95 percent of the average wholesale price; and

(B) in the case of a drug or biological furnished on or after January 1, 2004, the amount specified in—

(i) in the case of such a drug or biological that is first available for payment under this part on or before April 1, 2003, paragraph (4); and

(ii) in the case of such a drug or biological that is first available for payment under this part after such date, paragraph (5).’’; and

(2) by adding at the end the following new paragraphs:

(A) Subject to subparagraph (C), the amount specified in this paragraph for a year for a drug or biological is an amount equal to the lesser of—

(i) the average wholesale price for the drug or biological; or

(ii) the amount determined under subparagraph (B); and

(B)(i) Subject to clause (ii), the amount determined under this subparagraph is an amount equal to—

(I) in the case of a drug or biological furnished in 2004, 85 percent of the average wholesale price for the drug or biological (determined as of April 1, 2003); and

(II) in the case of a drug or biological furnished in 2005 or a subsequent year, the amount determined under this subparagraph for the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with J une of the previous year.

(ii) in the case of a vaccine described in subparagraph (A) or (B) of section 1861(s)(10), the amount determined under this subparagraph is an amount equal to the average wholesale price for the drug or biological; and

(C)(i) The Secretary shall establish a market price for a drug or biological for the year,

(ii) in the case of such a drug or biological for which payment may otherwise be made under part B, the amount specified in—

(II) in the case of such a drug or biological for the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

(iii) the information described in this clause is the following information.

(iv) Other data and information as determined appropriate by the Secretary.

(III) If the Secretary makes a determination under clause (i) with respect to the widely available market price for a drug or biological for the previous year, the following provisions shall apply.

(I) Subject to clause (iv), the amount determined under this subparagraph shall be substituted for the amount determined under subparagraph (B) for purposes of applying subparagraph (A)(ii) for the year and all subsequent years.

(II) The Secretary may make subsequent determinations under clause (i) with respect to the widely available market price for the drug or biological.

(III) If the Secretary does not make a subsequent determination under clause (i) with respect to the widely available market price for the drug or biological for a year, the amount determined under subparagraph (A)(ii) shall be an amount equal to the amount determined under this subparagraph for the previous year increased by the percentage increase described in subparagraph (B)(i)(ii) for the year involved.

(IV) If the first determination made under clause (i) with respect to the widely available market price for a drug or biological would result in a payment amount in a year that is more than 15 percent less than the amount determined under subparagraph (B) for the drug or biological for the previous year (or, for 2004, the amount determined under paragraph (1)(A), determined as of April 1, 2003), the Secretary shall provide for a transition to the amount determined under clause (i) so that the payment amount is reduced in annual increments equal to 15 percent of the amount determined under clause (i), as increased each year by the percentage increase in the consumer price index for medical care for the 12-month period ending with January 1, 2004 (even if the generic version of the drug or biological is not marketed under the chemical name of such drug or biological)."

"(S) In the case of a drug or biological that is first available for payment under this part after April 1, 2003, the following rules shall apply—

(A) As a condition of obtaining a code to report such new drug or biological and to receive payment under this part, a manufacturer shall provide the Secretary (in a timely, manner, and form approved by the Secretary) with data and information on prices at which the manufacturer estimates physicians and suppliers will be able to routinely obtain the drug or biological during the first year that the drug or biological is available for payment under this part and such additional information that the manufacturer determines appropriate.

(B) During the year that the drug or biological is first available for payment under this part, the manufacturer of the drug or biological shall provide the Secretary (in a timely, manner, and form approved by the Secretary) with updated information on the actual market prices paid by such physicians and suppliers for the drug or biological in the year.

(C) The amount specified in this paragraph for a drug or biological for the year determined under subparagraph (A) is equal to an amount determined by the Secretary based on the information provided under subparagraph (A) and other information that the Secretary determines appropriate.

(D) The amount specified in this paragraph for a drug or biological for the year following the year described in subparagraph (B) is equal to an amount determined by the Secretary based on the information provided under subparagraph (B) and other information that the Secretary determines appropriate.

(E) The amount specified in this paragraph for a drug or biological for the year beginning after the year described in subparagraph (D) and each subsequent year is equal to the lesser of—

(i) the average wholesale price for the drug or biological; or

(ii) the amount determined—

(I) by the Secretary under paragraph (4)(C)(i) with respect to the widely available market price for the drug or biological for the previous year (as determined by substituting ‘‘the payment determined under paragraph (5)(E)(ii) for the year’’ for ‘‘established under subparagraph (B) for the year’’); and

(II) if no description determined in subclause (I) is made for the drug or biological for the year, under this subparagraph with respect to the drug or biological for the previous year increased by the percentage increase described in paragraph (4)(B)(ii)(I) for the year involved.

(b) Adjustments to Payment Amounts for Administration of Drugs and Biologicals.—

(1) Adjustment in Physician Practice Expense Relative Value Units.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)) is amended—

(A) in subparagraph (B)—

(i) in clause (ii), by striking ‘‘ adjustments’’ and inserting ‘‘Subject to clause (iv), the adjustments’’; and

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

(II) Exemption from Budget Neutrality in 2004.—Any additional expenditures under this part that are attributable to subparagraph (H) shall not be taken into account in applying the budget neutrality provisions of section 1802.
(H) ADJUSTMENTS IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR DRUG ADMINISTRATION SERVICES FOR 2004.—In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished in 2004, the Secretary shall, in determining practice expense relative value units under this subsection, utilize a survey submitted to the Secretary as of January 1, 2003 by a physician specialty organization pursuant to section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 if that survey—

(i) covers practice expenses for oncology administration services; and

(ii) is established by the Secretary for acceptance of such surveys.

(2) PAYMENT FOR MULTIPLE CHEMOTHERAPY AGENTS FURNISHED ON A SINGLE DAY THROUGH THE PUSH TECHNIQUE.—

(A) REVIEW OF POLICY.—The Secretary shall review the policy, as in effect on the date of enactment of this Act, with respect to payment under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for the administration of more than 1 anticancer chemotherapy agent to an individual on a single hospital inpatient stay.

(B) MODIFICATION OF POLICY.—After conducting the review under subparagraph (A), the Secretary shall modify such payment policy, as determined by the Secretary, to determine such modification to be appropriate.

(C) EXEMPTION FROM BUDGET NEUTRALITY UNDER PHYSICIAN FEE SCHEDULE.—If the Secretary implements payment policy pursuant to subparagraph (B), any increased expenditures under title XVIII of the Social Security Act resulting from such modification shall be treated as additional expenditures attributable to subparagraph (H) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as added by paragraph (1)(B) of section 434 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

(D) ADMINISTRATION OF BLOOD CLOTTING FACTORS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4) and (6), is amended—

(iii) in paragraphs (4) and (5) and such separate payments for such factors for the years after 2004, the Secretary shall, as estimated by the Secretary, increase the composite rate for dialysis services furnished in 2004 or a subsequent year, the composite rate for such services shall be determined under paragraph (12), and—

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

(10) In the case of dialysis services furnished in 2004, the composite rate for such services shall be the composite rate that would otherwise apply under paragraph (7) for the year increased by an amount to ensure (as estimated by the Secretary) that—

(i) the sum of the total amount of—

(A) the composite rate payments for such services for the year, as increased under this paragraph; and

(B) the payments for drugs and biologicals (other than erythropoietin) furnished in connection with the furnishing of renal dialysis services and separately billed by renal dialysis facilities under paragraphs (4) and (5) of section 1841(o) for the year; is equal to

(ii) the sum of the total amount of the composite rate payments under paragraph (7) for the year and the payments for the separately billed drugs and biologicals described in clause (i)(I) that would have been made if the amendments made by section 439 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

(ii) the total amount of payment for drugs and biologicals described in clause (i)(I) that would have been made if the Secretary had not implemented a reduction in payment amount described in subparagraph (A)(iii) that is equal to the total amount of the composite rate payments under paragraph (7) for the year and the payments for the separately billed drugs and biologicals described in subparagraph (A)(iii) that would have been made if the reduction in payment amount described in subparagraph (A) had not been made.

(ix) There shall be no administrative or judicial review under section 1871, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under this paragraph.

(E) HOME INFUSION DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraph (4), is amended by adding at the end the following new paragraph:

(4) INCREASE IN COMPOSITE RATE FOR END STAGE RENAL DISEASE FACILITIES.—Section 1881(b)(2) (42 U.S.C. 1395rr(b)(2)), as amended by paragraph (1) of section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

(7) INHALATION DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4) and (6), is amended by adding at the end the following new paragraph:

(8) ADMINISTRATION OF BLOOD CLOTTING FACTORS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4) and (6), is amended by adding at the end the following new paragraph:

(9) PHARMACY DISPENSING FEE FOR CERTAIN DRUGS AND BIOLOGICS.—Section 1842(o)(2) (42 U.S.C. 1395w–4(o)(2)) is amended to read as follows:

(2) If payment for a drug or biological is made to a licensed pharmacy covered under section 1861(s)(2) and an oral drug described in subparagraph (Q) or (T) of such section, shall
pay a dispensing fee determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts) to the pharmacy; and

"(B) in the case of a drug or biological not described in subparagraph (A), may pay a dispensing fee determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts) to the pharmacy.".

(9) PAYMENT FOR CHEMOTHERAPY DRUGS PURCHASED BUT NOT ADMINISTERED BY PHYSICIANS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6), and (7), is amended by adding at the end the following new paragraph:

"(9)(A) Subject to subparagraph (B), the Secretary shall not pay a dispensing fee determined appropriate the amount of payments to physicians for anticancer chemotherapeutic drugs or biologicals that would otherwise be made under this part in order to compensate such physicians for anticancer chemotherapeutic drugs or biologicals that are purchased by physicians with a reasonable intent to administer to an individual enrolled under this part but which cannot be administered to such individual despite the reasonable efforts of the physician.

"(B) The total amount of increased payments made under subparagraph (A) in a year (as estimated by the Secretary) may not exceed an amount equal to 1 percent of the total amount of payments made under paragraphs (4) and (5) for such anticancer chemotherapeutic drugs or biologicals furnished by physicians in such a year (as estimated by the Secretary)."

(10) REIMBURSEMENTS FOR DRUG ADMINISTRATION.—The Secretary shall not implement the revisions in payment amounts for a category of drug or biological as a result of the amendment made by subsection (a) unless the Secretary determines that the revisions are appropriate to pay the increased costs for each drug and biological at the 95 percent confidence level; and

(11) PHYSICIAN FEE SCHEDULE.—Section 1848(b)(1)(II) (42 U.S.C. 1395v–4(II))(II)) is amended—

(A) in subparagraph (D), by striking "and" and inserting "and" at the end;

(B) in subparagraph (E), by striking the period at the end and inserting ";" and";

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

"(F) adjustments in practice expense relative value units under subsection (cl)(2)(H);"

(12) MULTIPLE CHEMOTHERAPY AGENTS AND OTHER SERVICES CURRENTLY ON THE NON-PHYSICIAN WORK FLOW.—There shall be no administrative or judicial review under section 1899, section 1879, subsection (a) of section 1855, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (2) and (3) of subsection (b).

(13) STUDY AND REPORT.—Section 1833(t) (42 U.S.C. 1395t(t)) is amended—

(A) by redesignating paragraph (13) as paragraph (14); and

(2) by inserting after paragraph (12) the following new paragraph:

"(13) SPECIAL RULES FOR CERTAIN DRUGS AND BIOLOGICALS.—

(A) BEFORE 2007.—

(i) IN GENERAL.—Notwithstanding paragraph (6), but subject to clause (ii), with respect to a separately payable drug or biological described in subparagraph (D) furnished on or after January 1, 2007, hospitals shall be reimbursed as follows:

"(I) DRUGS AND BIOLOGICALS FURNISHED AS PART OF OTHER OPD SERVICES.—The amount of payment for a drug or biological described in subparagraph (D) provided as part of a service that was a covered OPD service on May 1, 2003, would have been determined using the applicable percentage (as defined in subparagraph (C)) of the average wholesale price for the drug or biological that would have been determined under paragraph (5) of section 1833(t) of the Internal Revenue Code.

"(II) DRUGS AND BIOLOGICALS FURNISHED AS PART OF OTHER OPD SERVICES.—The amount of payment for a drug or biological described in subparagraph (D) provided as part of any other covered OPD service shall be the applicable percentage (as defined in subparagraph (C)) of the average wholesale price for the drug or biological that would have been determined using the applicable percentage (as defined in subparagraph (C)) of the average wholesale price for the drug or biological that would have been determined under paragraph (5) of section 1833(t) of the Internal Revenue Code.

(iii) The Secretary shall conduct 1 or more studies that—

(I) examine the market prices that drugs and biologicals covered under the medicare program are widely available to physicians and suppliers;

(ii) determine the hospital acquisition and handling costs for each individual drug or biological described in subparagraph (D).

(iv) The study conducted under clause (iii) shall provide—

(A) for the fiscal year ending with June 30, 2001, the amount determined under subparagraph (C);

(B) for the fiscal year ending with June 30, 2002, the amount determined under subparagraph (C);

(C) for the fiscal year ending with June 30, 2003, the amount determined under subparagraph (C); and

(D) for the fiscal year ending with June 30, 2004, the amount determined under subparagraph (C).

(ii) For each service on or after January 1, 2005, the amount determined under subparagraph (C) shall increase by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year, rounded to the nearest dollar.

(iii) The Inspector General shall conduct 1 or more studies that—

(A) examine the market prices that drugs and biologicals covered under the medicare program are widely available to physicians and suppliers;

(B) determine the hospital acquisition and handling costs for each drug and biological at the 95 percent confidence level; and

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

"(F) adjustments in practice expense relative value units under subsection (cl)(2)(H);"

(13) SPECIAL RULES FOR CERTAIN DRUGS AND BIOLOGICALS.—

(A) BEFORE 2007.—

(i) IN GENERAL.—Notwithstanding paragraph (6), but subject to clause (ii), with respect to a separately payable drug or biological described in subparagraph (D) furnished on or after January 1, 2007, hospitals shall be reimbursed as follows:

"(I) DRUGS AND BIOLOGICALS FURNISHED AS PART OF OTHER OPD SERVICES.—The amount of payment for a drug or biological described in subparagraph (D) provided as part of a service that was a covered OPD service on May 1, 2003, would have been determined using the applicable percentage (as defined in subparagraph (C)) of the average wholesale price for the drug or biological that would have been determined under paragraph (5) of section 1833(t) of the Internal Revenue Code.

"(II) DRUGS AND BIOLOGICALS FURNISHED AS PART OF OTHER OPD SERVICES.—The amount of payment for a drug or biological described in subparagraph (D) provided as part of any other covered OPD service shall be the applicable percentage (as defined in subparagraph (C)) of the average wholesale price for the drug or biological that would have been determined using the applicable percentage (as defined in subparagraph (C)) of the average wholesale price for the drug or biological that would have been determined under paragraph (5) of section 1833(t) of the Internal Revenue Code.

(iii) The Secretary shall conduct 1 or more studies that—

(I) examine the market prices that drugs and biologicals covered under the medicare program are widely available to physicians and suppliers;

(ii) determine the hospital acquisition and handling costs for each drug and biological described in subparagraph (D).

(iv) The study conducted under clause (iii) shall provide—

(A) for the fiscal year ending with June 30, 2001, the amount determined under subparagraph (C);

(B) for the fiscal year ending with June 30, 2002, the amount determined under subparagraph (C);

(C) for the fiscal year ending with June 30, 2003, the amount determined under subparagraph (C); and

(D) for the fiscal year ending with June 30, 2004, the amount determined under subparagraph (C).

(ii) For each service on or after January 1, 2005, the amount determined under subparagraph (C) shall increase by the percentage increase in the Consumer Price Index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year.

"(B) AFTER 2007.—

(i) ONGOING STUDY AND REPORTS ON ADEQUATE REIMBURSEMENT.—

The Secretary shall submit to Congress a report on any study conducted under paragraph (2) and (3) of section 1833(t) of the Internal Revenue Code.

(ii) STUDY.—The Secretary shall conduct a study to determine the hospital acquisition and handling costs for each individual drug or biological described in subparagraph (D)

(iii) STUDY.—The study conducted under clause (i) shall be the amount established for 2005 increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. average) for the 12-month period ending with June of the previous year.

(iv) ELIGIBLE ORGANIZATION DEFINED.—In this clause, the term "eligible organization" means a private, nonprofit organization within the meaning of section 501(c) of the Internal Revenue Code.

(iii) ESTABLISHMENT OF PAYMENT METHODS.—Notwithstanding paragraph (6), the Secretary, in establishing a payment method under clause (i) or (ii) in determining payment amounts for each drug and biological provided as part of a covered OPD service furnished on or after January 1, 2007, may determine to be appropriate.
"(i) with respect to a biological product (approved under a biologics license application under section 351 of the Public Health Service Act), a single source drug (as defined in section 1927(k)(7)(A)(i)), or an organ product designated under section 526 of the Food, Drug, and Cosmetic Act to which the prospective payment system established under section 1833(t) of the Social Security Act did not apply under the final rule for 2003 payments under such system, 94 percent;

(ii) with respect to an innovator multiple source drug (as defined in section 1927(k)(7)(A)(ii)), 71 percent; and

(iii) with respect to a noninnovator multiple source drug (as defined in section 1927(k)(7)(A)(iii)), 91 percent; and

(D) DRUGS AND BIOLOGICALS DESCRIBED.—A drug or biological described in this paragraph is any drug or biological described in this paragraph.

SEC. 439. MEDICARE COVERAGE OF ROUTINE EQUIVALENCE STANDARD.—

(a) DEFINITIONS.—In this section:

(1) CHIROPRACTIC SERVICES.—The term "chiropractic services" has the meaning given that term by the Secretary for purposes of the demonstration projects, but shall include, at a minimum—

(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and

(B) diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is performed.

(2) DEMONSTRATION PROJECT.—The term "demonstration project" means a demonstration project established by the Secretary under subsection (b)(1).

(3) ELIGIBLE BENEFICIARY.—The term "eligible beneficiary" means an individual who is enrolled under part B of the medicare program.

(b) MEDICARE PROGRAM.—The term "medicare program" means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(c) DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.—

(1) ESTABLISHMENT.—The Secretary shall establish demonstration projects in accordance with the provisions of this section for the purposes of evaluating the feasibility and advisability of covering chiropractic services under the medicare program (in addition to the coverage provided for services consisting of diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is performed). Such demonstration projects shall be conducted in accordance with the provisions of the demonstration projects, but the Secretary may include in the demonstration projects, at a minimum, eligible beneficiaries who are enrolled for coverage under a MedicareChoice plan (or, on and after January 1, 2006, under a MedicareAdvantage plan). No prior approval is required.

In establishing the demonstration projects, the Secretary shall ensure that an eligible beneficiary who participates in a demonstration project, including eligible beneficiaries who are enrolled for coverage under a MedicareChoice plan (or, on and after January 1, 2006, under a MedicareAdvantage plan), is enrolled under a MedicareAdvantage plan (or, on and after January 1, 2006, under a MedicareAdvantage plan) for at least 12 months preceding the date on which the demonstration project is implemented.

(d) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the demonstration projects and shall submit a report to Congress at least once every 2 years beginning with the date that is 1 year after the date on which the demonstration projects conclude, the Secretary...
shall submit to Congress a report on the evaluation conducted under paragraph (1) to gather with such recommendations for legislation or administrative action as the Secretary deems appropriate.

(e) Waiver of Medicare Requirements.—The Secretary shall waive compliance with such requirements of the Medicare program to the extent and for the period the Secretary finds necessary to conduct the demonstration projects.

(f) Implementation.

(1) Demonstration Projects.—

(A) In general.—Subject to subparagraph (B) and paragraph (2), the Secretary shall provide for the demonstration projects referred to in section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(B) Limitation.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.

(2) Evaluation and Report.—There are authorized under this section the amounts necessary for the purpose of developing and submitting the report to Congress under subsection (d).

SEC. 442. Medicare Health Care Quality Demonstration Programs.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866A the following new section:

"Health Care Quality Demonstration Program"

"Sec. 1866C. (a) Definitions.—In this section:

"(1) Beneficiary.—The term ‘beneficiary’ means a beneficiary who is enrolled in the original medicare fee-for-service program under parts A and B or a beneficiary in a staff model or a dedicated group model health maintenance organization under the Medicare+Choice program (or, on and after January 1, 2006, under the Medicare Advantage program) under part C.

"(2) Health care group.—"(A) In general.—The term ‘health care group’ means—

"(i) a group of physicians that is organized at least in part for the purpose of providing physician’s services under this title;

"(ii) an integrated health care delivery system that provides health care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent, or contracted physicians; or

"(iii) an organization representing regional coalitions of groups or systems described in clauses (i) and (ii);"

"(B) Inclusion.—As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such hospital, individual, or entity participates in a demonstration project under this section.

"(3) Physician.—Except as otherwise provided for by the Secretary, the term ‘physician’ includes all individuals who furnish items or services that are paid for as physicians’ services under this title.

(b) Demonstration Projects.—The Secretary shall establish a 5-year demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

"(1) the provision of incentives to improve the safety of care provided to beneficiaries;

"(2) the appropriate best practice guidelines by providers and services by beneficiaries;

"(3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;

"(4) encourage shared decision making between providers and patients;

"(5) the provision of incentives for improving the quality and safety of care and achieving the efficient use of resources;

"(6) the appropriate use of culturally and ethnically sensitive health care delivery; and

"(7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

"(c) Administration by Contract.—

"(1) In general.—Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program under section 1866A is administered in accordance with section 1866A.

"(2) Alternative Payment Systems.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

"(A) encourage the delivery of high quality care while achieving the objectives described in subsection (b); and

"(B) streamline documentation and reporting requirements otherwise required under the demonstration project.

"(3) Benefits.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the traditional fee-for-service program pursuant to paragraph (2) or a package of benefits available through a staff model or a dedicated group model health maintenance organization under part C.

"(d) Implementation.—The Secretary shall implement the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient’s physician) on the basis of the patient’s age or expected length of life or of the patient’s present or predicted disability, degree of medical dependency, or quality of life.

"(e) Eligibility Criteria.—To be eligible to receive assistance under this section, an entity shall—

"(1) be a health care group;

"(2) meet quality standards established by the Secretary, including—

"(A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;

"(B) the implementation of activities to increase the delivery of effective care to beneficiaries (including—

"(i) encouraging patient participation in preference-based decisions; and

"(D) the implementation of activities to encourage the coordination and integration of medical service delivery; and

"(E) the implementation of activities to monitor and document the impact on the health care marketplace of altering the incentives of health care delivery and changing the allocation of resources; and

"(f) Waiver Authority.—The Secretary may waive such requirements of titles XI and XVIII as may be necessary to carry out the purposes of the demonstration program established under this section.

"(g) Notice Requirements.—In the case of an individual that receives health care items or services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules applicable to such individual as a result of the participation of the individual in such program.

"(h) Participation and Support by Federal Agencies.—In carrying out the demonstration program under this section, the Secretary may direct—

"(1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical technologies and improve the foundation for evidence-based practice;

"(2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and

"(3) the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.

"(i) Implementation.—The Secretary shall not implement the demonstration program before October 1, 2004.

SEC. 443. Medicare Complex Clinical Care Management Payment Demonstration.

(a) Establishment.—

"(1) In general.—The Secretary shall establish a demonstration program to make the medicare program more responsive to needs of eligible beneficiaries requiring continuity of care, helping stabilize medical conditions, preventing or minimizing acute exacerbations of chronic conditions, and reducing the use of hospital services, such as adverse drug interactions related to polypharmacy.

"(2) Sites.—The Secretary shall designate 6 sites in which to conduct the demonstration program under this section, of which at least 3 shall be in an urban area and at least 1 shall be in a rural area. One of the sites shall be located in the State of Arkansas.

"(3) Duration.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

"(4) Demonstration Project.—The Secretary shall not implement the demonstration program before October 1, 2004.
(b) Participants.—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a principal care physician who agrees to manage the complex clinical care of the eligible beneficiary under the demonstration program.

(c) Principal Care Physician Responsibilities.—The Secretary shall enter into an agreement with a principal care physician who agrees to manage the complex clinical care of an eligible beneficiary under subsection (b) under which the principal care physician shall:

(1) serve as the primary contact of the eligible beneficiary in accessing items and services for which payment may be made under the Medicare program;

(2) maintain medical information related to care provided by other health care providers who provide health care items and services to the eligible beneficiary, including clinical reports, medication and treatments prescribed by other physicians, hospital and hospital outpatient services, skilled nursing home care, home health care, and medical equipment services;

(3) monitor and advocate for the continuity of care of the eligible beneficiary and the use of evidence-based guidelines;

(4) promote self-care and family caregiver involvement where appropriate;

(5) develop appropriate staffing arrangements to conduct patient self-management and other care coordination activities as specified by the Secretary;

(6) refer the eligible beneficiary to community service organizations and coordinate the services of such organizations with the care provided by health care providers; and

(7) meet such other complex care management requirements as the Secretary may specify.

(d) Complex Clinical Care Management Fee.—

(1) Payment.—Under an agreement entered into under subsection (c), the Secretary shall pay care management organizations a fee for the care management organization is a geographic area.

(2) Budget Neutrality.—In conducting the demonstration program under this section, the Secretary shall submit to Congress a report on such programs for such legislation and administrative action as the Secretary determines to be appropriate.

(h) Definitions.—In this section:

(1) Activity of Daily Living.—The term ‘‘activity of daily living’’ means eating, toileting, transferring, bathing, dressing, and continence.

(2) Chronic Condition.—The term ‘‘chronic condition’’ means a biological, physical, or mental condition that is likely to last a year or more, for which there is no known cure, for which care is needed on a long-term basis that is expected to affect an individual’s ability to conduct patient self-management and which may affect an individual’s ability to carry out activities of daily living or instrumental activities of daily living, or both.

(3) Eligible Beneficiary.—The term ‘‘eligible beneficiary’’ means any individual who—

(A) is enrolled for benefits under part B of the Medicare program;

(B) has at least 4 complex medical conditions (one of which may be cognitive impairment); and

(C) has—

(i) an inability to self-manage their care; or

(ii) a functional limitation defined as an impairment in 1 or more activity of daily living or instrumental activity of daily living.

(4) Institutional Activity of Daily Living.—The term ‘‘institutional activity of daily living’’ means meal preparation, shopping, fund keeping, laundry, money management, telephones, transportation use.

(5) Medicare Program.—The term ‘‘medicare program’’ means the health care programs under titles XV and XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(6) Principal Care Physician.—The term ‘‘principal care physician’’ means the physician with primary responsibility for overall coordination of the care of an eligible beneficiary (as specified in a written plan of care) who may be a primary care physician or a specialist.

SEC. 444. Medicare Fee-For-Service Care Coordination Demonstration Program

(a) Establishment.—

(1) In general.—The Secretary shall establish a demonstration program to contract with qualified care management organizations to provide health risk assessment and care management services to eligible beneficiaries who receive care under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) Sites.—The Secretary shall designate 6 sites at which to conduct the demonstration program under this section. In selecting sites under this paragraph, the Secretary shall give preference to sites located in rural areas.

(b) Duration.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(c) Implementation.—The Secretary shall not implement the demonstration program before October 1, 2004.

(b) Participants.—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a principal care management organization who agrees to furnish care management services to the eligible beneficiary under the demonstration program.

(c) Contracts with CMOS.—

(1) in general.—The Secretary shall enter into a contract with care management organizations to provide care management services to eligible beneficiaries residing in the area served by the care management organization.

(2) Cancellation.—The Secretary may cancel a contract entered into under paragraph (1) if the care management organization does not meet negotiated savings or quality outcomes targets for the year.

(3) Number of CMOS.—The Secretary may contract with more than 1 care management organization in a geographic area.

(d) Payment to CMOS.—

(1) Payment.—Under an agreement entered into under subsection (c), the Secretary shall pay care management organizations a fee for which the care management organization is partially at risk based on bids submitted by care management organizations.

(e) Portion of Payment at Risk.—The Secretary shall establish a benchmark for quality and cost against which the results of the care management organization are to be measured. The Secretary may not pay a care management organization of the fee described in paragraph (1) that is at risk unless the Secretary determines that the care management organization has met the negotiated savings and outcomes targets for the year.

(f) Funding.—

(1) in general.—The Secretary shall provide for the transfer from the Federal Health Insurance Trust Fund established under section 1817 of the Social Security Act (42 U.S.C. 1395j) and the Federal Supplementary Insurance Trust Fund established under section 1814 of such Act (42 U.S.C. 1395w) such amounts as are necessary for the costs of carrying out the demonstration program under this section.

(2) Budget Neutrality.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(g) Waiver Authority.—

(1) in General.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(h) Definitions.—In this section:

(1) Care Management Services.—The term ‘‘care management services’’ means services furnished to an eligible beneficiary (as defined in paragraph (2)) by a care management organization (as defined in paragraph (3)) in accordance with guidelines established by the American Geriatrics Society.
(2) ELIGIBLE BENEFICIARY.—The term ‘eligible beneficiary’ means an individual who is—
(a) entitled to (or enrolled for) benefits under part B and enrolled for benefits under part B of the Social Security Act (42 U.S.C. 1395c et seq.; 1395 et seq.); (b) not enrolled with a Medicare-Choice plan or a MedicareAdvantage plan under part C; and (c) at high-risk (as defined by the Secretary, but including eligible beneficiaries with a non-fee basis or another disabling chronic condition, eligible beneficiaries residing in a nursing home or at risk for nursing home placement, or eligible beneficiaries eligible for assistance under a State plan under title XIX).

(3) CARE MANAGEMENT ORGANIZATION.—The term ‘care management organization’ means an organization that meets such qualifications as the Secretary may specify and includes any of the following: (A) a physician group practice, hospital, home health agency, or other practice; (B) a disease management organization. (C) a Medicare-Choice or MedicareAdvantage organization. (D) insurance carriers offering Medicare supplemental policies under section 1852 of the Social Security Act (42 U.S.C. 1395ss).

(4) CONDUCTED UNDER SUBSECTION (A).—The report shall apply to referrals made under subsection (a) for a period after such subsection—(1) shall not apply to episodes and visits ending after such period; and (2) shall not be taken into account in calculating the payment amounts applicable for such episodes and services occurring after such period.

SEC. 405. INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in subsection (h)(7)) (as defined in section 1886(d)(2)(D)), the total amount payable for such services by the Secretary shall be—
   (1) an assessment of the validity of the geographic adjustment factors used for such area for the previous year; and
   (2) by adding at the end the following new clause:

(ii) LIMITATION ON REDUCTION IN FISCAL YEAR 2005 AND 2006.—For fiscal years 2005, 2006, and 2007, the area wage adjustment factor applicable to home health services furnished in an area in the fiscal year may not be more than 3 percent less than the area wage adjustment factor applicable to home health services for the area for the previous year.

(b) EFFECTIVE DATE.—Subject to paragraph (a), the Secretary shall—
   (i) by striking ‘‘FACTORS.—The Secretary shall’’; and
   (ii) by redesigning paragraph (b) as subparagraph (A) and (B) and inserting after subparagraph (A) the following:

(ii) LIMITATION ON REDUCTION IN FISCAL YEAR 2005 AND 2006.—For fiscal years 2005, 2006, and 2007, the area wage adjustment factor applicable to home health services furnished in an area in the fiscal year may not be more than 3 percent less than the area wage adjustment factor applicable to home health services for the area for the previous year.

(c) CLARIFICATIONS TO CERTAIN EXCEPTIONS TO INCOME LIMITS FOR PHYSICIAN REFERRALS.

(A) LIMITATION ON PAYMENT FOR SUBSTITUTE ADULT DAY SERVICES.

(i) LIMITATION ON PAYMENT FOR SUBSTITUTE ADULT DAY SERVICES.—(A) IN GENERAL.—Subject to clause (ii), the Secretary shall—

   (i) determine by the Secretary—
   (ii) patients with a cardiac condition; and
   (iii) patients with an orthopedic condition; and
   (iv) any other specialized category of patients or cases that the Secretary designates in the plan of care.

   (B) AUTHORITY TO MAKE DETERMINATIONS.—The Secretary may make such determinations in such cases as the Secretary determines in the plan of care.

   (C) DISCLOSURE.—The Secretary shall disclose to the adult day services facility any information regarding the basis for the Secretary’s determination of the plan of care.

   (D) NOTICE.—The Secretary shall notify adult day services facilities of the Secretary’s determinations in the plan of care.

   (E) LIMITATION ON PAYMENT FOR SUBSTITUTE ADULT DAY SERVICES.—(A) IN GENERAL.—Subject to clause (ii), for purposes of this section, except as provided in subsection (B), the Secretary shall not make the determination under clause (i) if the Secretary determines that the determination is based on the plan of care or the plan of care for substitute adult day services furnished by the hospital or the physician.

   (B) DETERMINATION BY THE SECRETARY.—The Secretary shall determine the amount that would otherwise be payable to the adult day services facility for substitute adult day services furnished by the hospital or the physician.

   (C) LIMITATION ON PAYMENT FOR SUBSTITUTE ADULT DAY SERVICES.—(A) IN GENERAL.—Subject to clause (ii), if the Secretary determines that the determination is based on the plan of care or the plan of care for substitute adult day services furnished by the hospital or the physician, the Secretary shall—

   (i) to be in operation before June 12, 2003; or
   (ii) under development as of such date;
   (iii) for which the number of beds and the number of patients in the demonstration program, the Secretary shall—
   (A) to be in operation before June 12, 2003; or
   (B) to be in operation before June 12, 2003; and
   (C) that meets such other requirements as the Secretary may specify.

   (2) OWNERSHIP AND INVESTMENT INTERESTS IN A RURAL PROVIDER.—Section 1877(d)(2)(A) (42 U.S.C. 1395nn(d)(2)(A)) is amended to read as follows:

   (RURAL PROVIDERS.—In the case of designated health services furnished in a rural area (as defined in subsection 1886(d)(2)(D)) by an entity, if—

   (A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area;
   (B) the entity is not a specialty hospital (as defined in subsection (h)(7)); and
   (C) the Secretary determines, with respect to such entity, that such services would not be available in such area but for the ownership or investment interest.

   (EFFECTIVE DATE.—The amendments made by this section shall apply to referrals made for designated health services on or after January 1, 2004.

   (2) APPLICABILITY TO RURAL PROVIDERS UNDER DEVELOPMENT.—For purposes of section 1877(h)(7)(B)(i)(III) of the Social Security Act, as added by subsection (a)(3)(B), in the case of a hospital that is under development as of June 12, 2003, the Secretary shall consider—

   (1) whether architectural plans have been completed, financing has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and
   (2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

   (3) DEMONSTRATION PROGRAM FOR SUBSTITUTE ADULT DAY SERVICES.

   (A) ESTABLISHMENT.—The Secretary shall establish a demonstration program (in this section referred to as the ‘‘demonstration program’’) under which the Secretary will provide eligible Medicare beneficiaries with coverage under the Medicare program for substitute adult day services furnished by an adult day services facility.

   (B) PAYMENT RATE FOR SUBSTITUTE ADULT DAY SERVICES.—(1) PAYMENT RATE.—(A) IN GENERAL.—For purposes of making payments to adult day services facilities under the demonstration program, the following rules shall apply:

   (i) LIMITATION ON PAYMENT AMOUNT.—The Secretary shall estimate the amount that would otherwise be payable to a home health agency under section 1895 of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)) for all home health services described in subsection (i)(4)(B)(I) under the plan of care.

   (ii) AMOUNT OF PAYMENT.—Subject to paragraph (3)(B), the total amount payable for substitute adult day services under the plan of care is equal to 95 percent of the amount estimated to be payable under paragraph (A).

   (2) LIMITATION ON BALANCE BILLING.—Under the demonstration program, an adult day services facility shall accept as payment in full on behalf of any beneficiary any balance billing in an amount not to exceed the amount otherwise payable under the plan of care. In determining the amount otherwise payable under the plan of care, there shall be no reduction in the amount payable under paragraph (A) because of any difference in the amount otherwise payable under the plan of care and the amount otherwise payable under section 1895 of the Social Security Act (42 U.S.C. 1395ss).
(B) INCLUSION.—Notwithstanding subparagraph (A), the term “adult day services facility” shall include a home health agency in which the items and services described in clauses (i) through (iv) of paragraph (4)(B) are provided—

(i) by an adult day services program that is licensed or certified by a State, or accredited, to furnish such items and services in the State; and

(ii) under arrangements with that program made by such agency.

(C) WAIVER OF SURGERY BOND.—The Secretary may waive the requirement of a surgery bond under section 1861(o)(7) of the Social Security Act (42 U.S.C. 1395x(o)(7)) in the case of an agency or organization that provides a comparable surety bond under State law.

(3) ELIGIBLE MEDICARE BENEFICIARY.—The term “eligible Medicare beneficiary” means an individual eligible for home health services under title XVIII of the Social Security Act.

(3) HOME HEALTH AGENCY.—The term “home health agency” has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(4) SUBSTITUTE ADULT DAY SERVICES.—

(A) IN GENERAL.—The term “substitute adult day services” means the items and services described in subparagraph (B) that are furnished to an individual by an adult day services facility as a part of a plan under section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)) that substitutes such services for some or all of the items and services described in subparagraph (B)(i) furnished by a home health agency under the plan, as determined by the physician establishing the plan.

(B) ITEMS AND SERVICES DESCRIBED.—The items and services described in subparagraph (A) are the following items and services:

(i) Items and services described in paragraphs (3) through (7) of such section 1861(m).

(ii) Meals.

(iii) A program of supervised activities designed to improve physical and mental health and furnished to the individual by a home health agency under the plan, as determined by the physician establishing the plan.

(Sec. 465. Make Conditional Payment When Certain Primary Plans Do Not Pay Promptly.)

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY’S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) by striking the first sentence and inserting the following: “A primary plan, and any entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan or any entity that receives payment from such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan’s responsibility for such payment may be demonstrated by a judgment, a payment condition, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means;”;

and

(B) in the final sentence, by striking “on the date such notice or other information is received” and inserting “on the date notice of, or information related to, a primary plan’s responsibility for such payment or other information is received”; and

(2) in subsection (b)(iii), as redesignated by amendment (a)(2), by redesigning the first sentence and inserting the following: “In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3) of this subsection, collect double damages against any such entity. In addition, the United States may recover under this clause from any entity that has received payment from a primary plan or from the proceeds of a primary plan’s payment by or on behalf of such entity”; and

(b) CLERICAL AMENDMENTS.—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking “such” before “paragraphs”. 
TITLE V—MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS

Subtitle A—Regulatory Reform

SEC. 501. RULES FOR THE PUBLICATION OF A FINAL REGULATORY ACTION ON OR AFTER THE DATE OF ENACTMENT OF THIS ACT.—The Secretary shall publish a notice in the Federal Register that there is good cause, specified in a clause (B), for the Secretary to publish an interim final regulation that is based on the interim final regulation that was published on or before the date of publication of the interim final regulation; and (iii) the final regulation shall include responses to comments submitted in response to the interim final regulation.

SEC. 502. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.—(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) (a) is amended by adding at the end the following new subsection: "(i) such retroactive application is necessary to comply with statutory requirements; or (ii) failure to apply the change retroactively would be contrary to the public interest.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of enactment of this Act and for such changes made by paragraph (1) shall apply to substantive changes issued on or after the date of enactment of this Act and shall continue in effect unless the Secretary publishes a notice described in subparagraph (B) by such deadline; and (iii) the final regulation shall include responses to comments submitted in response to the interim final regulation.

(3) AGENCY IMPLEMENTATION.—(A) The Secretary shall publish an interim final regulation that is based on the interim final regulation that was published on or before the date of enactment of this Act and for which no final regulation has been published. Such notice shall include the date by which the Secretary plans to publish the final regulation that is based on the interim final regulation.

SEC. 503. REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by section 502(a)(1), is amended by adding at the end the following new subsection: "(f) Not later than 2 years after the date of enactment of this Act and every 5 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

(2) In preparing a report under paragraph (1), the Secretary shall—

(i) such retroactive application is necessary to comply with statutory requirements; or (ii) failure to apply the change retroactively would be contrary to the public interest.

(3) AGENCY IMPLEMENTATION.—(A) The Secretary shall publish an interim final regulation that is based on the interim final regulation that was published on or before the date of enactment of this Act and for which no final regulation has been published. Such notice shall include the date by which the Secretary plans to publish the final regulation that is based on the interim final regulation.

SEC. 504. REPORT ON THE TRANSFER OF CASE TRACKING.- (a) Submission of Plan for the Transfer of Case Tracking.- (1) IN GENERAL.—Not later than 6 months after the date of enactment of this Act, the Secretary shall develop and submit to Congress and the Comptroller General of the United States a plan for the transfer of case tracking responsibilities to the Department of Health and Human Services. Such plan shall—

(1) evaluate the plan submitted under subsection (b)(2); and (2) not later than 6 months after such submission, submit to Congress, the Commissioner of Social Security and the Secretary a report on such evaluation.

(b) DAVID'S ACT.—(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding a new subsection as follows:

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of enactment of this Act and shall continue in effect unless the Secretary publishes a notice described in subparagraph (B) by such deadline; and (iii) the final regulation shall include responses to comments submitted in response to the interim final regulation.
"(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

"(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services, suppliers, or beneficiaries who has an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)) may obtain access to judicial review when an entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

"(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute, the Departmental Appeals Board, as the case may be, may, upon request by the appellant, determine that an issue of fact in dispute and that the only issues of fact in dispute and that there is no material issue of fact in dispute.

"(C) ACCESS TO JUDICIAL REVIEW.—

"(I) IN GENERAL.—If the appropriate review entity determines that the only issues of fact in dispute and that there is no material issue of fact in dispute, such entity shall be considered a final decision and not subject to review, except as provided in subsection (D).

"(II) clause (i)(I), within 60 days of the date such review entity receives the request, any accompanying documents and materials. Such a determination by such review entity shall be final and not subject to review, except as provided in subsection (D).

"(2) by adding at the end the following new subparagraph:

"(B) An institution or agency described in subparagraph (A) that has filed a hearing under subparagraph (A) shall have expended access to judicial review under this subpart in the same manner as providers of services, suppliers, and beneficiaries may obtain access to judicial review under the process established under section 1819 of this title during the pendency of an appeal under this subpart.

"(c) GAO STUDY AND REPORT ON ACCESS TO JUDICIAL REVIEW.—

"(1) STUDY.—The Comptroller General of the United States shall study the access of Medicare beneficiaries and health care providers to judicial review of actions of the Secretary and the Department of Health and Human Services with respect to items and services under title XVIII of the Social Security Act and subsections (a)(1) and (b) of section 1869 of this title, and shall submit to Congress a report on such study.

"(2) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations as the Comptroller General determines to be appropriate.

"(d) CONFORMING AMENDMENT.—Section 1869(b)(3)(B)(i)(II) of title 42, United States Code, is amended to read as follows:

"(ii) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For purposes of this section, the deadline for good cause.

"(III) clause (i)(I), within 60 days of the end of the period provided under subparagraph (B) for the determination.

"(iii) Venue.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located, or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located or in the District Court for the District of Columbia.

"(4) REQUIREMENTS OF NOTICE OF DETERMINATION.—

"(A) IN GENERAL.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) and 1395f(c)(3)(B)(i) in which—

"(i) a finding of good cause to a date specified by the judge or Board, as the case may be.

"(C) DELAY IN DECISION DEADLINES UNTIL COMPLETION OF RECORD.—Notwithstanding any other provision of this section, the deadline otherwise established under subsection (d) for the making of determinations in hearings or review under this section are 90 days after the date on which the record is complete.

"(D) COMPLETE RECORD DESCRIBED.—For purposes of this paragraph, a record is complete when the administrative law judge, in the case of a hearing, or the Departmental Appeals Board, in the case of a review, has received—

"(i) written or oral argument, or both, submitted by the person filing the request,

"(ii) written or oral argument, or both, the decision of, and the record for, the provider of appeal, see (B) or (D).

"(iii) such other evidence as such judge or Board, as the case may be, determines is required to make a determination on the record.

"(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1395ccc(c)(3)(B)(ii) of title 42, United States Code, is amended by inserting "(including the medical records of the individual involved)" after "clinical experience".

"(c) NOTICE REQUIREMENTS FOR MEDIСARE APPEALS.—

"(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1866(h)(1) of title 42, United States Code, is amended by adding at the end the following new paragraph:

"(B) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395ccc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums for fiscal year 2004 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges and such sums for fiscal year 2004 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges and such staffs at the Departmental Appeals Board of the Department of Health and Human Services to and on long-term care issues.

"(b) AMOUNTS.—Section 1866(h)(1) of title 42, United States Code, is amended by adding at the end the following new paragraph:

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

"(B) for the determination.

"(2) REQUIREMENTS OF NOTICE OF DETERMINATION.—

"(A) IN GENERAL.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) and 1395f(c)(3)(B)(i) in which—

"(i) upon request in the case of an initial determination, the provision of the policy, manual, or regulation that resulted in the denial; and
“(ii) in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination (as appropriate);”

“(B) the procedures for obtaining additional information concerning the decision; and

“(C) notification of the right to appeal such determination and instructions on how to initiate such an appeal under this section;’’.

“(ii) in the case of a determination of whether an item or service is necessary for the diagnosis or treatment of a pre-existing illness or injury (under section 1862(a)(1)(A)) as necessary for the conduct of activities under this section, the term ‘related party’ (as defined in paragraph (3)) includes—

“(A) each reviewing professional (or an employee of such reviewing professional),

“(B) each individual conducting a review (or an employee of such individual),

“(C) an intermediary, carrier, or other contractor, from which the entity—

“(i) is not a related party (as defined in subsection (g)(5)),

“(ii) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

“(iii) does not have a conflict of interest with such a party (as determined under regulations).

“(ii) EXCEPTION FOR COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section for the performance of duties consistent with clause (iii).

“(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.

“(A) Each reviewing professional, whether employed by a contractor or otherwise, is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

“(B) has medical expertise in the field of practice that is appropriate for the items or services at issue.

“(S) RELATED PARTY DEFINED.—For purposes of this section, the term related party means, with respect to a case under this title involving an individual beneficiary, any of the following:

“(A) the Secretary, the Medicare intermediary, carrier, or contractor;

“(B) a qualified independent contractor, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

“(C) the health care professional that provides, with respect to a case under this title involving an individual beneficiary, the items or services involved in the case.

“(D) the institution at which the items or services (or treatment) involved in the case are provided.

“(E) the manufacturer of any drug or other item that is included in the items or services involved in the case.

“(F) Any other party determined under any regulations to have a substantial interest in the case involved.

“(3) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1859(c)(4) (42 U.S.C. 1395f(c)(4)) is amended by striking ‘‘4’’ and inserting ‘‘4’’.

“(e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—

“(1) DELAY IN CERTAIN BIPA REFORMS.—Section 521(d) of BIPA (114 Stat. 2763-543) is amended to read as follows:

“(ii) EFFECTIVE DATE.—

“(I) IN GENERAL.—Except as specified in paragraph (2), the amendments made by this section shall apply with respect to initial determinations made on or after December 1, 2003.

“(II) APPLICABILITY.—The amendment made by this section shall not apply with respect to determinations made on or after October 1, 2003.

“(2) EXPEDITED PROCEEDINGS AND RECONSIDERATION REQUIREMENTS.—For the following provisions, the amendments made by subsection (a) shall apply with respect to initial determinations made on or after December 1, 2003:


“(B) Subsection (c)(3)(C)(iii) of such section.
"(C) Subsection (c)(3)(C)(iv) of such section to the extent that it applies to expedited reconsiderations under subsection (c)(3)(C)(iii) of such section.

(3) CONFORMING USE OF PEER REVIEW ORGANIZATIONS TO CONDUCT EXPEDITED RECONSIDERATIONS UNTIL QCS ARE OPERATIONAL.—

Expedited reconsiderations of initial determinations made under the Social Security Act shall be made by peer review organizations until qualified independent contractors are available for such reconsiderations.

(2) CONFORMING AMENDMENTS.—Section 521(c) of BIPA (114 Stat. 2763A–543) and section 1869(c)(3)(C)(ii)(III) of the Social Security Act (42 U.S.C. 1395ff(c)(3)(C)(ii)(III)), as added by section 521 of BIPA, are repealed.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to items and services furnished on or after such date.

SEC. 517. PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—

(a) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—Section 1869(f)(5) (42 U.S.C. 1395ff(f)(5)) is amended as follows:

"(g) AGGRIEVED PARTY DEFINED.—In this section, the term ‘aggrieved party’ means—

(1) a provider of services, physician, practitioner, or supplier that is adversely affected by such a determination;

(2) any local coverage determination made by or on behalf of the Secretary that is inconsistent with any national coverage determination, or any coverage provision in this title in relation to a local coverage determination that is inconsistent with any national coverage determination, or any coverage provision in this title in relation to such request shall be conducted;".

(b) EFFECTIVE DATE.—The Secretary shall establish a local coverage determination under this section with respect to an item or service.

SEC. 518. PROVIDER ENROLLMENT FORMS.—

(a) HEARING RIGHTS.—

(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

"(g) PROVIDER ENROLLMENT FORMS.

(1) IN GENERAL.—The Secretary shall provide for the establishment of the procedures under the amendment made by paragraph (1) within 18 months after the date of enactment of this Act.

(2) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—Section 1871 (42 U.S.C. 1395hh), as amended by sections 502 and 503, is amended by adding at the end the following new subsection:

"(f) The Secretary shall consult with providers of services, physicians, practitioners, and suppliers before making changes in the provider enrollment forms required of such providers, physicians, practitioners, and suppliers to be eligible to submit claims for which payment may be made under this title.".

SEC. 519. APPEALS WHEN THERE IS NO OTHER PARTY AVAILABLE.—

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395ggg) is amended by adding at the end the following new subsection:

"(b) FEE FLOOD DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 521. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

"(A) APPROVAL OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have not been satisfied, the Secretary shall reject the request for local coverage determination made by the provider local coverage determination request of a fiscal intermediary or carrier after a hearing before an administrative law judge on claims submitted by the provider in accordance with the provisions of this subsection.

(b) EFFECTIVE DATES.—The amendment made by this section shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, included in the enactment of the respective provisions of subtitle C of title V of BIPA, and a carrier under section 1869(f)(5) (42 U.S.C. 1395ff(f)(5)) is amended to read as follows:

"(5) AGGRIEVED PARTY DEFINED.—In this section, the term ‘aggrieved party’ means—

(1) a provider of services, physician, practitioner, or supplier that is adversely affected by such a determination;

(2) any local coverage determination made by or on behalf of the Secretary that is inconsistent with any national coverage determination, or any coverage provision in this title in relation to a local coverage determination that is inconsistent with any national coverage determination, or any coverage provision in this title in relation to such request shall be conducted;".

(d) STUDY AND REPORT ON THE USE OF CONTRACTORS TO MONITOR MEDICARE APPEALS.—

(1) STUDY.—The Secretary shall conduct a study on the feasibility and advisability of requiring fiscal intermediaries and carriers to monitor and track provider subject matter and status of claims denied by the fiscal intermediary or carrier (as applicable) that are appealed under section 1869(f)(5) (42 U.S.C. 1395ff(f)(5)) and any local coverage determination request filed on or after the date of enactment of this Act and any local coverage determination request filed on or after the date of enactment of this Act.

(2) APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the amendments made by subsections (a) and (c).

(f) EFFECTIVE DATES.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendment made by this section shall apply to items and services furnished on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUESTS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests as defined in section 1869(f)(2) of the Social Security Act, as added by section 522 of BIPA (114 Stat. 2763A–543) and amended by this Act; and

(b) any final determination made with respect to such claims.

(2) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under section 521(d) of BIPA (114 Stat. 2763A–543) and amended by this Act; and

(b) any final determination made with respect to such claims.

(2) EFFECTIVE DATES.—The amendment made by subsection (b) shall apply to any review of any local coverage determination filed on or after October 1, 2003.

(b) any request to make such a determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUESTS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests as defined in section 1869(f)(2) of the Social Security Act, as added by subsection (c) filed on or after the date of enactment of this Act.
Title XVIII is amended by inserting after section 1874 the following new section:

"CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS.—

SEC. 1874A. (a) AUTHORITY.—

(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a Medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of any or all of the functions described in paragraph (4) only if—

(A) the entity has demonstrated capability to carry out such function;

(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

(C) the entity has sufficient assets to financially support the performance of such function; and

(D) the entity meets such other requirements as the Secretary may impose.

(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

(A) IN GENERAL.—The term "Medicare administrative contractor" means an agency, organization, or other person with a contract under this section.

(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the 'appropriate' Medicare administrative contractor is the Medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers)

(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment, review of claims, medical necessity determinations, local coverage determinations, and any other Medicare functions necessary in developing local coverage determinations, as defined in section 1869(f)(2)(B)

(a) Determination of Payment Amounts.—Determining (subject to the provisions of sections 1877 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, physicians, practitioners, facilities, suppliers, and individuals.

(b) Making Payments.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for such payments).

(c) Beneficiary Education and Assistance.—Serving as a center for, and communicating to individuals entitled to benefits under part A or enrolled under part B, or both, with respect to education and outreach for those individuals, and assistance with specific issues, concerns, or problems of those individuals.

(d) Provider Consultative Services.—Providing consultative services to institutions, agencies, and other persons to enable them to maintain and maintain medical records necessary for purposes of this title and otherwise to qualify as providers of services, physicians, practitioners, facilities, or suppliers.

(e) Communication with Providers.—Serving as a center for, and communicating to, providers of services, physicians, practitioners, facilities, and suppliers, any information or instructions furnished to the Medicare administrative contractor by the Secretary and effectively and efficiently communicating from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

(f) Provider Education and Technical Assistance.—Performing the functions described in subsections (e) and (f), relating to education, training, and technical assistance, for providers of services, physicians, practitioners, facilities, and suppliers.

(g) Additional Functions.—Performing such other functions, including (subject to paragraph (3) functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title.

(h) Relationship to MIP Contracts.—

(i) Non-Duplication of Activities.—In entering into contracts under this section, the Secretary shall assure that activities of Medicare administrative contractors do not duplicate activities carried out under contracts entered into under the Medicare Integrity Program under section 1893. The provisions with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1862(a)(1)(A)(iv)) shall apply to contracts under this title.

(ii) Use of Competitive Procedures.—

(I) A Non-Duplication of Activities.—In entering into contracts under this section, the Secretary shall assure that activities of Medicare administrative contractors do not duplicate activities carried out under contracts entered into under the Medicare Integrity Program under section 1893. The provisions with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1862(a)(1)(A)(iv)) shall apply to contracts under this title.

(J) Use of Competitive Procedures.—

(K) Development of Specific Performance Requirements.—The Secretary shall develop contract performance requirements to the extent that such requirements are applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements. The Secretary shall make such requirements and measurement standards available to the public.

(L) Considerations.—The Secretary shall include, as 1 of the standards, provider and beneficiary satisfaction levels.

(M) Inclusion in Contracts.—All contract performance requirements shall be set forth in the contract between the Secretary and the appropriate Medicare administrative contractor. Such performance requirements shall—

(i) reflect the performance requirements published under subparagraph (A), but may include additional performance requirements applicable to providers of services, physicians, practitioners, facilities, and suppliers;

(ii) be used for evaluating contractor performance under the contract; and

(iii) shall be consistent with the written statement of work provided under the contract.

(N) Information Requirements.—The Secretary shall not enter into a contract with a Medicare administrative contractor under this section unless the contractor agrees—

(i) to furnish to the Secretary such timely information and reports as the Secretary may find pertinent or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate;

(ii) to retain diversity of local coverage determinations—A contract with a Medicare administrative contractor under this section may require the Medicare administrative contractor, and any of its officers, employees, consultants or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate;

(iii) to retaining diversity of local coverage determinations—A contract with a Medicare administrative contractor under this section may require the Medicare administrative contractor, and any of its officers, employees, consultants or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate;

(iv) to retaining diversity of local coverage determinations—A contract with a Medicare administrative contractor under this section may require the Medicare administrative contractor, and any of its officers, employees, consultants or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate;

(v) to retaining diversity of local coverage determinations—A contract with a Medicare administrative contractor under this section may require the Medicare administrative contractor, and any of its officers, employees, consultants or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate; and

(vi) to retaining diversity of local coverage determinations—A contract with a Medicare administrative contractor under this section may require the Medicare administrative contractor, and any of its officers, employees, consultants or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate;
(c) Appoint a contractor advisory committee with respect to each such State to provide a formal mechanism for physicians in the State to be informed of, and participate in the development of, a local coverage determination in an advisory capacity.

(c) Terms and Conditions.—

(1) In general.—Subject to subsection (a)(6), any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

(2) Prohibition on mandates for certain data collection.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the Medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

(d) Limitation on liability of Medicare administrative contractors and certain officers.—

(1) Certifying officer.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of his obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by such individual under this section.

(2) Disbursing officer.—No disbursing officer shall, in the absence of the reckless disregard of his obligations or the intent by that officer to defraud the United States, be liable with respect to any payment made by such officer under this section if it was based upon an authorization (which meets the requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

(3) Liability of Medicare administrative contractor.—No Medicare administrative contractor shall be liable to the United States for any payment made by a certifying officer unless, in connection with such a payment, the Medicare administrative contractor acted with reckless disregard of its obligations under its contract to defraud the United States, or with intent to defraud the United States.

(4) Relationship to false claims act.—Nothing in this section shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the "False Claims Act").

(5) Indemnification by Secretary.—

(A) In general.—Notwithstanding any other provision of law and subject to the succeeding proviso in this paragraph, in the case of a Medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process who is made a party to any judicial or administrative proceeding arising from, or relating directly to, the claims administration process under this title, the Secretary may, to the extent specified in the contract with the contractor, indemnify the contractor (and such persons).

(B) Conditions.—The Secretary may not provide indemnification under subparagraph (A) so as to limit the liability of such contractor and such persons.

(c) Scope of indemnification.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards of costs (including reasonable legal expenses).

(d) Written approval for settlement.—A contractor or other person described in paragraph (a)(4) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate a settlement. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement are conditioned upon the Secretary's prior written approval of the final settlement.

(e) Construction.—Nothing in this paragraph shall be construed—

(i) to change any common law immunity that may be available to a Medicare administrative contractor or person described in subparagraph (A); or

(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.

(2) Consideration of incorporation of current laws and standards.—Developing contract performance requirements under section 1874A(b) of the Social Security Act (as added by paragraph (1)) the Secretary shall consider the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and appeals), section 1874A(h) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of enactment of this Act.

Conforming amendments to section 1866 relating to fiscal intermediaries.—Section 1866 (42 U.S.C. 1395n) is amended as follows:

1. The heading is amended to read as follows: "PROVISIONS RELATING TO THE ADMINISTRATION OF PART A".

2. Subsection (a) is amended to read as follows:

(a) The administration of this part shall be conducted through contracts with Medicare administrative contractors under section 1874A.

3. Subsection (b) is repealed.

4. Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking "agreement under this section", and inserting "contract under section 1874A which provides for the disbursement of funds, as described in subparagraph (A)(i)(I), by striking the medicare administrative contractor or carriers", and inserting "mediicare administrative contractor or carriersundy this section which provides for the disbursement of funds, as described in section (a)(1)(B), and inserting "contract under section 1874A that provides for making payments under this part", and inserting "contract under section 1874A that provides for making payments under this part";

5. Subsections (d) through (l) are repealed.

6. Subsections (j) and (k) are each amended—

(A) by striking "An agreement with an agency or organization under this section" and inserting "A contract with a Medicare administrative contractor under section 1874A with respect to the administration of this part"; and

(B) by striking "such agency or organization" and inserting "such Medicare administrative contractor".

7. Subsection (l) is repealed.

Conforming amendments to section 1842 relating to carriers.—Section 1842 (42 U.S.C. 1395u) is amended as follows:

1. The heading is amended to read as follows: "PROVISIONS RELATING TO THE ADMINISTRATION OF PART A".

2. Subsection (a) is amended—

(A) by striking paragraph (1); and

(B) in paragraph (2), by striking "carrier responses", and inserting "contractor responses", respectively.

3. Subsection (b) is amended—

(A) by striking paragraph (1); and

(B) by striking paragraph (3)(A), by striking "carrier responses", and inserting "contractor responses", respectively.

4. Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in subparagraph (C), by striking "the medicare administrative contractor or carriers", and inserting "the medicare administrative contractor or contractors".

5. Subsection (d) is amended—

(A) by striking paragraph (1); and

(B) by striking paragraph (3)(A), by striking "carrier responses", and inserting "contractor responses", respectively.

6. Subsection (e) is amended—

(A) by striking paragraph (1); and

(B) by striking paragraph (3)(A), by striking "carrier responses", and inserting "contractor responses", respectively.

7. Subsection (f) is amended—

(A) by striking paragraph (1); and

(B) by striking paragraph (3)(A), by striking "carrier responses", and inserting "contractor responses", respectively.

8. Subsection (g) is amended—

(A) by striking paragraph (1); and

(B) by striking paragraph (3)(A), by striking "carrier responses", and inserting "contractor responses", respectively.

9. Subsection (h) is amended—

(A) by striking paragraph (1); and

(B) by striking paragraph (3)(A), by striking "carrier responses", and inserting "contractor responses", respectively.

10. Subsection (i) is amended—

(A) by striking paragraph (1); and

(B) by striking paragraph (3)(A), by striking "carrier responses", and inserting "contractor responses", respectively.

11. Subsection (j) is amended—

(A) by striking paragraph (1); and

(B) by striking paragraph (3)(A), by striking "carrier responses", and inserting "contractor responses", respectively.

12. Subsection (k) is amended—

(A) by striking paragraph (1); and

(B) by striking paragraph (3)(A), by striking "carrier responses", and inserting "contractor responses", respectively.

13. Subsection (l) is amended—

(A) by striking paragraph (1); and

(B) by striking paragraph (3)(A), by striking "carrier responses", and inserting "contractor responses", respectively.

14. Subsection (m) is amended—

(A) by striking paragraph (1); and

(B) by striking paragraph (3)(A), by striking "carrier responses", and inserting "contractor responses", respectively.

15. Subsection (n) is amended—

(A) by striking paragraph (1); and

(B) by striking paragraph (3)(A), by striking "carrier responses", and inserting "contractor responses", respectively.

16. Subsection (o) is amended—

(A) by striking paragraph (1); and

(B) by striking paragraph (3)(A), by striking "carrier responses", and inserting "contractor responses", respectively.

17. Subsection (p) is amended—

(A) by striking paragraph (1); and

(B) by striking paragraph (3)(A), by striking "carrier responses", and inserting "contractor responses", respectively.
A contractor having a contract under section 1874A that provides for making payments under this part; and
(ii) by striking "such carrier" and inserting "such medicare administrative contractor" each place it appears.

(c) In paragraph (3)(B), by striking "the carrier" and inserting "the contractor" each place it appears.

(d) In paragraphs (5)(A) and (5)(B)(i), by striking "the carrier" and inserting "medicare administrative contractors" each place it appears.

Subsection (l) is amended—
(A) in paragraph (1)(A)(i), by striking "carrier" and inserting "medicare administrative contractor"; and
(B) in paragraph (2), by striking "carrier" and inserting "medicare administrative contractor".

Subsection (q)(1)(A) is amended by striking "carrier" and inserting "medicare administrative contractor".

Subsection (q)(1)(A) is amended by striking "carrier" and inserting "medicare administrative contractor".

Subsection (q)(1)(A) is amended by striking "carrier" and inserting "medicare administrative contractor".

Subsection (l) is amended—
(A) in paragraph (1)(A)(ii), by striking "carriers" and inserting "medicare administrative contractors" each place it appears.

(B) in paragraph (1)(A)(iii), by striking "the carrier" and inserting "the contractor" each place it appears.

(C) in paragraph (1)(A)(iv), by striking "the carrier" and inserting "the contractor" each place it appears.

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking "the carrier" and inserting "the contractor" each place it appears.

(3) AUTHORIZING CONTINUATION OF MIP ACTIVITIES UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—The provisions contained in the exception to subparagraph (2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendment made by this section, and any reference to an agreement or contract shall be deemed to include agreements and contracts entered into pursuant to paragraph (2)(A).

(4) AUTHORIZING CONTINUATION OF MIP ACTIVITIES UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—The provisions contained in the exceptions to subparagraph (2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendment made by this section, and any reference to an agreement or contract shall be deemed to include agreements and contracts entered into pursuant to paragraph (2)(A).

(A) IN GENERAL.—The Social Security Act is amended by inserting after section 1889 the following new section:

"SEC. 531. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities for purposes of this subsection, the term 'medicare contractor' includes a medicare administrative contractor (as defined under section 1874A of the Social Security Act).

(2) REPORTS.—The Secretary shall submit to Congress a report to Congress and the Comptroller General of the United States that includes a description and evaluation of such plan and shall submit to Congress a report on such evaluation and to suggest more efficient and effective means of achieving such compliance.

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—Insofar as a medicare contractor conducts education and training activities, it shall take into consideration the special needs of small providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of medicare claims.

(c) PROVIDER EDUCATION AND TRAINING.—Insofar as a medicare contractor conducts education and training activities, it shall take into consideration the special needs of small providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of medicare claims.

(d) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004, and the Secretary shall submit to Congress a report to Congress and the Comptroller General of the United States that includes a description and evaluation of such plan and shall submit to Congress a report on such evaluation and to suggest more efficient and effective means of achieving such compliance.

(2) PROVIDING MEDICARE CONTRACTORS WITH THE AUTHORITY TO REQUIRE EDUCATION AND TRAINING.—Insofar as a medicare contractor conducts education and training activities, it shall take into consideration the special needs of small providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of medicare claims.
(B) a physician, practitioner, or supplier with fewer than 10 full-time-equivalent employees;.

(B) **Effective Date.**—The amendment made by subparagraph (A) shall take effect on January 1, 2004.

(d) **Additional Provider Education Provisions.**—

(1) **In General.**—Section 1889, as added by subsection (a) and as amended by subsection (c)(2), is amended by adding at the end the following new subsection:

(2) **Encouragement of Participation in Education Program Activities.**—A Medicare contractor may not use a record of attendance at (or failure to attend) educational activities, audit findings, or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services, physicians, practitioners, or suppliers for the purpose of conducting any type of audit or prepayment review.

(d) **Construction.**—Nothing in this section or section 1899(g) shall be construed as providing for disclosure by a Medicare contractor—

(1) of the screens used for identifying claimants that will be subject to medical review; or

(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audit.

(e) **Definitions.**—For purposes of this section and section 1811(k)(4)(C), the term "Medicare contractor" includes the following:

(1) A Medicare administrative contractor with a contract under section 1874A, a fiscal intermediary with a contract under section 1862, and a carrier with a contract under section 1842.

(2) An eligible entity with a contract under section 1851.

Such terms do not include, with respect to activities of a specific provider of services, physician, practitioner, or supplier an entity that has no authority under this title or title XIX with respect to such activities and such provider of services, physician, practitioner, or supplier.

(2) **Effective Date.**—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

**SEC. 532. ACCESS TO AND PROMPT RESPONSES FROM MEDICARE CONTRACTORS.**

(a) **In General.**—Section 1874A, as added by section 531, is amended by striking "(C)" and inserting "(A)" as a heading.

(b) **Communicating With Beneficiaries and Practitioners.**—

(1) **Communication Process.**—The Secretary shall develop a process for Medicare contractors to communicate with beneficiaries and with providers of services, physicians, practitioners, and suppliers under this title.

(2) **Response to Written Inquiries.**—Each Medicare contractor (as defined in section 1874A) shall provide written general responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries by beneficiaries, providers of services, physicians, practitioners, and suppliers concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

(3) **Response to Toll-Free Lines.**—The Secretary shall ensure that Medicare contractors provide a toll-free telephone number at which beneficiaries, providers, physicians, practitioners, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

(4) **Monitoring of Contractor Responses.**—

"(A) **In General.**—Each Medicare contractor shall, consistent with standards developed by the Secretary under subparagraph (B)

"(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

"(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

"(B) **Development of Standards.**—

"(i) **In General.**—The Secretary shall establish (and publish in the Federal Register) standards regarding the accuracy, consistency, and timeliness of the information provided in response to inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

"(ii) **Evaluation.**—In conducting evaluations of individual Medicare contractors, the Secretary shall consider the results of the monitoring conducted under subparagraph (A) taken into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled in a Medicare advantage plan (or an intermediary or entity operating a Medicare advantage plan), establish (and publish in the Federal Register) standards regarding the accuracy, consistency, and timeliness of the information so provided.

"(C) **Direction.**—The direction in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

"(D) **Effective Date.**—The amendment made by subsection (a) shall take effect October 1, 2004.

**SEC. 533. RELIANCE ON GUIDANCE.**

(a) **In General.**—Section 1871(d), as added by section 502(a), is amended by adding at the end the following new paragraph:

"(2) If—

"(A) a provider of services, physician, practitioner, or other supplier follows written guidance provided—

"(i) by the Secretary; or

"(ii) by a Medicare contractor (as defined in section 1899(e) and whether in the form of a written response to a written inquiry under section 1874A or otherwise) acting within the scope of the contractor's contract authority,

in response to a written inquiry with respect to the furnishing of items or services or the submission of a claim for benefits for such items or services;

"(B) the Secretary determines that—

"(i) the provider of services, physician, practitioner, or supplier has accurately presented the circumstances relating to such items, services, and claim to the Secretary;

"(ii) the contractor in the written guidance and

"(iii) there is no indication of fraud or abuse committed by the provider of services, physician, practitioner, or supplier against the program under this title; and

"(C) the guidance was in error;

the provider of services, physician, practitioner, or supplier shall not be subject to any penalty or interest under this title (or the provisions of title XI insofar as they relate to complaints, grievances, and requests for information concerning the programs under this title) and such provisions (including provisions of title X insofar as they relate to this title and are not administered by the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and Medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

"(B) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

"(i) recommendations to respond to recurring patterns of fraud, abuse, and error and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in programs and provisions of title XI) insofar as they relate to this title and are not administered by the Inspector General of the Department of Health and Human Services; and

"(ii) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

(3) **Staff.**—The Secretary shall provide the Medicare Provider Ombudsman with appropriate staff.

(b) **Funding.**—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account)) to carry out the provisions of subsection (b) of section 1833 of the Social Security Act (42 U.S.C. 1395ee) relating to the Medicare Provider Ombudsman, as added by subsection (a)(5), such sums as are necessary for fiscal years 2004 and each succeeding fiscal year.

**SEC. 534. MEDICARE PROVIDER OMBUDSMAN.**

(a) **In General.**—By not later than 1 year after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall appoint a Medicare Provider Ombudsman.

(b) **Medicare Provider Ombudsman.**—

"(1) **In General.**—By not later than 1 year after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall appoint a Medicare Provider Ombudsman.

**SEC. 535. BENEFICIARY OUTREACH DEMONSTRATION PROGRAMS.**

(a) **Demonstration on the Provision of Assistance and Guidance to Medicare Beneficiaries at Local Offices of the Social Security Administration.**—

"(1) **Establishment.**—The Secretary shall establish a demonstration project in which Medicare beneficiaries select and use in their local Social Security Administration (in this subsection referred to as the "demonstration program") under which medicare specialists
emphasize the Department of Health and Human Services provide advice and assistance to Medicare beneficiaries at the location of any local offices of the Social Security Administration.

(2) LOCATIONS.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to subparagraph (B), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by Medicare beneficiaries.

(B) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for Medicare specialists to travel to local offices in a rural area on a scheduled basis.

(3) DURATION.—The demonstration program shall be conducted over a 3-year period.

(4) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of:

(i) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(ii) the cost-effectiveness of providing beneficiary assistance through out-stationing Medicare specialists at local social security offices.

(B) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing Medicare specialists at local social security offices.

(C) LIMITATION ON RECOVERY UNDER RANDOM PREPAYMENT REVIEW.—Section 1874A, as added by section 531(b)(1) and as amended by section 532(a), is amended by adding at the end the following new subsection:

SEC. 541. PREPAYMENT REVIEW

(a) IN GENERAL.—Section 1874A, as added by section 531(a)(1) and as amended by sections 531(b)(1), 532(a), and 534(a), is amended by adding at the end the following new subsection:

(2) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A Medicare administrative contractor may not initiate nonrandom prepayment review of a provider of services, physician, practitioner, or supplier based on the initial identification by that contractor of a provider of services, physician, practitioner, or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

(3) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall establish protocols or standards relating to the termination of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances and timeframes of review.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

In the case of a provider of services, physician, practitioner, or supplier with respect to which amounts were previously overpaid, nothing in this subsection shall be construed as limiting the ability of a Medicare administrative contractor to request the periodic production of records or supporting documentation for a submitted claims to ensure that the previous practice is not continuing.

(5) RANDOM PREPAYMENT REVIEW DEFINED.—For purposes of this subsection, the term ‘random prepayment review’ means a demand for the production of records or documentation absent cause with respect to a claim.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall be effective on the date of enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall issue regulations under section 1874A(g) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(g)(1) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of enactment of this Act.

(4) USE OF RECOVERY PLAN.—The Secretary may use the terms and conditions provided under section 1869(c), the Secretary may not take any action under section 1869(c) unless the Secretary first publishes and approves a plan for random prepayment review, including a no fault provision.

(5) LIMITATION ON RECOVERY.—

(A) NO RECOVERY UNTIL RECONSIDERATION EXERCISED.—In the case of a provider of services, physician, practitioner, or supplier that is determined to have received an overpayment under the repayment plan, the Secretary shall provide for repayment of the amount under the repayment plan after a reconsideration of such determination by a qualified independent contractor under section 1892(c), the Secretary may take no action under section 1869(c) unless such provider, including any Medicare contractor, as defined in subparagraph (C), requests the Secretary to reconsider the amount of the overpayment, the interest, and the rate of interest upon the amount of the overpayment.

(B) PAYMENT OF INTEREST.—

(i) RETURN OF RECOUPED AMOUNT WITH INTEREST IN CASE OF REVERSAL.—Insofar as such determination on appeal against the provider of services, physician, practitioner, or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped under this subparagraph, including interest on the amount recouped, and the amount of interest paid.

(ii) INTEREST IN CASE OF AFFIRMATION.—Insofar as such determination on appeal against the provider of services, physician, practitioner, or supplier is affirmed, the Secretary shall provide for repayment of the amount recouped under this subparagraph, including interest on the amount recouped, and the amount of interest paid.

(6) EXCLUSIONS.—For purposes of this section, the term ‘Medicare contractor’ has the meaning given such term in section 1893(e).

(7) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a...
mmedicare contractor decides to conduct a post-payment audit of a provider of services, physician, practitioner, or supplier under this title, the contractor shall provide the provider of services, physician, practitioner, or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

(2) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a Medicare contractor audits a provider of services, physician, practitioner, or supplier under this title, the contractor shall provide the provider of services, physician, practitioner, or supplier with a full and complete explanation of findings in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appeal protocol. 

(i) inform the provider of services, physician, practitioner, or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary); and

(ii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

(4) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services, physicians, practitioners, and suppliers, a process under which the Secretary provides for notice to classes of providers of services, physicians, practitioners, and suppliers, by mail or other means, of any Medicare contractor (as defined in section 1861(s)(2)) that has audited a provider of services, physician, practitioner, or supplier and permits the development of an appeal protocol. 

(i) give the provider of services, physician, practitioner, or supplier a full and complete explanation of findings in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appeal protocol. 

(ii) inform the provider of services, physician, practitioner, or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary); and

(iii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

(5) STANDARD METHODOLOGY FOR PROBE OR INVESTIGATION OF DISCRIMINATION.—Subject to subparagraph (D), if a Medicare contractor audits a provider of services, physician, practitioner, or supplier under this title, the contractor shall provide the provider of services, physician, practitioner, or supplier with a full and complete explanation of findings in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appeal protocol.

(D) Consent settlement defined.—For purposes of this subparagraph, the term "consent settlement" means an agreement between the Secretary and a provider of services, physician, practitioner, or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services, physician, practitioner, or supplier agrees not to appeal the claims involved.

(1) Consent settlement agreement.—(A) The Secretary shall enter into a consent settlement agreement with a provider of services, physician, practitioner, or supplier in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appeal protocol.

(B) The consent settlement agreement shall include—

(i) a process for notice of over-utilization of codes subject to subparagraph (B) and paragraph (5); and

(ii) a process for notice to classes of providers of services, physicians, practitioners, and suppliers, by mail or other means, of any Medicare contractors (as defined in section 1861(s)(2)) that has audited a provider of services, physician, practitioner, or supplier and permits the development of an appeal protocol.

(i) give the provider of services, physician, practitioner, or supplier a full and complete explanation of findings in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appeal protocol. 

(ii) inform the provider of services, physician, practitioner, or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary); and

(iii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

(i) in the paragraph heading, by striking "after fiscal years 2002 and inserting "and certain fiscal years";

(ii) in order to resolve the overpayment, the contractor may offer the provider of services, physician, practitioner, or supplier—

(iii) give the provider of services, physician, practitioner, or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary); and

(iv) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

(2) Consent settlement offer.—(A) In general.—The Secretary shall make a consent settlement offer to the provider of services, physician, practitioner, or supplier, including an explanation of the reason for such determination; and

(B) Consent settlement agreement.—(1) Not later than 1 year after the date of enactment of this Act, the Secretary shall—

(i) develop standards for the recovery of overpayments under section 1874(h)(1)(B) of the Social Security Act, as added by subsection (a); and

(ii) establish the process for notice of over-utilization of codes subject to subparagraph (B) and paragraph (5).

(3) Sections 1874A(h)(3) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of enactment of this Act.

(4) The Secretary shall determine whether such settlements are consistent with the requirements under the Social Security Act.

(5) The Secretary shall establish a standard methodology for the selection of sample claims for abnormal billing patterns under section 1874(h)(5) of the Social Security Act, as added by subsection (a).

(6) Effective dates and deadlines.—(A) Not later than 1 year after the date of enactment of this Act, the Secretary shall—

(i) develop standards for the recovery of overpayments under section 1874(h)(1)(B) of the Social Security Act, as added by subsection (a); and

(ii) establish the process for notice of over-utilization of codes subject to subparagraph (B) and paragraph (5).

(B) Consent settlement offer.—(1) Not later than 1 year after the date of enactment of this Act, the Secretary shall—

(ii) in order to resolve the overpayment, the contractor may offer the provider of services, physician, practitioner, or supplier—

(iii) give the provider of services, physician, practitioner, or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary); and

(iv) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

(A) in general.—Section 1228(c)(3)(B) of title 42 (42 U.S.C. 1320a–7c(3)(B)) is amended to read as follows: "Subject to subparagraph (G), in the case of an exclusion under subsection (a), the Secretary shall, not less than 5 years, except that, upon the request of an administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries of that program, the Secretary may, after consulting the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a), (a)(1), (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.

TITLE VI—OTHER PROVISIONS


(a) IN GENERAL.—Section 1923(f)(4) of title 42 (42 U.S.C. 1395f–4(f)(4)) is amended—

(1) in the paragraph heading, by striking "fiscal years 2002 and inserting "certain fiscal years"; and

(2) in subparagraph (A) —

(A) in clause (i)—

(i) by striking "(2)" and inserting "(2) and (3)"; and

(ii) by striking "and" at the end; and

(B) in clause (ii), by striking the period and inserting a semicolon; and

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

(iii) for fiscal year 2005, shall be the DSH allotment determined under paragraph (3) for that fiscal year increased by the amount equal to the product of 0.50 and the difference between—

(i) the amount that the DSH allotment would be if the DSH allotment for the State determined under clause (ii) were increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002 and 2003; and

(ii) the DSH allotment determined under paragraph (3) for the State for fiscal year 2004; and

(iv) for fiscal year 2005, shall be the DSH allotment determined under paragraph (3) for that fiscal year increased by the amount equal to the product of 0.50 and the difference between—

(i) the amount that the DSH allotment would be if the DSH allotment for the State determined under clause (ii) were increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002, 2003, and 2004; and

(ii) the DSH allotment determined under paragraph (3) for the State for fiscal year 2005.

(b) DSH ALLOWMENT FOR THE DISTRICT OF COLUMBIA.—Section 1228(c)(3)(B) of title 42 (42 U.S.C. 1320a–7c(3)(B)) is amended by paragraph (1), as amended—

(1) in subparagraph (A), by inserting "and except as provided in subparagraph (C)" after paragraph (2); and

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following:

"(C) DSH ALLOWMENT FOR THE DISTRICT OF COLUMBIA.—

(I) in general.—Notwithstanding subparagraph (A), the DSH allotment for the District of Columbia for fiscal year 2004, shall be determined by subtracting "49" for "32" in the item in the table contained in paragraph (1) with respect to the DSH allotment for FY 00 (fiscal year 2000) for the District of Columbia, and then increasing such
alotment, subject to subparagraph (B) and paragraph (5), by the percent change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002 and 2003.

(ii) NO APPLIATION TO ALLOTMENTS AFTER FISCAL YEAR 2004.—The DSH allotment for the District of Columbia for fiscal year 2003, fiscal year 2004, and fiscal year 2005 shall be determined under paragraph (3) without regard to the DSH allotment determined under clause (i) of this subparagraph.

(c) CONFIRMING AMENDMENT.—Section 1923(f)(3) of such Act (42 U.S.C. 1396r–4(f)(3)) is amended by inserting "(4)," after paragraph (3), and by striking paragraph (4).


(a) IN GENERAL.—Section 1923(f)(5) (42 U.S.C. 1396r–4(f)(5)) is amended—

(i) by striking "in the case of" and inserting the following:

"(A) in the case of; and"

(ii) by adding at the end of the following:

"(B) INCREASE IN FLOOR FOR FISCAL YEARS 2004 AND 2005.—"

"(i) FISCAL YEAR 2004.—In the case of a State in which the total expenditures under the State plan for medical assistance during the fiscal year, but less than 3 percent of the State’s total expenditures as of August 31, 2004, is greater than 0 but less than 3 percent of the State’s total amount of expenditures under the State plan for fiscal year 2003, the DSH allotment for fiscal year 2004 shall be increased to 3 percent of the State’s total amount of expenditures under such plan for fiscal year 2003.

(ii) FISCAL YEAR 2005.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2004, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State’s total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2005 shall be the DSH allotment determined for the State for fiscal year 2004 (under clause (i) or paragraph (4) (as applicable)), increased by the percent change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2004.

(iii) NO APPLIATION TO ALLOTMENTS AFTER FISCAL YEAR 2006.—The DSH allotment for any State for fiscal year 2006 or any succeeding fiscal year shall be determined under this subparagraph without regard to the DSH allotments determined under this subparagraph.

(b) ALLOTMENT ADJUSTMENT.—


(A) by redesignating paragraph (6) as paragraph (7),

(B) by inserting after paragraph (5) the following:

"(6) ALLOTMENT ADJUSTMENT.—Only with respect to fiscal year 2005 or 2006, if a State-wide waiver under section 1115 that was implemented on January 1, 1994, is revoked or terminated before the end of such fiscal year or any succeeding fiscal year, a State may elect to provide medical assistance to uninsured children in low-income families described in section 1906(a)(1)(B) if the Secretary determines necessary to ensure that such children have equal access to appropriate medical care.

"(A) permit the State whose waiver was revoked or terminated to submit an amendment to its State plan that would describe the method that would be used by the State (after the effective date of such revocation or termination) to identify and make payments to disproportionate share hospital hospitals, including children’s hospitals and institutions for mental diseases or other mental health facilities (other than State-owned institutions) on the basis of the proportion of patients served by such hospitals that are low-income patients with special needs; and

"(B) provide for purposes of this subsection for computation of an appropriate DSH allotment for the State for fiscal year 2004 or 2005 (or both) that provides for the maximum amount (permitted consistent with paragraph (3)(B)(iii)) that does not result in greater expenditures under this title than would have been made if such waiver had not been revoked or terminated.

(ii) TREATMENT OF INSTITUTIONS FOR MENTAL DISEASES.—Section 1923(h)(1) of the Social Security Act (42 U.S.C. 1396r–4(h)(1)) is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by inserting "subject to paragraph (3)" after "the lesser of the following"; and

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

"(3) SPECIAL RULE.—The limitation of paragraph (1) shall not apply in the case of a State to which subsection (f)(6) applies.".

SEC. 603. INCREASED REPORTING REQUIREMENTS TO ENSURE THE APPROPRIATE ADJUSTMENTS TO DISPROPORTIONATE SHARE HOSPITALS UNDER THE MEDICAID DRUG REBATE PROGRAM.

Section 1923 (42 U.S.C. 1396r–4) is amended by adding at the end the following new subsection:

"(i) A NNUAL REPORTS REGARDING PAYMENT ADJUSTMENTS.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1903(a)(1), with respect to a payment adjustment made under this section, to submit an annual report that:

1. identifies each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year;

2. includes such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year."

"(ii) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2003.

SEC. 605. ASSISTANCE WITH COVERAGE OF LEGAL IMMIGRANTS UNDER THE MEDICAID PROGRAM AND SCHIP.

(a) MEDICAID PROGRAM.—Section 1903(v) (42 U.S.C. 1396n(v)) is amended—

(i) in paragraph (1), by striking "paragraph (2) and inserting "paragraphs (2) and (4)"; and

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

"(B) With respect to any or all of fiscal years 2005 through 2007, a State may elect (in a plan amendment under this title) to provide medical assistance under this title (including under a waiver by the Secretary) for aliens who are lawfully residing in the United States (including battered aliens described in section 431(c) of such Act) that are otherwise eligible for such assistance, within either or both of the following eligibility categories:

1. PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

2. CHILDREN.—Children (as defined under such plan), including optional targeted low-income children described in section 1905(u)(2)(B).

"(B) IN THE CASE OF A STATE THAT HAS ELECTED TO PROVIDE MEDICAID COVERAGE—In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of ownership of property to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

"(C) EFFECTIVE DATE.—The provisions of sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 shall apply to a State that makes an election under subparagraph (A)."

(b) SCHIP.—Section 4207(e)(1) (42 U.S.C. 1935g(e)(1)) is amended by inserting the following paragraphs (C) and (D) as subparagraph (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

"(C) Section 1903(v) (relating to optional coverage of categories of permanent resident alien children), but only if the State has elected to apply such section to the category of children under title XIX and only with respect to any or all of fiscal years 2005 through 2007.

SEC. 606. ESTABLISHMENT OF CONSUMER OMBUDSMAN ACCOUNT.

(a) IN GENERAL.—Section 1817 (42 U.S.C. 1395a) is amended by adding at the end the following new subsection:

"(ii) CONSUMER OMBUDSMAN ACCOUNT.—

"(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the Consumer Ombudsman Account (in this subsection referred to as the 'Account').

"(2) APPROPRIATED AMOUNTS TO ACCOUNT FOR HEALTH INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE GRANTS.—

"(A) IN GENERAL.—There are hereby appropriated to the Account for the purpose of making grants under section 4360 of the Omnibus Budget Reconciliation Act of 1990:

"(B) AMOUNT DESCRIBED.—For purposes of subparagraph (A), the amount described in such paragraph for such fiscal year is the amount equal to the product of—

1. $L.

2. the total number of individuals receiving benefits under this subpart for the calendar year ending on December 31 of the preceding fiscal year.

"(C) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2003.

SEC. 607. ESTABLISHMENT OF CONSUMER OMBUDSMAN ACCOUNT.
"(g) FUNDING.—The Secretary shall use amounts appropriated to the Consumerombudsman Account in accordance with section 1827(j) of the Social Security Act for a fiscal year for making grants under this section for that fiscal year.

SEC. 607. GAO STUDY REGARDING IMPACT OF ASSETS TEST FOR LOW-INCOME BENEFICIARIES.

(a) Study.—The Comptroller General of the United States shall conduct a study to determine the extent to which drug utilization and access to covered drugs for an individual described in subsection (b) differs from the drug utilization and access to covered drugs of an individual who qualifies for the transitional assistance prescription drug program under section 1807A of the Social Security Act (as added by section 111) or for the premiums and cost-sharing subsidies applicable to a qualified medicare beneficiary, a specified low-income medicare beneficiary, or a qualifying individual under section 1860–19 of the Social Security Act (as added by section 111).

(b) Individual Described.—An individual is described in this subsection if the individual—

(1) has coverage under the transitional assistance prescription drug program under section 1807A of the Social Security Act or for the premiums and cost-sharing subsidies applicable to a qualified medicare beneficiary, a specified low-income medicare beneficiary, or a qualifying individual under section 1860–19 of the Social Security Act solely by reason of the application of an assets test to the individual.

(c) Report.—Not later than September 30, 2007, the Comptroller General shall submit a report to Congress on the study conducted under subsection (a) that includes such recommendations for legislation as the Comptroller General determines are appropriate.

SEC. 608. HEALTH CARE INFRASTRUCTURE IMPROVEMENT.

At the end of the Social Security Act, add the following new title:

"TITLE XXII—HEALTH CARE INFRASTRUCTURE IMPROVEMENT"

"SEC. 2201. DEFINITIONS.

In this title, the following definitions apply:

(1) ELIGIBLE PROJECT COSTS.—The term 'eligible project costs' means amounts substantially all of which are paid by, or for the account of, a party primarily liable for payment of principal of, or interest on, a Federal credit instrument, which party may be a corporation, partnership, joint venture, trust, or governmental entity, agency, or instrumentality.

(2) PROJECT OBLIGATION.—The term 'project obligation' means any note, bond, debenture, lease, installment sale agreement, other debt obligation issued by an obligor and funded by a lender.

(3) RATING AGENCY.—The term 'rating agency' means any rating organization (as defined in section 230.144A(a) of title 17, Code of Federal Regulations (or any successor regulation), known to the Secretary of the Treasury, or the Securities and Exchange Commission, or established by Congress) that is a qualified institutional buyer.

(4) LENDER.—The term 'lender' means any credit instrument on behalf of the Secretary.

(5) CREDIT INSTRUMENT.—The term 'credit instrument' means—

(A) any investment security, including any obligation of a State or local government or an agency or instrumentality of a State or local government, the project that the entity is undertaking shall be engaged in research in the causes, prevention, and treatment of cancer;

(D) major medical equipment determined by the Secretary to be appropriate by the Secretary; and

(E) refinancing projects or activities that are otherwise eligible for financial assistance under this act (as added by section 111).

(2) FEDERAL CREDIT INSTRUMENT.—The term 'Federal credit instrument' means a secured loan, loan guarantee, or line of credit authorized to be made under section 1402 of title 31, United States Code.

(3) INVESTMENT-GRADE RATING.—The term 'investment-grade rating' means a rating category of BBB minus and higher, as defined by a rating agency to project obligations offered into the capital markets.

(4) LENDER.—The term 'lender' means any non-Federal qualified institutional buyer (as defined in section 230.144A(a) of title 17, Code of Federal Regulations (or any successor regulation), known to the Secretary of the Treasury, or the Securities and Exchange Commission, or established by Congress).

(5) LINE OF CREDIT.—The term 'line of credit' means an agreement entered into by the Secretary with an obligor under section 2204 to provide a direct loan at a future date upon the occurrence of certain events.

(6) LOAN GUARANTEE.—The term 'loan guarantee' means any guarantee or other arrangement by the Secretary to pay all or part of the principal of and interest on a loan or other debt obligation issued by an obligor and funded by a lender.

(7) LOCAL SERVICER.—The term 'local servicer' means a State or local government or any agency of a State or local government that is responsible for servicing a Federal credit instrument on behalf of the Secretary.

(8) OBLIGOR.—The term 'obligor' means any party primarily liable for payment of principal of, or interest on, a Federal credit instrument, which party may be a corporation, partnership, joint venture, trust, or governmental entity, agency, or instrumentality.

(9) PROJECT.—The term 'project' means any project that is designed to improve the health care infrastructure, including the construction, reconstruction, or rehabilitation of any hospital, medical research facility, or other medical facility or the purchase or replacement of any equipment to be used in a hospital, research facility, or other medical research facility.

(10) PROJECT OBLIGATION.—The term 'project obligation' means any note, bond, debenture, lease, installment sale agreement, or other debt obligation issued or entered into by an obligor in connection with the financing of a project, other than a Federal credit instrument.

(11) RATING AGENCY.—The term 'rating agency' means any bond rating agency identified by the Secretary or the Securities and Exchange Commission as a Nationally Recognized Statistical Rating Organization.

(12) SECURED LOAN.—The term 'secured loan' means a direct loan or other debt obligation issued by an obligor and funded by the Secretary in connection with the financing of a project under section 2203.

(13) STATE.—The term 'State' has the meaning given in section 101 of title 23, United States Code.

(14) SUBSIDY AMOUNT.—The term 'subsidy amount' means the amount of budget authority designated by the Secretary under section 1402 of title 31, United States Code, as a State as the official cancer center for the National Cancer Institute or be designated by the State as the official cancer institute of the State, and the estimated long-term cost to the Federal Government of a Federal credit instrument, calculated on a

net present value basis, excluding administrative costs and any incidental effects on governmental receipts or outlays in accordance with the provisions of the Federal Credit Reform Act of 1990 (2 U.S.C. 661 et seq.)."

"SEC. 2202. DETERMINATION OF ELIGIBILITY AND PROJECT SELECTION.

(a) ELIGIBILITY.—An eligible to receive financial assistance under this title, a project shall meet the following criteria:

(1) APPLICATION.—A State, a local servicer or an agency of a State or a local government or an agency or instrumentality of a State or local government, the project that the entity is undertaking shall be engaged in research in the causes, prevention, and treatment of cancer;

(b) SELECTION CRITERIA.—(A) IN GENERAL.—The selection criteria shall include the following:

(i) The extent to which the project is nationally or regionally significant, in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

(ii) The creditworthiness of the project, including a determination by the Secretary that any financing for the project has appropriate security features, such as a rate covenant, credit enhancement requirements, or debt services coverage, to ensure repayment.

(iii) The extent to which assistance under this title would foster innovative public-private partnerships and attract private debt or equity investment.

(iv) The likelihood that assistance under this title would enable the project to proceed at an earlier date than the project would otherwise be able to proceed.

(v) The extent to which the project uses or results in new technologies.

(vi) The amount of budget authority required to fund the Federal credit instrument made available under this title.

(vii) The extent to which the project helps maintain or protect the environment.

(B) SPECIFIC REQUIREMENTS.—The selection criteria shall require that a project applicant—

(i) be engaged in research in the causes, prevention, and treatment of cancer;

(ii) be designated by the National Cancer Institute or be designated by the State as the official cancer center for the National Cancer Institute or be designated by the State as the official cancer institute of the State, and the estimated long-term cost to the Federal Government of a Federal credit instrument, calculated on a

populess than 3,000,000 individuals.
shall not be subordinated to the claims of eligible project costs; (B) to refinance interim construction financing of eligible project costs; or (C) to refinance existing debt or prior project obligations of any project selected under section 2002.

2. LIMITATION ON REFINANCING OF INTERIM CONSTRUCTION FINANCING.—A loan under paragraph (1) shall not refinance interim construction financing of any project selected under paragraph (1) later than 1 year after the date of substantial completion of the project.

3. RISK ASSESSMENT.—Before entering into an agreement for a secured loan under this subsection, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate capital reserve subsidy amount for each secured loan, taking into account such letter.

4. SECURED LOAN RATING REQUIREMENT.—The funding of a secured loan under this section shall be contingent on the project's senior obligations receiving an investment-grade rating, except that—

(A) the Secretary may fund an amount of the secured loan not to exceed the capital reserve subsidy amount determined under paragraph (3) for the obligations receiving an investment-grade rating; and

(B) the Secretary may fund the remaining portion of the secured loan only after the obligations have received an investment-grade rating by at least 1 rating agency.

5. TERMS AND LIMITATIONS.—

(A) A secured loan under this section with respect to a project shall be on such terms and conditions and contain such covenants, representations, warranties, and other provisions (including provisions for audits) as the Secretary determines appropriate.

(B) MAXIMUM AMOUNT.—The amount of the secured loan shall not exceed 100 percent of the reasonably anticipated eligible project costs.

6. PAYMENT.—The secured loan—

(A) shall—

(i) be payable, in whole or in part, from reliable revenue sources; and

(ii) include a rate covenant, coverage requirements, and other security features to support the project obligations; and

(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

7. INTEREST RATE.—The interest rate on the secured loan shall be not less than the yield on United States Treasury securities of a similar maturity to the maturity of the secured loan on the date of execution of the loan agreement.

8. MATURITY DATE.—The maturity date of the secured loan shall be not later than 30 years after the date of substantial completion of the project.

9. SUBORDINATION.—The secured loan shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligations or the entity as of the date on which the line of credit is obligated.

10. FEES.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of making a secured loan under this section.

1. SCHEDULE.—The Secretary shall establish a repayment schedule for each secured loan under this section based on the projected cash flow from project revenues and other repayments under this section.

2. COMMENCEMENT.—Secured loan payments of principal or interest on a secured loan under this section shall commence not later than the date of substantial completion of the project.

3. SOURCES OF REPAYMENT FUND.—The sources of funds for scheduled loan repayments under this section shall include any revenue generated by the project.

4. DEFERRED PAYMENTS.—

(A) AUTHORIZATION.—If, at any time during the 10 years after the date of substantial completion of the project, the project is unable to generate sufficient revenues to pay the scheduled loan repayments of principal and interest on the secured loan, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate capital reserve subsidy amount for each secured loan, taking into account such letter.

(B) INTEREST.—Any payment deferred under subparagraph (A) shall—

(i) continue to bear interest in accordance with this section with respect to a project shall be consistent with the terms set forth in this section for a secured loan, except that the rate on the guaranteed loan and any prepayment features shall be negotiated between the obligor and the lender, with the consent of the Secretary.

4. LINES OF CREDIT.

1. IN GENERAL.—

(A) AGREEMENTS.—Subject to paragraphs (2) through (4), the Secretary may enter into agreements to make a line of credit to 1 or more obligors in the form of direct loans to be made by the Secretary at future dates on the occurrence of certain events for any project selected under section 2002.

(B) USE OF PROCEEDS.—The proceeds of a line of credit made available under this section shall be available to pay debt service on project obligations issued to finance eligible project costs, extraordinary repair and replacement costs, operation and maintenance expenses, and costs associated with unexpected Federal or State environmental restrictions.

(C) RISK ASSESSMENT.—Before entering into an agreement for a line of credit under this subsection, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate subsidy amount for each secured loan, taking into account such letter.

(D) INTEREST-GRADE RATING REQUIREMENT.—The funding of a line of credit under this section shall be contingent on the project's senior obligations receiving an investment-grade rating, except that—

(E) TERMS AND LIMITATIONS.—

(A) IN GENERAL.—A line of credit under this section with respect to a project shall be on such terms and conditions and contain such covenants, representations, warranties, and other provisions (including provisions for audits) as the Secretary determines appropriate.

(B) MAXIMUM AMOUNT.—The amount of the line of credit shall not exceed 100 percent of the reasonably anticipated eligible project costs.

(C) PAYMENT.—The line of credit—

(A) shall—

(i) be payable, in whole or in part, from reliable revenue sources; and

(ii) include a rate covenant, coverage requirements, and other security features to support the project obligations; and

(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

(D) INTEREST RATE.—The interest rate on the line of credit shall be not less than the yield on United States Treasury securities of a similar maturity to the maturity of the secured loan on the date of execution of the loan agreement.

(E) MATURITY DATE.—The maturity date of the line of credit shall be not later than 30 years after the date of substantial completion of the project.

(F) SUBORDINATION.—The line of credit shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligations or the entity as of the date on which the line of credit is obligated.

(G) FEES.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of making a secured loan under this section.

(H) SCHEDULE.—The line of credit—

(A) shall—

(i) be payable, in whole or in part, from reliable revenue sources; and

(ii) include a rate covenant, coverage requirements, and other security features to support the project obligations; and

(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.
"(A) shall—

(i) be payable, in whole or in part, from reliable revenue sources; and

(ii) include a rate covenant, coverage requirement, or similar security feature supporting the project obligations; and

(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

(6) PERIOD OF AVAILABILITY.—The line of credit shall be available during the period beginning on the date of substantial completion of the project and ending not later than 10 years after that date.

(7) RIGHTS OF THIRD-PARTY CREDITORS.—

(A) AGAINST FEDERAL GOVERNMENT.—A third-party creditor of the obligor shall none the have any right against the Federal Government with respect to any draw on the line of credit.

(B) ASSIGNMENT.—An obligor may assign the line of credit to 1 or more lenders or to a trustee on the lenders’ behalf.

(8) NONSUBORDINATION.—A direct loan under this section shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligor.

(9) FEES.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of providing a line of credit under this section.

(10) RELATIONSHIP TO OTHER CREDIT INSTRUMENTS.—A project that receives a line of credit under this section also shall not receive a secured loan or loan guarantee under section 2003 of an amount that, combined with the amount of the line of credit, exceeds 10 percent of eligible project costs.

(c) REPAYMENT.—

(1) TERMS AND CONDITIONS.—The Secretary shall establish repayment terms and conditions for direct loan under this section based on the projected cash flow from project revenues and other repayment sources.

(2) TIMING.—All scheduled repayments of principal or interest on a direct loan under this section shall commence not later than 5 years after the end of the period of availability specified in subsection (b)(6) and be fully repaid, with interest, by the date that is 25 years after the end of the period of availability specified in subsection (b)(6).

(3) PAYMENT FUNDS.—The sources of funds for scheduled loan repayments under this section shall include reliable revenue sources.

SEC. 2206. STATE AND LOCAL PERMITS.

The provision of financial assistance under this title with respect to a project shall not be subject to State or local permit or approval with respect to the project.

(2) LIMIT the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or

(3) otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

SEC. 2207. REGULATIONS.

The Secretary may issue such regulations as the Secretary determines appropriate to carry out this title.

SEC. 2208. FUNDING.

(a) FUNDING.—

(1) IN GENERAL.—There are authorized to be appropriated—

$50,000,000 to remain available during the period beginning on July 1, 2004 and ending on September 30, 2008.

(2) ADMINISTRATIVE COSTS.—From funds made available under paragraph (1), the Secretary may use, for the administration of this title, not more than $2,000,000 for each of fiscal years 2004 through 2008.

(b) CONTRACT AUTHORITY.—Notwithstanding any other provision of law, approval by the Secretary of a Federal credit instrument that uses funds made available under this title shall be deemed acceptance by the United States of a contractual obligation to fund the Federal credit instrument.

(c) AVAILABILITY.—Amounts appropriated under this section shall be available for obligations on July 1, 2004.

SEC. 2209. REPORT TO CONGRESS.

Not later than 4 years after the date of enactment of this title, the Secretary shall submit to Congress a report summarizing the financial performance of the projects that are receiving, or have received, assistance under this section that includes a recommendation as to whether the objectives of this title are best served—

(1) by continuing the program under the authority of the Secretary; or

(2) by establishing a Government corporation or Government-sponsored enterprise to administer the program;

(3) by phasing out the program and relying on the capital markets to fund the types of infrastructure investments assisted by this title without Federal participation.

SEC. 609. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM.

(a) In general.—Part A of title XVI of the Public Health Service Act (42 U.S.C. 300q et seq.) is amended by adding at the end the following new section:

"CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM

"SEC. 1603. (a) AUTHORITY TO MAKE AND GUARANTEE LOANS.—

(1) AUTHORITY TO MAKE LOANS.—The Secretary may make loans from the fund established under section 1602(d) to any rural entity for projects for capital improvements, including—

(A) the acquisition of land necessary for the capital improvements;

(B) the innovation or modernization of any building;

(C) the acquisition or repair of fixed or major movable equipment; and

(D) such other project expenses as the Secretary determines appropriate.

(2) AUTHORITY TO GUARANTEE LOANS.—

(A) IN GENERAL.—The Secretary may guarantee the payment of principal and interest of any loan made to a rural entity under subsection (a), the Secretary may pay to the holder of such loan, for and on behalf of the project for which the loan was made, amounts sufficient to reduce (by not more than 3 percent) the net effective interest rate otherwise payable on such loan.

(2) AMOUNT OF LOAN.—The principal amount of a loan directly made or guaranteed under subsection (a) for a project for capital improvement may not exceed $50,000,000.

(c) FUNDING LIMITATIONS.—

(1) GOVERNMENT CREDIT SUBSIDY EXPOSURE.—The total of the Government credit subsidy exposure under the Credit Reform Act of 1990 scoring protocol with respect to the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, under subsection (a) may not exceed $50,000,000 per year.

(2) TOTAL AMOUNTS.—Subject to paragraph (1), the total of the principal amount of all loans directly made or guaranteed under subsection (a) may not exceed $250,000,000 per year.

(d) CAPITAL ASSESSMENT AND PLANNING GRANTS.—

(1) NONREPAYABLE GRANTS.—Subject to paragraph (2), the Secretary may make a grant to a rural entity, in an amount not to exceed $50,000, for purposes of capital assessment and business planning.

(2) LIMITATION.—The cumulative total of grants awarded under this subsection may not exceed $2,500,000 per year.

(e) TERMINATION OF AUTHORITY.—The Secretary may not directly make or guarantee a loan under subsection (a) after September 30, 2008.

(b) RURAL ENTITY DEFINED.—Section 1604 of the Public Health Service Act (42 U.S.C. 300s–3) is amended by adding at the end the following new paragraph:

"(14)(A) The term ‘rural entity’ includes—

(i) a rural health clinic, as defined in section 1851(a)(2) of the Social Security Act;

(ii) any medical facility with at least 1 bed, but with less than 50 beds, that is located in—

(I) a county that is not part of a metropolitan statistical area; or

(II) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith map, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725));

(iii) a hospital that is classified as a rural, regional, or national referral center under section 1886(d)(5)(C) of the Social Security Act; and

(iv) a hospital that is a sole community hospital as defined in section 1861(d)(5)(C) of the Social Security Act.

(B) For purposes of subparagraph (A), the fact that a clinic, facility, or hospital has been geographically reclassified under the medicare program under title XVIII of the Social Security Act shall not preclude a hospital from being considered a rural entity under clause (i) or (ii) of subparagraph (A).

(2) CONFORMING AMENDMENTS.—Section 1602 of the Public Health Service Act (42 U.S.C. 300q–2) is amended—

(1) in subsection (b)(2)(D), by inserting ‘‘or 1603(a)(2)(B)’’ after ‘‘1601(a)(2)(B)’’; and

(2) in subsection (d)—

(A) in paragraph (1)(C), by striking ‘‘1601(a)(2)(B)’’ and inserting ‘‘sections 1603(a)(2)(B) and 1601(a)(2)(B)’’;

(B) in paragraph (2)(A), by inserting ‘‘or 1603(a)(2)(B)’’ after ‘‘1601(a)(2)(B)’’.
SEC. 610. FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—There is appropriated, out of any funds available or otherwise appropriated, $250,000,000 for each of fiscal years 2005 through 2008, for the purpose of making allotments under this section to States described in subsection (b) for each fiscal year.

(b) FORMULA.—The amount of the allotment for each State for a fiscal year shall be equal to the product of—

(i) the total amount available for allotments under this paragraph for the fiscal year; and

(ii) the percentage of undocumented aliens residing in the State with respect to the total number of aliens residing in the United States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 1, 2003, based on the 2000 decennial census.

SEC. 611. INCREASE IN APPROPRIATIONS FOR HEALTH CARE FRAUD AND ABUSE CONTROL ACT.

Section 1817(k)(3)(A) of the Social Security Act (42 U.S.C. 1395xviii) is amended—

(1) in clause (i)—

(A) in subclause (I), by striking “$5,000” and inserting “$7,500”; and

(B) in subclause (II), by striking “$10,000” and inserting “$15,000”.

(b) EFFECTIVE DATE.—The amendments made by this subsection shall apply to violations occurring on or after January 1, 2004.

SEC. 612. INCREASE IN CIVIL PENALTIES UNDER THE FALSE CLAIMS ACT.

(a) IN GENERAL.—(1) Section 3729(a) of title 31, United States Code, is amended—

(A) by striking “$10,000” and inserting “$15,000”;

(B) by striking “$15,000” and inserting “$30,000”; and

(C) by striking “$15,000” and inserting “$60,000”.

(b) EFFECTIVE DATE.—The amendments made by this subsection shall apply to violations occurring on or after January 1, 2004.

TITLE VII—ACCESS TO AFFORDABLE PHARMACEUTICALS

SEC. 701. SHORT TITLE.

This title may be cited as the “Greater Access to Affordable Pharmaceuticals Act”.

SEC. 702. 30-MONTH STAY-OF-EFFECTIVENESS PERIOD.

(a) ABBREVIATED NEW DRUG APPLICATIONS.—Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended—

(1) in paragraph (2), by striking subparagraph (B) and inserting the following:

“(B) NOTICE OF OPINION THAT PATENT IS NOT VALID OR WILL NOT BE INFRINGED.—

“(i) if the certification is in the application, or

“(ii) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application;

“(B) in subclause (VII)—

(i) by striking ‘‘each fiscal year after fiscal year 2002’’ and inserting ‘‘fiscal year 2003’’; and

(ii) by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

“(XII) for each fiscal year after fiscal year 2006, not less than $150,000,000 and not more than $200,000,000.”.

(b) EFFECTIVE DATE.—The amendments made by this subsection shall apply to viola-
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claimed by the patent or a use of which is
claimed by the patent (or a representative of
the holder designated to receive such a notice).
‘‘(iv) CONTENTS OF NOTICE.—A notice required under this subparagraph shall—
‘‘(I) state that an application that contains
data from bioavailability or bioequivalence
studies has been submitted under this subsection for the drug with respect to which
the certification is made to obtain approval
to engage in the commercial manufacture,
use, or sale of the drug before the expiration
of the patent referred to in the certification;
and
‘‘(II) include a detailed statement of the
factual and legal basis of the opinion of the
applicant that the patent is not valid or will
not be infringed.’’; and
(2) in paragraph (5)—
(A) in subparagraph (B)—
(i) by striking ‘‘under the following’’ and
inserting ‘‘by applying the following to each
certification
made
under
paragraph
(2)(A)(vii)’’; and
(ii) in clause (iii)—
(I) in the first sentence, by striking ‘‘unless’’ and all that follows and inserting ‘‘unless, before the expiration of 45 days after
the date on which the notice described in
paragraph (2)(B) is received, an action is
brought for infringement of the patent that
is the subject of the certification and for
which information was submitted to the Secretary under subsection (b)(1) or (c)(2) before
the date on which the application (excluding
an amendment or supplement to the application), which the Secretary later determines
is substantially complete, was submitted.’’;
and
(II) in the second sentence—
(aa) by striking subclause (I) and inserting
the following:
‘‘(I) if before the expiration of such period
the district court decides that the patent is
invalid or not infringed (including any substantive determination that there is no
cause of action for patent infringement or
invalidity), the approval shall be made effective on—
‘‘(aa) the date on which the court enters
judgment reflecting the decision; or
‘‘(bb) the date of a settlement order or consent decree signed and entered by the court
stating that the patent that is the subject of
the certification is invalid or not infringed;’’;
(bb) by striking subclause (II) and inserting the following:
‘‘(II) if before the expiration of such period
the district court decides that the patent has
been infringed—
‘‘(aa) if the judgment of the district court
is appealed, the approval shall be made effective on—
‘‘(AA) the date on which the court of appeals decides that the patent is invalid or
not infringed (including any substantive determination that there is no cause of action
for patent infringement or invalidity); or
‘‘(BB) the date of a settlement order or
consent decree signed and entered by the
court of appeals stating that the patent that
is the subject of the certification is invalid
or not infringed; or
‘‘(bb) if the judgment of the district court
is not appealed or is affirmed, the approval
shall be made effective on the date specified
by the district court in a court order under
section 271(e)(4)(A) of title 35, United States
Code;’’;
(cc) in subclause (III), by striking ‘‘on the
date of such court decision.’’ and inserting
‘‘as provided in subclause (I); or’’; and
(dd) by inserting after subclause (III) the
following:
‘‘(IV) if before the expiration of such period
the court grants a preliminary injunction

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prohibiting the applicant from engaging in
the commercial manufacture or sale of the
drug until the court decides the issues of
patent validity and infringement and if the
court decides that such patent has been infringed, the approval shall be made effective
as provided in subclause (II).’’;
(B) by redesignating subparagraphs (C) and
(D) as subparagraphs (E) and (F), respectively; and
(C) by inserting after subparagraph (B) the
following:
‘‘(C) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—
‘‘(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—If an owner of the patent or the holder of the approved application
under subsection (b) for the drug that is
claimed by the patent or a use of which is
claimed by the patent does not bring a civil
action against the applicant for infringement of the patent on or before the date that
is 45 days after the date on which the notice
given under paragraph (2)(B) was received,
the applicant may bring a civil action
against the owner or holder (but not against
any owner or holder that has brought such a
civil action against that applicant, unless
that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that
the patent is invalid or will not be infringed
by the drug for which the applicant seeks approval.
‘‘(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—
‘‘(I) IN GENERAL.—If an owner of the patent
or the holder of the approved application
under subsection (b) for the drug that is
claimed by the patent or a use of which is
claimed by the patent brings a patent infringement action against the applicant, the
applicant may assert a counterclaim seeking
an order requiring the holder to correct or
delete the patent information submitted by
the holder under subsection (b) or (c) on the
ground that the patent does not claim either—
‘‘(aa) the drug for which the application
was approved; or
‘‘(bb) an approved method of using the
drug.
‘‘(II) NO INDEPENDENT CAUSE OF ACTION.—
Subclause (I) does not authorize the assertion of a claim described in subclause (I) in
any civil action or proceeding other than a
counterclaim described in subclause (I).
‘‘(iii) NO DAMAGES.—An applicant shall not
be entitled to damages in a civil action
under subparagraph (i) or a counterclaim
under subparagraph (ii).’’.
(b) APPLICATIONS GENERALLY.—Section 505
of the Federal Food, Drug, and Cosmetic Act
(21 U.S.C. 355) is amended—
(1) in subsection (b), by striking paragraph
(3) and inserting the following:
‘‘(3) NOTICE OF OPINION THAT PATENT IS NOT
VALID OR WILL NOT BE INFRINGED.—
‘‘(A) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in
paragraph (2)(A)(iv) shall include in the application a statement that the applicant will
give notice as required by this paragraph.
‘‘(B) TIMING OF NOTICE.—An applicant that
makes a certification described in paragraph
(2)(A)(iv) shall give notice as required under
this paragraph—
‘‘(i) if the certification is in the application, not later than 20 days after the date of
the postmark on the notice with which the
Secretary informs the applicant that the application has been filed; or
‘‘(ii) if the certification is in an amendment or supplement to the application, at
the time at which the applicant submits the
amendment or supplement, regardless of
whether the applicant has already given notice with respect to another such certifi-

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cation contained in the application or in an
amendment or supplement to the application.
‘‘(C) RECIPIENTS OF NOTICE.—An applicant
required under this paragraph to give notice
shall give notice to—
‘‘(i) each owner of the patent that is the
subject of the certification (or a representative of the owner designated to receive such
a notice); and
‘‘(ii) the holder of the approved application
under this subsection for the drug that is
claimed by the patent or a use of which is
claimed by the patent (or a representative of
the holder designated to receive such a notice).
‘‘(D) CONTENTS OF NOTICE.—A notice required under this paragraph shall—
‘‘(i) state that an application that contains
data from bioavailability or bioequivalence
studies has been submitted under this subsection for the drug with respect to which
the certification is made to obtain approval
to engage in the commercial manufacture,
use, or sale of the drug before the expiration
of the patent referred to in the certification;
and
‘‘(ii) include a detailed statement of the
factual and legal basis of the opinion of the
applicant that the patent is not valid or will
not be infringed.’’; and
(2) in subsection (c)(3)—
(A) in the first sentence, by striking
‘‘under the following’’ and inserting ‘‘by applying the following to each certification
made under subsection (b)(2)(A)(iv)’’;
(B) in subparagraph (C)—
(i) in the first sentence, by striking ‘‘unless’’ and all that follows and inserting ‘‘unless, before the expiration of 45 days after
the date on which the notice described in
subsection (b)(3) is received, an action is
brought for infringement of the patent that
is the subject of the certification and for
which information was submitted to the Secretary under paragraph (2) or subsection
(b)(1) before the date on which the application (excluding an amendment or supplement to the application) was submitted.’’;
(ii) in the second sentence—
(I) by striking ‘‘paragraph (3)(B)’’ and inserting ‘‘subsection (b)(3)’’;
(II) by striking clause (i) and inserting the
following:
‘‘(i) if before the expiration of such period
the district court decides that the patent is
invalid or not infringed (including any substantive determination that there is no
cause of action for patent infringement or
invalidity), the approval shall be made effective on—
‘‘(I) the date on which the court enters
judgment reflecting the decision; or
‘‘(II) the date of a settlement order or consent decree signed and entered by the court
stating that the patent that is the subject of
the certification is invalid or not infringed;’’;
(III) by striking clause (ii) and inserting
the following:
‘‘(ii) if before the expiration of such period
the district court decides that the patent has
been infringed—
‘‘(I) if the judgment of the district court is
appealed, the approval shall be made effective on—
‘‘(aa) the date on which the court of appeals decides that the patent is invalid or
not infringed (including any substantive determination that there is no cause of action
for patent infringement or invalidity); or
‘‘(bb) the date of a settlement order or consent decree signed and entered by the court
of appeals stating that the patent that is the
subject of the certification is invalid or not
infringed; or
‘‘(II) if the judgment of the district court is
not appealed or is affirmed, the approval

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shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code; 

(iv) if before the expiration of such period the court decides that such patent has been infringed, the approval shall be made effective as provided in clause (ii).''; and 

(iii) in the third sentence, by striking "paragraph (3)(B)" and inserting "subsection (b)(3)"; 

(b) by redesignating subparagraph (D) as subparagraph (E), and 

(c) by inserting after subparagraph (C) the following: 

"(D) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—" (i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by a use of which is claimed by the patent does not bring a civil action against the applicant for infringement before the date on which the notice given under subsection (b)(3) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice for a declaratory judgment action under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval."

(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—"(i) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a civil action against the applicant for infringement, before the date on which the notice given under subsection (b)(3) was received, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder or to correct a mistake in the information on the ground that the patent does not claim either—

"(aa) a drug for which the application was approved; or

"(bb) an approved method of using the drug.

"(ii) NO INDEPENDENT CAUSE OF ACTION.—Subclause (i) does not authorize the assertion of a claim described in subclause (i) in any civil action or proceeding other than a counterclaim described in subsection (c).

"(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under clause (i) or a counterclaim under clause (ii).

(c) INFRINGEMENT ACTIONS.—Section 271(e) of title 35, United States Code, is amended by adding at the end the following:

"(3) if the filing of an application described in paragraph (2) that includes a certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(iv) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and the failure of the owner of the patent to bring an action for infringement of a patent that is the subject of the certification before the earlier of 45 days after the date on which the notice given under subsection (b)(3) or (j)(2)(B) of that section is received, shall establish an actual controversy between the applicant and the patent owner sufficient to confer subject matter jurisdiction in the courts of the United States in any action brought under section 2201 of title 28 for a declaratory judgment that any patent that is the subject of the certification is invalid or not infringed.

(d) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by subsections (a)(1) and (b)(1) and the amendments made by subsection (b)(2)(A)(iv) or (j)(2)(A)(iv) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) that is pending on or after the date of enactment of this Act in an application filed under subsection (b)(2) or (j)(2) or in an amendment or supplement to an application filed under subsection (b)(2) or (j) of that section.

(2) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—The amendments made by subsections (a)(1) and (b)(1) apply with respect to any certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(iv) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) made after the date of enactment of this Act.

SEC. 702. FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.

(a) IN GENERAL.—Section 505(j)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)) (as amended by section 1802(b)(1) of the Patient Protection and Affordable Care Act) is amended by adding after subparagraph (A)(ii) the following:

"(AA) 75 days after the date on which the patent or in a declaratory judgment action brought by that applicant with respect to the patent, a court enters a final decision from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the patent is invalid or not infringed.

(bb) in an infringement action or a declaratory judgment action described in subsection (A), a court signs a judgment that includes a finding that the patent is invalid or not infringed.

(c) THE PATENT EXPIRES.—The patent expires:

"(DD) the patent is withdrawn by the holder of the application approved under subsection (b).

(b) WITHDRAWAL OF APPLICATION.—The first applicant withdraws the application or the Secretary considers the application to have been withdrawn as a result of a determination by the Secretary that the application does not meet the requirements for approval under paragraph (4)."
EXCLUSIVITY PERIOD HAS NOT BEEN TRIGGERED.—With respect to an application filed before, on, or after the date of enactment of this Act for a listed drug for which a certification under section 505(j)(5)(D) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended—

(1) require that safeguards be in place to ensure that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug, with sections 510 and 520, and with other applicable requirements of this Act; (2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e); and (3) contain any additional provisions determined by the Secretary to be appropriate as a safeguard to protect the public health or as a means to facilitate the importation of prescription drugs.

SEC. 801. IMPORTATION OF PRESCRIPTION DRUGS.

(A) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 381 and inserting the following:

"(A) A description of the dosage form of the prescription drug.

"(B) The date on which the prescription drug was shipped.

"(C) The point of origin and destination of the prescription drug.

"(D) The price paid by the importer for the prescription drug.

"(E) Documentation from the foreign seller specifying—

"(i) the original source of the prescription drug;

"(ii) the quantity of each lot of the prescription drug originally received by the seller from that source.

"(F) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

"(G) The name, address, telephone number, and professional license number (if any) of the importer.

"(H) In the case of a prescription drug that is shipped directly from the first foreign recipient to the importer: (i) the name, address, telephone number, and professional license number (if any) of the importer.

"(ii) the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

"(III)(aa) In the case of an initial imported shipment, documentation demonstrating that the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(bb) In the case of any subsequent shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(cc) In the case of a prescription drug that is shipped directly from the first foreign recipient to the importer: (i) the name, address, telephone number, and professional license number (if any) of the importer.

"(ii) the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

"(III)(aa) In the case of an initial imported shipment, documentation demonstrating that the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(bb) In the case of any subsequent shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(cc) In the case of a prescription drug that is shipped directly from the first foreign recipient to the importer: (i) the name, address, telephone number, and professional license number (if any) of the importer.

"(ii) the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

"(III)(aa) In the case of an initial imported shipment, documentation demonstrating that the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(bb) In the case of any subsequent shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(cc) In the case of a prescription drug that is shipped directly from the first foreign recipient to the importer: (i) the name, address, telephone number, and professional license number (if any) of the importer.

"(ii) the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

"(III)(aa) In the case of an initial imported shipment, documentation demonstrating that the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(bb) In the case of any subsequent shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(cc) In the case of a prescription drug that is shipped directly from the first foreign recipient to the importer: (i) the name, address, telephone number, and professional license number (if any) of the importer.

"(ii) the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

"(III)(aa) In the case of an initial imported shipment, documentation demonstrating that the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(bb) In the case of any subsequent shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(cc) In the case of a prescription drug that is shipped directly from the first foreign recipient to the importer: (i) the name, address, telephone number, and professional license number (if any) of the importer.

"(ii) the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

"(III)(aa) In the case of an initial imported shipment, documentation demonstrating that the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(bb) In the case of any subsequent shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(cc) In the case of a prescription drug that is shipped directly from the first foreign recipient to the importer: (i) the name, address, telephone number, and professional license number (if any) of the importer.

"(ii) the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

"(III)(aa) In the case of an initial imported shipment, documentation demonstrating that the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(bb) In the case of any subsequent shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(cc) In the case of a prescription drug that is shipped directly from the first foreign recipient to the importer: (i) the name, address, telephone number, and professional license number (if any) of the importer.

"(ii) the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

"(III)(aa) In the case of an initial imported shipment, documentation demonstrating that the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(bb) In the case of any subsequent shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

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"(ii) the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

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"(cc) In the case of a prescription drug that is shipped directly from the first foreign recipient to the importer: (i) the name, address, telephone number, and professional license number (if any) of the importer.

"(ii) the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

"(III)(aa) In the case of an initial imported shipment, documentation demonstrating that the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(bb) In the case of any subsequent shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

"(cc) In the case of a prescription drug that is shipped directly from the first foreign recipient to the importer: (i) the name, address, telephone number, and professional license number (if any) of the importer.

"(ii) the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.
(K) Certification from the importer or manufacturer of the prescription drug that the prescription drug—
   (i) is approved for marketing in the United States;
   (ii) meets all labeling requirements under this Act;
   (L) Laboratory records, including complete data derived from all tests necessary to ensure that the prescription drug is in compliance with established specifications and standards, as necessary;
   (M) Documentation demonstrating that the testing required by subparagraphs (J) and (L) was conducted at a qualifying laboratory;
   (N) Any other information that the Secretary determines is necessary to ensure the protection of the public health.

(2) MAINTENANCE BY THE SECRETARY.—The Secretary shall maintain information and documentation submitted under paragraph (1) for such period of time as the Secretary determines is necessary.

(e) TESTING.—The regulations under subsection (b) shall require—
   (1) that testing described in subparagraphs (J) and (L) of subsection (d) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory;
   (2) if the tests are conducted by the importer—
      (A) that information needed to—
         (i) authenticate the prescription drug being tested; and
         (ii) confirm that the labeling of the prescription drug complies with labeling requirements under this Act; be supplied by the manufacturer of the prescription drug to the pharmacist or wholesaler; and
      (B) that the information supplied under subparagraph (A) be kept in strict confidence and used only for purposes of testing or otherwise complying with this Act; and
   (3) may include such additional provisions as the Secretary determines to be appropriate to provide for the protection of trade secrets and commercial or financial information that is privileged or confidential.

(f) REGISTRATION OF FOREIGN SELLERS.—Any establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment.

(g) SUSPENSION OF IMPORTATION.—The Secretary shall require that importations of a prescription drug or importations by a specific importer under subsection (b) be immediately suspended on discovery of a pattern of importation of that specific prescription drug or by that specific importer of drugs that are counterfeit or in violation of any requirement under this section, until an investigation is completed and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported under subsection (b).

(h) APPROVED LABELING.—The manufacturer of a prescription drug shall provide an importer written authorization for the importation at no cost, of the approved labeling for the prescription drug.

(i) PROHIBITION OF DISCRIMINATION.—(1) A prescription drug shall be unlawful for a manufacturer of a prescription drug to discriminate against, or cause any other person to discriminate against, a pharmacist or wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer that is unlawful.

(2) DISCRIMINATION.—For the purposes of paragraph (1), a manufacturer of a prescription drug shall be considered to discriminate against a pharmacist or wholesaler if the manufacturer enters into a contract for sale of a prescription drug, places a limit on supply, or employs any other measure, that has the effect of—
   (A) providing pharmacists or wholesalers access to prescription drugs on terms or conditions that are less favorable than the terms or conditions provided to a foreign purchaser (other than a charitable or humanitarian organization) of the prescription drug;
   (B) restricting the access of pharmacists or wholesalers to a prescription drug that is permitted to be imported into the United States under the regulations under subsection (b).

(3) DRUGS IMPORTED FROM CANADA.—In general, the Secretary shall require that importations of prescription drugs from Canada, other than with respect to section 801(d)(1) as provided in this section.

(i) IN GENERAL.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct a study of—
   (1) the number of shipments made during the study period that are determined to be counterfeit, misbranded, or adulterated, and compare that number with the number of shipments made during the study period within the United States that are determined to be counterfeit, misbranded, or adulterated; and
   (2) consultation with the Secretary, the United States Trade Representative, and the Commissioner of Patents and Trademarks to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under Federal law.

(ii) REQUIREMENTS.—In conducting the study, the Institute of Medicine shall—
   (1) evaluate the compliance of importers with the regulations under subsection (b);
   (2) compare the number of shipments made during the study period under the regulations under subsection (b) with the number of shipments made during the study period within the United States that are determined to be counterfeit, misbranded, or adulterated; and
   (3) consult with the Secretary, the United States Trade Representative, and the Commissioner of Patents and Trademarks to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under Federal law.

(m) CONSTRUCTION.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

(i) EFFECTIVENESS OF SECTION.—
   (1) IN GENERAL.—If, after the date that is 1 year after the effective date of the regulations under subsection (b) and before the date that is 18 months after the effective date of the regulations under subsection (b) and before the date that is 18 months after the effective date of this section, the Secretary submits to Congress a report describing the findings of the study under subparagraph (A).

(A) STUDY.—The Comptroller General of the United States shall conduct a study to determine the effect of this section on the price of prescription drugs sold to consumers at retail.

(B) REPORT.—Not later than 18 months after the effective date of the regulations under subsection (b), the Secretary shall submit to Congress a report describing the findings of the study under subparagraph (A).

(C) CONSTRUCTION.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

(ii) EFFECTIVENESS OF SECTION.—
   (1) IN GENERAL.—If, after the date that is 1 year after the effective date of the regulations under subsection (b) and before the date that is 18 months after the effective date of this section, the Secretary submits to Congress a report describing the findings of the study under subparagraph (A).

(A) STUDY.—The Comptroller General of the United States shall conduct a study to determine the effect of this section on the price of prescription drugs sold to consumers at retail.

(B) REPORT.—Not later than 18 months after the effective date of the regulations under subsection (b), the Secretary shall submit to Congress a report describing the findings of the study under subparagraph (A).

(C) CONSTRUCTION.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

(i) IN GENERAL.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct a study of—
   (1) the number of shipments made during the study period that are determined to be counterfeit, misbranded, or adulterated, and compare that number with the number of shipments made during the study period within the United States that are determined to be counterfeit, misbranded, or adulterated; and
   (2) consult with the Secretary, the United States Trade Representative, and the Commissioner of Patents and Trademarks to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under Federal law.
"(B) identifies specifically, in qualitative and quantitative terms, the benefits that would result from implementation of this section (including the benefit of reductions in the cost of covered products to consumers in the United States, allowing consumers to procure needed medication that consumers might not otherwise be able to procure without foregoing other necessities of life); and

"(C)(i) compares in specific terms the detriment identified under subparagraph (A) with the benefits identified under subparagraph (B); and

"(ii) determines that the benefits do not outweigh the detriment.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

(b) CONFORMING AMENDMENTS.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301(aa) (21 U.S.C. 333(aa)), by striking "covered product in violation of section 804" and inserting "prescription drug in violation of section 804"; and

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6)), by striking "covered product pursuant to section 804" and inserting "prescription drug under section 804(b)".

TITLE IX—OFFSET

SEC. 901. INCREASE IN MEDICAID BEST PRICE REBATE PERCENTAGE.

(a) IN GENERAL.—Section 102(c)(1)(B)(ii) (42 U.S.C. 1396-8c(1)(B)(ii)) is amended—

(1) in clause (IV), by striking "and at the end; and

(2) in clause (V)—

(A) by inserting "and before January 1, 2004," after "December 31, 1995,"; and

(B) by striking the period at the end and inserting "and, as a result of the rebate percentage increase, the Federal government will save an estimated $393,000,000,000 during the 10-fiscal-year period that begins on October 1, 2003.

Mr. THOMPSON of California (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

Mr. THOMPSON of California (Mr. THOMPSON). Mr. Speaker, I recognize for 5 minutes on his motion to recommit.

Mr. THOMPSON of California. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, during tonight’s debate we have heard a number of times the Democrats do not have a feasible Medicare prescription drug proposal. This is just not true. The Blue Dogs have a motion to recommit that offers a real and an affordable prescription drug alternative, and it does so without calling for an end of Medicare. And we have included strong safeguard language that specifically instructs the Secretary to keep the costs of this measure under $400 billion budget window. The Blue Dog motion to recommit provides Medicare fallback, unlike the Republican bill, protects traditional fee for service Medicare, unlike the Republican bill, and provides billions of dollars of relief for rural providers.

Unfortunately, for America’s seniors, our proposal will only get 5 minutes of discussion tonight, 5 minutes to protect Medicare from privatization. 5 minutes. For our seniors to have a benefit if the PPOs do not come to their areas. And for all of the Members tonight who have said they are supporting the Republican bill in order to move the debate, the best way to do that is support this recommit so we can promptly get a measure back here in the morning to vote on.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to the gentleman from Texas (Mr. STENHOLM).

Mr. STENHOLM. Mr. Speaker, I rise in humble appreciation for the 45 seconds being allowed to me tonight to speak for what I am for in Medicare, and to express my extreme disappointment in the leadership of this House for bringing to the floor a bill based on an ideological agenda that will undermine the traditional Medicare program and fail to provide prescription drug coverage for seniors in rural areas, or seriously address the issue of prescription drug costs.

The motion to recommit promptly reported back to the floor will have a provision in Medicare, for rural areas if private plans are not available, stronger provisions for rural providers, stays within the $400 billion allocation which safeguards to make sure that that happens, and it is based on the compromise in the other body that will give strong bipartisan support and become law.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to the gentlewoman from Tennessee (Mr. TANNER).

Mr. TANNER. Mr. Speaker, I did not vote for the Democratic substitute because I thought it was too light on reformation. The Republican bill is too light on substance.

Mr. Speaker, we have a middle ground here, if we were only allowed to offer it, and it is what the gentleman from Texas (Mr. STENHOLM) said. Basically, any meaningful reform in the Medicare or health care area, the focus of that matter is, one, a Federal fallback for rural America, which is not in the bill we are considering; and, two, some measure of cost containment. That is how we save the program. Neither one of these essential elements in my judgment is in the bill. If we could get this motion to recommit, we could fix it and we could come back here with strong bipartisan support.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to our colleague, the gentleman from Georgia (Mr. SCOTT).

Mr. SCOTT. Mr. Speaker, I yield 20 seconds to the gentleman from Vermont (Mr. SANDERS).

Mr. SANDERS. Mr. Speaker, I am not really a Blue Dog. Mr. Speaker, the Republican proposal ignores the most important prescription drug issue facing our country, cost containment and the need to end the national disgrace by which our citizens are forced to pay, by far, the highest prices in the world for prescription drugs. If we do not pass this motion to recommit, the pharmaceutical industry will have succeeded in keeping prices high and their profits high.

This motion to recommit removes the poison pill in H.R. 1, the so-called Cochran amendment, and establishes a real prescription drug reimportation program with Canada. This provision alone, without costing the taxpayers one penny, will do more to help seniors and all Americans get affordable drugs than the $400 billion being spent by the Republicans.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to our colleague, the gentleman from Illinois (Mr. EMANUEL), who is not a Blue Dog, but knows a good deal when he sees one.

Mr. EMANUEL. Mr. Speaker, the speaker earlier talked about using competition and market forces. This bill allows competition between generics versus name brand, so we get lower prices. It does not have the poison pill in H.R. 1, the so-called Cochran amendment, which is giving up our market share, which we do not have competition whether we want to buy here in the United States, England, France, Germany, and allows competition between those prices. It would save money. It uses market forces to reduce prices.

Third, it allows the Secretary of HHS to get the best available price, just like all of the Sam’s Clubs all over America. It does that here. It allows competition and market forces to reduce prices.

These provisions have, in the past, received bipartisan support. They should receive bipartisan support today because they represent our common
principles of reducing prices and making medications affordable to all Americans.

Mr. THOMPSON of California. Mr. Speaker, I urge this body to vote to send this motion back to committee and promptly report back a solid Medicare prescription drug benefit that we can pass tomorrow.

Mr. THOMAS. Mr. Speaker, I rise in opposition to the motion to recommit. I do want to announce that today is the gentleman from Iowa’s (Mr. Nussle) birthday as well.

As my colleagues know, I have a reputation for reading legislation. I apologize. As I began reading the motion to recommit, as I got to page 3, the comment of the gentleman from Vermont ringing in my ears, about how they are really concerned about cost containment.

It turns out subtitle D has been scratched from the bill, my colleagues might like to know. It contains section 131, additional requirements for annual financial report and oversight on the Medicare program. Section 132, trustee report on Medicare’s unfunded obligations. That has been scratched from the bill.

And I continued to try to get through, but actually, you only need the front page. My colleagues heard them say over and over again: “promptly.” We know by now: “forthwith,” “it works.” “It comes back, we can vote on it.” I say: promptly, it does not mean a thing.

Vote “no” on the motion to recommit.

Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit. The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.
ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The vote was taken by electronic device, and there were—yeas 410, nays 9, not voting 13, as follows: [Roll No. 333]

YEAS—410

Mr. ISTOOK with Mr. YOUNG of Florida: Mr. ISTOOK. Mr. Speaker, on my vote just recorded I voted "no." I have a pair with the gentleman from Florida, Mr. YOUNG, who is at a funeral, and desire to change my vote and be recorded as "present."

Mr. OTTER and Mrs. EMERSON changed their vote from "no" to "aye."

So the bill was passed. The vote was announced as above recorded.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore. Pursuant to section 3 of House Resolution 299, the text of H.R. 2596 shall be appended to the engrossment of H.R. 1, and H.R. 2596 shall be laid on the table.

INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The pending business is the question of the passage of the bill, H.R. 2417, on which further proceedings were postponed earlier today.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the passage of the bill on which the yeas and nays are ordered. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 410, nays 9, not voting 13, as follows: [Roll No. 333]
The SPEAKER pro tempore (Mr. OSE). Is there any objection to the request of the gentleman from Texas?

There was no objection.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. OSE). The Speaker will now announce the following appointment:

APPOINTMENT OF HON. TOM DAVIS OF VIRGINIA TO ACT AS SPEAKER PRO TEMPORE TO SIGN ENROLLED BILLS AND JOINT RESOLUTIONS THROUGH JULY 7, 2003

The SPEAKER pro tempore laid before the House the following Communication from the Speaker:


I hereby appoint the Honorable Tom Davis to act as Speaker pro tempore to sign enrolled bills and joint resolutions through July 7, 2003.

J. DENNIS HASTERT, Speaker of the House of Representatives.

There was no objection.

HONORING THE NORTHWESTERN BAND OF THE SHOSHONE NATION

Mr. BISHOP of Utah asked and was given permission to address the House for 1 minute and to revise and extend his remarks.

Mr. BISHOP of Utah. Mr. Speaker, I rise today to honor the Northwestern Band of the Shoshone Nation, headquartered in my hometown of Brigham City, Utah, and located throughout northern Utah and southern Idaho, and specifically to pay tribute to this tribe as it enters a new chapter in its history.

For more than 1,500 years, the Northwestern Band of the Shoshone Nation has cared for much of the land that consumes my district as well as the districts of my colleagues in Idaho and Nevada. Last month, the Shoshones took ownership of a portion of the land along the Bear River in Idaho where as many as 380 of their ancestors were killed by the U.S. Cavalry on January 29, 1863. The Bear River Massacre, as it is called, was the worst slaughter of Native Americans west of the Mississippi, with an estimate of double the number of deaths of those at Wounded Knee. Now, for the first time in its history, 26 acres where so many Shoshones perished will be treated as the sacred burial ground that it is. In a solemn and very moving ceremony, the Northwestern Band of the Shoshone Nation was able to perform burial rites for the men, women and children who died on that site 140 years ago.

Mr. Speaker, today I wish to honor those members of this tribe who gave their lives on that day in 1863.

I also want to commend the efforts of the tribe, the American West Heritage Center, and the Trust for Public Lands for working together to bring closure to this issue.

Mr. Speaker, I rise today to honor the Northwestern Band of the Shoshone Nation, headquartered in my hometown of Brigham City, Utah, and located throughout northern Utah and southern Idaho, and to pay tribute to this tribe as it celebrates a new chapter in its history.

For more than 1,500 years, the Northwestern Band of the Shoshone Nation has cared for much of the land that makes up my district—and the districts of my colleagues from Idaho and Nevada. Last month, the Northwestern Shoshones took ownership of a portion of the land along the Bear River in Idaho where as many as 380 of their ancestors were killed by the U.S. Cavalry on January 29, 1863. The Bear River Massacre, as it
As the United States gears up to mark the Mississippi of Native Americans, with estimates of the dead nearly double those of Wounded Knee, South Dakota. Now, for the first time in its history, 26 acres where so many Shoshones perished will be treated as the sacred burial ground that it is. In a ceremony and meeting held in the Northern Band of the Shoshone Nation was able to perform burial rites for the men, women, and children who died on that site over 140 years ago. Mr. Speaker, today I wish to honor those members of the tribe who gave their lives on that day in 1863.

I want to commend the efforts of the tribe, the American West Heritage Center, and the Trust for Public Lands for working together to bring closure to this episode in our nation's history. Their goal is to obtain a total of 150 acres so that the Bear River Massacre site can be turned into a memorial. This story, along with the tribe's history and culture, will be preserved and shared with the public at the nearby American West Heritage Center in Wells, Utah, which is also located in my district.

Mr. Speaker, for the benefit of our colleagues, I am also submitting an article for the Record from a Salt Lake newspaper, which details the history of this site. I commend the past and current Shoshone leadership for their vision and efforts.

[From the Salt Lake Tribune, Feb. 4, 2003]

THIS Hallowed GROUND

It never made any sense to call what happened at Idaho's Bear River 140 years ago a "battle." When soldiers based in Salt Lake City were dispatched to Idaho to defend people who at least 250 men, women and children of the Northwestern Shoshone tribe on Jan. 29, 1863, it was a massacre.

And it still makes no sense that the site of that blot on our shared history is not officially designated as a national historic site. Descendants of the Northwestern Shoshone see the historic significance of the place, and so does the National Park Service. But, while the site near Preston in southeastern Idaho drew a small crowd of devoted friends to mark the anniversary of the horrible event, what happened there remains something that has been largely air-brushed, Stain-like, from our official memory.

The irony, apparently, is that Idaho Sen. Larry Craig has for eight years been battling up a resolution to create a $4 million Bear River National Historic Site and Visitors Center. Craig says the park service has more immediate needs and, given the constant scuffle within all federal agencies for adequate funding, it is true that not every idea for a new national historic site can be fulfilled.

But the Bear River massacre is important enough to be buried into our collective memory. It was one of the earliest and one of the bloodiest encounters between Native Americans and European settlers in the Far West. Its memory has been preserved through the tireless efforts of a few Shoshone, most notably Utah's Mae Timbimboo Parry, efforts that deserve us to be chronicled at an official historic site.

As the United States starts up to mark the 200th anniversary of Lewis and Clark's Corps of Discovery, with proper notice given to their departure at Mackinac, Michigan, now would be the proper time to note this terribly sad bit of fallout from that courageous expedition. The extra amount of attention that will bring to the lives and Clark's Corps will be used to earn support from historians, Congress, foundations and the general public to properly mark the site of the Bear River Massacre and formally mourn those who died there.

The place of the Bear River Massacre is a national historic site, whether we say so or not. We should say so.

THE CRISIS IN LIBERIA

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in response to the troubling situation of unrest in our ally nation of Liberia. Because of the rich history of its birth in 1820 with the valiant acts of freed American slaves in founding the capital of Christopolis, now Monrovia, we certainly have a stake in the need for restoring peace.

Since the end of the seven-year civil war that claimed the lives of over 250,000 people, more than 1.3 million residents have had to flee the country for refuge in neighboring countries, many of which have already reached the end of their meager resources. The series of events in Liberia presents a hardship on any yesterday's events: we celebrated a Constitutional victory in the Gruuter v. Bollinger decision that came out of the highest court in the nation. Similarly ironic, on that same day, we saluted the Honorable Mayor Maynard Jackson, J. R., one of the most charismatic civic leaders of all time in his departure at age 65. This ironic juxtaposition of emotions reminds us that no matter how far we think we've gotten, there is always distance to be traveled in the work of making peace in the world.

The U.N. High Court indictment of Liberian President Charles Taylor on charges of crimes against humanity, largely stemming from his participation in the civil war in Sierra Leone, has created a deaf ear in Monrovia. A Liberian woman stated that "We are all tired of Charles Taylor, but we are afraid that his arrest in Ghana will create chaos." We in the United States now know the feeling of panic as we check the terror threat on a daily basis—today's threat level being Yellow, or "heightened." People shouldn't have to live in fear.

The economic effect of the renewed arms embargo, bar on dealing in rough diamonds, and airline restrictions on Liberia will be substantial for the citizens and business community. However, the human rights abuses such as summary executions, recruitment of child soldiers, sexual violence, looting of civilian property, and forced labor must end now. The mass evacuation aboard the French vessel Oraje of the hundreds of foreigners, including Americans, holding dual U.S. and Liberian citizenship, Europeans, Lebanese, Ivoirian and Indian nationals, Egyptians and South Africans who represent a departure from our goal of uniting our international community in peace. It is a moral imperative that we end the chaos caused by anarchy and criminal behavior. The Ceasefire Agreement between the Republic of Liberia, the Liberians United for Reconciliation and Democracy (LUR) groups, and the Movement for Democracy in Liberia (MODEL) is a start, but our help is imperative. We must make our voices heard and incite action from our colleagues in order to restore peace.

SPECIAL ORDERS GRANTED

By unanimous consent, leave of absence was granted to:

Mr. Wynn at the request of Ms. Pelosi for today until 11:00 a.m. on account of personal business.

Mr. Young of Florida at the request of Mr. DeLay for today from 6:00 p.m. and the balance of the week on account of attending a funeral.

SENATE BILLS REFERRED

Bills of the Senate of the following titles were taken from the Speaker's table and, under the rule, referred as follows:

S. 163. An act to reauthorize the United States Institute for Environmental Conflict Resolution, and for other purposes; to the Committee on Education and the Work Force and the Committee on Resources.

S. 496. An act to authorize the President to posthumously award a gold medal on behalf of Carl W. Northway, for his work as a mediator and peacemaker in the end of their meager resources. The chaos caused by anarchy and criminal behavior. The Ceasefire Agreement between the Republic of Liberia, the Liberians United for Reconciliation and Democracy (LUR) groups, and the Movement for Democracy in Liberia (MODEL) is a start, but our help is imperative. We must make our voices heard and incite action from our colleagues in order to restore peace.

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The U.N. High Court indictment of Liberian President Charles Taylor on charges of crimes against humanity, largely stemming from his participation in the civil war in Sierra Leone, has created a deaf ear in Monrovia. A Liberian woman stated that "We are all tired of Charles Taylor, but we are afraid that his arrest in Ghana will create chaos." We in the United States now know the feeling of panic as we check the terror threat on a daily basis—today's threat level being Yellow, or "heightened." People shouldn't have to live in fear.

The economic effect of the renewed arms embargo, bar on dealing in rough diamonds, and airline restrictions on Liberia will be substantial for the citizens and business community. However, the human rights abuses such as summary executions, recruitment of child soldiers, sexual violence, looting of civilian property, and forced labor must end now. The mass evacuation aboard the French vessel Oraje of the hundreds of foreigners, including Americans, holding dual U.S. and Liberian citizenship, Europeans, Lebanese, Ivoirian and Indian nationals, Egyptians and South Africans who represent a departure from our goal of uniting our international community in peace. It is a moral imperative that we end the chaos caused by anarchy and criminal behavior. The Ceasefire Agreement between the Republic of Liberia, the Liberians United for Reconciliation and Democracy (LUR) groups, and the Movement for Democracy in Liberia (MODEL) is a start, but our help is imperative. We must make our voices heard and incite action from our colleagues in order to restore peace.
Mr. DELAY. Mr. Speaker, pursuant to the jurisdiction of the Committee on Armed Services, the House of Representatives on Thursday, at 2 o'clock and 47 minutes a.m., Friday, June 27, 2003, pursuant to the previous order of the House of today, the House adjourned until 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its adoption of House Concurrent Resolution 231, in which case the House shall stand adjourned pursuant to that concurrent resolution. 

The resolution (at 2 o'clock and 47 minutes a.m., Friday, June 27, 2003, pursuant to the previous order of the House of today, the House adjourned until 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its adoption of House Concurrent Resolution 231. 

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

2896. A letter from the Deputy Secretary, Department of Defense, transmitting notification of munitions disposal, pursuant to 50 U.S.C. 1512(a); to the Committee on Armed Services.

2897. A letter from the Acting Under Secretary, Department of Defense, transmitting a report on evaluation of the programmatic impact of combining funding and administration for the Historically Black Colleges and Universities and Minority Institutions in Disparity-Serving Institutions program, and the American Indian Tribal Colleges program; to the Committee on Armed Services.

2898. A letter from the Secretary, Department of Transportation, transmitting the Department's annual report as required by the Superfund Amendments and Reauthorization Act of 1986, as amended, pursuant to 42 U.S.C. 9620; to the Committee on Energy and Commerce.

2899. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Natural Emission Source Categories: General Provisions; and Requirements for Control Technology Determinations for Major Sources in Accordance with the New Source Performance Standards; Sections 112(g) and 112(i) [FRL-7484-8 (RIN: 2060-AK2)] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2900. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Approval and Promulgation of State Air Quality Plans for Designated Facilities and Pollutants; State of West Virginia; Control of Emissions from Existing Small Municipal Waste Combustion Units [WW06-6027a; FRL-7503-2] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.


2902. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Approval of the Clean Air Act, Section 112(h), Authority for Hazardous Air Pollutant and Control of Asbestos Disposal Sites Not Operated After July 9, 1981; State of New Hampshire Department of Environmental Services [FRL-7490-6] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.


2904. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Natural Emission Source Categories: Standards of Performance for Stationary Process Plants Under the Clean Air Act, Sections 112(g) and 112(i); [FRL-7502-4] (RIN: 2060-AK35) received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2905. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Natural Emission Standards for Hazardous Air Pollutants for Chemical Recovery Combustion Sources at Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian Tribes; for Nine Western States and Eligible Indian...

2021. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department’s final rule — Airworthiness Directives; Cessna Aircraft Company Model C414-210 and C414-212 Turboprop Engines; and DC-9-81 (MD-81), DC-9-82 (MD-82), and DC-9-83 (MD-83) Series Airplanes [Docket No. 2000-NE-03-AD; Amendment 39-13098; AD 2003-07-11] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2022. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department’s final rule — Airworthiness Directives; Bombardier Model CL-600-2B19 (Regional Jet Series 440) Series Airplanes [Docket No. 2002-CE-18-AD; Amendment 39-13138; AD 2003-09-09] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2023. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department’s final rule — Airworthiness Directives; Schweizer Aircraft Model 2001-NE-48-AD; Amendment 39-13139; AD 2003-09-09] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.
June 26, 2003

CONGRESSIONAL RECORD — HOUSE

H6261

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions were introduced and severally referred, as follows:

By Mr. CASE (for himself, Mr. SANDERS, Ms. BORDALLO, and Mr. FROST):

H.R. 2607. A bill to modify the contract consolidation requirements in the Small Business Act, and for other purposes; to the Committee on Small Business.

By Mr. SMITH of Michigan (for himself, Mr. BERNIE SANDERS of Vermont, Ms. BORDALLO, and Mr. FROST):

H.R. 2608. A bill to reauthorize the National Earthquake Hazards Reduction Program, and for other purposes; to the Committee on Science, and in addition to the Committee on Transportation and Infrastructure, pursuant to the jurisdiction of the committee concerned.

By Mr. CONYERS:

H.R. 2609. A bill to amend title IJ, United States Code, to provide for the avoidance of certain transfers, and the alternate prosecution of certain actions, relating to certain retirement benefits; to the Committee on the Judiciary.

By Mr. PETERSON of Minnesota (for himself, Mr. LATHAM, Mr. CRAMER, Mr. BOEHNER, Mr. HALL, Mr. SIMPSON, Mr. DOOLEY of California, Mr. GUTNECK, Mr. BOSWELL, Mr. JANKOW, Mr. LUCAS of Kentucky, and Ms. HARISI):

H.R. 2610. A bill to amend the Internal Revenue Code of 1986 to restore the estate tax to the generally applicable capital gains income tax rate; to the Committee on Ways and Means.

By Mr. MICHAUD (for himself, Mr. BROWN of South Carolina, Mr. EVANS, Mr. FILNER, Mr. GUTIERREZ, Ms. CORRINE BROWN of Florida, Mr. RODRIGUEZ, Mr. RYAN of Ohio, and Mr. EVANS):

H.R. 2611. A bill to amend title II of the Social Security Act to exempt from the windfall elimination provision of such title individuals who are entitled to retired pay based on at least 20 years of service as a member of a uniformed service; to the Committee on Ways and Means.

By Mr. MICHAUD (for himself and Mr. EVANS):

H.R. 2612. A bill to amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to provide specially adapted housing assistance to veterans with permanent and total service-connected disabilities due to the loss of use of both upper extremities and to preclude use of the arms at and below the elbows; to the Committee on Veterans' Affairs.

By Mr. SABO (for himself, Ms. KAPTUR, Mr. KIRK, Mr. BAIRD, Ms. EDDIE BERNERS-LEE of New York, Mr. WEINER, Mr. NEISS, Ms. MILLENDER-McDONALD, Ms. BERKLEY, Mr. PASCARELL, Mr. BOSWELL, Ms. CORRINE BROWN of Florida, Ms. CARSON of Indiana, Mr. HUDDLE of California, Mr. HOFELER, Mr. LAMPSON, Mr. MATHESON, and Mr. CARSON of Oklahoma):

H.R. 2613. A bill to provide funding for infrastructure investment to restore the United States economy and to enhance the security of transportation and environmental facilities throughout the United States; to the Committee on Transportation and Infrastructure, and in addition to the Committees on Ways and Means, Energy and Commerce, Financial Services, and Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. FARR (for himself, Mr. WOLF, Mr. HOEFFEL, Mr. LEACH, and Mr. WEXLER):

H.R. 2614. A bill to increase the capabilities of the United States to provide reconstruction assistance to countries or regions impacted by armed conflict, and for other purposes; to the Committee on International Relations.

By Mr. SHADEGG:

H.R. 2615. A bill to protect American consumers from identity theft and other forms of fraud; to the Committee on Financial Services, and in addition to the Committees on Ways and Means, and Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. OBRY:

H.R. 2616. A bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes; to the Committee on Appropriations.

By Mr. CASSEY:

H.R. 2617. A bill to protect American consumers from identity theft and other forms of fraud; to the Committee on Financial Services, and in addition to the Committees on Ways and Means, and Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. SMITH of New Jersey (for himself, Mr. LANTOS, Mr. PITTS, Ms. SLAUGHTER, and Ms. ESPOSO):

H.R. 2620. A bill to authorize appropriations for fiscal years 2004 and 2005 for the Trafficking Victims Protection Act of 2000, and for other purposes; to the Committee on International Relations, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

REPORTS OF COMMITTEE ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. BOEHNER: Committee on Education and the Workforce. H.R. 438. A bill to increase the amount of student loans that may be forgiven for teachers in mathematics, science, and special education; with an amendment (Rept. 108-182). Referred to the Committee on the Whole House on the State of the Union.

Mr. BOEHNER: Committee on Education and the Workforce. H.R. 2211. A bill to reauthorize the Head Start Act to improve school readiness of disadvantaged children, and for other purposes; with an amendment (Rept. 108-184). Referred to the Committee of the Whole House on the State of the Union.

Mr. BOEHNER: Committee on Education and the Workforce. H.R. 2210. A bill to reauthorize the Head Start Act to improve school readiness of disadvantaged children, and for other purposes; with an amendment (Rept. 108-184). Referred to the Committee of the Whole House on the State of the Union.

Mr. BOEHNER: Committee on Education and the Workforce. H.R. 2212. A bill to reauthorize the Head Start Act to improve school readiness of disadvantaged children, and for other purposes; with an amendment (Rept. 108-184). Referred to the Committee of the Whole House on the State of the Union.

Mr. BOEHNER: Committee on Education and the Workforce. H.R. 2213. A bill to reauthorize the Head Start Act to improve school readiness of disadvantaged children, and for other purposes; with an amendment (Rept. 108-184). Referred to the Committee of the Whole House on the State of the Union.
By Mr. ALLEN (for himself, Mr. SIMMONS, Mr. DELAHUNT, Mrs. CAPPS, Mr. CAPUANO, Mr. FARR, Mr. MARKEY, Mr. GEORGE MILLER of California, and Ms. WELCH):  
H.R. 2642. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS (for himself, Ms. Holloway of Oregon, Mr. BALLENGET, Mr. MOORE, Mr. LATOURETTE, Mr. KANJORSKI, Mr. CASTLE, Mrs. MALONEY, Mr. SHADEGG, Mr. FORD, Mr. TIBERI, Mr. HERNSHARG, Mr. CROWLEY, Mr. SESSIONS, Mr. ROSS, Mr. MATHESON, Mr. DAVIS of Alabama, Mr. BAKER, Mr. KING of New York, Ms. LUCAS of Kentucky, Mr. NEY, Mrs. KELLY, Mr. JONES of North Carolina, Mr. ISRAEL, Mr. HART, Mr. MILLER of North Carolina, Mrs. CAPITO, Mrs. MCCARTHY of New York, Mr. BARRETT of South Carolina, Mr. FEENEY, and Ms. HARRIS):  
H.R. 2623. A bill to amend the Internal Revenue Code of 1986 to make permanent the inclusions in the jurisdiction of the committee concerned.

By Mr. BOSWELL:  
H.R. 2635. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2631. A bill to amend Federal laws respecting the purchase of items of arms and services provided to the armed forces in the use of, and in addition to the Committee on Armed Services.

By Mr. BACHUS:  
H.R. 2632. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2624. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2625. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2626. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2627. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2628. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2629. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2630. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2631. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

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By Mr. BACHUS:  
H.R. 2633. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2634. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2635. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2636. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2637. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2638. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2639. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2640. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2641. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2642. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2643. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2644. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2645. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2646. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2647. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2648. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2649. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2650. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2651. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2652. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2653. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2654. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2655. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2656. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2657. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2658. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2659. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2660. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2661. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.

By Mr. BACHUS:  
H.R. 2662. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fisheries data systems; to the Committee on Resources.
By Mrs. MYRICK: H.R. 2645. A bill to suspend temporarily the duty on Dianix Black XF; to the Committee on Ways and Means.

By Mr. UDALL: H.R. 2646. A bill to suspend temporarily the duty on Dianix Crimson SF; to the Committee on Ways and Means.

By Ms. NORTON: H.R. 2647. A bill to provide for nuclear disarmament and economic conversion in accordance with the Columbia Initiative Measure Number 37 of 1992; to the Committee on Armed Services, in addition to the Committee on International Relations, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. POMBO: H.R. 2648. A bill to amend the Internal Revenue Code of 1986 to permit the use of proceeds of tax exempt private activity bonds for community and water facility loans guaranteed under the Consolidated Farm and Rural Development Act; to the Committee on Ways and Means.

By Mr. PETER (for himself, Mr. CARTER, and Mr. COLE): H.R. 2649. A bill to prohibit the Secretary of Education from making any funds available to any program administered by the Department of Education unless the Secretary determines that the State has in place a criminal information sharing system; to the Committee on Education and the Workforce.

By Mr. RAHALL (for himself, Ms. PELOSI, Mr. UDALL of New Mexico, Mr. RODRIGUEZ, and Mr. HOYER): H.R. 2650. A bill to prohibit the study or implementation of any plan to privatize, divest, or otherwise cede part of the function, or responsibility of the National Park Service; to the Committee on Resources.

By Ms. LINDA T. SANCHEZ of California (for herself, Mr. GEORGE MILLER of California, Mr. TOWNS, Mr. RUSH, Ms. MILLER-MCDONALD, Mr. FROST, Mr. GRIJALVA, Mr. PATOR, Mr. ORTIZ, Mr. REYES, Mr. HIJOSA, Mr. BACA, Ms. JACKSON-LEE of Texas, Mr. MCGOVERN, Mr. SOTO, Mr. TOWTGER, Mr. MCDEMCERT, Mr. NADRPL, Mrs. DAVIS of California, and Ms. DELAURER): H.R. 2651. A bill to direct the Secretary of Education to make grants to States to establish antibullying programs; to the Committee on Education and the Workforce.

By Mr. STUPAK: H.R. 2652. A bill to amend the Federal Food, Drug, and Cosmetic Act with respect to the sale of prescription drugs through the Internet; to the Committee on Energy and Commerce.

By Mr. UDALL of Colorado: H.R. 2653. A bill to facilitate the repositioning by the Secretary of the Interior of certain mineral rights, and for other purposes; to the Committee on Resources.

By Mr. VITTER: H.R. 2654. A bill to amend the Outer Continental Shelf Lands Act to direct the Secretary of the Interior to issue regulations authorizing the use of a decommissioned offshore oil and gas platform for culture of marine organisms, an artificial reef, or scientific research, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. WALSH (for himself, Mr. KING of New York, Mr. NEAL of Massachusetts, Mr. CROWLEY, Mr. SWEENEY, Mr. MCDERMOTT, Mrs. MCCARTHY of New York, Mr. QUINN, Mr. MOLLHAHN, Mr. HOLDEN, Mr. SMITH of New Jersey, Mr. ACKERMAN, Mr. MCNULTY, Mr. ENGLE, Mr. PAYNE, Mr. FROST): H.R. 2655. A bill to amend and extend the Irish Peace Process Cultural and Training Program Act of 1998, to authorize the Secretary of the Interior, in addition to the Committee on International Relations, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. WOOLSEY (for herself and Mr. THOMPSON): H.R. 2656. A bill to amend the Grotan Rancheria Restoration Act to give the Secretary of the Interior discretion regarding taking land into trust; to the Committee on Resources.

By Mr. KING of New York (for himself, Mr. WALSH, Mr. NEAL of Massachusetts, Mr. PAYNE, Mr. SWEENEY, Mr. SMITH of New Jersey, Mr. DELAHUNT, Mr. QUINN, Mr. CAPUANO, Mr. ACKERMAN, Mr. ENGLE, Mr. EVANS, Mr. HOLDEN, Mr. MALONEY, Mr. MCNULTY, Mr. OWENS, Mr. SOUDER, and Mr. WEINER): H.R. 2657. A joint resolution recognizing Commodore John Barry as the first flag officer of the United States Navy; to the Committee on Armed Services.

By Mr. POMEROY: H.R. 2658. A concurrent resolution expressing the sense of the Congress regarding the need to support democratic institutions in Liberia; to the Committee on International Relations.

By Mr. RENZI (for himself, Mr. FRANKS of Arizona, and Mr. GRIJALVA): H. Con. Res. 237. Concurrent resolution honoring the late Rick Lupe, lead forestry technician for the Bureau of Land Management's Fort Apache Agency, for his dedication and service to the United States and for his essential service in fighting wildfires and protecting wild and scenic resources; to the Committee on Resources.

By Mr. ROHRABACHER: H. Con. Res. 238. Concurrent resolution expressing the sense of the Congress that the global diamond industry, as represented by the World Diamond Council, should provide transition development assistance to communities in Sierra Leone, Angola, and the Democratic Republic of Congo, where the illicit trade in conflict diamonds for arms fueled civil war, and for other purposes; to the Committee on International Relations.

By Mr. HOEKSTRA: H. Con. Res. 239. Concurrent resolution expressing the sense of the Congress that the appropriate government agencies, including the State Department and the Treasury Department, should take action to implement international agreements and the Domestic Transfer Order to combat the illicit trade in conflict diamonds.

By Ms. WATSON (for herself, Mr. LANTOS, and Mr. PAYNE): H. Res. 303. A resolution recognizing the outstanding contributions of the faculty, staff, students, and alumni of Christian colleges and universities; to the Committee on Education and the Workforce.

By Mr. ABERCROMBIE: H. Res. 304. A resolution expressing the sense of the House of Representatives that the Federal Government should actively pursue a unified approach to strengthen and protect the national nuclear non-proliferation policy; to the Committee on Resources, and in addition to the Committee on Agriculture, for a period to be subsequently determined by the Speaker; to the Committee on International Relations.

By Ms. KILPATRICK (for herself, Mr. CHRISTENSEN, Mr. SERRANDO, Mr. STARK, Mr. OWENS, Mr. HOFFELER, Mr. DAVIS of Illinois, Ms. CARSON of Indiana, Mr. WAXMAN, Ms. LEE, Mrs. JONES of Ohio, Ms. NORTON, and Mr. KILDIE): H. Con. Res. 234. Concurrent resolution recognizing the significance of preserving the survival of essential urban hospitals; to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. PASCARELL (for himself, Mr. OXLEY, Mr. BROWN of Ohio, Mr. CLAY, Mr. ETHERIDGE, Mr. FERGUSON, Mr. FORD, Mr. FROST, Mr. HOLT, Mr. JEFFERSON, Mr. PAYNE, Mr. TOWNS, Mr. GRIJALVA, Mr. MCDERMOTT, Mrs. CHRISTENSEN, Mr. PALLONE, Mr. SABO, Mr. KING of New York, Mr. PAYNE, Ms. Kaptur, Mr. ACEVEDO-VILA, Mr. NEAL of Massachusetts, Mr. DOYLE, Mr. CAPUANO, and Mr. BRADY of Pennsylvania): H. Con. Res. 235. Concurrent resolution celebrating the life and achievements of Lawrence Eugene "Larry" Daley; to the Committee on Government Reform.

By Mr. POMEROY: H. Res. 236. Concurrent resolution permitting the use of the rotunda of the Capitol for a ceremony to commemorate the unveiling of the statue of Sakakawea provided by the State of North Dakota for display in Statuary Hall; to the Committee on House Administration.

By Mr. BARR: H. Res. 237. Concurrent resolution honoring the late Rick Lupe, lead forestry technician for the Bureau of Land Management's Fort Apache Agency, for his dedication and service to the United States and for his essential service in fighting wildfires and protecting wild and scenic resources; to the Committee on Resources.

By Mr. ROHRABACHER: H. Res. 303. A resolution recognizing the outstanding contributions of the faculty, staff, students, and alumni of Christian colleges and universities; to the Committee on Education and the Workforce.

By Mr. ABERCROMBIE: H. Res. 304. A resolution expressing the sense of the House of Representatives that the Federal Government should actively pursue a unified approach to strengthen and protect the national nuclear non-proliferation policy; to the Committee on Resources, and in addition to the Committee on Agriculture, for a period to be subsequently determined by the Speaker; to the Committee on International Relations.

By Mr. HOEKSTRA: H. Con. Res. 239. Concurrent resolution expressing the sense of the Congress that the global diamond industry, as represented by the World Diamond Council, should provide transition development assistance to communities in Sierra Leone, Angola, and the Democratic Republic of Congo, where the illicit trade in conflict diamonds for arms fueled civil war, and for other purposes; to the Committee on International Relations.

By Mr. KING of New York (for himself, Mr. LANTOS, and Mr. PAYNE): H. Res. 303. A resolution recognizing the outstanding contributions of the faculty, staff, students, and alumni of Christian colleges and universities; to the Committee on Education and the Workforce.
H. Res. 303. A resolution honoring Maynard Holbrook Jackson, J. r., former Mayor of the City of Atlanta, and extending the condolences of the House of Representatives on his death; to the Committee on Government Reform.

By Mrs. NORTHPUP.

H. Res. 304. A resolution expressing the sense of the House of Representatives regarding United States citizens adopting children from the People's Republic of China; to the Committee on the Judiciary.

By Mr. ROTHMAN (for himself, Mr. GARRETT of New Jersey, Mr. Andrews, Mr. LOBIONDO, Mr. PASCREL, Mr. FERGUSON, Mr. PALLONE, Mr. SAXTON, Mr. PAYNE, Mr. FRELINGHUYSEN, Mr. HOLT, Mr. SMITH of New Jersey, and Mr. MENENDEZ).

H. Res. 305. A resolution congratulating the New York Yankees on the occasion of the New Jersey Devils for winning the 2003 Stanley Cup championship; to the Committee on Government Reform.

By Mr. SERRANO (for himself and Mr. NEY).

H. Res. 306. A resolution congratulating the New York Yankees on the occasion of their 100th anniversary; to the Committee on Government Reform.

By Mrs. TAUSCHER (for herself, Mr. Boucher, Mr. PAYNE, Mr. PAYNE, Mr. SCHIFF, Mr. DOOLEY of California): MEMORIALS

Under clause 3 of rule XII:

134. The SPEAKER presented a memorial for the following:

By Mr. KILDEE and Mr. HOEKSTRA.

H. Res. 307. A resolution creating a select committee to investigate the effectiveness of the United States' intelligence structure to meet global threats; to the Committee on Rules.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 22: Mr. WAMP.

H.R. 91: Mr. NEUGEBAUER.

H.R. 193: Mr. BOOZMAN.

H.R. 218: Mr. KILDEE and Mr. HOEKSTRA.

H.R. 236: Mr. ROSS, Mr. RUPPERSBERGER, and Mr. SCOTT of Georgia.

H.R. 276: Mr. HASTINGS of Washington.

H.R. 438: Mr. MURPHY, Mr. MILLER of Michigan, Mr. YOUNG of Alaska, Mr. DICKS, Mr. BOOZMAN, and Mr. BONILLA.

H.R. 239: Mr. ROGERS of Michigan.

H.R. 394: Mr. GOODE.

H.R. 401: Mr. MURPHY.

H.R. 438: Mr. MILLER of Michigan, Mr. YOUNG of Alaska, Mr. DICKS, Mr. BOOZMAN, and Mr. BONILLA.

H.R. 645: Mr. LEWIS of Kentucky and Mr. MANZULLO.

H.R. 705: Mr. JANKLOW.

H.R. 505: Mrs. WILSON of New Mexico.

H.R. 528: Mr. RAMSTAD and Mr. FERGUSON.

H.R. 577: Mr. DINGELL and Mr. BALLENGER.

H.R. 1385: Mr. OBERSTAR, Mr. MATHESON, Mr. ENGEL, and Ms. VELAZQUEZ.

H.R. 1400: Mr. BLUMENAUER, Mr. BOOZMAN, Mr. DIAZ-FRANCISCO, Mr. EVANS.

H.R. 1410: Mr. ROSENFELD, Mr. ROTHMAN, Mr. GONZALEZ, Mr. GONZALEZ.

H.R. 1429: Mr. WILSON of Florida, Mr. DIAZ-FRANCISCO, Mr. DIAZ-FRANCISCO, Mr. EVANS.

H.R. 1461: Mr. ROTHMAN.

H.R. 1466: Mr. GONZALEZ.

H.R. 1477: Mr. WILSON of Florida, Mr. WILSON of Florida, Mr. WILSON of Florida.

H.R. 1482: Mr. OWENS.

H.R. 1499: Mr. OWENS.

H.R. 1500: Mrs. NAPOLITANO.

H.R. 1532: Mr. SCHIFF.

H.R. 1563: Mr. WEXLER.

H.R. 1569: Mr. JANKLOW, Mr. HENSLING, Mr. GUZMAN, Mr. GONZALEZ, and Mr. KING of Iowa.

H.R. 1592: Mrs. DAVIS of California.

H.R. 1613: Ms. DELAURO.

H.R. 1622: Mr. DeMINT, Mr. BOOZMAN, and Mr. BONILLA.

H.R. 1639: Mr. Moran of Virginia, Mr. WEXLER, Mr. GREEN, and Mr. BERKLEY.

H.R. 1641: Mr. BLUMENAUER.

H.R. 1676: Mr. HASTINGS of Washington.

H.R. 1684: Mr. VAN HOLLEN, Ms. DEGETTE.

H.R. 1705: Mr. CROWLEY, Mr. FARR, Mr. MORAN of Virginia, Ms. CARSON of Indiana, Mr. ENGEL, Mr. TIERNY, Mr. RANDOLPH, Mr. MEeks of New York, Ms. ESHOO, Mr. SCHIFF, Mr. CARNEY, Mr. NORTON, Mr. WEXLER, Mr. FINGER, Mr. HOLT, Mr. SERRANO, Mrs. NAPOLITANO, Mr. FRANK of Massachusetts, Mr. PRICE of North Carolina, and Mr. BLUMENAUER.

H.R. 1692: Mrs. MOORE.

H.R. 1707: Mr. SOUDER, Mr. ADERMOUTH, Mr. FORBES, Mrs. J O ANN DAVIS of Virginia, and Mr. MCCLURE.

H.R. 1749: Mr. PUTNAM, Mr. LEWIS of Kentucky, Mr. FROST, and Mrs. CHRISTENSEN.

H.R. 1767: Mr. HASTINGS of Washington, Mr. TOM Emmer, Mr. BILIKERT, Mr. MORAN of Virginia, and Mr. NETHERCUTT.

H.R. 1769: Mr. THOMPSON of California and Ms. LINDA T. SANCHEZ of California.

H.R. 1771: Mr. CALVERT.

H.R. 1776: Mr. EMANUEL.

H.R. 1792: Mr. FROST, Mr. RODRIGUEZ, Ms. BORDALLO, Mr. SANDERS, Mr. BRADY of Pennsylvania, Mr. BAIRD, and Mr. PASCAREL.

H.R. 1828: Ms. NORTON, Mr. BECERRA, Mr. UDALL of New Mexico, Mr. COOPER, Mr. MENENDEZ, Mr. FRELINGHUYSEN, Mr. LOBIONDO, Mr. FLETCHER, Mrs. CAPITO, and Mr. CASTLE.

H.R. 1829: Mr. PLATTS and Mr. MEENAH.

H.R. 1856: Mr. LEACH.

H.R. 1867: Mr. PAUL and Mr. DUNCAN.

H.R. 1874: Mr. ENGEL and Mr. KUCINICH.

H.R. 1895: Ms. VELAZQUEZ and Mr. DAVIS of Tennessee.

H.R. 1918: Mr. MURPHY.

H.R. 1919: Mr. McGovern, Mr. GRIJALVA, and Ms. CARSON of Indiana.

H.R. 1920: Mr. McGovern, Mr. OWENS, and Mrs. CHRISTENSEN.

H.R. 1921: Mr. McGovern and Mr. OWENS.

H.R. 1924: Mr. McGovern, Mr. OWENS, Mr. FROST, and Mr. MCINTYRE.

H.R. 1997: Mr. RAHALL and Mr. LUCAS of Oklahoma.

H.R. 2008: Mrs. CHRISTENSEN.

H.R. 2009: Mr. McGovern and Mr. SIMMONS.

H.R. 2011: Mr. DEUTSCH, Mr. WATERS, Mr. MCHUGH, Mr. PASTOR, and Ms. McCollum.

H.R. 2042: Ms. LE, Mr. PAYNE, Ms. MCCARTHY of Missouri, Mr. Inslee, Ms. BALDWIN, Ms. WALSH, Ms. NAPOLITANO, Ms. SLAUGHTER, Ms. CASE, Mrs. TAUSCHER, Ms. CARSON of Indiana, Mr. DELAHUNT, and Mr. ISRAEL.

H.R. 2047: Mr. POMEROY.

H.R. 2053: Mr. ABERCROMBIE and Mr. GRIJALVA.

H.R. 2075: Mr. GOSS, Mr. FOLEY, Ms. ROSLEHTINEN, and Mr. CRENshaw.

H.R. 2096: Mr. KUCINICH.

H.R. 2096: Mr. GREEN of Texas, Mr. FOLEY, Mr. COLLINS, Mr. SIMMONS, Mr. SKELTON, Ms. VELAZQUEZ, Mr. SMITH of New Jersey, and Mr. MORAN of Virginia.
H.R. 2172: Mr. GILLMOR, Mr. McGovern, and Mr. Camp.
H.R. 2178: Mr. RAMSTAD.
H.R. 2180: Mrs. BIGGERT.
H.R. 2193: Mr. ACKERMAN and Mrs. McCarthy of New York.
H.R. 2203: Mr. OWENS.
H.R. 2220: Mr. BRADY of Texas.
H.R. 2237: Mrs. JONES of Ohio and Mr. Ney.
H.R. 2249: Mr. OSBORNE.
H.R. 2309: Mr. MCKEON, Mr. DREIER, Mr. HERGER, Mr. OGE, Mr. DOOLITTLE, Mr. POMBO, Mr. RADANOVICH, Mr. NUNES, Mr. THOMAS, Mr. GALLEGLY, Mr. ROYCE, Mr. LEWIS of California, Mr. GARY G. MILLER of California, Mr. CALVERT, Mrs. BOND, Mr. ROHRABACHER, Mr. COX, Mr. ISSA, Mr. CUNNINGHAM, Mr. HUNTER, Mr. THOMPSON of California, and Ms. ROYBAL-ALLARD.
H.R. 2314: Mr. CASE, Mr. KENNEDY of Rhode Island, Mr. MCINTYRE, and Mr. BROWN of Ohio.
H.R. 2327: Mrs. CAPITO.
H.R. 2340: Mr. BURR and Mr. KOLBE.
H.R. 2357: Mrs. JO ANN DAVIS of Virginia.
H.R. 2379: Mr. PAUL.
H.R. 2386: Mrs. CUBIN, Mr. REHBERG, Mr. BISHOP of Utah, and Mr. HAYWORTH.
H.R. 2419: Mr. BLUMENTAuer.
H.R. 2433: Mr. GUTIERREZ, Mr. Michaud, and Mr. SNYDER.
H.R. 2435: Mr. NADLER, Mr. THOMPSON of California, and Mr. Davis of Florida.
H.R. 2441: Mrs. MCCARTHY of New York, Mrs. NAPOLITANO, Mr. SHIMKUS, Ms. MCCOLLMUM, Mr. CALVERT, Mr. PLATTS, Mr. LARSON of Connecticut, and Mr. SCHIFF.
H.R. 2455: Mr. BERNAN.
H.R. 2462: Mr. CLAY and Mr. OBEY.
H.R. 2470: Mr. CROWLEY, Mr. PAYNE, Mr. MCNULTY, Mr. CONYERS, Mrs. CHRISTENSEN, and Mr. EVANS.
H.R. 2478: Mr. MCDERMOTT, Mr. LANTOS, and Mr. OWENS.
H.R. 2485: Mr. KUCINICH.
H.R. 2516: Mrs. OSWALD.
H.R. 2517: Mr. COBLE.
H.R. 2519: Mr. SABO, Mr. SIMMONS, Mr. KLEczka, and Mr. GILCHREST.
H.R. 2524: Mr. WAXMAN and Mr. SANDERS.
H.R. 2533: Mr. LINDER, Mr. ISAKSON, and Mr. SCOTT of Georgia.
H.R. 2537: Mr. OWENS.
H.R. 2546: Ms. LEE.
H.R. 2553: Ms. LOFGREN, Mr. ABERCROMBIE, Mr. RANGEL, and Mr. Ross.
H.R. 2556: Mr. COX, Mr. TERRY, and Mr. SOUDER.
H.R. 2564: Mr. MCGOVERN.
H.R. 2568: Mr. GORDON and Ms. DEGETTE.
H.R. 2570: Mr. WU and Mr. CLYBURN.
H.R. 2595: Mr. ABERCROMBIE, Mr. CASE, and Ms. BORDALLO.
H.J. Res. 9: Mr. BARR of South Carolina.
H.J. Res. 36: Mr. SPRATT.
H.J. Res. 59: Mr. LAHOOD.
H. Con. Res. 19: Mr. DINGELL and Mr. BALLANCE.
H. Con. Res. 60: Mr. BEAUPREZ, Mr. DEMINT, and Mr. ROHRABACHER.
H. Con. Res. 78: Ms. ESHOOD.
H. Con. Res. 98: Ms. BORDALLO, Mr. SCOTT of Georgia, and Mr. AKIN.
H. Con. Res. 99: Ms. EDDIE BERNICE JOHNSON of Texas.
H. Con. Res. 111: Ms. EDDIE BERNICE JOHNSON of Texas and Mr. ISSA.
H. Con. Res. 119: Mr. SHIMKUS, Mrs. TAUssCHer, and Mr. BERNAN.
H. Res. 49: Mr. SCHIFF.
H. Res. 103: Mr. SANDERS.
H. Res. 142: Mr. NADLER and Mr. GUTIERREZ.
H. Res. 234: Mr. CARSON of Oklahoma and Mr. WATTS.
H. Res. 237: Ms. MAJETTE.
H. Res. 259: Mr. MCGOVERN and Mr. ACKERMAN.
H. Res. 286: Mr. MNUlTY, Mr. WAXMAN, and Mr. BURR.
H. Res. 290: Ms. SLAUGHTER.

DELETIONS OF SPONSORS FROM PUBLIC BILLS AND RESOLUTIONS

Under clause 7 of rule XII, sponsors were deleted from public bills and resolutions as follows:
H.R. 2407: Mr. Michaud.

DISCHARGE PETITIONS

Under clause of rule XV, the following discharge petition was filed:

DISCHARGE PETITIONS—ADDITIONS OR DELETIONS

The following Members added their names to the following discharge petitions:
PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Continued

AMENDMENTS NOs. 1014, 1015, 1059, 1106, 1067, 1083, 995, 999, 1038, 1095, IN BLOC

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the pending amendments be temporarily set aside and that the following amendments be called up en bloc: No. 1014, by Senator BOND, study of pharmacy services; No. 1015, by Senator DODD, study of blind and disabled; No. 1059, by Senator HATCH, HHS review; No. 1106, by Senator HATCH, citizens councils; No. 1086, by Senator MURkowski, pharmacy access; No. 1067, by Senator LINCOLN, kidney disease; No. 1033, by Senator MUKULski, municipal health services; No. 935, by Senator LINCOLN, geriatric GME; No. 959, by Senator LINCOLN, physical therapy demo; No. 1038, by Senator ODDED, critical access hospitals; No. 1095, by Senator JOHNSON, study of pharmacy access; No. 1011, by Senator MURKOWSKI, pharmacy access; No. 1014, by Senator KERRY, study of pharmacy access; No. 1038, by Senator BOND, study of pharmacy access; No. 1038, by Senator BINGAMAN, study of pharmacy access; No. 1015, by Senator DODD, study of pharmacy access; No. 1095, by Senator JOHNSON, study of pharmacy access; and that the following amendments be temporarily set aside unamnious consent that the pending amendments be agreed to en bloc.

I further ask unanimous consent that the following amendments be agreed to en bloc and the motion to reconsider be laid upon the table en bloc.

Senator JEFFORDS, critical access hospitals; No. 1038, by Senator BOND, study of pharmacy access; No. 1067, by Senator LINCOLN, geriatric GME; No. 959, by Senator LINCOLN, physical therapy demo; No. 1038, by Senator ODDED, critical access hospitals; No. 1095, by Senator JOHNSON, study of pharmacy access.

The amendments were agreed to.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "nay".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 33, nays 65, as follows:

[Rollcall Vote No. 256 Leg.]

VOTE ON AMENDMENT NO. 1011

The PRESIDING OFFICER. Under the previous order, the question is on agreeing to the Sessions amendment No. 1011.

Mr. BAUCUS. Mr. President, I ask for the yeas and nays. The PRESIDING OFFICER. Is there an objection?

Without objection, it is so ordered.

The amendments were agreed to.

YEAS—33

Aliard
Alien
Allen
Benett
Bennett
Bning
Burns
Byrd
Campbell
Chambliss
Curnyn
Craig
Crapo

Lott
McConnell
Murkowski
Nickles
Sanatorium
Sessions
Shelby
Stevens
Summers
Talent
Thomas

NAYS—65

Akaka
Alexander
Baucus
Bayh
Biden
Bingaman
Bond
Boxer
Breaux
Brownback
Cantwell
Carper
Chafee
Clinton
Cochran
Coleton
Collins
Confard
Curnin
Dasechie
Dayton
DeWine

Dodd
Domenici
Dorgan
Durbin
Edwards
Feingold
Feinstein
Fitzgerald
Graham (FL)
Grasley
Harkin
Hollings
Inouye
Kennedy
Kohl
Landrieu
Lautenberg
Leahy
Levin
Lincoln

Lugar
McCain
Mikulski
Miller
Murray
Nickles
Nelson (FL)
Nelson (NE)
Pryor
Reed
Reid
Roberts
Rockefeller
Sarbanes
Schumer
Smith
Snure
Specter
Stabenow
Voinovich
Warner
Wyden

NOT VOTING—2

Kerry
Lieberman

The amendment (No. 1011) was rejected.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. GRAHAM of Florida. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

This “bullet” symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.
in our underlying legislation. The point being, they will not be taken care of better. It is just it is going to cost the Federal Government more.

I hope you will take those things into consideration and vote down this amendment.

I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second? There is a sufficient second.

The question is on agreeing to amendment No. 975, as modified. The clerk will call the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea."

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 51, nays 51, as follows:

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Kerry—Lieberman

The amendment (No. 975), as modified, was rejected.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote and I move to lay that motion on the table. The motion to lay on the table was agreed to.

The amendment (No. 1066) was rejected.

Mr. GRASSLEY. Mr. President, I move to reconsider the vote and I move to lay that motion on the table. The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The majority leader is recognized.

Mr. FRIST. Mr. President, very briefly, it is almost 6:25, and we have just completed our 12th rollcall vote. We still have a fair amount of work to do. But in discussion with the managers of the bill and the Democratic leader, it is our intent to finish this bill tonight. I am optimistic that we can finish in 2 or 3 hours, or this bill can go until midnight, or 1, or 2, or 3 in the morning.

Part of the problem we are having now is that people are still coming up and submitting amendments, and because we have been working in good faith over the last 2 weeks in the amendment process, we have not set strict filing deadlines.

Now that we are in the last several hours of consideration, I want to make the case and, in fact, plead with my colleagues that any amendments that need to be considered—let us hear about them. Let the managers hear about them in the next 15 minutes. That is the only way we can get a list to deal with them, and we will have rollcall votes on those that are necessary.

There will be a certain number of those amendments looked at by the managers. The ones I encourage you to bring to them for consideration to be adopted need to be budget neutral and have bipartisan support, and they need to be scored by the CBO. People keep bringing amendments forward now.
June 26, 2003

CONGRESSIONAL RECORD — SENATE

S8649

Mr. DASCHLE. Mr. President, I hope we can do as the majority leader has suggested. We have had a good debate. I think this has been an excellent debate. The managers deserve credit for the way they have managed the legislation. We have had 12 rollcall votes today already. It is likely that we will have 16 or 17 by the end of the day, if not more; we had 9 yesterday. More than 50 amendments have now been considered.

I think it is time that we bring the debate to a close. There will be many more opportunities to talk about prescription drugs and health care with the array of legislative challenges that we face in health. This has not been an easy job, and I hope we can get cooperation now on both sides of the aisle. I hope the majority leader will hold to the commitment that we finish tonight. That would accommodate people's travel schedules tomorrow.

If we are going to do that—it is now 6:30—over the course of the next 4 or 5 hours, we have a lot of work to do even with what we know we have to vote on. I hope everybody will cooperate so we can minimize the time required to consider amendments. I hope those who may have remarks to make will perhaps hold off until after final passage and make those remarks after final passage. That would accommodate our time as well.

We will work with the majority leader to see if we can accomplish the schedule he has laid out. I hope we can do so well before the rewinding hour.

I yield the floor.

Mr. FRIST. Mr. President, when we finish this bill tonight, my expectation would be that we would not have votes tomorrow. That is assuming we are going to finish. I encourage anyone who has an amendment that needs to be considered to get it to the managers within the next 15 minutes. If we can do that, we can finish tonight and we will be able to consider each of those amendments, as the Democratic leader said.

I know some people want to talk for an hour but I ask Senators to keep their comments to a few minutes and we can vote throughout the night. We will have the opportunity after final passage tonight, or through tomorrow, to make statements—for those who wish to continue the debate.

The PRESIDING OFFICER. The Senator from New Hampshire is recognized.

Mr. BREGG. Mr. President, I rise to address this bill. I had hoped to do it earlier in the day but, unfortunately, the managers of the bill were unable to work the time in. I certainly regret taking time out of the schedule, which is obviously crowded. I do think it is important to speak up on the issue of this piece of legislation.

This is the most significant piece of spending legislation, and maybe even public policy legislation, outside of an international issue, that I expect I will vote on in my tenure in the Senate. Ironically, when I ran for this job, after serving as Governor of New Hampshire, one of the reasons I sought the job and one of the reasons I pursued a term in the Senate was that I was concerned about entitlement spending. In fact, during my first few years, I aggressively pursued setting up an entitlement commission to address entitlement spending, which I sponsored with Senator Kempthorne, who came in with me that year, and Senator Coverdell and Senator Bennett, all of whom came in the year I was elected, in a bill to end unfunded mandates, many of which were entitlement oriented.

I tried to be an earnest supporter in passing legislation to address reform of the Social Security system. I consider that to be a huge entitlement that we confront. My basic reason for seeking entitlement reform and responsibility was that I wanted not only is what is driving the deficits of our country—which they continue to do—but, more importantly, as the demographics shifted in the Nation and we saw the baby boom generation, which represents people going toward retirement, we, as a nation, were going to be placing on our children and our children's children an inordinate burden in the area of taxes in order to support the older generation—my generation—which would be retiring. It is because all the major programs, whether they are Social Security or Medicare, are built on the theory that there is a pyramid out there, that there will always be more people working and a lot more people working than those people who are retirement benefits out of the system. That, of course, is the way it began.

Back in 1960, there were 12.5 people working for every person who retired under Social Security. Today, we are down to 3.5 people working for every 1 person retired on Social Security and under Medicare, and that is stressing the system.

Unfortunately, when we hit the retirement generation of the baby boom generation, the largest generation in the history of our Nation, the generation born between 1946 and 1955, we go down to two people working for every one person retired. We go from a pyramid to basically a rectangle, and the result is that we will end up putting an inordinate amount of stress on those people who are working to support those folks who are retired. So we need to address thoughtfully any entitlement expansion, to say nothing of the entitlements that are already on the books.

That is what brings me to the Chamber today to address this legislation because I believe very strongly that needy senior citizens should have a drug benefit. Clearly, prescription drugs have become the new way to treat disease and maintain public health in our Nation. We have been able to move from a system where you have invasive activity in the health care system, where you had to go through surgery, to a system where people can, as result of the keen use of our scientific community, take a pharmaceutical and actually have a better life if they were to go under the knife, have surgery.

This is a revolution, and it is a revolution that is exploding and growing. Biotech activity, the nanotech activity, is only going to lead to more and more and better and better pharmaceuticals coming on the market to help people with their health.

It is absolutely unfair, in my opinion, that people who are in a low-income situation, especially retired people who are on a fixed low income, have to choose between their food and their housing and maybe the pharmaceuticals. That is not right in our society, and we can certainly afford to have that addressed.

It was my hope as we brought forward a pharmaceutical drug benefit for senior citizens that we would do it in a way that would address low-income seniors. Equally important, it is important that a middle-income senior should not have to spend all their assets for health care as a result of pharmaceutical costs. After a certain amount of spending, there should be catastrophic coverage that kicks in, relieving that person of the full responsibility or a large portion of their responsibility for the pharmaceutical cost. That is the type of structure at which we should be pointed.

Putting in place this brand new drug benefit, we also have to look at the underlying Medicare system which we all know is fundamentally broken as we look out into the future. When the baby boom generation hits, it simply is not going to work. It is not going to support that generation. That is because it is a 1959 design, an automobile built in the fifties driving on the highways of the year 2000 which, when it gets to 2015, is going to be too old to function effectively. It needs to have put in place forces which are going to cause it to be more efficient, to be more effective in addressing a person's approach to their health care. Those forces have to be basically marketplace oriented. They cannot be price-control oriented.

My hope, my goal, my belief was that we would create a drug benefit that would help low-income seniors and, at the same time, give catastrophic coverage, and that would, fundamentally, reform the Medicare system so that we would end up with a more market-oriented system, something that was going to contain costs as we moved into the outyears.
What did we get? What is before us today? Essentially, what we have before us today is a drug benefit that will plant a fiscal disease that will afflict our children and our children’s children. It is a drug benefit that is going to put in place a fiscal disease that will afflict our children’s children for the next 75 years. By afflict them, I mean that our children and our children’s children, under the benefit in this bill, are going to have to pay $6 trillion. That is the estimate. That may be the high end. It is somewhere between $4.6 trillion and $6 trillion. When you get into those numbers, it is pretty hard to get very definitive.

That is the burden this drug benefit in this bill puts on our children and our children’s children to support my generation which is going to retire and take advantage of it.

That is a huge problem because what we are essentially saying to the person who is working in a restaurant or working in a garage or working on a computer line or working as a sales person, who is young and trying to raise a family, is that they are going to have to pay an inordinate amount of tax burden to support people who are retiring and into the public system. It makes no sense.

Then there is the issue of the underlying question of Medicare. Not only is the drug benefit fundamentally flawed because it migrates huge numbers of people off the private sector, but the underlying purpose of the Medicare effort in this bill is flawed. If we are going to put in place this huge new benefit for seniors, and especially if it is going to be as grand and as pervasive, where we are basically saying to all seniors that they get a benefit here, no matter what their income is—if that is going to be the basis of how they are going to be at least coupled with some sort of reform of the underlying Medicare system to try to bring under control those costs which are driving the outpatient liability, which will be the tax burden for our children and our children’s children, the estimated outyear cost of Medicare that is unfunded is $13.3 trillion. When the baby-bom generation starts to retire and move it out of the private sector and into the public sector, the fundamental flaws of having a drug benefit that migrates a large number of people out of the private sector into the public sector and essentially causes low-income working Americans who are young to have to support middle-income Americans who are retired and who had a private sector benefit, and even though the bill has this illusory appearance of the private sector representing really no real reform of Medicare, we are told we should vote for it because it is going to be improved in conference. At least that is what we are being told on our side of the aisle. I do not know what is being said on the other side of the aisle. Maybe they are not getting that same message. We are being told that by the administration.

The problem is, we are betting on the come. I mean, this is $6 trillion of unfunded liability we are passing on to our kids. It is massive. If this bill were to pass in its present form, or anything near to its present form, it would fundamentally extinguish the torch which the Republican Party has allegedly—and I thought pretty effectively—cared for for years which was the torch of spending responsibility.

That is why I came here, as I said when I began my statement. I came to try to do something about controlling the rate of growth of spending in the Federal Government, especially in the area of entitlements. I was told by one of the finest legislators I have ever met...
in my experience in 20 years in Government—a man named Barber Conable—one time on the floor of the House when I was mumbling about the fact that some bill was coming through that was a little expensive, you have to understand, Judd, all Government workers work in this building and it is just a question of how many engines are on that train—think of it as a train—as it moves to the left, and our job as fiscal conservatives is to limit the number of engines that go on that train.

This bill, as it passes in its present form, is going to be all engine, and it is going to undermine our capacity to assure our children they have the opportunity to have the type of lifestyle which we have, because it is going to put a huge and unfair tax burden on them.

I yield the floor.

The PRESIDING OFFICER. The Senator from Louisiana.

Mr. BRUSSON. Mr. President, this morning one of the very able legislative assistants who has worked on this legislation for almost 7 years, going back to the time on the Medicare Commission when we first started doing Medicare reform, was on the floor working on amendments in this legislation. She had to temporarily leave because at 5:47 this afternoon she had a little baby girl. That is a very good excuse to not be on the Senate floor. But my legislative director, Sarah Walter, is doing fine. It is a baby girl. The name is yet to be determined, but I wanted to bring it to the attention of my colleagues and all of her colleagues on the professional staff.

I yield the floor.

The PRESIDING OFFICER. The Senator from Idaho.

AMENDMENT NO. 1097 WITHDRAWN

Mr. CRAIG. Mr. President, this afternoon I will speak to amendment 1087. That amendment was pulled up last night by the manager of the bill, Senator Grassley. I believe that amendment is at the desk.

The PRESIDING OFFICER. The Senator is correct. The amendment has been called up and is pending.

Mr. CRAIG. Mr. President, it is my intent within a few moments to withdraw this amendment, but I thought I should speak to it tonight because I am disappointed at this time that we could not get the CBO rating on this legislation. We felt this would produce a revenue-neutral bill, or a cost-neutral bill, going into the final hours of this debate.

This is an amendment that produces in this legislation, and hopefully to take up in conference, a consumer-driven health care plan under the new MedicareAdvantage program all of us are talking about at this moment. The Senator from New Hampshire gave a very impassioned speech from the depths of his heart, frustrated that this bill had come out and provide enough of the incentives in the market that will offset and create the kind of competitive forces being designed for Medicare with the extension of prescription drugs in it offers.

For a few moments tonight, I did want to speak about that and explain it. As we get into conference with the House, the House has a consumer-driven health care concept within their legislation that is critical. It is something we ought to address.

First, the amendment before the Senate is designed to dovetail with and not disturb the overall MedicareAdvantage competitive dynamic. As a complement to MedicareAdvantage, consumer-driven health care plans would be subject to the same competitive rules as preferred provider organizations.

Second, I emphasize this amendment is carefully crafted. We thought it would ensure budget neutrality. But CBO says tonight, no, and I am not going to be too critical of them: we pushed them very hard in the last good number of days to quickly analyze and bring forth estimates. I think they are doing their best to work with us. We believe what we are offering is budget neutral.

Additionally, the Finance Committee chairman, the majority leader, and the White House have expressed the kind of support that my amendment will receive. I appreciate that. As everyone begins to examine this structure, they become increasingly enthusiastic that this could become a component of the MedicareAdvantage program.

For the benefit of my colleagues, let me describe for a moment the key features of this amendment. The amendment establishes a new category of competition within MedicareAdvantage designed to encourage participation by consumer-driven health plans. These plans would be subject to the same requirements of PPOs in MedicareAdvantage, including prescription drug benefits and risk adjustment parameters.

Consumer-driven health care is one of the fastest growing innovations emerging in the employer health insurance market. Already 1.5 million Americans are estimated to be in consumer-driven health care plans. These accounts then roll over into the next year.

High deductibles, that is true insurance, to protect against financial ruin in an acute health care crisis, in other words catastrophic, or even more preventative services. All are within this kind of health care plan. All are available today offered by the postal workers.

Patient control of personal care accounts for routine health care services are also included. Unused funds in these accounts then roll over into the next year.

High deductibles, that is true insurance, to protect against financial ruin in an acute health care crisis, in other words catastrophic, or even more preventative services. All are within this kind of health care plan. All are available today offered by the postal workers.

A limit on annual out-of-pocket spending is an especially important feature. Traditional Medicare does not have an out-of-pocket limit and drives many seniors into bankruptcy. In other words, it limits financial risk when it kicks in at a certain point.

It includes care coordination, disease management, and provider network discounts. Consumer-driven health care gives control of health care back to patients. This is why more and more are enrolling in it. We know today, many who work in the health care area with our seniors know they look at the details of their spending; they look at the billing; they know more about their health care and what is being charged than most people realize. Patients and their physicians, ultimately, with this kind of insurance, join in partnerships to seek the finest care at the most reasonable costs.

Consumer-driven care is especially suited for patients who like to be personally involved in their health care decisions. More and more Americans who can use the necessary information
want that kind of personal involvement. Consumer-driven care eliminates wasteful Medicare spending, it increases patient awareness of health care costs, and encourages prudent purchasing of health care services. Any unused funds in the personal care account would be returned to the Medicare trust fund upon the death or the disenrollment. That is a key factor. Federal dollars go into the trust fund and, if there are dollars remaining, they flow back into the trust fund of Medicare upon disenrollment or the death of the individual.

This amendment would be an important addition to the bill. I wish we could get it into the bill tonight. But it would be unfair to the manager of the bill at this time because it cannot get scored. I would not want to drive the cost up of the already-fixed segment of the Medicare Advantage side. Already, it is less competitive than we would like to see. I don’t want to add to that disadvantage.

We believe ultimately that this will be a budget-neutral program. At that time, it will be the right thing to offer as part of the dynamics that we want to see in health care delivery system and in an improved Medicare with a prescription drug program.

I thank my colleagues for listening. We will return with this when it is a final product. It may well make it into the conference between the House and the Senate. We will be working with our colleagues in the House because they have already provided that kind of a provision within the legislation which they are currently debating and voting upon.

With that, I ask unanimous consent to withdraw amendment No. 1086.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment (No. 1086) was withdrawn.

The PRESIDING OFFICER. The Senator from Pennsylvania.

Mr. SPECTER. Since Medicare was established in 1965, people are living longer and living better. Today Medicare covers more than 40 million Americans, including 35 million over the age of 65 and nearly 6 million younger adults with permanent disabilities.

Congress now has the opportunity to modernize this important Federal entity to address the rapidly changing health care delivery system and to improve the Medicare delivery system.

The proposal before the Senate would make available a voluntary Medicare prescription drug plan for all seniors. If enacted, Medicare beneficiaries have access to a discount card for prescription drug purchases starting in 2004. Projected savings from cards for consumers would range between 10 to 25 percent of the expected costs applied to the card, offering additional assistance for low-income beneficiaries defined as 160 percent or below the Federal poverty level. Effective January 1, 2006, a new optional Medicare prescription drug benefit would be established under Medicare Part D.

This bill has the potential to make a dramatic difference for millions of Americans. Average annual incomes vary from special needs and chronic health care needs. Low-income Medicare beneficiaries, who make up 44 percent of all Medicare beneficiaries, would be provided with prescription drug coverage with minimal out-of-pocket costs. Variations in these seniors’ copayments would not exceed 20 percent of the cost of the drugs.

For medical services, Medicare beneficiaries will have the freedom to remain in traditional fee-for-service Medicare for drug coverage, or to enroll in Health Maintenance Organizations (HMOs) or Preferred Provider Organizations (PPOs), also called Medicare Advantage, which offers beneficiaries a wide choice of health care providers, while also coordinating health care for those with multiple chronic conditions. Medicare Advantage health plans would be required to offer at least the standard drug benefit, available through traditional fee-for-service Medicare.

The legislative process has the committee turning out a bill, and then another amendment which is pending at the desk which I will call up at an appropriate time.

The amendment directs the Secretary of Health and Human Services to include in its annual “Medicare And You” handbook, to be provided to each beneficiary, a section that specifies information on advanced directives and details on living wills, durable powers of attorney for health care, and directs the Secretary of HHS, in the introductory letter to the “Medicare And You” handbook, to reference the inclusion of advanced directives.

AMENDMENT NO. 1085

I have also submitted an amendment which is pending at the desk, amendment No. 1085, which has not yet been acted upon but which I will call up at an appropriate time.

This is an amendment which would update the Medicare physician fee formula. It is a sense-of-the-Senate resolution. The projections from the Medicare payment formula called for a 4.4 percent reduction on March 1, which would have been very problematic. The fact is, the Center for Medicare and Medicaid Services, CMS, now projects a 3.7 percent cut, which is a reduction of 4.2 percent will be projected for the year 2004. This reduction threatens to destabilize an important element of the
There is a serious concern that if there is not a coordinated program, people will not be informed as to how to move from PACE to another program. This affects not only Pennsylvania but, as I stated, 17 other States.

The pending bill does not provide for coordination of benefits between States, private insurance companies and private insurers. Without a coordination of benefits for State plans to facilitate enrollment in private plans, many of these State program beneficiaries will be unable to assess the new Medicare benefit.

This amendment provides for coordination of benefits between States and private insurance companies and facilitates the enrollment of State pharmacy assistance beneficiaries in the private plans. Without this amendment, the majority of seniors enrolled in their State pharmacy programs will not be able to effectively access private plans.

I note the presence of other Senators who are seeking recognition. I attempted to be brief in my general statement about the bill and also in my descriptions of these four amendments, one of which has already been adopted.

I ask unanimous consent that at the conclusion of my remarks, there be printed in the RECORD a summary of the end-of-life directive amendment, a summary of the updating of the Medicare physician fee formula, a summary of the lifestyle modification program, and a summary of the State pharmaceutical assistance programs for the elderly and disabled, and also printed in the RECORD at this point the amendments themselves.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

**SUMMARY ON THE AMENDMENT TO UPDATE THE MEDICARE PHYSICIAN FEE FORMULA**

The purpose of this amendment is to make it easier for beneficiaries to make their own choices regarding their treatment when nearing the end of their life. A health care advance directive is a document where a beneficiary gives instructions regarding his or her health care if, in the future, that beneficiary cannot speak for him or herself. The beneficiary can give someone they name (“agent” or “proxy”) the power to make health care decisions on their behalf. They may also give instructions about the kind of health care they do or do not want.

In a traditional living will, a health care advance directive is not limited to cases of terminal illness. If the beneficiary cannot make or communicate decisions because of a temporary or permanent illness or injury, a health care advance directive helps them keep control over important health care decisions.

It is clear that this scheduled 4.2% reduction in the physician fee formula threatens to destabilize an important element of the Medicare program, namely physician participation and willingness to accept Medicare patients.

The primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians’ services under Medicare.

The sustainable growth rate (SGR) system has a number of defects that result in unrealistically low spending targets, such as the use of the increase in the gross domestic product (GDP) as a proxy for increases in the volume and intensity of services provided by physicians, no tolerance for variance between what Medicare pays for services and what private insurance pays and even the failure to consider the effects of Medicare payment systems on the pricing and use of other health care costs and our Nation’s GDP, and a requirement for the immediate recoupment of the overpayment.

Both administrative and legislative action is needed to return stability to the Medicare physician payment system.

In its March 2003 report, the Medicare Payment Advisory Commission (MedPAC) stated that if Congress does not change current law, then payments may not be adequate in 2003 and a compensating adjustment in payments would be necessary.

With 47 percent of its population eligible for Medicare, the Pennsylvania Medical Society has calculated that Pennsylvania’s physicians have already lost $2.6 billion, or $4,074 per physician, as a result of the 2002 Medicare payment reduction. If not corrected, the flawed formula will cost Pennsylvania physicians another $583 million or $17,396 per physician for the period 2003–2005.

Your amendment expresses the sense of the Senate that the conferences on Medicare reform and prescription drug legislation should include in the conference agreement a provision to establish a separate reoprecipitation adjustment in physician fees for the next 2 years and should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to recoup the revised target trend.

**SUMMARY OF THE AMENDMENT ON UPDATE THE MEDICARE PHYSICIAN FEE FORMULA**

Heart disease kills more than 500,000 Americans per year. The number and costs of interventions to treat heart disease are rising and currently cost the health care system $58 billion annually.
The Medicare Lifestyle Modification Program (also known as the Dean Ornish Program for Reversing Heart Disease) has been operating throughout 12 states and has been demonstrated to decrease the need for coronary procedures by 88 percent per year.

The Medicare Lifestyle Modification Program is less expensive to deliver than interventional cardiovascular procedures and could reduce cardiovascular expenditures by $36 billion annually.

Lifestyle choices such as diet and exercise effect cardiovascular disease outcomes by 50 percent or greater.

Intensive lifestyle interventions which include teams of nurses, doctors, exercise physiologists, dieticians, and behavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

The National Institutes of Health estimates that 17 million Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to more than double by 2050.

Lifestyle programs are superior to medication therapy for treating diabetes. Individuals with diabetes are now considered to have coronary disease at the date of diagnosis when diabetic.

The Medicare Lifestyle Modification Program has been an effective lifestyle program for the reversal and treatment of heart disease.

Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification. Therefore, these lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

Your amendment expresses the sense of the Senate that the Secretary of Health and Human Services should carry out the Lifestyle Modification Program Demonstration at the national level on a permanent basis and include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis.

**SUMMARY OF THE AMENDMENT ON STATE PHARMACEUTICAL ASSISTANCE PROGRAMS FOR THE ELDERLY AND DISABLED**

Currently, 18 states have comprehensive pharmaceutical assistance programs that provide prescription drug coverage to more than 1.1 million older and disabled residents. The majority of these beneficiaries receive life-saving medications to treat high blood pressure, heart disease, arthritis, diabetes, and eye disease.

Pennsylvania’s Pharmaceutical Assistance Contract for the Elderly (PACE), established in 1984, provides prescription drug coverage to 230,000 Medicare beneficiaries, the vast majority of whom have incomes below 160% of the federal poverty level. This enrollment comprises largely of 70 and 80-year-old widows who have multiple disease states, and less than a tenth grade education, and have been enrolled in PACE for more than a decade.

Currently, the pending bill the Senate does not provide for ‘coordination of benefits’, between state pharmaceutical programs and private insurers. Without a coordination of benefit mandate and a role for the state plans to facilitate enrollment in private plans, state programs for beneficiaries will not be able to access the new Medicare drug benefit.

This amendment provides for the coordination between state pharmaceutical programs and private insurers, and facilitates the enrollment of state pharmacy assistance bene-

ficiaries into private plans, without this amendment the majority of the seniors enrolled in their state pharmacy programs will not be able to effectively access private plans.

**AMENDMENT NO. 983**

(Purpose: To provide Medicare beneficiaries with information on advance directives)

On page 676, after line 22, insert the following:

**SEC. 3. PROVISION OF INFORMATION ON ADVANCE DIRECTIVES.**

Section 1904(c) of the Social Security Act (42 U.S.C. 1395w-2(c)) is amended—

(1) by redesignating paragraphs (i) through (k) as subparagraphs (A) through (D), respectively;

(2) in the matter preceding subparagraph (A), as so redesignated, by striking “the notice” and inserting “(1) The notice”;

(3) by adding at the end the following:

“(2)(A) The Secretary shall annually provide each Medicare beneficiary with information concerning advance directives. Such information shall be provided by the Secretary as part of the Medicare and You handbook that is provided by the Secretary. Such handbook shall include a separate section on advanced directives and specific details on living wills and the durable power of attorney for health care. The Secretary shall ensure that the introductory letter that accompanies such handbook contain a statement concerning the inclusion of such information.

“(B) In this section:

“(i) The term ‘advance directive’ has the meaning given to that term in section 628(b)(5).

“(ii) The term ‘medicare beneficiary’ means an individual who is entitled to, or enrolled for, benefits under part A or enrolled under part B, and is entitled to benefits under part D or enrolled for part D benefits.”

**AMENDMENT NO.**

(Purpose: To permit existing State pharmaceutical assistance programs to wrap around the coverage provided by Medicare Prescription Drug Plans and to facilitate the enrollment of eligible beneficiaries for prescription drug coverage)

On page 133, after line 25, insert the following:

“(3) **COORDINATION WITH EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.**—

“(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug Plan, or a Medicare Advantage organization offering a Medicare Advantage plan (other than an MSA plan or a private fee-for-service plan that does not provide prescription drug coverage), shall enter into an agreement with each existing State pharmaceutical assistance program to coordinate the coverage provided under the plan with the assistance provided under the existing State pharmaceutical assistance program.

“(B) **ELECTION.**—Under the process established under section 1990D-3(a), an eligible beneficiary who resides in a State with an existing State pharmaceutical assistance program and who is eligible to enroll in such program shall elect to enroll in a Medicare Prescription Drug Plan or MedicareAdvantage plan through the existing State pharmaceutical assistance program.

“(C) **EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.**—In this paragraph, the term ‘existing State pharmaceutical assistance program’ means a program that is established pursuant to section 628(b)(5) of title 20 or under section 1155 or otherwise before January 1, 2004.”

**AMENDMENT NO. 1087**

(Purpose: To express the sense of the Senate regarding payment reductions under the Medicare physician fee schedule)

At the end of title VI, insert the following:

**SEC. 1. SENSE OF THE SENATE ON PAYMENT REDUCTIONS UNDER MEDICARE PHYSICIAN FEE SCHEDULE.**

(a) **FINDINGS.**—Congress finds that—

(1) the fees Medicare pays physicians were reduced by 5.4 percent across-the-board in 2002;

(2) recent action by Congress narrowly averted another across-the-board reduction or freeze for 2003;

(3) based on current projections, the Centers for Medicare & Medicaid Services (CMS) estimates that, absent legislative or administrative action, fee will be reduced across-the-board once again in 2004 by 4.2 percent;

(4) the prospect of continued payment reductions under the Medicare physician fee schedule for the foreseeable future threatens to destabilize an important element of the program, namely physician participation and willingness to accept Medicare patients;

(5) the primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians’ services under Medicare;

(6) the SGR system has a number of defects that result in unwarranted sacrifices for prescription drugs and biologicals administered to patients under the annual spending targets without making corresponding adjustments to reflect price increases in these drugs and biologicals or the growing reliance on such therapies in the treatment of Medicare patients;

(7) between 1996 and 2002, annual Medicare spending on these drugs grew from $1,800,000,000 to $6,200,000,000, or from $55 per beneficiary to an estimated $187 per beneficiary; and

(8) although physicians are responsible for prescribing these drugs and biologicals, neither the price of the drugs and biologicals, nor the standards physicians are encouraged to use, are within the control of physicians; and

(9) SGR target adjustments have not been made for cost increases due to new coverage decisions and new rules and regulations.

(b) **SENSE OF THE SENATE.**—It is the sense of the Senate that—

(1) the Center for Medicare & Medicaid Services (CMS) should use its discretion to exclude drugs and biologicals administered to patients from the sustainable growth rate (SGR) system; and

(2) CMS should use its discretion to make SGR target adjustments for new coverage decisions and new rules and regulations; and

(3) in order to provide ample time for Congress to consider more fundamental changes to the system, the Congress on the Prescription Drug and Medicare Improvement Act of 2003 should include in the conference agreement a provision to establish a minimum percentage update in physician fees for the next 2 years and should consider adding provisions that would mitigate the swings in payment, such as establishing multi-year adjustments to reduce the variance and creating ‘tolerance’ corridors for variations around the update target range.
The Medicare Lifestyle Modification Program has been operating throughout 12 States and has been demonstrated to reduce the need for coronary procedures by 88 percent per year.

(4) The Medicare Lifestyle Modification Program is less expensive to deliver than the Health Care Financing Administration and the Centers for Disease Control and Prevention estimates that 17,000,000 Americans have diabetes.

(5) Lifestyle choices such as diet and exercise affect heart disease and heart disease outcomes by 50 percent or greater.

(6) Intensive lifestyle interventions which include teaching patients, doctors, exercise physiologists, registered dietitians, and bavioral health clinicians have been demonstrated to reduce heart disease risk factors and enhance heart disease outcomes dramatically.

(7) The National Institutes of Health estimates that 17,000,000 Americans have diabetes and the Centers for Disease Control and Prevention estimates that the number of Americans who have a diagnosis of diabetes increased 61 percent in the last decade and is expected to double by 2020.

(8) Lifestyle modification programs are superior to medication therapy for treating diabetes.

(9) Individuals with diabetes are now considered to have coronary disease at the date of diagnosis of their diabetic state.

(10) The Medicare Lifestyle Modification Program is an effective lifestyle program for the reversal and treatment of heart disease.

(11) Men with prostate cancer have shown significant improvement in prostate cancer markers using a similar approach in lifestyle modification.

(12) These lifestyle changes are therefore likely to affect other chronic disease states, in addition to heart disease.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that—

(1) the Secretary of Health and Human Services should carry out the demonstration project known as the Lifestyle Modification Program Demonstration, as described in the Health Care Financing Administration Memorandum of Understanding entered into on November 13, 2000, on a permanent basis;

(2) the project should include as many Medicare beneficiaries as would like to participate in the project on a voluntary basis; and

(3) the project should be conducted on a national basis.

Mr. SPECTER. I thank the Chair. I yield the floor.

Mr. REID. Mr. President, I ask unanimous consent that the distinguished Senator from West Virginia be recognized to speak on the bill for 5 minutes and that following his statement, the Senator from Florida, Mr. GRAHAM, be recognized for 15 minutes.
Today, they are a primary form of medical care and often substitute for more costly treatments like hospitalization and surgery.

Today, 40 million Americans rely on Medicare to help provide for their medical needs more than one-third of all Medicare beneficiaries lacking insurance coverage for the cost of needed medications, finding affordable prescription drug coverage is a critical issue for our Nation’s seniors. Prescription drug coverage is essential to treating and preventing many acute and chronic conditions, but Medicare fails to cover them on an outpatient basis. Too many seniors and disabled persons in this country, especially those living on fixed incomes, are forced to choose each month between paying for food and paying for shelter, or buying the essential medicines that their doctors have prescribed.

Our Nation’s senior citizens are losing their patience. They are losing their savings and they are fed up with fast-rising drug costs that they cannot afford. Older citizens should not have to travel in bus loads to Canada and Mexico just to obtain the medications their doctors prescribe. What does it say about a country and its values when we fail to take care of our elderly citizens whose lifetime of work and sacrifice and dedication and industry helped to endow this country with the greatness it now enjoys?

Mr. President, I fear that the legislation before us today is a glaring example of how this Nation shortchanges our senior citizens. We are not taking care of our elderly citizens as they wrestle with the most serious issue in their lives. We are offering a partial fix to assuage senior anger. This bill fails to go far enough to meet the needs of our Nation’s senior citizens. I am concerned that this measure would force Medicare beneficiaries to rely on a private, unregulated, drug insurance market for their prescription drug coverage, rather than the traditional Medicare program that they know and trust. We split drug benefit off from Medicare.

I am concerned that this administration and some Members of Congress plan to phase out the traditional Medicare program as an option for new beneficiaries in the future. Some people have asserted that this legislation is more horse dead than the so-called Medicare drug benefit. But Mr. President, this is a hollow promise and little assurance that the bill before us to-
will be available, 2006, their drug costs will double but they will continue to pay the monthly premiums?

That would be analogous to car insurance which says: You will be covered in case you have an accident from January to August but if you have another accident from September to December it is out of your pocket. Who would buy that automobile coverage?

The worst thing is that millions of seniors will never realize they have bought into such an inadequate policy until it is too late.

Second, this bill does not provide a universal drug benefit. Under this plan, for instance, if you are a Medicare beneficiary but you are also poor, you will not get the prescription drug benefits for Medicare. That is right. Seniors at 74 percent or below the poverty level would be excluded from the Medicare benefit.

They would get their prescription drugs through Medicaid. This is a clear Federal Government to unload a substantial part of its prescription drug expenses on the States, States which are already struggling with serious financial problems.

It is for that reason that the National Association has opposed this design saying:

It is not good health policy. It is not good precedent.

The argument is made that this is all we can do. We cannot do better because we do not have the resources to do better. This is a song that the child has just shot his mother and his father and now throws himself on the mercy of the court claiming to be an orphan.

We have made the decision to be in the financial status that we are, and the consequence of that decision, as we debated a few weeks ago when we adopted the Senate's budget for the year, is that we are going to have to have an unnecessarily and unacceptably low level of financial support for a meaningful prescription drug benefit.

Third, this plan will cost many seniors more than they can afford. From repeated surveys, seniors have stated that they need a plan with no deductible so that coverage starts from the first prescription. And they need a premium of no more than $25 a month. Yet the sponsors of this bill suggest a $275 deductible and an average premium of $35 per month, an average premium which could actually be higher because the private companies will determine the level of the premium.

You can look through the over 600 pages of this bill and find the number $35. That is a hope number but the actual number will be determined by the private insurance carriers.

Fourth, this bill would subject millions of America's seniors to a giant experiment, a giant experiment in delivering prescription drugs through an untested delivery system, a system which is unheard of in the private market.

It is stated that this system will be justified because it will be efficient and will use the power of competition to suppress cost. If this was such a good system, why don't we provide it for all Federal employees so they can get, we as Federal employees can get, the benefit of this greater efficiency and cost savings? The reason is because insuring drugs only is not an actuarially sustainable risk. It has been analogous to an insurance policy just to cover the kitchen. No insurance company is going to sell you a policy for the most vulnerable area of your house to actually experience a fire.

That is why the private insurance plan is available today which will provide you a prescription-only coverage. That is the equivalent of the kitchen in terms of its intensity and potential for explosion of cost within health care. Yet we are about to say that some 40 million of the most vulnerable and frail Americans are going to be the experiment for this ideology.

I have said it before and I will say it again: There is simply no reason to subject our Nation's seniors to this brand new experiment when we already know what works. There is no reason to pump extra dollars into private insurance plans.

A few hours ago we adopted an amendment which will pump in $6 billion to help those HMOs. Those $6 billion could have been used to reduce the monthly premium, to close part of the gap of coverage. But what did we decide to do? We are going to give it to the HMOs so the Federal Government is aware of the risk of coverage as opposed to these plans whose reason for being is to assume the risk and, therefore, have the incentive to provide the most efficient plans.

We are begging these HMOs to participate in the Medicare Program for the sake of a private sector venere, for the sake of an ideology untested. We actually tried a version of this before. Guess what. It didn't work. I speak of the pre-experiment which has dumped hundreds of thousands of Floridians from their rolls as they have in virtually every other State, and more are being dumped each day. But this Congress, rather than look to the reality of past experience, has determined to embark on this collision course at the expense of seniors and at the expense of common sense.

Fifth, I fear that we will have difficulty in convincing healthier seniors to sign up for a mean drug benefit. As it is with virtually all insurance plans, it is critical that there be a mixture of those who have the greater likelihood of experiencing the risk with those who have the lesser likelihood in order to create an actuarially sound plan.

One-third of our seniors would not break even under this legislation. That is, one-third of seniors with drug spending of less than $1,135 per year would get no benefit should they voluntarily sign up for this plan. Therefore, how do we induce them to do so? One of the ways that we had induced them in the past was to have a meaningful catastrophic care provision, so that seniors who, today, are relatively healthy are insuring themselves against the risk that they might have a disease or an accident that would put them into much higher prescription drug costs.

Last year we determined that the level necessary to be an inducement for a large enough number of healthy seniors to participate was $4,000 in an annual drug expenditure, and if their previous employer made a contribution, that would be counted toward that $4,000. This bill increases the level so that a person would be eligible for catastrophic care to $5,800, and employer contributions would be excluded. This new level is significantly less of an inducement for healthy seniors to participate, and the effect is likely to be disappointing levels of participation.

Mr. President, I ask unanimous consent that a copy of today's front page article "For Struggling Seniors, Medicare Drug Plan's Proof Is in the Purse" from the Washington Post be printed in the RECORD following my remarks.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRAHAM of Florida. The reported active, healthy seniors at centers in Cleveland, OH, and they were skeptical of the cost of the benefits that would be offered under this bill.

Since the fact that this bill doesn't take effect until 2006 is another brutal hoax on seniors, truly an abusive, shameful, misleading ploy.

The fact is, many of those who most need prescription drug coverage today simply will not live long enough to get any benefits under this plan. As much as I have wanted to vote for a drug bill, for those reasons, I simply cannot vote for the one before us this evening.

We have lost our focus. The focus should be on the Medicare Program in regard to how to help our 40 million seniors and disabled persons. Instead, the focus is everywhere else—insurance companies, drug companies, and hiding the flaws which ought to be exposed.

This focus is often presented as the issue of choice. Choice has different meanings. For the idealog, choice means a choice among delivery systems. But for seniors, choice means doctors, hospitals, and, hopefully, prescription drugs. Yes, this gives seniors a choice among delivery systems. For instance, if you are one of the 89 percent of seniors in a fee-for-service Medicare Program, you will get a choice of between two or more prescription drug plans. If that fails, you will then drop back into traditional Medicare.

The Stabenow amendment, which was defeated earlier in the debate, would have given seniors at least real choice between a prescription drug delivery system and fee-for-service Medicare as the delivery system.

The tragedy is that we know what we ought to be doing. What we ought to be doing is building on the strengths of

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our current Medicare system—one of the most popular health care programs in this Nation’s history. We also ought to be seeing that we have a plan that is affordable and comprehensive.

I think the dye is cast and this bill is likely to pass, provide for a patients’ Bill of Rights, so that as we herd more seniors into HMOs, at least they will know the standards by which they will be asked to operate within that.

We are beginning to hear the first rumbles—especially in the New York Times—and 15 minutes. That editorial will be printed in the RECORD after my remarks.

The PRESIDING OFFICER. Without objection, it is ordered.

See exhibit 2.) Mr. GRAHAM of Florida. Medicare has served our seniors superbly. And where it has not, as in the area of prescription drugs, it has been because Congress has not allowed it to do so.

I hope friends back from conference, it will be better but I doubt that will be the case.

The PRESIDING OFFICER. The Senator has consumed 15 minutes.

Mr. GRAHAM of Florida. Mr. President, today is the hope that soon we will have an opportunity to pass a prescription drug bill that will fully meet the needs and expectations of older Americans.

EXHIBIT 1
(From The Washington Post, June 26, 2003)

FOR STRUGGLING SENIORS, MEDICARE DRUG PLAN’S PROOF IS IN THE PURSE

(By Ceci Connolly)

CLEVELAND—As the Medicare drug program moves through Congress takes on an air of inevitability. Washington politicians are already in the program’s 38-year history and could prove but I doubt that will be the case.

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He will speak for 10 or 15 minutes, is my understanding. We are at a point where we have very few amendments left. We have a couple that may take a little debate but I think most of them will be disposed of rather quickly. Everyone understands we are moving this along as quickly as possible. The managers have worked for 2 weeks on this matter.

After the Senator from Arizona finishes his statement, we should be in a position to have a number of votes lined up for later this evening.

The PRESIDING OFFICER. The Senator from Arizona is recognized.

Mr. MCCAIN. Mr. President, the passage of the Medicare prescription drug benefits legislation is a difficult vote for me. It is unacceptable that in a country as wealthy as ours seniors across the country are struggling to afford the high cost of prescription drugs. By passing a prescription drug benefit to Medicare because I believe no beneficiary should have to choose between life-sustaining prescription medications and other vital necessities. For too many American seniors face those choices every day. Many suppliers' supplies, medication, skip dosages, or cut pills in half.

In Arizona, busloads of seniors depart from Phoenix and Tucson every week, heading south to Mexico to purchase lower priced drugs. The story is similar across the northern border, where seniors make daily trips to Canadian pharmacies. Throughout the country, an increasing number of seniors are looking to online pharmacies, selling reduced-priced prescriptions imported from other countries, oftentimes with questionable safety.

That said, I also recognize, as does every other Member of Congress, that Medicare is on a fast track toward bankruptcy. The recent Trustee's Report adjusted down the year Medicare will reach financial insolvency by 4 years, to 2026. Clearly, it is incumbent upon us to include comprehensive reform of the system in any Medicare prescription drug package in order to ensure that Medicare is financially sound for current beneficiaries as well as future generations.

Medicine has changed substantially since the creation of the Medicare system in 1965. Medical technology and pharmaceuticals have led to more prescription-based treatments. The simple fact is, Americans now consume more prescriptions than ever before. In 1968, soon after the enactment of Medicare, American seniors spent about 25% of their income on prescription medications. Today, seniors fill an average of 22 prescriptions a year, spending an estimated $999.

The bill before us represents one of the largest enhancements to Medicare since its creation, setting up an entirely new bureaucracy and establishing a sizable new entitlement program. I believe this bill addresses a real problem, the need to help struggling middle and low-income seniors. However, we must have no illusions. There are dangerous complexities and potential unintended consequences associated with this bill.

We are not being realistic about the cost of this new entitlement program. For anyone who believes this bill will cost a maximum of $100 billion over the next 10 years, I have some oceanfront property in Gila Bend to sell you.

Medicare and Social Security, together, represent an enormous unfunded liability for our Nation. In a few short years, millions of baby boomers will hit retirement age and the system will quickly become insolvent.

The numbers speak for themselves. Medicare currently has an unfunded liability of $13.3 trillion. Some have estimated the unfunded liability of the package before us in the $5 to $7 trillion range. A Senate at the American Enterprise Institute Scholar estimated that if passed, the Senate’s prescription drug benefit legislation will result in a $12 trillion unfunded liability. Social Security and Medicare, with a prescription drug benefit, would each consume an estimated 21 percent of income taxes by the year 2020.

Long after the Members of this Congress and administration have left office, our children and our grandchildren, and a future Congress and administration, will be struck with the burden of cleaning up the mess we have created.

In the past 2 years, we have passed two large tax cuts. Government spending, however, has continued to increase well above the inflation use. Much of that spending is unnecessary, and represents a lack of fiscal discipline more common in times of federal budget surpluses. Yet our current budget deficit and national debt have risen dramatically. Security concerns in the post 9/11 era necessitate substantial increases in spending on defense and homeland security. We cannot sustain this level of fiscal profligacy indefinitely.

This extraordinary large new entitlement we are debating will impose an equally extraordinary burden on taxpayers. The money has to come from somewhere, and none of the “somewheres” are desirable. The reality is, this new benefit will be funded by raiding other entitlement trust funds, or by increasing our national debt, or by substantially increasing taxes.

Regardless of the cost of this bill, this new entitlement will not provide the prescription drug coverage many seniors expect to receive. Nor does it enact significant reform measures needed to ensure the long-term solvency of the Medicare system.

Those seniors who think this bill will solve their financial problems will soon learn that there are substantial limitations to the benefit. When it does pass, the new prescription benefit will not be available immediately. It will take several years just to establish the new bureaucracy which will administer the prescription benefits.
Low-income seniors will benefit from this package, and I am pleased that they will. Many other seniors, however, will not receive a generous benefit, and might not even get out of the system what they will pay in deductible sand premiums. The nonpartisan Congressional Budget Office estimates that 37 percent of employees currently providing coverage to Medicare eligible seniors, will drop coverage if this bill passes. Last week, the Wall Street Journal quoted one analyst who called this bill the “auto-maker enrichment act,” because companies such as the automakers who currently provide their retired employees with a prescription drug benefit are unlikely to continue doing so if the Federal Government assumes part of the burden for them.

I am concerned that we are about to repeat—I emphasize repeat—an enormous mistake. I have been around here long enough to remember another large Medicare prescription drug entitlement program that was adopted in 1965: Catastrophic. The image of seniors outraged by the high cost and ineffectiveness of that package should be a cautionary tale to all of us.

Moreover, I am not confident that the Medicare portion of this new scheme, which establishes regional PPO options for seniors, will succeed. Many in the insurance industry have expressed skepticism and concern that such plans will not be profitable. In the end, if the Federal Government, which acts as a fallback if no private plans are available, might end up covering the majority of the country. Not exac-

The American people should be aware that this new benefit has substantial cost to seniors, and to current and future generations of taxpayers, who will bear the majority of a crushing financial burden. There will be unintended consequences of our actions. We can be sure that if this approach does not work, we should be honest about the costs of this measure—$400 billion is merely a down payment for what we are creating. Given the fiscal realities we face, realities that will become more dire with every passing year, Congress and the administration should have committed to addressing the acute need for a drug benefit to alleviate the impossible choices confronting lower income seniors. And, most importantly, begun to seek consensus among responsible Members of both parties for the reforms we all know are necessary to save Medicare.

I recently heard a good assessment of this package: it is “an effort to do too much with too little, and thus doing nothing very well at all.”

There are several good amendments that have been adopted during this debate. I am encouraged that a bill Senator SCHUMER and I worked on for the last 4 years, might finally be enacted into law as part of this package. Our amendment would increase competition in the pharmaceutical industry and ensure that all Americans have access to lower cost generic drugs. That amendments, which would not have been possible without the leadership of Senator GREGG and the support of Senator KENNEDY, will reduce the cost to the government of any Medicare prescription drug benefit.

I was happy to cosponsor an important amendment with Senators FEINSTEIN, NICKLES, CHAFEE, and GRAHAM, which I believe will add some fiscal discipline to the bill and the Medicare program. The amendment will add meaningful funding to Medicare Part B—increasing co-payments for wealthier seniors.

I am also pleased that several measures which I have supported and cosponsored as separate bills, have been adopted as part of this package, including the Improving Children’s Health Insurance Act, the Blind Empowerment Act, and funds to reimburse hospitals for the uncompensated cost of caring for undocumented immigrants. Additionally, there have been several good amendments that I think will improve overall health care in our country. In particular, I believe Senator GRASSLEY’s amendment which requires agreements between brand and generic pharmaceutical companies to be reported to the Federal Trade Commission and the Justice Department will shine some much needed light on potential collusive agreements.

Despite these welcome improvements, and recognizing that this legislation will address the crisis faced by lower income seniors, the costs of this entitlement remain, simply put, beyond the means of this country absent real reform of Medicare. Therefore, after much thought, I regret that I cannot vote for this legislation. I have reached this conclusion, not because I believe our seniors and disabled do not need or deserve prescription drug coverage, but because I do not believe our country can sustain the cost of this benefit. We have already paid a huge and staggering expense, provide the assistance many beneficiaries will expect.

As I noted, Congress and the administration should have addressed the acute need for an insurance benefit to alleviate the impossible choices confronting lower income seniors. And before we consider extending that assistance to other seniors, we should save Medicare first by instituting the reforms we all know are necessary, but which we apparently prefer to defer until we have retired from public office. Senator ALLEN’s reforms pose a very difficult political challenge to us, and that the bipartisan and bicameral approach we have commended in the drafting and consideration of the legislation before us today would be put to a far more severe test should we genuinely attempt to save the Medicare system from insolvency. However, should we simply add another huge, new unfunded liability to an already fiscally unsound entitlement, imposing a breathtakingly heavy tax burden on our children, with devastating consequences for their prosperity and the national economy, we will have done the one thing no public servant should want to be remembered for, we will have left the country worse off than we found it. I yield the floor.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. Mr. President, the Senator from Michigan, Mr. LEVIN, has been extremely patient. He has been waiting for us to get a unanimous consent for his amendment. We are very shortly going to get that, but prior to that being announced, the Senator from Michigan is going to offer amendment No. 1111. He is going to speak for 10 minutes. Senator STABENOW will speak for 10 minutes. Mr. Senator GRASSLEY and Senator BAUCUS will speak for up to 10 minutes in opposition, if they need to. The leaders will arrange a vote at some time that they have agreed upon.

I ask unanimous consent that that be the case.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Michigan.

AMENDMENT NO. 1111

Mr. LEVIN. Mr. President, the amendment which I will be offering is designed to ensure that the CBO estimates of 37 percent of current retirees who now get their prescription drug coverage from their former employer and who will lose that coverage as a result of this bill will at least have the option of a prescription drug coverage under the Medicare fallback.

There are a number of problems which have been identified with this bill. Some of them are significant problems which cause many of us, who very favor having a prescription drug benefit available to our seniors, great pause before we support this bill. For instance, there is a so-called yo-yo effect in this legislation. Some have called it the revolving door effect. The problem there is that seniors who are offered two private plans in their service area must pick one of those private plans. They cannot use the Medicare fallback. There will not be a Medicare fallback with a guaranteed premium because if two or more private companies offer a prescription drug program, with whatever premium they decide upon, then the seniors in that service area must pick one of those two private plans.

What happens if the senior says, okay, I am going to pick that private plan A, and then a couple of years later the private sector decides to pull out of that service area? At that point, the senior will have the Medicare fallback. Then what happens if the private insurance folks decide to come back into
that service area? Could the senior keep the Medicare fallback plan? No. If they are kicked out of that plan even if they want it. They have to go into one of the private plans again. Then that can be repeated over and over again. If private insurance companies decide to pull out of an area, the seniors then can get into a Medicare fallback, but when private companies come into the service area again, they are removed from the Medicare program and have to go back to one of the others. It is confusing, uncertain, unfair. It is the yo-yo effect, what others call the revolving door. It is a real problem with this plan. We ought to give much more certainty to that.

Another problem identified is the so-called donut hole problem. We have heard quite a bit about that problem where once a senior is told her drug spending reaches $4,500 for a year, she will have to pay 100 percent of the costs for her prescriptions. Her total drug spending reaches $5,800. Now, premiums will continue to be paid during that period, but the gap in coverage will be there, so from $4,500 to $5,800. There is not a 50/50 deal between the premium and the prescription. That is 100 percent burden of the senior during that period. That is a real gap in coverage. That is a gaping hole in coverage. I don’t know of any other insurance program that has so unfairly structured. That is another problem which has been identified. There have been efforts made to correct that, without success.

Another problem identified is that the private insurance plans that may come into a service area do not have a cap on the premium; it is an unlimited premium. That is a problem which has been identified. The effort to put a cap on the premiums has failed.

But of all the flaws that have been identified, the weaknesses in this program, the one that troubles me most and that troubled seniors most is the fact that it has been estimated by the CBO and by the Health and Human Services folks who operate Medicare that 37 percent of current retirees who have a prescription drug program through their former employer are going to lose their prescription drug benefit following the enactment of the plan before the Senate; that is, a situation where we are actually going to see 37 percent of our seniors——that is the estimate—who currently have a benefit being worse off as a result of what we do.

There is a debate here as to whether the plan before the Senate is going to be good for seniors because of the donut hole or because of the fact there is no cap on premiums or because of this yo-yo effect, this revolving door effect. Is it a good plan? Is it not a good plan? Will seniors who don’t have health insurance, a prescription drug program that they want to opt into this program? That people can debate. But, at a minimum, we should do no harm. At a minimum, we should not have millions of seniors who will lose an existing prescription drug program as a result of our enacting a plan. That is the time bomb in the bill before the Senate. We should not let people worse off than they otherwise would be.

During the markup of this bill, we had some experts who testified. One was Tom Scully, Administrator of the Centers for Medicare and Medicaid Services at HHS:

Among employees who have employer-sponsored insurance, the one that troubles me most is the donut hole or because of the fact there is no cap on premiums or because of the fact there has been identified. The effort to put a cap on premiums has failed. That is a problem which has been identified. There have been efforts made to correct that, without success.

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Among employees who have employer-sponsored insurance, the one that troubles me most is consistent with 37 percent having their coverage dropped.

A little later on, page 6 of the transcript of the markup of the Finance Committee:

The Director of the CBO said the following:

Mr. HOLTZ-EAKIN: Thirty-seven percent of those retirees who have employer-sponsored coverage . . . [will lose their coverage].

Then, a little later on in the markup of the Finance Committee, Senator CONRAD was going to ask a question of Mr. Scully, our CBO Director, about this issue, and the majority leader posed a question.

Senator FRIST: Senator Conrad, could I—

TOM SCULLY: On that last—I’m over here—on this employer—

Senator CONRAD: Yeah. Absolutely.

Senator FRIST: You said—is it 37 percent of employers are going to drop——

TOM SCULLY: Yes.

Colleagues, Senator FRIST said something which I hope will reverberate in this Chamber.

Senator FRIST: This has huge implications.

The Director of the CBO said the following:

Mr. HOLTZ-EAKIN: Thirty-seven percent of employees—of retirees with such employer insurance.

Then there was a voice, unidentified by the reporter:

MALCOLM: As I understand it, this 37 percent is the effect of our legislation.

Mr. HOLTZ-EAKIN: Correct.

Colleagues, Senator FRIST is correct.

This has huge implications. And we ought to address it. The least we can do is to direct Health and Human Services to make available to designate a Medicare backup plan for the 37 percent of our current seniors who have a prescription drug program through their previous employer to make available to them the Medicare backup program so they at least know there will be a Medicare backup for them if they lose their current prescription drug program, as it is projected by the Congressional Budget Office and by Health and Human Services. It seems to me that is the least we can do.

It still will be harmful because it is very unlikely for most of the people that the Medicare backup will be as good as their current prescription drug program. It is unlikely. But at least we can say, for those people, there will be some Medicare backup plan designated by HHS which will have the criteria established by HHS and the premium established by HHS. That is the least we can do for those who are going to lose their prescription drug benefit that they currently have following the enactment of this legislation.

I reserve the remainder of my time.

The PRESIDING OFFICER. The amendment is pending.

Mr. LEVIN. I ask unanimous consent that my colleague from Michigan, Senator STABENOW, be listed as a cosponsor of this amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. LEVIN. I ask unanimous consent that the excerpts from the quoted testimony be printed in the Record.

There being no objection, the material was ordered to be printed in the Record, as follows:

Senator ROCKEFELLER. Okay. Actual data in the plan that are spent on number one, the drug benefit itself, provider add backs and that’s all I can see. I don’t need that third one I’ve written down.

TOM SCULLY. These are figures that were in the table. We issued it to the Committee. Since this table was put together, there were some recent modifications to the drug benefit. In particular, putting the cap at $1,500.00 instead of $1,725.00. That changes the estimate on the drug benefit from $408 billion to $902 billion over ten years.

Senator ROCKEFELLER. Four hundred two?

TOM SCULLY. Four hundred two. Six billion dollars lower. And, the provider add backs are listed on pages 2 and 3—or, pages 1 and 2.

Senator ROCKEFELLER. Could you give them to me?

TOM SCULLY. There’s a long list of them, and simply adding them up is not that—they interact in many ways.

Senator ROCKEFELLER. [Unintelligible].

TOM SCULLY. [Unintelligible].

Senator ROCKEFELLER. Next one is, percent of employers who drop retiree coverage. And, the number and percent of beneficiaries who will lose retiree coverage under this plan so far.

TOM SCULLY. We don’t have an estimate on the number of employees of employees who have employer-sponsored insurance, our estimate is consistent with 37% having their coverage dropped. Of that 37% of those who have such coverage, about 11% of beneficiaries overall.

MALCOLM. Could you repeat that?

TOM SCULLY. Thirty seven percent of those employees who have employer-sponsored coverage, it’s 11% of beneficiaries overall.

Senator ROCKEFELLER. And, what percent would drop it?

TOM SCULLY. We don’t know the number of employers who would drop coverage. We know the number of employees who are affected.

MALCOLM. I thought you gave an estimate—excuse me—this is Senator Rockefeller’s time, and I just want to make sure——
MALE VOICE. Could I also add into this, Senator Rockefeller? What we also need to know is, what percentage of the figure you said might drop—or, case would be dropped even.

Or, they could drop it entirely. In those latter two cases, they can use the additional resources to provide other kinds of employment opportunities.

What we’ve done is examine the literature to the extent that we can find it on employer response to flaws in the shape of compensation packages in shaping our estimate of the number that would drop.

Senator CONRAD. Okay. Let me get to something I found difficult to follow. And, I’d like, if I could, to have the attention of the Chairman.

Senator FRIST. Senator Conrad, could I—on that last—I’m sorry—on this employer dropping it, can I just ask a follow up question just real quick.

Senator CONRAD. Yeah, absolutely. Senator FRIST. You said—is it 37% of employers are going to drop—

TOM SCULLY. Yes.

Senator FRIST. This has huge implications.

Mr. HOLTZ-EACKIN. Thirty seven percent of employees—of retirees with such employee insurance.

Senator FRIST. Okay.

Mr. HOLTZ-EACKIN. And, that’s 11% of overall Medicare beneficiaries.

MALE VOICE. Okay. If we did nothing, how many would be dropped over the next ten years? If you look at these curves, the employer's dropping out of the business, anyway—not out of the business, but the curve is going down.

What would it be ten years from now?

Mr. HOLTZ-EACKIN. We don’t have an estimate of that. We isolated our estimate on the impact of the bill above the baseline. That’s a question about the baseline estimate, and I don’t have that.

MALE VOICE. Okay.

MALE VOICE. It’s 37%, just so we’re clear with each other. As I understand it, this 37% is the effect of our legislation.

Mr. HOLTZ-EACKIN. Correct.

MALE VOICE. I think the question Senator Frist has is, in your baseline you have an assumption that there will be changes, though, correct? Or, don’t you?

Mr. HOLTZ-EACKIN. NO. We do not.

MALE VOICE. Okay. Would you suggest that that is an inaccurate baseline?

Mr. HOLTZ-EACKIN. In reality.

MALE VOICE. In reality is not that. And, I can have a few of my retirees in Pennsylvania give you a call if you have any questions on that subject.

I mean, I think that’s an unfair—I mean, baselines are supposed to be real, but not supposed to be artificial. That’s artificial.

Mr. HOLTZ-EACKIN. The baseline issue that we—that is most important, that we capture is new retirees not having such coverage.

This is a provision that would induce existing retirees who have such coverage to have their coverage dropped or modified by the their employer.

MALE VOICE. I understand what this provision does. I just want you—I just want an understanding of what would happen without this being calculated into the baseline.

Mr. HOLTZ-EACKIN. And Senator Santorum, we’ve looked at the literature and the surveys of the employee benefits consultants of retiree offerings.

We understand is mainly happening is, for current workers who are newly hired, they are—employers are no longer putting as part of their compensation package a three healthcare.

As far as we can tell, the base of people who are near retirement or retired are not having their healthcare—there’s not that much erosion going on.

MALE VOICE. I’ll have the people from Bethlehem Steel and about seven other steel companies around Pennsylvania that I can just think of off the top of my head give you a call, and let you know that their retiree health benefits have been eliminated. I mean, in my first choice is, the Senator Rockefeller, would you like to join into this? I mean—so, I just—I think you need to look at your baseline, please.

And, then give us an understanding of maybe looking back over the last few years and projecting forward given the trends that have already taken place, that would affect it. And, I think that would much—a be much fairer score as to what the impact of this bill would be.

Senator CONRAD. Mr. Chairman?

The CHAIRMAN. Senator Conrad.

Senator CONRAD. Let me just say that I agree entirely with Senator Santorum. We know that that’s an inaccurate baseline?

And, I understand your answer to this question is the effect of this bill.

I think one of the things we’ve got to do—Senator Frist said it well—this has got major implications; 37% having their health benefits dropped, that means it’s going from being on the company’s nickel to being on our nickel; that dramatically increases the cost.

So, if we can find ways to hold that number down, that’s in our interest and we should pursue it.

Let me give—

Mr. HOLTZ-EACKIN. If we could, before we—

Senator CONRAD. Yes, sir.

Mr. HOLTZ-EACKIN. I understand the policy interest, and * * *

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, I am very proud to be joining with my colleague on this very critical amendment. Can you imagine, you are some- one who has worked hard all of your life, you have been fortunate enough to have a good-paying job with benefits, you are now retired and you are fortunate to have good health benefits and you find yourself in that situation that, as a result of an action taken here—and certainly there is an effort to move for- ward and provide people with prescrip- tion drug coverage—but if those who already have coverage find, as a result of an action we take, there is an incen- tive for their employer to drop their coverage, how would you feel about that?

I know how I would feel about that. This amendment is about making sure those who have worked hard all of their lives, who have retired and have had the confidence and the security to face the future, that you are now retired and you are fortu- nate enough to have health care insurance and pre- script ion drug coverage, how would you feel about that if, in fact, their employer would have the incentive to change or drop their coverage, they should be guaranteed that something else is right there, that Medicare as a backup should be there. Preference was to change the formulas so there is not the incentive to drop anyone. That was one of the reasons I strongly supported Senator Rockefeller’s amendment and other amendments that have been on the floor. Because my first choice is, we take away any incentive for anyone to lose their prescription drug coverage. But unfortunately those amend- ments were not successful. We did not have the support to do that here.

That was, we are now coming in and saying if, in fact, an employer, be- cause of the incentives, makes a deter- mination to drop coverage, that at a minimum, out of a sense of decency and fairness, at a minimum that re- tiree needs to know that Medicare pre- script ion drug coverage, through Medi- care, is available without wading through tons of insurance forms or picking through plans or going through all the ups and downs that have been described so many times in this Cham- ber, they need to know, after having coverage, having it available, having it dependable, that another plan is right there for them. That is the least we can do.

I hope we will join together in a bi- partisan way this evening to agree to this very important amendment, and let us send a message to those fortunate enough to have health care insur- ance and prescription drug coverage that we remember them, we care about them, and we are going to make sure no harm is done to them in the process of putting together this prescription drug plan.

I yield the floor.

Mr. REID. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk pro- ceeded to call the roll.

Mr. REID. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.
Mr. REID. Mr. President, this is the greatest and most prosperous Nation in history. Nobody has worked harder to make this country great than our senior citizens. And few things weigh more heavily on their minds than the soaring cost of prescription drugs.

You would think such a great, prosperous Nation would honor its elders, by making sure they get the medicines they need. That is why a comprehensive, meaningful and voluntary drug benefit for our senior citizens has been among my top priorities.

Over the last several weeks, this Senate has worked hard to achieve that. In the process, many of us who shared that goal have disagreed about how to react in the end. We wound up with a bill that is not how I would have created a prescription drug benefit. But it is a start.

I am voting for this bill, because I believe some benefit is better than none. I am voting for it because of people like Shirley, who is 78 years old, raised eight children in the Sierra Nevada. She currently spends $400 a month on medicine, and has less than $400 left over to live on. This bill would reduce her medicine costs to less than $300 a month. It would provide a similar level of assistance for tens of thousands of Nevada seniors.

I am voting for this bill in the hope it will be like the camel's nose under the tent—a foot in the door for our senior citizens.

I am hoping we will pass this bill today, and then improve it in the future. And, yes, there is plenty of room for improvement.

For example, this bill will do little to help seniors whose income is $15,000 a year or more. Even if they spend more than $100 a month on prescription drugs, that is why I voted to make the program more generous.

This bill could take effect soon enough. That is why I voted for and cosponsored the Lautenberg amendment to move the start date up to 2004, instead of 2006.

There are gaps in the coverage this bill provides. That is why I voted for Senator Boxer's amendment to close the coverage gap, and Senator Graham's amendment to cancel premiums while coverage is suspended.

There were other amendments that were not agreed upon. Finally, this plan is just plain confusing—which means it won't give our senior citizens the peace of mind they deserve.

I voted to address all of these issues. I wish we had succeeded, and that this bill would provide the kind of coverage our senior citizens need. We didn't and it doesn't.

We have to be honest with our senior citizens, and with the American people. This isn't the best way to do it, but it is the best we can do tonight.

I will vote for this bill today, because it provides a start toward fulfilling our promise to senior citizens. It is a start, and I won't stop fighting until we finish the job.

The PRESIDING OFFICER. The minority leader is recognized.

Mr. DASCHLE. Mr. President, I know we are in the middle of 10-minute votes on negotiations on an amendment. As I understand it, no one is seeking recognition to continue work on other amendments. So I will speak for a couple of minutes until somebody is prepared to come to the floor to continue our work. I don't want to delay the business of the Senate but I want to express myself, as the distinguished Democratic whip has been doing with regard to the legislation.

I, too, intend to support this bill. I am thinking of the old joke about a camel being designed by a committee. Oftentimes, I think of that as we work our will on legislation. In many respects, this is the legislative version of a committee horse, a camel, and the king said, 'It is not good.' It is not the kind of bill I would cosponsor. It is not the kind of bill I would enthusiastically endorse.

I look at some of the concerns we have about this legislation: about the premium, uncertainty about the benefit package, uncertainty with regard to the deductible, uncertainty with regard to the backup, uncertainty with regard to the way the provisions can be provided in the States. There are many issues. Mostly I think there is far greater confusion than there is understanding with regard to the benefits themselves as seniors attempt to determine whether they will be assisted by this bill.

The confusion and the uncertainty will be issues that we have to address at some later date. But having said that, I must say that the rural provision—the effort made by our two distinguished colleagues to address the rural needs to overcome the inequities that exist today—alone merit consideration and I would suggest support for this legislation. The help for low-income seniors—tens of thousands of South Dakotans will get help they are not getting today in part because of this bill. The possibility that seniors could access generic drugs with far more regularly and successfully, and the possibility that we could reimplement drugs at a lower price from Canada, all are reasons why I think this bill merits our support.

As I look to the balance and look to all of those things I wish were better, my response is that we are going to make them better. It may take months, if not years, but we are going to continue to work to make this a better bill and a better program.

There are so many ways that I hope we as Senators—Republican and Democrat—can work together to make this a better bill in future years. There is a warning and a hope as we complete our debate tonight. The warning is that if this legislation comes back from conference in a significantly different form we will not be in the same position we are tonight. This bill will enjoy broad bipartisan support tonight. But if we fail, if we endorse a bill with some of the provisions in this legislation, I believe it will be a very difficult job to make the legislation better and that we can address what I would consider to be serious shortfalls, especially the benefits that we need.

My hope is that we can do what I have just suggested—that over the course of the next several years we can take a very close look at ways to make this legislation better and that we can address what I would consider to be serious shortfalls, especially the benefits that we need. That is why I voted for and co-sponsored Senator Boxer's amendment to close the coverage gap, and Senator Boxer's amendment to move the start date up to 2004, in stead of 2006.

Mr. REID. Mr. President, I ask unanimous consent that the Hagel-Ensign amendment, No. 1026, be recognized for up to 15 minutes and Senator HAGEL, for up to 10 minutes, and the two managers be given up to 5 minutes each; further, that it be in order for the Hagel-Ensign amendment to be modified up to the beginning of the stacked votes.

The PRESIDING OFFICER. Is there objection?

Mr. DASCHLE. Mr. President, reserving the right to object, I suggest that the managers and the two managers be given up to 5 minutes each; further, that it be in order for the Hagel-Ensign amendment to be modified up to the beginning of the stacked votes.

The PRESIDING OFFICER. Is there objection?

Mr. FRIST. Mr. President, let us make it 10-minute votes.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The Senator from Nevada.
stand-alone bill. We actually made some improvements to it. We think if this amendment is adopted, it will dramatically improve what the committee has attempted to do to add a prescription drug benefit to Medicare. The only portion of the bill we are modifying in substantial form is the prescription drug part of it.

Let me talk about what our amendment exactly does. It would say to a person who is below 200 percent of poverty, they would pay the first $1,500 out of pocket. After that, the Government is going to pay for the rest of their drug costs, other than a 10-percent copay the person would pay.

However, if a person is up to 160 percent of poverty, we will give them, in a pharmaceutical benefit account, $500 per year, which they can use to go to a local pharmacy to buy their prescription drugs or they can use that money and negotiate the price of their prescription drugs through a pharmacist. The Government is not the manager, and mass buy with their drug discount card. If they want to use their local pharmacist, they can do that. And this $500, if they did not spend it that year, would be rolled over to the next year where it would cover the first part of their deductible. So if you are below 160 percent of poverty, the most you are going to pay out of pocket is less than $100 per month.

There are several benefits to our plan. First of all, with the committee mark, you pay a monthly premium of $35. You also have a deductible of $275. With our bill, you have no monthly premiums, you have a one-time annual fee of $25, and for low-income people, we waive that.

Our plan is completely voluntary. It also gives the most help to lower income seniors and gives progressively less help the more money you make.

So between 200 percent and 400 percent of poverty, $500 is your out-of-pocket expenses. Above that amount, the Government pays 90 percent. And from 400 percent to 600 percent of poverty, $5,500 is your out-of-pocket expenses. Above that amount, 20 percent is your deductible before catastrophic coverage kicks in.

For all of these people, though, who want to sign up for the plan, they get a drug discount card where they will save between 25 to 40 percent on their prescriptions. It is a completely voluntary program. And in this program, we have several benefits that we think are better than the committee's underlying bill.

One is, under our bill, States that have already enacted programs will be encouraged to keep their programs. Under the committee mark, every State that has a program for low-income seniors is going to drop those. There is no debate about that. As a matter of fact, the Secretary of HHS was here. The person who oversees Medicare was before us. Both of them said there is nothing in this bill that will say to the States: Don't drop your plans. And they agreed they will probably drop their plans.

Our bill works with the States that have those programs, States such as my State of Nevada, and encourages those programs to be kept.

A couple of advantages that our bill has: I want to illustrate those with a couple of examples. These are real-life cases. This is a fictitious name, of course, to protect this woman's identity, but this is a real person. We call her Doris Jones. She is 75 years old. She has an income of about $17,000 a year. She is being treated for diabetes, hypertension, and high cholesterol. She is taking medications that are very typical of what this type of a disease management would require. Her out-of-pocket expenses right now are $3,648.

Let's compare how our amendment, the Hagel-Ensign approach, would affect her out-of-pocket expenses versus the bill on the floor if our amendment is not accepted and mass buy with their drug discount card. If they want to use their local pharmacist, they can do that. And this $500, if they did not spend it that year, would be rolled over to the next year where it would cover the first part of their deductible. So if you are below 160 percent of poverty, the most you are going to pay out of pocket is less than $100 per month.

Under our bill, she would have $1,700 out-of-pocket expenses a year. Under the committee bill that is before us today, she would have $2,383 a year. So it is a savings of almost $700 under our approach.

Another person: James is 68 years old. He has an income of about $16,000 a year. He is being treated for diabetes, a pretty severe case of diabetes, and he has all these different medications—very common medications today for a diabetic. His total out-of-pocket expenses today are $5,700.

How does he compare under the two provisions?

Under the Hagel-Ensign approach, about $1,900 would be his out-of-pocket expenses for the year; under the bill that is before us today, a little over $1,000 in out-of-pocket expenses a year. So the difference is almost $2,200 to this senior who is sick. And we certainly can't call him a rich person. I would call this person certainly a low-to moderate-income senior.

Now, Betty is another example. These are real-life examples taking real medicine, prescribed by real doctors. She is 66 years old. She has an income of $15,500. She is being treated for breast cancer and she is taking commonly prescribed medications for that. She is on low-dose radiation. She pays about $8,000 for her prescription drugs a year.

What would happen to her under the two different scenarios?

Under our scenario, she would pay about $2,100 out of pocket. Under the bill that is before us today, she would pay $4,300.

What we have done with our amendment is we have said: Let's help the seniors who need it the most. And we put the dollars to them. Under our amendment, people who are sick, with low and moderate income, they really get help. For people above that, they are treated about the same between our amendment and the bill. The out-of-pocket expenses for people between 200 and 400 percent of poverty are about the same.

When you start getting to the wealthier seniors, there is no question, the committee bill is more generous. For very low income seniors, the committee bill is slightly more generous. But for those who are really sick, our amendment is much better.

Also, there are a couple of other advantages.

In the future, to control costs, our amendment says: The person receiving the medication has something at stake. They are paying out of their own pocket for the first dollars, so they are going to shop. They are going to go around and see: Do I need generics? First of all, do I need the drug? Could I take a generic, which may be less expensive? Are there perhaps other alternatives for treatment that may be cheaper and just as effective? They will have that conversation with their doctor because they have something at stake.

I would argue that what the committee is doing—and I applaud what they are doing, trying in a bipartisan fashion—I believe our amendment would strengthen the committee's bill drastically because it would target the dollars, those precious taxpayers' dollars, to the people who need it the most. It will also, though, in the future, control costs and, therefore, be more responsible to the next generation.

The committee mark, especially for very low income people, pays 97.5 percent of their drug costs, maybe a $1 to $2 copay. Well, there is going to be a tremendous amount of overutilization in that group.

Our amendment gives that group help by putting $500 of their first costs into an account. They will use that to go shop because if they do not use it, it gets rolled over to the next year where it covers more of their deductible. So they have something to benefit by if they do not use it.

So I implore our colleagues to look and compare. If you look and compare, you will see there truly is a difference.

Mr. President, I reserve the remainder of my time.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. I commend Senator HAGEL and Senator ENSIGN because they have been working very carefully over the last few years to help move this legislation. They did have a different approach than I have had. I have had what I call a comprehensive, universal, voluntary approach. They have
President Bush has proposed and our amendments to the Medicare Program that doesn’t include any of the improvements that come in without any effort what- soever, no effort to contain costs.

Second, the Hagel-Ensign plan has far less reform and is less sensitive to that, so they work to become more efficient, to keep their costs down, because individuals shop.

Another thing S. 1 does very well is that it is very significant—the difference between the underlying bill and their bill. We are going to drive drug prices down more through competition.

I would like to explain: First, this amendment would rule out any true competition in the delivery of Medicare drug benefits. S. 1 would have sterile, competitive reform as many of us have wanted for a long time. Moreover, the Medicare Part D drug plans assume a modest amount of financial risk, giving them an incentive to drive hard bargains and keep taxpayers’ costs down. It seems to me that is very significant—the difference between the underlying bill and their bill. We are going to drive drug prices down more through competition.

The Hagel-Ensign plan, it is pretty obvious from my point of view, allows for no such exemption, specifically mandating that the Government—in this case we are talking about the tax- payers—bears all the financial risk for delivering the benefit, much as Senator Bob Graham’s did the last year when we debated this very issue.

Under this amendment, the benefit would be delivered just like other Medicare benefits are today—by contractors that merely pay the claims that come in without any effort whatsoever, no effort to contain costs.

I come to this based on my experience in the private sector and how health care can be delivered by individuals shopping. I reserve the remainder of my time.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum and ask unanimous consent that the time be equally charged.

Mr. HAGEL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

Mr. HAGEL. Mr. President, in the last 2 weeks the Senate has engaged in an historic effort to reform and strengthen Medicare. When we opened this debate 2 weeks ago, I said that what we would do here debating this bill would affect every American and future generations.

Health care is a defining issue for our Nation and future generations. Just a reminder: When Medicare was enacted in 1965, the Federal Government’s lead actuary at that time projected that the hospital program, Medicare Part A, would grow to $9 billion by 1990. In fact, the program, in 1990, had then cost the taxpayers $66 billion. So we have some sense of how these programs can get out of hand if not defined clearly at the front end.

In addition to the internal problems of the changing realities of health care, Medicare is facing a looming external problem. The largest generation in American history, the baby boomers, are aging. These Americans—over 75 million of them—will be added to the Medicare rolls over the next few years. The baby boom generation has changed and shaped every market it has ever entered. Medicare will be no exception. We have a responsibility to address this demographic pressure now or risk the system collapsing under its own weight in the future.

Mr. ENSIGN and I have come to this based on my experience in the private sector and how health care can be delivered by individuals shopping. 

I come to this based on my experience in the private sector and how health care can be delivered by individuals shopping. 

I urge my colleagues to defeat the amendment.

Mr. PRESIDING OFFICER. The Senator from Nevada.

Mr. ENSIGN. Mr. President, I want to clear up something. We don’t touch any of the other Medicare reforms in your bill. The whole thing with the PPOs, we touch the prescription drug part of the underlying bill.

You mentioned competition. I practiced veterinary medicine, built, owned, and operated two different animal hospitals. Why do I bring that up? It is because in veterinary medicine people pay out of their own pocket. Veterinarians are in an incredibly competitive field because we know that if somebody brings a case to you, they are going to shop about half the time based on price. So veterinarians have learned to be very sensitive to that, so they work to become more efficient, to keep their costs down, because individuals shop.

In our health care system today, individuals do not shop because we have low deductible policies, and a lot of times the doctors waive those deductibles. Senator Frist will be able to tell you about that. The hospitals waive the deductibles. So the person receiving the care is not accountable for the care, and so they don’t shop. The doctor tells them, go get this service or this drug, and they don’t think about it. They have modest, low copays, and they don’t think about it.

The cost control, the competition, is established by 40 million people on Medicare, 40 million people receiving drugs. If they are paying out of their own pocket or low-income people have the $500 in a pharmaceutical benefit account, they have something at stake, so they go shop.

They ask the questions: Do I need the drug in the first place? Maybe I can get a generic. So they do the shopping. Also, we have pharmaceutical benefit managers in the bill. That is what the whole drug discount card is about. So those pharmaceutical benefit managers help lower the costs as well.

We have several reforms in this bill that are true reforms, that introduce competition to keep the costs down. That is why our bill actually scored lower.

Because of that, we were able to add a couple other things. When Senator HAGEL arrives, he will modify the amendment. For instance, we will allow Medicaid, the dual eligibles that people have been talking about today, to give States help in handling those dual eligibles through Medicare because our prescription drug cost to the taxpayer was less. Because we made more reform on the prescription drug part of it than the underlying bill. It just a difference of philosophy of how you do it.

I come to this based on my experience in the private sector and how health care can be delivered by individuals shopping.

I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?
Our amendment is a simple amendment. Seniors will be able to understand it clearly. Unlike the underlying bill, our amendment contains no premium, no deductibles, and no gaps in coverage. Our modified amendment addresses most of those major issues we have tried to deal with in constructing this plan. First, it helps low-income seniors, those who need it the most. Two, it protects seniors from high out-of-pocket expenses, and it eases the burden prescription drug costs have placed on the States.

Our modified amendment would replace the prescription drug benefit in the Finance Committee plan with, No. 1, a prescription drug discount card for all seniors on Medicare with $30 billion in added funds for low-income seniors; No. 2, catastrophic coverage for all seniors; No. 3, $35 billion in cost-sharing for catastrophic drug costs with the States for the lowest income seniors eligible for both Medicare and Medicaid. We give the Secretary of Health and Human Services the discretion to divide $65 billion for seniors and for help with drug costs at the State level. With our amendment, the Secretary will provide low-income seniors with money on a drug discount card to help defray their drug expenses.

States would also benefit under our amendment, and $35 billion is available to help States cover the catastrophic drug expenses for the dual eligibles. These are the very poorest of seniors.

These modifications to the amendment make it stronger by targeting aid to those who need it the most. This bill has been scored. We fall within the $400 billion budget number that is required. This is a commonsense plan that is workable and responsible, and it addresses prescription drug concerns in the right way.

**AMENDMENT NO. 1026, AS MODIFIED**

Mr. HAGEL. Mr. President, I have a motion of the desk, to amend No. 1026. I ask unanimous consent that the amendment be modified.

The PRESIDING OFFICER. The amendment is so modified. The amendment (No. 1026), as modified, is as follows:

**TITLE I—MEDICARE PRESCRIPTION DRUG DISCOUNT**

**SEC. 101. VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.**

(a) Establishment of Program.—Title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) is amended—

(1) by redesignating part D as part E; and

(2) by inserting after part C the following new part:

"PART D—VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM"

"DEFINITIONS"

"Sec. 1860. In this part:

"(1) COVERED DRUG—

"(A) DEFINITION.—Except as provided in this paragraph, the term 'covered drug' means—

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

(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section, and such term includes officinal licensed under section 351 of the Public Health Service Act and any use of a covered drug for a medically accepted indication (as defined in section 1862(o)(7)); or

(B) EXCLUSIONS.—

(i) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medicinals, unless excluded from coverage or otherwise restricted under section 1927(f)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1860(a)(4)(B).

(ii) AVOIDANCE OF DUPLICATIVE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

(c) Application of Formulary Restrictions.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

(d) Application of General Exclusion Provisions.—A prescription drug discount card plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered drug—

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

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

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1861(k).

(iii) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is—

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

(B) not eligible for prescription drug coverage under a State plan under the medicaid program under title XIX.

(iv) ELIGIBILITY.—The term 'eligible entity' means any—

(A) pharmaceutical benefit management company;

(B) Medicare+Choice organization;

(C) State (in conjunction with a pharmaceutical benefit management company);

(D) employer-sponsored plan;

(E) other entity that the Secretary determines to be appropriate to provide benefits under this part; or

(f) MEANS OF PROVIDING COVERAGE.—The Secretary shall establish a Medicare Prescription Drug Discount and Security Program under which the Secretary endorses prescription drug card plans offered by eligible entities in which eligible beneficiaries may voluntarily enroll and receive benefits under this part.

(f) Requirement of Prescription Drug Discount Card Plans.—

(1) IN GENERAL.—The Secretary shall endeavor to establish a Medicare Prescription Drug Discount Card Plan offered by an eligible entity with a contract under this part if the eligible entity meets the requirements of this part with respect to that plan.

(h) National Plans.—In addition to other types of plans, the Secretary may endorse national prescription drug plans under paragraph (1).

(i) Financing.—The costs of providing benefits under this part shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

**ENROLLMENT**

"Sec. 1860B. (a) Enrollment Under Part D.—

"(1) Establishment of Process.—

"(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a Medicare+Choice plan offered by a Medicare+Choice organization) may make an election to enroll in this part. Except as otherwise provided in this subpart, such process shall be similar to the process for enrollment under part B under section 1857.

(b) Requirement of Enrollment.—An eligible beneficiary must enroll under this part in order to receive the benefits under this part during any period after the beneficiary's initial enrollment period under part B (as determined under section 1857).

(c) Enrollment Periods.—

(A) IN GENERAL.—Except as provided in this paragraph, an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary's initial enrollment period under part B (as determined under section 1857).

(B) Special Enrollment Period.—In the case of eligible beneficiaries that have recently lost eligibility for prescription drug coverage under a State plan under the medicaid program under title XIX, the Secretary shall establish a special enrollment period in which such beneficiaries may enroll under this part.

(d) Open Enrollment Period in 2006 for Current Beneficiaries.—The Secretary shall establish a period, which shall begin on the date on which the Secretary first begins to accept elections for enrollment under this part, during which any eligible beneficiary may—

(i) enroll under this part; or

(ii) enroll or reenroll under this part after having previously declined or terminated such enrollment.

(e) Period of Coverage.—

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

(f) Enrollment During Open and Special Enrollment.—Subject to subparagraph (C), an eligible beneficiary who enrolls under the program under this part under subparagraph (B), (C), or (D) of paragraph (2) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

(h) Part D Coverage Terminated by Termination of Coverage Under Parts A and B or Eligibility for Medical Assistance.—
tion in which the beneficiary is enrolled if the organization has been awarded a contract under this part.

"(4) CONTINUOUS PRESCRIPTION DRUG COVERAGE.

\[\text{Where the benefits are provided under a prescription drug card plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides.}\]

"(5) ELECTION PERIODS.

\[\text{For purposes of this section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug card plan under this part at the time of the election of coverage under the original fee-for-service plan.}\]

"(6) SPECIAL ELECTION PERIODS.

\[\text{In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2003, there shall be an initial election period of 6 months beginning on that date.}\]

\[\text{In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial enrollment period which is the same as the initial enrollment period under section 1877(d).}\]

"(7) ADDITIONAL SPECIAL ELECTION PERIODS.

\[\text{In the case of individuals who have and involuntarily lose prescription drug coverage described in subparagraph (3)\(\text{;}\) or who are eligible to enroll in a prescription drug card plan offered by an eligible entity per year.}\]

"(8) MEDICARE+CHOICE ENROLLMENT.

\[\text{An eligible beneficiary who is enrolled under this part shall make an annual election to enroll in a prescription drug card plan offered by an eligible entity that has been awarded a contract under this part and serves the geographic area in which the beneficiary resides.}\]

"(9) PROVIDING ENROLLMENT AND COVERAGE INFORMATION TO BENEFICIARIES.

\[\text{The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i)), relating to default enrollment of section 1851(g) (relating to priority and limitation on termin- nation of election) shall apply to eligible en- titles under this subsection.}\]

"(10) BONDING.

\[\text{An eligible entity offering prescription drug coverage under this part shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrol- ltees.}\]

"(11) DISCLOSURE OF INFORMATION.

\[\text{Information.}\]

\[\text{(i) GENERAL INFORMATION.}\]

\[\text{Each eligible entity with a contract under this part shall disclose to the Secretary the following information:}\]

\[\text{(I) How enrollees will have access to covered drugs, including access to such drugs through pharmacy networks.}\]

\[\text{(II) Any other information that the Sec- retary determines is necessary to promote informed choices by eligible beneficiaries among eligible entities.}\]

\[\text{(b) DISCLOSURE UPON REQUEST OF GENERAL CONGRESS.}\]

\[\text{Upon request of an eligible benefi- ciary, the eligible entity shall provide the...}\]
under a Medicare+Choice plan under part C.

Section 1860D(a)(3) that ensure such convenient access.

Each eligible entity offering a prescription drug discount card plan shall establish an optional point-of-service method of operation under which:

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

(ii) the plan accounts under the plan may not be available.

The additional copayments so charged shall not be counted as out-of-pocket expenses for purposes of section 1860D(a).

(B) USE OF STANDARDIZED TECHNOLOGY.—

(i) In general.—Each eligible entity offering a prescription drug discount card plan shall issue (and, if appropriate, supply) a card (or other technology) that may be used by an enrolled beneficiary to access negotiated prices under section 1860D(b). The card for prescription drugs for which coverage is not otherwise provided under the prescription drug discount card plan.

(ii) Standards.—The Secretary shall provide for the development of national standards relating to a standardized format for the card or other technology referred to in clause (i). The standards shall be compatible with standards established under part C of title XI.

(C) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity that offers a prescription drug discount card plan pursuant to paragraph (1) of section 1860D(a) develops and reviews the formulary. Such committee shall include at least 1 physician and at least 1 pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a practicing pharmacist (or both).

(2) FORMULARY DEVELOPMENT.—In developing any formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

(3) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered drugs (although not necessarily for all drugs within such categories and classes).

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

(5) NOTICE BEFORE REMOVING DRUGS FROM FORMULARY.—Any removal of a drug from a formulary shall take effect only after appropriate notice is made available to beneficiaries for the purchase of prescription drugs for which coverage is otherwise provided under the prescription drug discount card plan.

(6) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, refer to paragraphs (3) and (4) of section 1860D(a).

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

(A) IN GENERAL.—Each eligible entity offering a prescription drug discount card plan shall have in place with respect to covered drugs:

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

(ii) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in subparagraph (B); and

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

Nothing in this section shall be construed as including an eligible entity complying with cost management tools (including differential payments) under all methods of operation.

(b) MEDICATION THERAPY MANAGEMENT PROGRAM.—

(i) In general.—A medication therapy management program described in this paragraph is a program of drug therapy management and education that is designed to ensure, with respect to beneficiaries with chronic diseases (such as diabetes, hypertension, hyperlipidemia, congestive heart failure) or multiple prescriptions, that covered drugs under the prescription drug discount card plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

(ii) ELEMENTS.—Such program may include:

(I) enhanced beneficiary understanding of such appropriate use through benefit education, counseling, and other appropriate means;

(ii) increased beneficiary adherence with prescription medication regimens through education and provision of reminder mailings, packaging, and other appropriate means; and

(iii) detection of patterns of overdose and undertreatment of prescription drugs.

(c) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed pharmacists and pharmacists.

(d) CONSIDERATIONS IN PHARMACY FEES.—Each eligible entity offering a prescription drug discount card plan shall take into account, in establishing fees for pharmacists providing services in the prescription drug discount card plans, the resources and time used in implementing the program.

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

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

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

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

(f) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each eligible entity offering a prescription drug discount card plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost drug discount card plan under the plan that is therapeutically equivalent and bioequivalent.

ANNUAL ENROLLMENT PERIOD SEC. 1860E. (a) AMOUNT.
"(1) IN GENERAL.—Except as provided in subsection (b), the amount under the program under this part is conditioned upon payment of an annual enrollment fee of $25.

(2) ADJUSTED INCREASE.—

(A) IN GENERAL.—In the case of any calendar year beginning after 2006, the dollar amount in paragraph (1) shall be increased by an amount equal to

(i) such dollar amount; multiplied by

(ii) the inflation adjustment.

(B) INFLATION ADJUSTMENT.—For purposes of subparagraph (A), the inflation adjustment for any calendar year is the percent increase in the Consumer Price Index for All Urban Consumers for the United States over the July-September period ending in July of the previous year, exceeded

(ii) such aggregate expenditures for the 12-month period ending with July 2005.

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

(b) COLLECTION OF ANNUAL ENROLLMENT FEE.—

"(1) IN GENERAL.—Unless the eligible beneficiary makes an election under paragraph (2), the applicable annual enrollment fee described in subsection (a) shall be collected and credited to the Federal Supplementary Medical Insurance Trust Fund in the same manner as the monthly premium determined under section 1851 is collected and credited to such Trust Fund under section 1840.

(2) DIRECT PAYMENT.—An eligible beneficiary or an entity that shall be designated by the Secretary may elect to pay the annual enrollment fee directly or in any other manner approved by the Secretary. The Secretary shall establish procedures for making such an election.

(c) WAIVER.—The Secretary shall waive the enrollment fee described in subsection (a) in the case of an eligible beneficiary whose income is below 200 percent of the poverty line.

"BENEFITS UNDER THE PROGRAM

"SEC. 1860F. (a) ACCESS TO NEGOTIATED PRICES.

"(1) NEGOTIATED PRICES.—

(A) IN GENERAL.—Subject to subparagraph (B), each prescription drug card plan offering a discount card program by an eligible entity with a prescription drug discount program shall have, for each eligible beneficiary enrolled in such plan with access to negotiated prices (including applicable discounts) for such prescription drug plan, such entity determine and modify such prices appropriately. Such discounts may include discounts for nonformulary drugs. If such a beneficiary becomes eligible for the catastrophic benefit under subsection (b), the negotiated prices (including applicable discounts) shall continue to be available to the beneficiary for those prescription drugs for which payment is made under the program under section 1860E(B). For purposes of this subparagraph, the term ‘prescription drugs’ is not limited to covered drugs, but does not include any over-the-counter drug that is not a covered drug.

(B) LIMITATIONS.—

(i) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for nonformulary drugs may differ.

(ii) AVOIDANCE OF DUPLICATE COVERAGE.—The negotiated prices (including applicable discounts) for prescription drugs shall not be available for any drug prescribed for an eligible beneficiary, for which the program is available under part A or B (but such negotiated prices shall be available if payment under part A or B is not available because the beneficiary has not met the deductible or has exhausted benefits under part A or B).

(iii) DISCOUNT CARD.—The Secretary shall develop a standard format to be issued by each eligible entity offering a prescription drug card discount plan that shall be used by an enrolled beneficiary to ensure the access of such beneficiary to negotiated prices under paragraph (1).

(3) ENSURING DISCOUNTS IN ALL AREAS.—

The Secretary shall develop procedures that ensure that a prescription drug discount card plan that resides in an area where no prescription drug discount card plans are provided with access to discounts for prescription drugs (including applicable discounts).

(b) CATASTROPHIC BENEFIT.—

(1) TEN PERCENT COST-SHARING.—Subject to any applicable caps on cost-sharing for prescription drug discount card program in which the eligible beneficiary is enrolled, the catastrophic benefit shall provide benefits at cost-sharing that is equal to 10 percent of the negotiated price (taking into account any applicable discounts) of each drug dispensed to such beneficiary after the catastrophic benefit has incurred expenses (as described in paragraph (3)) for covered drugs in a year equal to the applicable annual out-of-pocket limit specified in section 18601.

(2) ANNUAL OUT-OF-POCKET LIMITS.—For purposes of this part, the annual out-of-pocket limits specified in this paragraph are as follows:

(A) BENEFICIARIES WITH ANNUAL INCOMES BELOW 200 PERCENT OF THE POVERTY LINE. In the case of an eligible beneficiary whose income is below 200 percent of the poverty line, the annual out-of-pocket limit is equal to $1,500.

(B) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 200 AND 400 PERCENT OF THE POVERTY LINE. In the case of an eligible beneficiary whose income (as determined under section 1860I) is between 200 percent and 400 percent of the average per capita aggregate expenses for covered drugs that are incurred by an eligible beneficiary during calendar year ending in the previous fiscal year; exceeds

(i) such dollar amount; multiplied by

(ii) the inflation adjustment determined under section 1860E(a)(2)(B) for such calendar year.

(3) APPLICATION.—In applying paragraph (2), the Secretary shall take into account the expenses for covered drugs that are incurred by the eligible beneficiary using a card approved by the Secretary under this part that the Secretary determines is not supported by such information as the Secretary may require.

(4) ANNUAL PERCENTAGE INCREASE.—

(A) IN GENERAL.—In the case of any calendar year after 2006, the dollar amounts in subparagraphs (A), (B), and (C) of paragraph (2) shall be increased by an amount equal to

(i) such dollar amount; multiplied by

(ii) the inflation adjustment determined under section 1860E(a)(2)(B) for such calendar year.

(4) BOUNDING.—If any increase determined under subparagraph (A) is not a multiple of $1, such increase shall be rounded to the nearest multiple of $1.

(5) ELIGIBLE ENTITY NOT AT FINANCIAL RISK FOR CATASTROPHIC BENEFIT.—

"(A) IN GENERAL.—The Secretary, and not the eligible entity, shall be at financial risk for the provision of the catastrophic benefit under this subsection.

(b) REQUIREMENTS RELATING TO PAYMENTS TO ELIGIBLE ENTITIES.—For provisions relating to payments to eligible entities for administering the catastrophic benefit under this subsection, see section 1860H.

(6) ENSURING CATASTROPHIC BENEFIT IN ALL AREAS.—The Secretary shall develop procedures for the provision of the catastrophic benefit under this subsection to each eligible beneficiary that resides in an area where there are no prescription drug discount card plans offered that have been awarded a contract under this part.

"REQUIREMENTS FOR ENTITIES TO PROVIDE PRESCRIPTION DRUG COVERAGE

"SEC. 1860G. (a) ESTABLISHMENT OF BIDDING PROCESS.—The Secretary shall establish a process under which the Secretary accepts bids from eligible entities and awards contracts to the entities to provide the benefits under this part to eligible beneficiaries in an area.

(b) SUBMISSION OF BIDS.—Each eligible entity desiring to enter into a contract under this part shall submit a bid to the Secretary at such time, for such period, and for such purposes and in such manner as the Secretary may require.

(1) ADMINISTRATIVE FEE BID.—

(A) IN GENERAL.—In the case of an eligible beneficiary whose income is below 200 percent of the poverty line, the annual out-of-pocket limit is equal to $3,500.

(B) BENEFICIARIES WITH ANNUAL INCOMES BETWEEN 200 AND 400 PERCENT OF THE POVERTY LINE. In the case of an eligible beneficiary whose income (as determined under section 1860I) is between 200 percent and 400 percent of the average per capita aggregate expenses for covered drugs that are incurred by an eligible beneficiary during calendar year ending in the previous fiscal year; exceeds

(i) such dollar amount; multiplied by

(ii) the inflation adjustment determined under section 1860E(a)(2)(B) for such calendar year.

(2) BID SUBMISSION REQUIREMENTS.—In the case of an eligible entity desiring to enter into a contract under this part, the entity shall include, in the bid submitted, separate costs for administering the discount card component, if applicable, and the catastrophic benefit. The entity shall submit the administrative fee with the bid in a form and manner specified by the Secretary, and shall include a statement of projected enrollment and a separate statement of the projected administrative costs for at least the following functions:

(i) Enrollment, including income eligibility determination.

(ii) Claim processing.

(iii) Quality assurance, including drug utilization review.

(iv) Beneficiary and pharmacy customer service.

(v) Coordination of benefits.

(vi) Fraud and abuse prevention.

(b) NEGOTIATED ADMINISTRATIVE FEE BID AMOUNT.—The Secretary shall use the bid amounts to calculate a benchmark amount consisting of the enrollment-weighted average of all bids for each entity class. If the benchmark amount for an entity class is either a regional or national entity, or such other classes as the Secretary may determine to be appropriate, the functions are the discount card and catastrophic components. If an eligible entity’s combined bid for both functions is above the combined benchmark within the entity’s class for the discount card and catastrophic components, the Secretary shall collect additional necessary revenue through 1 or both of the following:

(i) Additional fees charged to the beneficiary, not to exceed $25 annually.

(ii) Use of rebate amounts from drug manufacturers to defray administrative costs.
"(d) AWARDING OF CONTRACTS.—

"(1) IN GENERAL.—The Secretary shall, consistent with the requirements of this part and the goal of containing Medicare program costs, award at least 2 contracts in each area, unless only 1 bidding entity meets the terms and conditions specified by the Secretary under paragraph (2).

"(2) REQUIREMENTS FOR AWARD.—The Secretary shall not award a contract to an eligible entity under this section unless the Secretary finds that the eligible entity is in compliance with the terms and conditions as specified by the Secretary.

"(3) REQUIREMENTS FOR ELIGIBLE ENTITIES PROVIDING THE PROGRAM.—Except as provided in subsection (e), in determining which of the eligible entities that submitted bids that meet the terms and conditions specified by the Secretary under paragraph (2) to award a contract, the Secretary shall consider whether the bid submitted by the entity meets at least the following requirements:

"(A) LEVEL OF SAVINGS TO MEDICARE BENEFICIARIES.—The program passes on to Medicare beneficiaries who enroll in the program discounted prescription drug prices, including discounts negotiated with manufacturers.

"(B) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The program applies to drugs that are dispensed by mail rather than solely through mail order and provides convenient access to retail pharmacies.

"(C) LAWS AND REGULATIONS.—The program complies with laws and regulations, including those laws and regulations that are administered by the Secretary.

"(D) EXTENT OF DEMONSTRATED EXPERIENCE.—The program has demonstrated experience in operating a similar program or a similar program.

"(E) EXTENT OF QUALITY ASSURANCE.—The program has demonstrated adequate quality assurance processes in operating a similar program or a similar program.

"(F) PRIVACY COMPLIANCE.—The program has procedures to safeguard the use and disclosure of program beneficiaries’ individually identifiable health information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

"(1) ADDITIONAL PROTECTION OF BENEFICIARIES.—The program meets such additional requirements as the Secretary determines to protect and promote the interest of Medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

"(4) BENEFICIARY ACCESS TO SAVINGS AND REBATES.—The Secretary shall require eligible entities offering a discount card program to pass on savings and rebates negotiated with manufacturers to eligible beneficiaries enrolled with the entity.

"(5) NEGOTIATED AGREEMENTS WITH EMPLOYER-SPONSORED PLANS.—Notwithstanding any other provision of law, the Secretary may negotiate agreements with employer-sponsored plans under which eligible beneficiaries are provided with a benefit for prescription drug coverage that is more generous than the benefit that would otherwise have been available under this part if such an agreement results in cost savings to the Federal Government.

"(6) REQUIREMENTS FOR OTHER ELIGIBLE ENTITIES.—An eligible entity that is licensed under State law to provide the health insurance benefits shall be required to meet the requirements of subsection (d)(3). If an eligible entity offers a national plan, such entity shall be required to meet the requirements of subsection (d)(3), but shall meet the requirements of the Medicare Prescription Drug Coverage Act of 2003 that apply with respect to such plan.

"PAYMENTS TO ELIGIBLE ENTITIES FOR ADMINISTERING THE CATASTROPHIC BENEFIT

"SEC. 1860H. (a) IN GENERAL.—The Secretary may establish procedures for paying to an eligible entity under this part for:

"(1) the costs of providing drugs to eligible beneficiaries enrolled with such entity under this part that is eligible for the catastrophic benefit under section 1860B(b); and

"(2) costs incurred by the entity in administering the catastrophic benefit in accordance with section 1860G.

"(b) PAYMENT FOR COVERED DRUGS.—

"(1) IN GENERAL.—Except as provided in subsection (c) and subject to paragraph (2), the Secretary may pay an eligible beneficiary for covered drugs furnished by the eligible entity to an eligible beneficiary enrolled with such entity under this part that is eligible for the catastrophic benefit under section 1860B(b).

"(2) LIMITATIONS.—

"(A) FORMulary RESTRICTION.—Insofar as an eligible entity with a contract entered under this part uses a formulary, the Secretary may not make any payment for a covered drug that is not included in such formulary, except to the extent provided under section 1860D(a)(4)(H).

"(B) NEGOTIATED PRICES.—The Secretary may not pay for a covered drug furnished to an eligible beneficiary that exceeds the negotiated price (including applicable discounts) that the beneficiary would have been responsible for under section 1860(a) or the price negotiated for insurance coverage under the Medicare-Choice program under part C, a Medicare supplemental plan, or an individual plan.

"(C) COST-SHARING LIMITATIONS.—An eligible entity may not charge an individual enrolled with such entity who is eligible for the catastrophic benefit under this part any co-payment, tiered copayment, coinsurance, or other cost-sharing that exceeds 10 percent of the cost of the drug that is dispensed to the individual.

"(3) PAYMENT IN COMPETITIVE AREAS.—In a geographic area in which 2 or more eligible entities offer a plan under this part, the Secretary may take into account the costs incurred in providing the benefit under this part on a capitated basis.

"(c) SECURING DISCOUNTS ON PRESCRIPTION DRUGS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.
"(1) IN GENERAL.—Three members shall be appointed by the President, by and with the advice and consent of the Senate.

"(2) LIMITATION.—Not more than 2 such members may be from the same political party.

"(B) SENATORIAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the President pro tempore of the Senate with the advice of the Chairman and the Ranking Minority Member of the Committee on Finance of the Senate.

"(C) CONGRESSIONAL APPOINTMENTS.—Two members (each member from a different political party) shall be appointed by the Speaker of the House of Representatives, with the advice of the Chairman and the Ranking Minority Member of the Committee on Ways and Means of the House of Representatives.

"(2) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Board.

"(3) COMPOSITION.—Of the members appointed under paragraph (1),

"(A) at least 1 shall represent the pharmaceutical industry;

"(B) at least 1 shall represent physicians;

"(C) at least 1 shall represent Medicare beneficiaries;

"(D) at least 1 shall represent practicing pharmacists; and

"(E) at least 1 shall represent eligible entities.

"(d) TERMS OF APPOINTMENT.—

"(1) IN GENERAL.—Subject to paragraph (2), each member of the Board shall serve for a term of 6 years.

"(2) CONTINUANCE IN OFFICE AND STAGGERED TERMS.—

"(A) CONTINUANCE IN OFFICE.—A member appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

"(B) STAGGERED TERMS.—The terms of service of the members initially appointed under this section shall begin on January 1, 2006, and expire as follows:

"(i) 2 years;

"(ii) 4 years; and

"(iii) 6 years.

"(ii) SENATORIAL APPOINTMENTS.—The terms of service of members initially appointed by the President pro tempore of the Senate shall expire as designated by the President pro tempore of the Senate at the time of nomination, 1 each at the end of—

"(i) 2 years;

"(ii) 4 years; and

"(iii) 6 years.

"(ii) CONGRESSIONAL APPOINTMENTS.—The terms of service of members initially appointed by the Speaker of the House of Representatives shall expire as designated by the Speaker of the House of Representatives at the time of nomination, 1 each at the end of—

"(i) 4 years; and

"(ii) 5 years.

"(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

"(D) VACANCIES.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member’s predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member’s term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

"(e) CHAIRPERSON.—A member of the Board shall be designated by the President to serve as Chairperson for a term of 4 years or, if the remainder of such member’s term is less than 4 years, for such remainder.

"(f) EXPENSES AND PER DIEM.—Members of the Board shall serve without compensation, except that, while serving on business of the Board away from their homes or regular places of business, members may be allowed travel expenses, including per diem in lieu of subsistence, at rates approved by the President by and with the advice of the Chairman and the Ranking Minority Member of the Committee on Governmental Operations of the Senate, in an amount not to exceed the per diem equivalent of a rate determined under section 5701 of title 5, United States Code, for persons in the Government employed intermittently.

"(g) MEETINGS.—

"(1) DUTIES.—The Board shall meet at the call of the Chairperson (in consultation with the other members of the Board) not less than 4 times each year to carry out the functions of the Board (as described in paragraph (a)).

"(II) LIMITATION.—Any member who has served more than 4 years, shall not be eligible to serve a subsequent term as Chairperson of the Board.

"(h) VOTING.—

"(1) IN GENERAL.—Any member of the Board who is not a member of the Senate or the House of Representatives shall vote in the absence of the Chairperson or a member of the Board designated by the Chairperson as a presiding officer only on questions relating to the consideration of nominations for the positions of the heads of the Board.

"(2) APPOINTMENTS.—The Board shall not vote on any nominations made by the President that have not been referred to the President by the Chairperson or a member of the Board designated by the Chairperson as a presiding officer.

"(i) MEMBERSHIP.—The Board shall consist of 5 members appointed by the President, by and with the advice of the Chairman and the Ranking Minority Member of the Committee on Finance of the Senate.

"(j) STAFF.—The Board shall employ a staff director who shall be responsible for the exercise of all powers, duties, and functions of the Board.

"(2) STAFF.—

"(A) IN GENERAL.—The Board may employ, without regard to chapter 31 of title 5, United States Code, such officers and employees as are necessary to administer the activities to be carried out by the Board.

"(B) FLEXIBILITY WITH RESPECT TO CIVIL SERVICE LAWS.—

"(i) IN GENERAL.—The staff of the Board shall be paid at a rate equivalent to a rate determined under section 5303 of title 5, United States Code, relating to the competitive service, and, subject to clause (ii), shall be paid without regard to the provisions of chapters 51 and 55 of such title (relating to classification and schedule pay rates).

"(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

"(k) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated, out of the Federal Supplemental Medical Insurance Trust Fund established under section 1844, and the general fund of the Treasury, such sums as are necessary to carry out the purposes of this section.

"(l) COMPENSATION REFERENCES TO PREVIOUS PARAGRAPH.—

"(1) IN GENERAL.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act (as added by subsection (a)), the Secretary of Health and Human Services shall implement the Medicare Prescription Drug Discount and Security Program established under such part in a manner such that—

"(A) benefits under such part for eligible beneficiaries (as defined in section 1860 of such Act, as added by such subsection) with incomes below 200 percent of the Federal poverty line (as defined in such section) are available to such beneficiaries not later than the date that is 6 months after the date of enactment of this Act; and

"(B) benefits under such part for eligible beneficiaries are available to such beneficiaries not later than the date that is 1 year after the date of enactment of this Act.

"(m) EFFECTIVE DATE.—

"(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act.

"(2) IMPLEMENTATION.—Notwithstanding any provision of part D of title XVIII of the Social Security Act (as added by subsection (a)), the Secretary of Health and Human Services shall implement the Medicare Prescription Drug Discount and Security Program established under such part in a manner such that—

"(A) benefits under such part for eligible beneficiaries (as defined in section 1860 of such Act, as added by such subsection) with incomes below 200 percent of the Federal poverty line (as defined in such section) are available to such beneficiaries not later than the date that is 6 months after the date of enactment of this Act; and

"(B) benefits under such part for eligible beneficiaries are available to such beneficiaries not later than the date that is 1 year after the date of enactment of this Act.

"(o) ADMINISTRATION OF VOLUNTARY MEDICARE PRESCRIPTION DRUG DISCOUNT AND SECURITY PROGRAM.—

"(a) ESTABLISHMENT OF CENTER FOR MEDICARE PRESCRIPTION DRUGS.—There is established within the Centers for Medicare & Medicaid Services of the Department of Health and Human Services, a Center for Medicare Prescription Drugs. Such Center shall be separate from the Center for Beneficiary Choices, the Center for Medicare Management, and the Center for Medicaid and State Operations.

"(b) DUTIES.—It shall be the duty of the Center for Medicare Prescription Drugs to administer the Voluntary Medicare Prescription Drug Discount and Security Program established under part D of title XVIII of the Social Security Act (as added by section 101).

"(c) DIRECTOR.—

"(1) APPOINTMENT.—There shall be in the Center for Medicare Prescription Drugs a Director of Medicare Prescription Drugs, who shall be appointed by the President, by and with the advice and consent of the Senate.

"(2) RESPONSIBILITIES.—The Director shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Prescription Drugs and shall have authority and control over all personnel and activities thereof.

"(3) PERSONNEL.—The Director of the Center for Medicare Prescription Drugs may appoint and terminate such personnel as may be necessary to perform the functions of the Medicare Prescription Drug Discount and Security Program to perform its duties.

"(p) EXCLUSION OF PART D COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—

"(qd) DISCOUNT AND SECURITY PROGRAM.—

"(a) EXCLUSION OF PART D COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—

"(sec) Medigap Revisions.

"(a) In general.—Section 1882 of the Social Security Act (42 U.S.C. 1395xx) is amended—

"(1) by striking "attributable to the application of section" and inserting "attributable to—

"(i) the application of section; and

"(ii) by striking the period and inserting ";and"

"(3) by adding at the end the following new paragraph:

"(aa) Voluntary Medicare Prescription Drug Discount and Security Program under part D.

"(sec) Medigap Revisions.

"(a) In general.—Section 1882 of the Social Security Act (42 U.S.C. 1395xx) is amended by adding at the end the following new subsection:

"(aa) Modernization of Medicare Supplemental Policies.

"(1) PROMULGATION OF MODEL REGULATION.—

"(A) NAIC MODEL REGULATION.—(i) Within 9 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the National Association of
Insurance Commissioners (in this subsection referred to as the ‘NAIC’) changes the 1991 NAIC Model Regulation (described in subsection (p)) to revise the benefit package classified as ‘J’ under the standards established by subsection (p)(2) (including the benefit package classified as ‘J’ with a high deductible feature, as described in subsection (p)(11)) shall be deemed to be a reference to the appropriate date under this subsection.

(ii) any reference to a date under such paragraphs of subsection (p) shall be deemed to be a reference to the appropriate date under this subsection.

B) OTHER REFERENCES.—Any reference to a provision of subsection (p) or a date applicable to such provision shall also be considered to be a reference to the appropriate provision or date under this subsection.

SEC. 4. PARTIAL FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR CATASTROPHIC COST-SHARING SUBSIDIES FOR Dually ELIGIBLE INDIVIDUALS.

(i) IN GENERAL.—Section 1903(a)(1) (42 U.S.C. 1396r(a)(1)) is amended by inserting before the semicolon the words ‘‘(reduced by the amount computed under section 1935(d)(1) for the State and the quarter’’.

(ii) any reference to the model regulation referred to in this section as the ‘2006 NAIC Model Regulation’.

(iii) such revised standards meet any additional requirements imposed by the Prescription Drug and Medicare Improvement Act of 2005; subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, was a reference to the 1991 NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to in this section as the ‘2006 NAIC Model Regulation’).

(B) REGULATION BY THE SECRETARY.—If the NAIC does not make the changes in the 2006 NAIC Model Regulation within the 9-month period specified in subparagraph (A), the Secretary shall promulgate, not later than 9 months after the end of such period, a regulation and subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, was a reference to the 1991 NAIC Model Regulation as changed by the Secretary under this subparagraph such changed regulation referred to in this section as the ‘2006 Federal Regulation’.

(C) CONSULTATION WITH WORKING GROUP.—In promulgating standards under this paragraph, the NAIC or Secretary shall consult with a working group similar to the working group described in subsection (p)(1)(D).

(D) STANDARDS FOR MEDICARE BENEFITS CHANGE.—If benefits under part D of this title are changed and the Secretary determines, in consultation with the NAIC, that the 2006 NAIC Model Regulation or 2006 Federal Regulation are needed to reflect such changes, the preceding provisions of this paragraph shall apply to the standards previously established in the same manner as they applied to the original establishment of such standards.

(2) CONSTRUCTION OF BENEFITS IN OTHER MEDICARE SUPPLEMENTAL POLICIES.—Nothing in the benefit packages classified as ‘A’ through ‘I’ under the standards established by subsection (p) or including the benefit package classified as ‘F’ with a high deductible feature, as described in subsection (p)(11) shall be construed as providing coverage for benefits for which payment may be made under part D.

(3) APPLICATION OF PROVISIONS AND CONFORMING REFERENCES.—

(A) PROVISIONS.—The provisions of paragraphs (4) through (10) of subsection (p) shall apply under this section, except that

(i) any reference to the model regulation applicable under that subsection shall be deemed to be a reference to the applicable 2006 NAIC Model Regulation or 2006 Federal Regulation adopted under this section.

(ii) any reference to a date under such paragraphs of subsection (p) shall be deemed to be a reference to the appropriate date under this subsection.

(B) APPLICABLE AMOUNT DEFINED.—For purposes of subparagraph (A), the term ‘applicable amount’ means the total amount that the Secretary determines will not cause expenditures under this part to exceed the amount of payment that would have been made under this title if this part had not been enacted by more than $30,000,000,000 during the period beginning on January 1, 2005, and ending on September 30, 2010.

(2) REDUCTION FOR LATE ENROLLMENT.—For each month during a calendar quarter in which an eligible beneficiary is not enrolled in a prescription drug benefit contract under this part, the amount of assistance available under paragraph (1) shall be reduced by $20.

(3) CREDITING OF UNUSED BENEFITS TOWARD FUTURE YEARS.—

(A) IN GENERAL.—The dollar amount of coverage described in paragraph (1) shall be increased by any amount of coverage described in such subparagraph that was not used during the previous calendar year.

(B) REGULATION OF EXCEPTED EXPENSES.—If the Administrator shall refund to the eligible beneficiary the amount (if any) by which the dollar amount of coverage described in subparagraph (A) exceeds the catastrophic limit described in subsection (b).

(4) WAIVER TO ENSURE PROVISION OF BENEFITS.—The Administrator may waive such requirement of this part, as may be necessary to ensure that each eligible beneficiary has access to the assistance described in subparagraph (A) of paragraph (4) of section 1860L.

(5) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible beneficiary that would otherwise be a covered drug under this section shall not be considered a covered drug if the drug exceeds the catastrophic limit described in subsection (b).

(6) LIMITATION AND CAPS.—The Secretary shall not pay more than $35,000,000,000.

FUTURE YEARS.—

(1) AMOUNT OF ANNUAL ASSISTANCE.—

(i) any reference to the Model Regulation adopted on June 6, 1979, were a reference to the 1991 NAIC Model Regulation.

(ii) any reference to a date under such subsection shall also be a reference to the appropriate date under such subsection.

(iii) such revised standards meet any additional requirements imposed by the Prescription Drug and Medicare Improvement Act of 2005; subsection (g)(2)(A) shall be applied in each State, effective for policies issued to policy holders on and after January 1, 2006, as if the reference to the Model Regulation adopted on June 6, 1979, was a reference to the 1991 NAIC Model Regulation as changed under this subparagraph (such changed regulation referred to here in this section as the ‘2006 Federal Regulation’).

(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the ‘phase-out proportion’ for a calendar quarter is—

(A) 2005 is 90 percent;

(B) a subsequent year before 2014, is the amount computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the ‘phase-out proportion’ for a calendar quarter is—

A) a subsequent year before 2014, is the amount computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

(B) 2005 is 90 percent;
I think that is what the goal of this Congress should be, and that is why we have in the provisions here to give them prescription drugs, which would be within the Medicare Program, that people can voluntarily continue to accept the traditional Medicare or, if they have been in an expanded Medicare Advantage and get all of the benefits through a private, competitively delivered system.

What we have is the beginning of a program that can be improved upon. I think you have a substantially an insurance-type program, similar to what we have as Federal employees, which can be improved upon. But it is for everybody. We, too, give special attention to lower income individuals, and maybe they can do it better, but it is going to have to come from somewhere else, and the somewhere else is the vast number of other seniors who would have some of their benefits diluted and reduced in order to make this a little bit better than what is in this bill. The goal is to try to create a universal program across the board, and one that is fair to everyone. I think that is what is in the bill as it now stands.

Mr. GREGG. Will the Senator yield for a question?

Mr. BREAX. Mr. President, I am happy to yield.

Mr. GREGG. Would the Senator agree that there wasn't, in the original program, an insurance-type program, which you would pay into during your working life under the Part A part of the insurance program, with the concept that when you retired, you would have paid for your health insurance. That is why everyone is covered under it. But is it not also true that under this drug benefit as proposed, nobody will have paid into the Medicare insurance program for the purposes of this drug program? This drug program will be a new entitlement, and therefore it is reasonable that since it is going to be borne not by the people who worked for it but by the people who are working— it is going to be borne by them rather than the recipients— then it should be set up in a different structure along the lines that are proposed, which is you benefit the low income and you benefit people who have a catastrophic event rather than have a program that puts the benefit out to everyone and forces 37 percent of the population off private insurance plans and the benefit people who have a catastrophic event rather than the recipients—then it is going to be borne by them rather than the recipients—then it should be set up in a different structure along the lines that are proposed, which is you benefit the low income and you benefit people who have a catastrophic event rather than have a program that puts the benefit out to everyone and forces 37 percent of the population off private insurance plans and on to a public plan.

Mr. BREAX. I am not sure whose time this is on. I will respond to the Senator's question. We have a health delivery system supervised by the Federal Government as an entitlement that is going to contribute to it. Those benefiting from it are going to have an average premium of $35 a month, a $275 deductible, and 50 percent copayment.

The PRESIDING OFFICER. Mr. BREAX. I yield the floor. The PRESIDING OFFICER. The Senator from Montana.
I encourage a "yes" vote on this amendment.

Mr. HAGEL. Mr. President, to summarize our amendment is simple: It helps those who need it most. It helps the States provide a discount drug card. It is affordable, with no monthly premiums, no deductibles, catastrophic coverage, and accountable market-based tools. It is a complete, affordable, discount drug plan that the next generation of this country can support. We can be proud of what we are doing for seniors today.

I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, the major fatal problem with this amendment is it dispenses with the underlying principle of the underlying bill. That is universality. We are, in the legislation before us, providing for universal benefits.

This amendment violates that principle by saying no, not across the board for Americans but, rather, it introduces a whole new means testing provision for catastrophic. I just think it fatally violates the spirit of the legislation we are about to pass.

The PRESIDING OFFICER. All time has expired. The question is on agreeing to the amendment No. 1026, as modified. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from New Mexico (Mr. DOMENICI) and the Senator from Oklahoma (Mr. INHOFE) are necessarily absent.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea."

The PRESIDING OFFICER (Mr. GREGG). Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 42, nays 54, as follows:

[Rollcall Vote No. 259 Leg.]

YEAS—42
Akaka  Durbin  Levin
Biden  Feingold  Mikulski
Bingaman  Feinstein  Murray
Boxer  Graham (FL)  Nelson (FL)
Byrd  Harkin  Nelson (NE)
 Cantwell  Hollings  Pryor
Clinton  Inouye  Reid
Conrad  Johnson  Reid
Corzine  Kennedy  Rockefeller
Daschle  Kohl  Sarbanes
Dayton  Landrieu  Schumer
Dorgan  Leaves  Wyden

NAYS—54
Alexander  Craig  McCain
Allard  Crapo  McConnell
Allen  DeWine  Miller
Baucus  Dale  Markowitz
Bennett  Ensign  Nickles
Bond  Enzi  Roberts
Breaux  Fitzgerald  Santorum
Brownback  Frist  Sessions
Bunning  Graham (SC)  Shelby
Burns  Gramm  Smith
Campbell  Gregg  Snowe
Carper  Hagel  Specter
Chafee  Hatch  Stevens
Chambliss  Hutchison  Sununu
Cochran  Judd  Talent
Coleman  Kyl  Thomas
Collins  Lott  Voinovich
Cornyn  Miller  Warner

NOT VOTING—4
Domencic  Kerry
Inhofe  Lieberman

The amendment (No. 1111) was rejected.

Mr. LOTT. Mr. President, I move to reconsider the vote and I move to lay that motion on the table.

The motion to lay on the table was agreed to.

AMENDMENT NO. 1026, AS MODIFIED

The PRESIDING OFFICER. Before we can go to the next amendment, we will have to have order in the Senate. There are 2 minutes equally divided. Who seeks recognition? The Senator from Nevada.

Mr. ENSIGN. Mr. President, I will use 30 seconds and Senator HAGEL will use 30 seconds on this side.

The Hagel-Ensign amendment corrects several wrinkles in the bill. Let me go over those real briefly.

We have no monthly premiums. We do not make middle-class taxpayers pay for prescription drugs for wealthy seniors. We preserve the State and the private plans that are already out there, which the underlying bill does not do. We give most of our help to low- and moderate-income seniors but we still control costs in our bill.

Ms. HAGEL. Mr. President, in summary our amendment is simple: It helps those who need it most. It helps the States provide a discount drug card. It is affordable, with no monthly premiums, no deductibles, catastrophic coverage, and accountable market-based tools. It is a complete, affordable, discount drug plan that the next generation of this country can support. We can be proud of what we are doing for seniors today.
The amendment (No. 1026), as modified, was rejected.

The PRESIDING OFFICER. The majority leader.

Mr. FRIST. Mr. President, for the information of Senators, we have made tremendous progress today, and we are on the final leg. In conversations with the managers, it appears we will have one more series of stacked votes tonight and that will include final passage. That series will be it. The bill will be done.

We need somewhere between 45 minutes and an hour—hopefully 45 minutes, and hopefully people can yield back their time—before we can begin those votes. I think that is all we can say at this juncture, working in good faith. There are a lot of details. We are waiting for some of the final wording to come through in terms of the managers’ package. Once we have that, we will be able to proceed with the voting.

I don’t know how many amendments it will be. It could be two amendments; it could be four amendments; it could be one amendment or passage. But it is going to be probably two or four amendments beginning in about 45 minutes to an hour.

Mr. BYRD. Will the leader yield?

Mr. FRIST. Yes.

Mr. BYRD. On the preceding rollcall vote, 28 minutes were required. On this rollcall vote, 22 or 23 minutes were required. So we have over 50 minutes on two rollcall votes. Now, time is worth a little something around here to many of us who don’t have much time left. I wonder if we can’t do better than that. I think the Senate ought to treat itself better than that. Senators owe it to other Senators to not just lag and cause rollcall votes to last so long. Eighty-eight minutes on a rollcall vote? Why can’t we go over to tomorrow? We are going to be here anyhow. Why can’t we go over? Here it is 15 minutes after 10. Do I have the floor, Mr. President?

The PRESIDING OFFICER. The majority leader has the floor.

Mr. BYRD. Very well.

Mr. FRIST. Mr. President, we can do better, and I think we ought to do our best to do maybe 10 minutes on the last series. It is late at night. We have all been working about 12, 13 hours nonstop. It is an important bill. We set out this morning to finish to tonight. People are here. They are ready to finish it. It is late. After talking to the leadership on both sides, there is a general consensus that we ought to push ahead, get this bill done for the American people.

Mr. BYRD. The PRESIDING OFFICER. Not voting—4.

The amendment (No. 1026), as modified, was rejected.

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We can do it. Things have gone very well. We have had adequate time for debate and amendment. The distinguished Senator from West Virginia told me from day one: My advice to you as the majority leader is to make sure you give time for debate and amendment. He did forget to tell me that it is sometimes hard dealing back and forth as you are waiting for language to come, as you are trying to get the order for amendments in these last hours of a bill, a bill that is as big as any bill we have passed this year and as complex, and it has taken a little bit more time.

I would have liked to have finished at 9 o’clock tonight. I think at this juncture, if we proceed over the next 45 minutes—let’s do those rollcall votes in 10 minutes—we will be out of here. People will be able to leave tomorrow or stay and come to the floor and talk. I think that is the general sense of where we should be.

Mr. BYRD. Mr. President, will the Senator yield?

Mr. FRIST. The Senator is happy to yield to the Senator from West Virginia.

Mr. BYRD. Mr. President, we are falling into this way of doing things. Three-day work weeks. I will tell you, Mr. Leader, one night I am going to get the floor and Senator Frist will be planning on finishing and going home the next day. They won’t get to do that. I have seen this happening over and over and over more recently. Three-day work weeks, and we don’t come in on Friday and work and vote.

If the Senator will continue to yield, just briefly?

Mr. FRIST. If the Senator will yield for a couple more minutes because we do have people who want to get on to the business. I certainly do yield for a few more minutes.

Mr. BYRD. Mr. President, I don’t want to overtax the leader at this point or overtax other Senators. Just suffice it to say I have had a practice of just having 3-day workweeks, staying here until 10, 11, 12 on Thursday night so that people can go out on Friday. I started this thing of having a week at home every 4 weeks, but we worked the 5 days. We worked 5 days in each of the 3 weeks in between, and we started voting early on Monday days and we voted a full day on Friday.

I know things have changed. I am not majority leader. I don’t mean to be a probationary majority leader. But this is getting to be a problem with some of us.

Mr. FRIST. Mr. President, let me just reply and say: Last Friday, you and I were on the floor at 3 in the afternoon. Just because we are not voting doesn’t mean we are not working. I have stopped early on two occasions lately just to go be with her and let the Senate run its course. There is going to come a time when this Senator is going to keep the Senate in session a while. He can still do it. I say this in the very best of spirit to the leader—and he is doing the best he can—there comes a time when some of us have duties elsewhere and we would like to keep our rollcall records clean.

Soon I will have cast 17,000 rollcall votes. So I have been here for my share of the votes. I am getting a little bit fed up staying around here. This last rollcall vote was 23 minutes and the one before that was 28 minutes. There is a lot of hooping and hollering. What do the American people think of us? It is time we went home if we don’t work.

I hope, Mr. Leader, that those of you who are so good at working out these things can get people to have voice votes or maybe cut down the time on their amendments.

Mr. FRIST. Mr. President, I suggest that, since we have our colleagues here and ready to work, we go back to work now. I think the Senator made his point. I am listening and I will heed that advice and counsel. I suggest we go back to work and votethome—vote—vote at home tonight to our families as well.

I yield the floor.

The PRESIDING OFFICER. Who seeks recognition? The Senator from Oklahoma is recognized.

Mr. NICKLES. Mr. President, I believe we are in the process of trying to wrap up debate on a few amendments. I believe momentarily Senator FEINSTEIN and Senator CHAFEE and I will be discussing our amendment. I will make my comments very brief. I know Senator FEINSTEIN wishes to speak on it. I hope we can conclude debate. I think there will only be two more amendments. I urge colleagues to make their comments brief and let’s vote and finish action on this bill. I will defer my comments on the amendment because I believe the Senator from California is ready to speak.

The PRESIDING OFFICER. The Senator from California is recognized.

AMENDMENT NO. 1060, AS MODIFIED

Mr. FEINSTEIN. Mr. President, I call up amendment No. 1060, as modified.

The PRESIDING OFFICER. The amendment (No. 1060), as modified, is as follows: At the end of title IV, insert:

Subtitle D—Part B Premium

SEC. 4. INCOME-RELATED INCREASE IN MEDICARE PART B PREMIUM.

(a) In General. Section 1839 (42 U.S.C. 1395t) is amended by adding at the end the following:
(b) Increase in Premium for High-Income Beneficiaries.—

"(1) Amount of increase.—

(A) In general.—Except as provided in paragraph (b), if the modified adjusted gross income of an individual for a taxable year ending with or within a calendar year (as initially determined by the Secretary in accordance with subparagraph (B)) exceeds the threshold amount, the amount of the premium under subsection (a) for the individual for the calendar year shall, in lieu of the amount otherwise determined under subsection (a), be equal to the applicable percentage of an amount equal to 200 percent of the monthly actuarial rate for enrollees age 65 and over as determined under subsection (a)(1) for the calendar year.

(B) Applicable percentage.—The term ‘applicable percentage’ means the percentage determined in accordance with the following tables:

(1) Individuals not filing joint returns.

If the modified adjusted gross income exceeds the threshold amount by:

<table>
<thead>
<tr>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not more than $50,000</td>
<td>50%</td>
</tr>
<tr>
<td>More than $50,000 but not more than $100,000</td>
<td>75%</td>
</tr>
<tr>
<td>More than $100,000</td>
<td>100%</td>
</tr>
</tbody>
</table>

(2) Individuals filing joint returns.

If the modified adjusted gross income exceeds the threshold amount by:

<table>
<thead>
<tr>
<th>Amount</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not more than $100,000</td>
<td>50%</td>
</tr>
<tr>
<td>More than $100,000 but not more than $200,000</td>
<td>75%</td>
</tr>
<tr>
<td>More than $200,000</td>
<td>100%</td>
</tr>
</tbody>
</table>

(2) Determination of modified adjusted gross income for a taxable year.—In determining the amount of the premium under this part for months in a year would have been decreased pursuant to subparagraph (A) if the individual were enrolled under this part for the year, the Secretary may take such steps as the Secretary considers appropriate to recover from the individual the total amount by which the individual’s monthly premium under this part for months during the year would have been increased under subparagraph (A) if the individual were enrolled under this part for the year.

(C) Deceased beneficiary.—In the case of a deceased individual, the Secretary may, in determining the amount of the premium under this part for months in a year would have been decreased pursuant to subparagraph (A) if the individual were not deceased, the Secretary shall make a payment to the individual’s surviving spouse (or, in the case of an individual who does not have a surviving spouse, to the individual’s estate) in an amount equal to the difference between—

(i) the total amount by which the individual’s premium would have been decreased for all months during the year pursuant to subparagraph (A); and

(ii) the amount (if any) by which the individual’s premium was decreased for months during the year pursuant to subparagraph (A).

(D) Waiver by Secretary.—The Secretary may waive the imposition of all or part of the increase of the premium or all or part of any interest due under this subsection for any period if the Secretary determines that a gross injustice would otherwise result without such waiver.

(3) Transfer to Part B Trust Fund.—

(A) In general.—The Secretary shall transfer amounts recovered under this subsection to the Federal Supplementary Medical Insurance Trust Fund.
Much has changed since the creation of Medicare in 1965. People are living longer, due in large part to improved diagnostic tools and treatment. There is no way Congress could have predicted the number of people who would come to rely on Medicare or the rate at which medical costs would increase. When Medicare was established in 1965, the Part B premium was set at a level to cover about 50 percent of program costs. With medical inflation, the dollar amount of the premium has decreased to cover only 25 percent of program costs.

The Omnibus Budget Reconciliation Act of 1993 established the Medicare Part B premium to equal 25 percent of the program cost from 1996 to 1998. The Balanced Budget Act of 1997 permanently established the Part B premium at 25 percent. The bill to balance the budget in 1997 that passed out of the Senate Finance Committee included a provision to increase the Medicare Part B premium. So this is nothing new.

The provision included in 1997 would have had beneficiaries with incomes over $50,000 for an individual and $75,000 for a couple paying a greater share of the Part B premium. The Part B premium was stripped out during conference.

Well, we were in a different financial situation when Congress made the decision to set the beneficiary's share of the Part B premium at 25 percent in 1997. At that time, there was a $22 billion deficit. The next year the budget was in surplus to the tune of $69 billion.

With a Federal budget deficit of over $400 billion in the year 2003 and an increase in the Federal debt of $3.3 trillion, for a total of $12 trillion in debt expected by 2013, I believe that now is the time to rethink the premium structure of Medicare Part B.

As the baby boomers age, there will be a greater need for the Medicare trust fund to meet the needs of the beneficiaries. The number of people age 65 and older will more than double over the coming decades, rising from 37 million today to 70 million in 2030 and 82 million in 2050. Over the next 75 years, the Medicare program will cost 71 percent more than that provided under current law in order to meet its needs.

It is predicted the Medicare hospital trust fund will be insolvent by 2030. Medicare beneficiaries' taxes—will nearly quadruple by 2075 in order to meet the growing need for the program, with budget outlays of $277 billion in 2003. This means spending for the program could reach $1.1 trillion by 2017.

With the legislation currently before the Senate, Congress is proposing some major changes to the Medicare Program. I am in full support of adding a drug benefit, but Congress should also rethink the financing mechanisms of this program, and this bill is part in that direction. High-income beneficiaries can afford to pay a larger share of Medicare's costs, at least of
the premium. They can afford to pay for the benefits they receive.

In light of the fact the Federal Government has just provided tax cuts in the range of $1,841 for people with incomes between $77,000 and $154,000 and up to $2,793 for people with incomes above $374,000, it seems to me people with annual incomes above $200,000 can afford to pay $2,793, which is the annual premium for Medicare Part B this year.

We should focus funding so that 98 percent of Medicare beneficiaries who have an annual adjusted gross income of less than $100,000 can continue to access benefits. I think it is reasonable to ask those who can afford it to pay a greater share of the premium. We are still waiting for an official cost savings score from CBO, but I believe this amendment could save billions of dollars.

Once again, Mr. President, this amendment affects less than 2 percent and only those with incomes of more than $200,000 a year adjusted gross income would pay the full premium of about $2,900 a year. We think this is a reasonable proposal. It is scaled up. It impacts no one below $100,000 adjusted gross income a year, and at the maximum, a couple could make $400,000 a year in adjusted gross income, the premium would be just $2,900.

The income levels would be indexed to medical inflation and, according to current population survey data from 2002, or about 1 million people of the 38 million Medicare beneficiaries, have incomes of over $100,000 a year. This would protect the tax subsidy for people who need it by encouraging those who have the dollars simply to pay either a greater share of the premium cost or the full premium cost. I thank the Chair. I yield the floor.

The PRESIDING OFFICER (Mr. Ensign). The Senator from Rhode Island.

Mr. CHAFEE. Mr. President, I join with Senator Frist, Senator Nickles, and others in presenting this amendment this evening. I believe this income-related Part B premium for only the wealthiest of seniors, a little over 1 percent of the entire Medicare population, is necessary to sustain the long-term solvency of the Medicare Program.

I wish to make just three points on this issue. First, as Senator Feinstein has said, previous Congresses have worked on this issue. In 1997, the Senate voted 70 to 30 to do exactly what we are doing here, and most of those Senators are still here today.

Second, many of these seniors can afford this added premium. Most seniors, it is safe to say, who are making over $100,000 a year have already paid off their mortgages. They have paid off their loans. They have educated their children. They can afford these higher premiums which would go from only $1,400 a year to $2,800 a year in 2007, at the most, depending on the income they make. So seniors who are making $100,000 at the most will pay only $1,400 a year, and those making $200,000 will pay $2,800 a year. I do not think that is too much to ask to help keep this program solvent.

Finally, if we do not do this today, some other Congress is going to do it. In 1997, the National Bipartisan Commission on the Future of Medicare was created to resolve the long-term insolvency of the system. That was in 1997 and it was known as the Breaux-Frist Commission. They did not report their work to Congress. They fell short of the votes necessary to report their work to Congress.

However, it is interesting to note that one of the reasons they failed to get the votes to report to Congress was the President at the time, President Clinton, called for putting aside 15 percent of budget surpluses the next 15 years to pay down the debt and to shore up Medicare. Fifteen years of budget surpluses—when will we see those again?—to shore up Medicare. Because the Breaux-Frist plan did not include that, they did not get the votes necessary.

Mr. President, now is the time to adopt this amendment. If we do not adopt it, future Congresses will have to wrestle with this dilemma.

I thank the Chair.

The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICHOLS. Mr. President, for the information of our colleagues, I am going to make a couple comments on this amendment. There may be an amendment by the Senator from Pennsylvania that will require a vote on or in relation to Senator Corzine’s amendment. I think we are close to finishing. I hope we can. I just make those comments.

I compliment Senator Feinstein and also Senator Chafee, Senator Alexander, Senator McCain, and others for supporting this amendment. Senator Chafee mentioned we passed the income-related Part B premium several years ago with 70 votes. I believe the majority of that majority is still here. I am looking at the people who voted for it—are still here. I hope we vote for it again.

Medicare has some big problems long term. The bill before us has a lot of new subsidies but does not have a lot of reform to make it affordable for future generations.

Part B right now is subsidized by general revenues 3 to 1 Federal Government and individuals. The amendment before us says if individuals have income above $100,000, they should pay at least 50 percent. If they have income above $200,000, they should pay it all. For couples, that would be $400,000. A couple could make $400,000 before they pay all the premium.

Surely we can do that. Why should we ask our kids and/or our grandkids, who might have incomes of $20,000 or $30,000, to be subsidizing individuals to that degree? I compliment my colleagues for this amendment. I will read from the annual report of the board of trustees of the HI trust fund. It says:

Similarly, SMI general revenues in the year 2002 were equivalent to about 7.8 percent of personal and corporate Federal income tax collected in that year. If such tax revenue remains at the current level relative to the national economy, then SMI—

That is Part B—
general revenue financing in 2077 would represent roughly 32 percent of total income taxes.

That is almost one-third of total income taxes. That is not affordable. That is not sustainable. So I think the amendment we have before us by Senator Feinstein and Senator Chafee and others is a small step in the right direction to try to make this system more affordable for future generations.

I compliment my colleagues for this amendment. I urge our colleagues to support this small step toward reform.

I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

IN REMEMBRANCE OF STROM THURMOND

Mr. FRIST. Mr. President, a few moments ago we were made aware that at 9:45 tonight a close friend, a confidant, a colleague to most of us in this body, Strom Thurmond, passed away.

It was a century ago when Mark Twain was alive and Teddy Roosevelt was President that James Strom Thurmond was born in South Carolina and at that time began a life unmatched in public service. Just about all of us in this body have had the real privilege of serving alongside Strom Thurmond. A long-time friend of Senator Thurmond, Hortense Woodson, once said of him: Everything he’s done has been done in the full. There’s no halfway doings about Strom.

Indeed, Strom Thurmond will forever be a symbol of what one person can accomplish when they live life, as we all know he did, to the fullest. To his family and his friends, we offer our sincere sympathies.

It was unexpected that he would die this evening while we are in the middle of completing a very historic bill, and it would be clearly appropriate for us to make recognition of his passing for a moment now, with plans, either after completion of the bill tonight or tomorrow, for people to make more extended statements.

Again, we extend to his family our deepest sympathies and our continued prayers.

The PRESIDING OFFICER. The Democratic leader.

Mr. DASCHLE. Mr. President, I join with the majority leader in expressing
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our heartfelt condolences to the family and to the State of Strom Thurmond. In many respects, he was a legend. Many of us had the good fortune to serve with him as a Senator. He was a Governor, a Presidential candidate, a soldier, a father, a father of a citizen. In many respects, he fought, lived, contributed, and legislated in a way that will be written about and commented on for years and decades to come.

Much more will be said, but I think as we consider his contribution tonight we can say, as we consider the opportunity that we had to serve with him, Republicans and Democrats, that it was our privilege to do so.

The PRESIDING OFFICER. The Senator from South Carolina.

Mr. HOLLINGS. Mr. President, my friend and colleague of 36 years in the Senate is gone. A giant oak in the forest of public service has fallen.

I started with Senator Thurmond as a young law student in 1946 when he first ran for Governor and have been more or less with him over these many, many years. I will have a real recount of our work together later. That is the way it was even though we ended up on other sides of the aisle. There was never any doubt about the interests of South Carolina.

We have all this argument going on now with respect, for example, to judges. He and I got together very early. We agreed when his President was in office from his particular party that he had the appointment, but he always asked me about it and, of course, I in turn asked him about it. We checked with each other. That is the kind of way we worked together over the some 36 years.

I can say just a living legend of South Carolina now has been terminated. But I want to give Nancy and the children my heartfelt condolences. Peatsy and I have known them and the children over the many years. I will have more to say at a later time. I thank the leadership for their recognition. I hope, perhaps, when we complete our work tonight, we might adjourn out of respect for our colleague.

Mr. FRIST. Why don’t we take just a moment of silence in honor of Strom Thurmond.

(Moment of Silence.)

Mr. FRIST. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. SANTORUM. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To allow eligible beneficiaries in MedicareAdvantage plans to select zero premium, stop-loss drug coverage protection)

On page 343, between lines 15 and 16, insert the following:

(i) Zero Premium Stop-Loss Protection and Access to Negotiated Prices for Eligible Beneficiaries Enrolled in MedicareAdvantage Plans.—

(1) In general.—Notwithstanding any provision of this part or part D, a MedicareAdvantage plan shall be treated as meeting the requirements of this section if, in lieu of the qualified prescription drug coverage otherwise required, a prescription drug coverage plan that meets the following requirements:

(A) No premium.—Notwithstanding subsection (d) or sections 1860D–13e(2) and 1860D–17, the amount of the MedicareAdvantage monthly beneficiary obligation for required prescription drug coverage shall be zero.

(B) Beneficiary receives access to negotiated prices and stop-loss protection for no additional premium.—Notwithstanding section 1860D–6, qualified prescription drug coverage shall include coverage of covered drugs that meets the following requirements:

(i) The coverage has cost-sharing (for costs up to the annual out-of-pocket limit under subsection (c)(4) of such section) that is equal to 100 percent.

(ii) The coverage provides the limitation on out-of-pocket expenditures under such subsection (c)(4), except that in applying such subsection the term "beneficiary" shall be substituted for "$3,700" in subparagraph (B)(i)(I) of such subsection.

(iii) The coverage provides access to negotiated prices and stop-loss protection.

(C) Application of low-income subsidies.—Notwithstanding subsection (f) or section 1860D–17, the Administrator shall not apply the following provisions of subsection (a) of such section:

(i) Subparagraphs (A), (B), (C), and (D) of paragraph (1).

(ii) Subparagraphs (A), (B), and (D) of paragraph (2).

(iii) Clauses (i), (ii), (iii), and (iv) of paragraph (3)(A).

(D) Penalty for enrolling in a zero premium stop-loss protection plan after initial eligibility for such enrollment.—In the case of an eligible beneficiary that enrolled in a plan offered pursuant to this subsection at any time after the initial enrollment period described in section 1860D–2, the Secretary shall establish procedures for imposing a monthly beneficiary obligation for enrollment under such plan. The amount of such obligation shall be an amount that the Administrator determines is reasonable and sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled but was not so enrolled. The provisions of subsection (b) of such section shall apply to the penalty under this paragraph in a manner that is similar to the manner such provisions apply to the penalty under part D.

(3) Procedures.—The Administrator shall establish procedures for the enforcement of this subsection. Under such procedures, the Administrator may waive or modify any of the preceding provisions of this part or part D to the extent necessary to carry out this subsection.

(4) No effect on Medicare drug plans.—This subsection shall have no effect on eligible beneficiaries enrolled under part D in a Medicare Prescription Drug Plan or under a contract under section 1860D–13(e).

Mr. SANTORUM. Mr. President, one of the key components that many Members on this side of the aisle would like to see accomplished is to draw as many people as possible into the competitive model set up in this bill. We believe it is the more efficient, higher quality delivery of health care services, the Medicare Advantage plan.

Unfortunately, through negotiations, a lot of the incentives the President has to encourage people to get into those plans and thereby make them work have been taken out in the current version on the floor. That is to the great consternation, I know, of the White House and many Members on this side of the aisle.

For quite some time I have been trying to think how they can create incentives—carrots, if you will, as opposed to sticks—to encourage people to get into these kinds of plans. Originally, I intended to offer a differential benefit—in other words, a benefit that would have what I call a standard benefit in the fee-for-service option and an enhanced benefit in the Medicare Advantage option. I was fairly convinced, in discussing with the people on my side of the aisle, we probably would not have a chance to succeed; that there were people who had made commitments that a differential benefit was not something they wanted.

I went about trying to figure out, could we create incentives to people to come into Medicare Advantage, which I believe is the future of Medicare and the best way to run the system without creating a differential benefit. The amendment before the Senate does that. The amendment before the Senate creates an option for beneficiaries who participate in Medicare Advantage. It is a pharmaceutical option. Instead of just having no pharmaceutical benefit, which you could if you do not get into the Medicare Advantage Program, we have the standard benefit which is required if you participate in the PPOs, HMOs, and POSs that will be created here.

What I will do with this amendment is create another option for seniors who select Medicare Advantage. That option would be a zero premium catastrophic benefit. So you could choose between the standard benefit, the $35 premium, and the 50 percent copay, and the donut hole, or the catastrophic benefit described over and over again, or if you did not want to pay a premium but wanted some catastrophic coverage,
wanted some benefit, no premium, no cost, you could join this.

The CBO scored this as attracting twice as many people into the PPOs and HMOs as the underlying bill. It would make those plans much more desirable. I believe that should be one of the goals of this legislation, to make the new and improved and stronger plan a more robust plan.

Unfortunately, according to the Congressional Budget Office, when people move from the fee-for-service plan into the Medicare Advantage plan, the Congressional Budget Office assumes those plans will be more expensive. And because they will be more expensive, this amendment costs money. It doubles the participation but costs $20 to $25 billion, which is the back of the envelope. And God bless the CBO; that is the best they could do at this late hour.

I firmly believe this is a reasonable compromise between those who would not want to have differential benefit and those who would because it is unfair to the fee-for-service participants and those who believe we need to have an incentive for people to get into the Medicare Advantage Program. This strikes the right compromise. This is where we could go.

There are all sorts of things we have done to eliminate adverse selection and all the other problems inherent in offering two different benefits. We believe we actually address the vast majority of those problems in this amendment. Nevertheless, we have run into the roadblock that this bill has run into the entire time when it comes to the competitive model and CBO and their estimation of costs.

For the record, the White House does not see it that way. The White House sees the competitive model as saving money. Under their scoring, this would probably actually save money and move people into a higher quality, more efficient system.

AMENDMENT NO. 1090 WITHDRAWN

As a result of the fact of the score which is $20 to $25 billion, and we do not have that, I am going to withdraw my amendment and hope this idea which I believe is in the center here is a compromise between two competing ideas of how to structure this bill.

It will be considered in conference as a way of trying to bring the two sides together in something that does not disadvantage the fee-for-service plan but creates an opportunity for incentives to go to the Medicare Advantage plan.

Mr. President, with that I ask unanimous consent to withdraw my amendment.

The PRESIDING OFFICER. The amendment is withdrawn.

The Senator from Oklahoma.

Mr. NICKLES. I compliment my colleagues from Pennsylvania. Especially this late at night, when a lot of us are thinking about our departed friend and colleague, Senator Thurmond, I appreciate his withdrawing this amendment.

For the information of our colleagues, I think we are very close to finishing this bill. We may have one or two roll call votes. I think we are just about ready to vote on the Feinstein-Chafee amendment and possibly one other amendment, and I think we are very close to being able to vote on final passage, for the information of our colleagues.

I yield the floor.

I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will strike the record.

The assistant legislative clerk proceeded to call the roll.

Mr. KENNEDY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1090

Mr. KENNEDY. Mr. President, I will just take a moment to address the amendment of the Senator from California, Mrs. FEINSTEIN, and her colleagues in transforming the Medicare system. That is what we would be doing, changing what is effectively an insurance system into a welfare system. There is, really, no question about that.

The fact is, the Part B of the Medicare system is basically a progressive system as it is at the present time. Wealthy people are paying a great deal more into that system than they are taking out.

Mr. President, if this passes, it is only a question of time before the healthiest individuals who can qualify under the Part B premium are going to leave the Medicare system and it is going to deteriorate into a general welfare system. The kind of Medicare system seniors relied on, day in and day out, would be destroyed. Make no mistake about it.

That is why the AARP is strongly opposed to it, as well as the National Committee to Preserve Social Security.

I hope this amendment is not accepted. I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

At the end of subtitle A of title V, add the following:

SEC. 1885. STREAMLINING AND SIMPLIFICATION OF MEDICARE REGULATIONS.

(a) in General.—The Secretary of Health and Human Services shall conduct an analysis of the regulations issued under title XVIII of the Social Security Act and related laws in order to determine how such regulations may be streamlined and simplified to increase the efficiency and effectiveness of the Medicare program without harming beneficiaries or providers and to decrease the burdens on the Medicare payment systems imposed on both beneficiaries and providers.

(b) Reduction in Regulations.—The Secretary, after completion of the analysis under subsection (a), may by regulation issue amendments to the regulations described in subsection (a) in such a manner as to—
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(1) reduce the number of words comprising all regulations by at least two-thirds by October 1, 2004, and

(2) ensure the simple, effective, and efficient operation of the medicare program.

(c) APPLICATION OF THE PAPERWORK REDUCTION ACT.—The Secretary shall apply the provisions of chapter 35 of title 44, United States Code (commonly known as the “Paperwork Reduction Act”) to the provisions of this Act to ensure that any regulations issued to implement this Act are written in plain language, are streamlined, promote the maximum efficiency and effectiveness of the medicare and medicaid programs without harming beneficiaries or providers, and minimize the burdens the payment systems affected by this Act impose on both beneficiaries and providers.

If the Secretary determines that the two-thirds reduction in words by October 1, 2004 required in (b)(1) is not feasible, he shall inform Congress in writing by July 1, 2004 of the reasons for its infeasibility. He shall then establish a possible reduction to be achieved by January 1, 2005.

VITATION OF VOTE ON AMENDMENT NO. 1041

Mr. GRASSLEY. Mr. President, I ask unanimous consent to vitiate the vote by which amendment No. 1040 was adopted.

Mr. BAUCUS. Amendment No. 1041.

Mr. GRASSLEY. I am sorry, No. 1041. The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1096

Mr. GRASSLEY. I ask unanimous consent that the pending amendment be temporarily set aside, amendment No. 1096 be called up, adopted, and the motion to reconsider be laid on the table.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment (No. 1096) was agreed to, as follows:

(A) To require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project.

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT.

(a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT. The Secretary shall waive such provisions of the medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred quickly to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms “hospital” and “critical access hospital” have the meanings given such terms in subsections (a) and (b), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

AMENDMENT NO. 988, AS MODIFIED

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Collins amendment, amendment No. 988, be modified with modifications that I send to the desk.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To increase medicare payments for home health services furnished in a rural area.)

At the appropriate place in subtitle C of title IV, insert the following:

SEC. 118. INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895 of the Social Security Act (42 U.S.C. 1395f) is amended by adding at the end the following:

"(1) INCREASE IN PAYMENT FOR SERVICES FURNISHED IN A RURAL AREA.—

"(A) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—(i) In General.—The Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

"(B) PAYMENT ADJUSTMENT.—Section 1895(b)(5) of the Social Security Act (42 U.S.C. 1395f(b)(5)) is amended by adding at the end the following: "(Purpose: To provide for the establishment of a demonstration project to clarify the definition of homebound)

At the appropriate place in subtitle B of title IV, insert the following:

AMENDMENT NO. 1074

(Purpose: To amend title XVIII of the Social Security Act to make improvements in the national coverage determination process to respond to changes in technology.)

At the end of subtitle C of title IV, add the following:

SEC. 3. IMPROVEMENTS IN NATIONAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the third sentence of subsection (a), by inserting “consistent with subsection (l)” after “the Secretary shall ensure”; and

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

"(l) NATIONAL COVERAGE DETERMINATION PROCESS.—

"(1) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In the case of a request for a national coverage determination that—

"(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made no later than 6 months after the date of the request; or

"(B) requires such an assessment or deliberation in which a clinical trial is not requested, the decision on the request shall be made no later than 9 months after the date of the request.

"(2) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—At the end of the 6-month period (with respect to a request under paragraph (1)(A)) or 9-month period (with respect to a request under paragraph (1)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall—

"(A) make a draft of proposed decision on the request available to the public through the Medicare Internet site of the Department of Health and Human Services or other appropriate means;

"(B) provide a 30-day period for public comment on such draft;

"(C) make a final decision on the request within 60 days of the conclusion of the 30-day period referred to in subparagraph (B); and

"(D) include in such final decision summaries of the public comments received and responses thereto;

"(E) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

"(F) in the case of a decision to grant the coverage determination, assign a temporary or permanent code and implement the coverage decision at the end of the 60-day period referred to in subparagraph (C);

"(G) NATIONAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection, the term ‘national coverage determination’ has the meaning given such term in section 1862(l)(1)."

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to national coverage determinations as of January 1, 2004.

AMENDMENT NO. 1023

(Purpose: To provide for the establishment of a demonstration project to clarify the definition of homebound)

At the appropriate place in subtitle B of title IV, insert the following:
SEC. DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of enactment of this Act, the Secretary shall conduct a two-year demonstration project under part B of title XVIII of the Social Security Act for purposes of receiving home health services under the Medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a Medicare beneficiary is deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if the beneficiary—

(1) has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) requires the individual to receive assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the individual’s life;

(3) requires 1 or more home health services to achieve or maintain an examination condition that gives the individual the ability to leave home; and

(4) requires technological assistance or the assistance of another person to leave the home.

(c) DEMONSTRATION PROJECT SITE.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) DEMONSTRATION PROJECT REPORT.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to Medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the Medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report containing the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to Medicare beneficiaries—

(A) adversely affects the provision of home health services under the Medicare program; or

(B) directly causes an unreasonable increase of expenditures under the Medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is a directly attributable to the demonstration project, and the impact in absolute terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the Medicare program; and

(3) specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency, and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the Medicare program.

(2) DEMONSTRATION PROJECT.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such duration as the Secretary determines is necessary to conduct demonstration projects.

(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such title, including penalties for false certifications for purposes of receipt of items or services under title XVIII.

(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Medicare Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395l).

(1) DEFINITIONS.—In this section—

(1) MEDICARE.—The term “Medicare beneficiary” means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) HOME HEALTH SERVICES.—The term “home health services” has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395l).

(iii) SERVICES.—The term “secretary” means the Secretary of Health and Human Services.

AMENDMENT NO. 131

(Purpose: To require the GAO to study the impact of price controls on pharmaceuticals)

At the appropriate place, insert the following:

SEC. GAO STUDY OF PHARMACEUTICAL PRICE CONTROLS AND PATIENT PROTECTIONS IN THE G-7 COUNTRIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of the impact of price controls, if any, on pharmaceuticals in France, Germany, Italy, Japan, the United Kingdom and Canada to review the impact such regulations have on consumers, including American consumers, and on innovation in medicine. Such study shall include—

(1) the pharmaceutical price control structures, costs, and other regulations for the pharmaceuticals in the countries selected; and

(2) The impact on American consumers, in terms of reduced research into new or improved pharmaceuticals (including the cost of delaying the introduction of significant advances in certain major diseases), if similar price controls were adopted in the United States.

(b) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project, the Secretary shall submit to Congress a report containing the data collected under subsection (b) and shall include—

(1) the operation and impact on the pharmaceutical and health professionals fall 14 percent because of the physician payment update, is linked to the gross domestic product and penalizes physicians and other practitioners for volume increases that they cannot control and that the government actively promotes through new coverage decisions, quality improvement activities and other initiatives that, while beneficial to patients, are not reflected in the SGR.

(b) SENSE OF THE SENATE.—It is the sense of the Senate that Medicare accessibility to quality care may be compromised if Congress does not take action to prevent cuts next year and the following that result from the SGR formula.

AMENDMENT NO. 1045

(Purpose: To provide for a demonstration project for the exclusion of brachytherapy devices from the prospective payment system for outpatient hospital services)

At the end of subtitle B of title IV, add the following:

SEC. DEMONSTRATION PROJECT FOR EXCLUSION OF BRACHYTHERAPY DEVICES FROM PROSPECTIVE PAYMENT SYSTEM FOR OUTPATIENT HOSPITAL SERVICES.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which brachytherapy devices shall be excluded from the prospective payment system for outpatient hospital services under the Medicare program and, notwithstanding section 1833(t) of the Social Security Act (42 U.S.C. 1395t), the amount of payment furnished under the demonstration project shall be equal to the hospital’s charges for each device furnished, adjusted to cost.

(b) DEMONSTRATION PROJECT—BRACHYTHERAPY DEVICES.—The Secretary shall create additional groups of covered devices.
OPD services that classify devices of brachytherapy furnished under the demonstration project separately from the other services (or group of services) paid for under section 1833(t) of the Social Security Act (42 U.S.C. 1395t) in a manner reflecting the number, isotope, and radioactive intensity of such devices, including palladium-103 and iodine-125 de- 
vices.

(c) DURATION.—The Secretary shall con- 
duct the demonstration project under this section for 3 years beginning on the date that is 90 days after the date of enactment of this Act. 

(d) Report.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the demonstration project con- ducted under this section. The report shall include an evaluation of patient outcomes under the demonstration project, as well as an analysis of the cost effectiveness of the demonstration project.

(e) WAIVER AUTHORITY.—The Secretary shall waive compliance with the require- ments of section 1818 of the Social Security Act to such extent and for such period as the Secretary determines is necessary to con- duct the demonstration project under this section.

(f) FUNDING.—

(1) IN GENERAL.—The Secretary shall pro- 
vide for the transfer of the Federal Sup- plementary Insurance Trust Fund estab- 
lished for the transfer from the Federal Sup- 
plementary Insurance Trust Fund with the goal being that, after such actions are taken, the holdings of the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to be equal to the interest income lost by the Trust Fund through the date on which the appropriation is being made as a result of the clerical error.

AMENDMENT NO. 1041

(Purpose: To adjust the urban health provider payment)

At the appropriate place, insert the fol- 

lowing:

SEC. 1. URBAN HEALTH PROVIDER ADJUST- 
MENT.

(a) IN GENERAL.—Beginning with fiscal year 2004, notwithstanding section 1923(f) of the Social Security Act (42 U.S.C. 1395t-6(f)), and subject to subsection (c), with respect to a State, payment adjustments made under title XIX of the Social Security Act (42 U.S.C. 1396a) shall be made in accordance with section 1923(f) of that Act (42 U.S.C. 1396a-4(c)(1)).

(b) HOSPITAL DESCRIBED.—A hospital is de- 
scribed in this subsection if the hospital—

(1) is owned or operated by a State (as de-

fined for purposes of title XIX of the Social 
Security Act), or by an instrumentality or 
a municipal governmental unit within a State 
as so defined as of January 1, 2003; and

(2) is located in Indiana.

(c) LIMITATION.—The payment adjustment 

described in subsection (a) for fiscal year 2004 and each fiscal year thereafter shall not ex- ceed 175 percent of the costs of furnishing hospital services described in section 1923(f)(1)(A) of the Social Security Act (42 U.S.C. 1396a-4(c)(1)(A)).

AMENDMENT NO. 1056

(Purpose: To prevent the Secretary of 
Health and Human Services from modifying the treatment of certain long-term care hos- pitals as subsection (d) hospitals)

At the end of subtitle A of title IV, add the follow- ing:

(3) Medicare's current structure does not 
meet the ever-increasing needs of our seniors; 

(b) STRATEGY FOR PAYMENT ADJUSTMENT.

(1) The method by which the national pre- 

determined payment adjustment is to be applied to the Secretary a report concerning the rec- ommendations of the Committee to improve 
and protect patient safety.

(d) TERMINATION.—The Committee shall 
terminate on the date that is 1 year after the date of enactment of this Act.

AMENDMENT NO. 1059

(Purpose: To express the sense of the Senate concerning the structure of Medicare re- form and the prescription drug benefit)

At the appropriate place, insert the fol- 

lowing:

SEC. 2.SENATE CONCERNING THE STRUCTURE OF MEDICARE REFORM AND THE PRESCRIPTION DRUG BENEFIT.

(a) FINDINGS.—The Senate makes the fol- 
lowing findings:

(1) America’s seniors deserve a fiscally- 

secure Medicare system that fulfills its 
promise to them and future retirees.

(2) The impending retirement of the “baby 
boom” generation will dramatically increase the costs of providing Medicare benefits. 

(3) Medicare costs will double relative to 
the size of the economy from 2 percent of GDP today to 4 percent in 2025 and double again to almost 10 percent of GDP in 2043 and accelerate substantially when Congress adds a necessary prescription drug benefit.

(4) Medicare’s current structure does not have the flexibility to quickly adapt to rapid advances in modern health care. Medicare lags far behind other insurers in providing prescription drug coverage, disease manage- ment programs, and host of other advances.

(5) Reforming Medicare to create a more self-ad- 
justing, innovative structure is essential to improve Medicare’s efficiency and the qual- ity of the medical care it provides.

(6) Private-sector choice for Medicare beneficiaries would provide two key benefits: it would be tailored to the needs of Amer- ica’s seniors, not the government, and would create a powerful incentive for private-sec- tor Medicare plans to provide the best qual- ity of care to seniors at the most afford- able price.

(7) The method by which the national pre- 
determined payment adjustment is to be applied to the Secretary a report concerning the rec- ommendations of the Committee to improve 
and protect patient safety.

(8) Medicare’s current structure does not have the flexibility to quickly adapt to rapid advances in modern health care. Medicare lags far behind other insurers in providing prescription drug coverage, disease manage- ment programs, and host of other advances.

(9) Reforming Medicare to create a more self-ad- 
justing, innovative structure is essential to improve Medicare’s efficiency and the qual- ity of the medical care it provides.

(10) Private-sector choice for Medicare beneficiaries would provide two key benefits: it would be tailored to the needs of Amer- ica’s seniors, not the government, and would create a powerful incentive for private-sec- tor Medicare plans to provide the best qual- ity of care to seniors at the most afford- able price.

(11) The method by which the national pre- 
determined payment adjustment is to be applied to the Secretary a report concerning the rec- ommendations of the Committee to improve 
and protect patient safety.
(a) PAYMENT AMOUNT.—(1) IN GENERAL.—Notwithstanding any other provision of law, effective for discharges occurring on or after October 1, 2003, for purposes of computing payments to hospitals (as defined in section 1886(d) and 1833(t) of the Social Security Act (42 U.S.C. 1395d) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina Metropolitan Statistical Area.

(2) BUDGET NEUTRAL WITHIN NORTH CAROLINA.—The Secretary shall adjust the area wage index referred to in paragraph (1) with respect to payments to hospitals located in North Carolina in a manner which assures that the total payments made under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)) in a fiscal year for the operating cost of inpatient hospital services are not greater or less than the total of such payments that would have been made in the year if this subsection had not been enacted.

(b) PAYMENTS TO SKILLED NURSING FACILITIES AND HOME HEALTH AGENCIES.—(1) IN GENERAL.—Notwithstanding any other provision of law, effective October 1, 2003, for purposes of making payments to skilled nursing facilities (SNFs) and home health agencies (as defined in sections 1861(j) and 1861(o) of the Social Security Act (42 U.S.C. 1395x(j); 1395x(o)) under the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area.

(2) APPLICATION AND BUDGET NEUTRAL WITHIN NORTH CAROLINA.—Effective for fiscal year 2004, the skilled nursing facility PPS and home health PPS rates for Iredell County, North Carolina, and Rowan County, North Carolina, will be updated by the prefloor, preclassification hospital wage index available for the Charlotte-Gastonia-Rock Hill, North Carolina, South Carolina Metropolitan Statistical Area. This subsection shall be budget neutral in a manner, using a methodology that ensures that the total amount of expenditures for skilled nursing facility services and home health services in a year does not exceed the amounts that would have been made in the year if this subsection had not been enacted. Required adjustments by reason of the preceding sentence shall be done with respect to skilled nursing facilities and home health agencies located in North Carolina.

(3) CONCLUSION.—The provisions of this section shall have no effect on the amount of payments made under title XVIII of the Social Security Act to entities located in States other than North Carolina.

SEC. 2. INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.

(a) IN GENERAL.—Section 1895 of the Social Security Act (42 U.S.C. 1395f) is amended by adding at the end the following:—

"(f) INCREASE IN PAYMENT FOR SERVICES FURNISHED IN A RURAL AREA.—

(1) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2004 and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.

(2) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall make payments with respect to home health services in a rural area (as defined in section 1886(d)(2)(D)) on or after October 1, 2004 and before October 1, 2006, for purposes of the medicare program under title XVIII of such Act (42 U.S.C. 1395 et seq.), Iredell County, North Carolina, and Rowan County, North Carolina, are deemed to be located in the Charlotte-Gastonia-Rock Hill, North Carolina Metropolitan Statistical Area.

(3) BUDGET NEUTRALITY.—The provisions of this section shall have no effect on the amount of payments made under title XVIII of the Social Security Act to entities located in States other than North Carolina and Rowan County, North Carolina.

(b) PAYMENT ADJUSTMENT.—(1) IN GENERAL.—Section 1895(l)(b)(5) of the Social Security Act (42 U.S.C. 1395f(b)(5)) is amended by adding at the end the following:—

"(6) an evaluation of the appropriateness of extending such adjustment or making such adjustment permanent.

(7) an evaluation of the adjustment of the work geographic practice cost index required under section 1848(e)(1)(A)(iv) of the Social Security Act (42 U.S.C. 1395w-4(e)(1)(A)(iv)) to reflect ¾ of the area cost difference in physician work;"
AMENDMENT NO. 1085

(Purpose: To express the sense of the Senate regarding payment reductions under the Medicare physician fee schedule)

At the end of title VI, insert the following:

SEC. 1. SENSE OF THE SENATE ON PAYMENT REDUCTIONS UNDER MEDICARE PHYSICIAN FEE SCHEDULE.

(a) FINDINGS.—Congress finds that—

(1) the fees Medicare pays physicians were reduced by 5.4 percent across-the-board in 2002;

(2) recent action by Congress narrowly averted another across-the-board reduction of 4.4 percent for 2003;

(3) based on current projections, the Centers for Medicare & Medicaid Services (CMS) estimates that a legislative or administrative action, fees will be reduced across-the-board once again in 2004 by 4.2 percent;

(4) the prospect of continued payment reductions under the Medicare physician fee schedule for the foreseeable future threatens to destabilize an important element of the program, namely physician participation and willingness to accept Medicare patients;

(5) the primary source of this instability is the sustainable growth rate (SGR), a system of annual spending targets for physicians' services for Medicare.

(b) REDUCTION IN REGULATIONS.—The Secretary, after completion of the analysis under subsection (a), shall direct the rewriting of the regulations described in subsection (a) in such a manner as to—

(1) reduce the number of words comprising all regulations by at least two-thirds by October 1, 2004, and

(2) ensure the simple, effective, and efficient operation of the medicare program.

(c) APPLICATION OF THE PAPERWORK REDUCTION ACT.—The Secretary shall apply the provisions of chapter 35 of title 44, United States Code (i.e., the ‘‘Paperwork Reduction Act’’) to the provisions of this Act to ensure that any regulations issued under title XVIII of the Social Security Act are streamlined and simplified to increase the efficiency and effectiveness of the medicare program without harming beneficiaries or providers and to decrease the burdens the medicare payment systems impose on both beneficiaries and providers.

AMENDMENT NO. 960

(Purpose: To Require a Streamlining of the Medicare Regulations)

At the end of subtitile A of title V, add the following:

SEC. 2. STREAMLINING AND SIMPLIFICATION OF MEDICARE REGULATIONS.

(a) In General.—The Secretary of Health and Human Services shall conduct an analysis of the regulations issued under title XVIII of the Social Security Act and related laws in order to determine how such regulations may be streamlined and simplified to increase the efficiency and effectiveness of the medicare program without harming beneficiaries or providers and to decrease the burdens the medicare payment systems impose on both beneficiaries and providers.

(b) Reduction in Regulations.—The Secretary, after completion of the analysis under subsection (a), shall direct the rewriting of the regulations described in subsection (a) in such a manner as to—

(1) reduce the number of words comprising all regulations by at least two-thirds by October 1, 2004, and

(2) ensure the simple, effective, and efficient operation of the medicare program.

(c) Application of the Paperwork Reduction Act.—The Secretary shall apply the provisions of chapter 35 of title 44, United States Code (i.e., the ‘‘Paperwork Reduction Act’’) to the provisions of this Act to ensure that any regulations issued under title XVIII of the Social Security Act are streamlined and simplified to increase the efficiency and effectiveness of the medicare and medicaid programs without harming beneficiaries or providers, and minimize the current systems affected by this Act to impose on both beneficiaries and providers. If the Secretary determines that the two-thirds reduction in words by October 1, 2004 required in (b)(1) is not feasible, he shall inform Congress in writing by July 1, 2004, of the reasons for its unfeasibility. He shall then establish a feasible reduction to be received by January 1, 2005.

Mr. GRASSLEY. I ask unanimous consent that these amendments and the following pending amendments be adopted and that the motion to reconsider be laid upon the table:

Amendment No. 1017, Allard; No. 968, Harkin; No. 948, Graham of South Carolina; No. 960, Dayton: No. 1054, Feingold; No. 1030, Enzi.

The PRESIDENT pro tempore. Is there objection?

Mr. GRASSLEY. I ask unanimous consent that the amendments be adopted and that the motion to reconsider be laid upon the table:

Amendment No. 1017, Allard; No. 968, Harkin; No. 948, Graham of South Carolina; No. 960, Dayton: No. 1054, Feingold; No. 1030, Enzi.

The PRESIDENT pro tempore. Is there objection?

Without objection, it is so ordered.

The amendments were agreed to.

Mr. GRASSLEY. Thank you. I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.

Mr. GRAHAM of South Carolina. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

Then the PRESIDENT pro tempore. Without objection, it is so ordered.

STROM THURMOND

Mr. GRAHAM of South Carolina. Mr. President, I rise to make a brief statement, like my colleague from South Carolina, Senator Hollings, about the passing of Senator Thurmond. This is something I really don’t know how to put in words. All of us from South Carolina knew Senator Thurmond in so many ways. But his colleagues in this body, the vast majority of you, have not been fortunate to have great admiration and fondness for Senator Thurmond but I stand before you as his successor. I often state back home that we change Senators every 50 years and that so many people have been writing into Thurmond’s place. The jokes just go on and on about what a rich life he has lived.

Tonight his family is mourning his passing. Whether a person lives to be 100 or 200, it is difficult to lose your father. If you lose someone you love, it is always difficult. But when you think about Senator Thurmond, you always have a smile on your face.

He lived a rich life. He lived at times a controversial life. But the biggest thing I can say to give to Senator Thurmond is that he changed. He changed the times.

Those of you who embraced him during difficult times your love was much appreciated. Recently people have tried to say that Senator Thurmond wasn’t the man of time which is unfair to him or anyone else. Those who knew him best understood that he changed with the times. And his legacy in my State across party lines, across racial lines, and across religious lines was truly a noble-to-guy. If you had a problem with your family or with your business, the first thought in your mind, if the Government was involved, or if somebody was treating you unfairly, was get on the phone and call Senator Thurmond. You would get a phone call back, and he would go to bat for you. Whether you owned the company, or you were the janitor, whether you were black, white, rich or poor, his office and he as a person had a reputation of going to bat for individuals. To me, that is his greatest legacy.

I stand before you as his successor—but not only that, as his friend. He embraced my campaign in 1995. He came to campaign for me when he was 93 years of age. And I was worried to death about if he could make it through the day. Three days later I was glad to see him leave because he about killed me. But I had enthusiasm and passion like no one I have ever met in my life. He did things he didn’t have to do. He was a sitting judge in South Carolina in his 40s. He left the judgeship to go volunteer for the Army. He landed in a glider on D-Day. He was shot up, the pilot was killed, and he fought the Germans until they quit, and then he went over to Japan and fought until they quit.

This man, your friend, my friend, South Carolina’s favorite son, is gone. There are no words, there are no lines, across racial lines, and across religious lines, across party lines, across time which is unfair to him or anyone else. Those who knew him best understood that he changed with the times. And his legacy in my State across party lines, across racial lines, and across religious lines was truly a noble-to-guy. If you had a problem with your family or with your business, the first thought in your mind, if the Government was involved, or if somebody was treating you unfairly, was get on the phone and call Senator Thurmond. You would get a phone call back, and he would go to bat for you. Whether you owned the company, or you were the janitor, whether you were black, white, rich or poor, his office and he as a person had a reputation of going to bat for individuals. To me, that is his greatest legacy.

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This man, your friend, my friend, South Carolina’s favorite son, is gone but he will never be forgotten. His biggest legacy is in the many things he did—not the large things he did. There are so many large things he accomplished. But he lives on in families.
Great relationships were established, and good constituent service. He won his last election by getting more African-American votes than any Republican in the South. All I can say about Senator Thurmond is that we pray for his family, we mourn his loss, but we thank God that he provided us a great public servant. Well done, Senator Thurmond. Thank you, Mr. President.

Mr. NICKLES. Mr. President, I suggest the absence of a quorum. The PRESIDENT pro tempore. The clerk will call the roll.
The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded. The PRESIDENT pro tempore. With- out objection, it is so ordered.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate immediately proceed to executive session to consider the following nomination on today’s executive calendar:

Calendar No. 232, the nomination of Joshua Bolten to be Director of the Office of Management and Budget. I further ask unanimous consent that the nomination be confirmed, the motion to reconsider be laid upon the table, the President be immediately notified of the Senate’s action, and the Senate then return to legislative session.

The PRESIDENT pro tempore. Is there objection? Without objection, it is so ordered.
The nomination was considered and confirmed.

The assistant legislative clerk read the following:

The amendment (No. 1060), as modified, was rejected.

Mr. BAUCUS. Mr. President, I move to reconsider the vote.

Mr. REID. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

The PRESIDENT pro tempore. The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I have a unanimous consent request to correct a previous unanimous consent request. In a previous unanimous consent request, I referred to amendment No. 990 when I meant to refer to the previously adopted Murray amendment No. 961.

I ask unanimous consent to make that change.

I referred to the Kyl amendment No. 1128 when I meant to refer to Kyl amendment No. 1121.

I also ask unanimous consent to make that change.

The PRESIDENT pro tempore. Is there objection? Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, I suggest the absence of a quorum.

The PRESIDENT pro tempore. The clerk will call the roll.
The legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDENT pro tempore. Without objection, it is so ordered.

Mr. GRASSLEY. Mr. President, I send an amendment to the desk.

The PRESIDENT pro tempore. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Iowa [Mr. GRASSLEY] proposes an amendment numbered 1133.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment (No. 1133), is printed in today’s RECORD under “Amendments Submitted.”

Mr. GRASSLEY. Mr. President, is there no discussion necessary on the amendment?

The PRESIDENT pro tempore. Who seeks recognition?

The Senator from Texas.

Mrs. HUTCHISON. Mr. President, I would just like to say that we have help for our teaching hospitals in the managers’ amendment. It is not much. But I am working with all of the managers, the ranking member as well as the chairman, to try to increase funding for teaching hospitals.

I want to point out our teaching hospitals must have the support that is in this bill at a higher percentage if we are going to keep the young physicians trained and if our country will keep the greatest health care system in the world.

I thank the managers for helping me put that in the managers’ amendment.
The PRESIDENT pro tempore. The Senator from Pennsylvania.

Mr. SANTORUM. Mr. President, I oppose the managers’ amendment because of an amendment that is in the managers’ amendment, the Corzine amendment provides for three States the opportunity to basically opt out of the Medicare Program for prescription drugs and have an entitlement flow of funding to go to the States for the States to develop their own drug benefit. As a result of that, States like mine and two others will not have the advantage of an integrated drug benefit which I fought very strongly on this floor and which I believe will also lead potentially to this unlimited entitlement flow of funds to the States because of the way this language is drafted, the potential for lots of mischief in respect to double dipping, inter-government transfers, disproportionate share payments. We could be opening a virtual Pandora’s box. Yes. For my States and two others. But I think, frankly, it is not good policy and does not do the kind of improvement of the overall Medicare program which my State should participate in as well as the other States represented here.

There is no Federal oversight by the Secretary of Health and Human Services for this plan.

There are a host of other problems with this amendment. It is my understanding that the managers gave a commitment that this amendment be included in the package. And so to honor the chairman’s commitment, I will not object to this amendment nor call for a vote to strike the amendment. But I, unfortunately, will have to vote against this bill.

The PRESIDENT pro tempore. Is there further debate?

Mr. GRASSLEY. I ask unanimous consent that the amendment be agreed to.

The PRESIDENT pro tempore. Is there objection? Without objection, it is so ordered.

The amendment (No. 1133) was agreed to.

AMENDMENTS EN BLOC WITHDRAWN

Mr. GRASSLEY. Mr. President, I ask unanimous consent to withdraw the pending amendments.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendments (Nos. 953, 958, 934, 964, 965, 980, 979, 973, 986, 990, 977, 993, 962, 1004, 1019, 1020, 1021, 999, 954, 1037, 1039, 1051, 1012, 1061, 1075, 1076, 1077, 1024, 1073, 1088, 1089, 1090, 1091, 1110, and 1041) were withdrawn.

ADULT DAY CARE

Mr. BUNNING. Mr. President, during consideration of this bill in the Finance Committee, I submitted language regarding adult day care which I and my staff were told by Finance Committee staff was acceptable and included in S. 1, the Prescription Drug and Medicare Improvement Act of 2003, as part of the base bill to be considered on the Senate floor. I was very thank-
been cosponsored by 41 members of the Senate.

Again, I appreciate the opportunity to join my colleagues from Nevada today. It is my sincere hope, Mr. President, that we will be able to address the issue of the $15,590 cap on outpatient therapy services.

Mr. GRASSLEY. I thank both the Senator from Nevada and the Senator from Arkansas for their comments and for withdrawing the amendment. As you all know, the Senate-endorsed CMS Administrator Scully at the Finance Committee markup to further delay implementation of these beneficiary caps. Unfortunately, as a result of the Senate Budget Resolution constraints, I do not have Medicare dollars to repeal the beneficiary cap on therapy services. I agree that this arbitrary limit does not make sense and have sought to address this issue in the past. I will work in conference to enact a therapy cap moratorium and appreciate your hard work and progress on this issue.

Mr. ENSIGN. I appreciate the Chairman’s leadership on this issue and I thank my colleague for agreeing, at a minimum, to work toward another moratorium on implementation of the therapy cap. I also like to thank the Senator from Arkansas for her words of support. Mr. President, I yield the floor.

I ask unanimous consent that this full statement be included in the Record as if read.

Mr. HATCH. Mr. President, I strongly support Senator Kyl’s sense of the Senate resolution to S. 1. His resolution asks Congress to rectify problems with the formula that is used to update Medicare physician reimbursement.

Due to flaws in this formula, payment rates for physicians and other practitioners are predicted to fall by 4.2 percent in 2004. This cut in physician compensation would be the fifth since 1991, including a 5.4 percent decrease in 2002. According to Medicare’s own conservative estimates, between the years 1991 and 2003, reductions for physicians and other health professionals resulted in Medicare physician reimbursement that equates to 14 percent below their actual practice costs.

The 2004 reduction would decrease Utah physician income by $13 million which translates to $3003 per physician in 2004. And this is in addition to the $9 million in Medicare reimbursement that Utah physicians received in 2002. Furthermore, unless we correct this formula, it is estimated that more cuts will occur in 2005, 2006, and 2007.

The Medicare Payment Advisory Commission, MedPAC, has stated that these reimbursement reductions are the result of a problem with the Sustained Growth Rate that is used as part of the calculation to adjust rates each year. The SGR expenditure target is linked to gross domestic product. Therefore, the formula may decrease linked to gross domestic product.

It is true that as the population of our country ages, the volume of Medicare health care services consumed increases. However, physicians have no control over this and our Medicare system penalizes them because of it. As a result, some physicians no longer take new Medicare patients or decline to participate in the Medicare program altogether, and young people are considering other professions.

I would submit that as the baby-boomer generation ages and increasing numbers of Americans become Medicare beneficiaries, we need physicians and other health care providers more than ever. If anything, we should be rewarding our physicians, not penalizing them.

An additional problem with the Sustained Growth Rate calculation is that it does not account for many changes in health care that improve quality but increase physician work also. The federal government actively promotes new technology and improvement activities and other initiatives that benefit patients but are not taken into account by the Sustained Growth Rate calculation.

MedPAC’s recommendation to Congress is that increases in physician payments should reflect increases in the Medicare Economic Index or MEI rather than the gross domestic product. Using the Medicare Economic Index would eliminate the penalty that physicians and other practitioners currently experience when the volume of health care services increases due to factors that they are unable to control.

What we have before us is a flawed formula that is threatening the health of Americans and the future of our country. Congress has addressed this problem before, but it seems that we were only putting a bandage over the wound; we never cured the disease that caused it. The wound continues to fester and it will continue to do so until we cure the problem. And the cure, it seems, is to revise the formula.

I for one, am tired of applying bandages to this wound. I believe that it is time to address this problem directly and definitively. I urge my colleagues to join me in supporting this resolution and in working to correct this problem.

Mr. FEINGOLD. Mr. President, I joined my colleague, the distinguished Senator from Oregon, Mr. Smith, in offering an amendment to promote better care for frail elderly and disabled. This amendment will allow the Secretary of the Department of Health and Human Services to designate health plans that disproportionately serve special needs beneficiaries as specialized Medicare Advantage plans.

A number of States have successfully chosen to serve seniors and the disabled by combining Medicare and Medicaid services through a waiver approved by the Department of Health and Human Services that integrates services under Medicare and Medicaid at capped financing arrangements. These programs provide beneficiaries with a comprehensive benefit package that combines the services traditionally provided by Medicare, Medicaid, and home and community-based waiver programs.

In Wisconsin, the home State of Wisconsin, the Wisconsin Partnership Program is one such success, a community-based program that has improved the quality, access, and cost-effectiveness of the services delivered to its enrollees. Perhaps most important to the beneficiaries, these programs help the disabled and the frail elderly remain in their own community, and avoid institutionalized care. Wisconsin is lucky to have such programs because our State: Elder Care and Community Living Alliance of Dane County, Community Care for the Elderly of Milwaukee County, and Community Health Partnership Eau Claire, Dunn, and Chippewa Counties.

In order to qualify for these programs, a person must be Medicaid-eligible, have physical disabilities or frailties of aging, and require a level of care provided by nursing homes. Though programs providing services under the Wisconsin Partnership Program, these frail elderly and disabled beneficiaries are able to receive quality preventive care upfront, which allows more beneficiaries to stay in their communities and reduces the rate of hospitalization.

In Wisconsin, about 26 percent of all Medicaid recipients age 65 or older are in nursing homes. This rate drops dramatically for those enrolled in the Wisconsin Partnership Program, where only 5.9 percent of recipients age 65 or older are in nursing homes.

While the Wisconsin Partnership Program is a success, we must ensure that the Federal Government continues to support these State solutions to our long-term care needs and other specialty managed care programs that focus on frail, chronically ill seniors. Last year I introduced the Frail Elderly Act of 2002, which promoted specialty managed care programs and helped those already in existence to continue to operate. This amendment will work to accomplish both goals by providing a population-based designation that allows plans to be recognized for specialization in services for special needs beneficiaries. By establishing this specialized designation, we hope to be able to more easily move specialized plans from demonstration status to mainstream provider status, helping to promote a more effective way of caring for the frail elderly and disabled.

Mr. President I also want to point out that this amendment does not change payments, does not change administrative rules, and therefore does not have a fiscal effect.

Fundamental long-term care reform is vital to any health care reform that
Advantage designation would provide CHP beneficiaries. The Secretary also to designate as special-needs beneficiaries. Your amendment would allow and Reform Act of 2003 begins to address this into the mainstream of Medicare. I understand that the Secretary is offering with Senator Gordon Smith Community Health Partnership, and Elder Care of Dane County be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Hon. RUSSELL FEINGOLD, U.S. Senate, Washington, DC.

DEAR SENATOR FEINGOLD: I am writing to express my support for the amendment you will be offering with Senator Gordon Smith to create a designation for Medicare Advantage plans that target special needs beneficiaries. Community Health Partnership, Inc. (CHP) is one of four Wisconsin Partnership Program demonstration sites that has developed innovative models of care specifically for frail seniors and people with physical disabilities that would benefit from a specialty designation.

The Wisconsin Partnership Program (WPP) is an integrated program of acute and long-term care services and administrative functions across programs. The WPP includes a representative cross-section of Medicare beneficiaries in Madison. Thank you for all of your work on behalf of Wisconsin’s seniors.

Sincerely,
KAREN A. BULLOCK,
CEO.

ELDER CARE OF DANE COUNTY, Madison, WI, June 24, 2003.
Hon. RUSSELL FEINGOLD, U.S. Senate, Washington, DC.

DEAR SENATOR FEINGOLD: I am writing to express my support for the amendment you will be offering with Senator Gordon Smith to create a designation for Medicare Advantage plans that target special needs beneficiaries. Elder Care of Dane County is one of four Wisconsin Partnership Program demonstration sites that has developed innovative models of care specifically for frail seniors and people with physical disabilities that would benefit from a specialty designation.

The Wisconsin Partnership Program (WPP) is an integrated program of acute and long-term care services designed to improve access to needed care, reduce fragmentation of care across providers and settings, and help people remain independent in the community, while achieving cost savings. The target populations for WPP include both elderly and physically disabled individuals who meet nursing home level of care criteria. CHP serves both populations in a county, rural area. Participants must be Medicare eligible or dually eligible for Medicare and Medicaid services. The use of an inter-disciplinary care team comprised of a physician, nurse practitioner and social worker that help coordinate beneficiary health care settings. The WPP also participates in the Medicare/ Medicaid Integration Program, a demonstration to test strategies for integrating Medicare and Medicaid services. The goal of this program is to create a seamless system of care for beneficiaries and to reduce costs related to duplication of services and administrative functions across programs.

Like a number of other specialty Medicare+Choice programs, the WPP currently operates demonstration activities, which expires at the end of next year. Like virtually all Medicare demonstration programs, there is no mechanism for transitioning from demonstration status into the mainstream of Medicare. I understand that The Medicare Prescription Drug and Reform Act of 2003 begins to address this problem by establishing a special designation for specialized Medicare Advantage plans that exclusively serve special needs beneficiaries. The Secretary will also designate as special-needs Medicare Advantage plans those that disproportionately serve special needs beneficiaries.

The expansion of the specialized Medicare Advantage designation would provide CHP and other WPP members additional flexibility in expanding our unique program to other beneficiary groups such as those who are eligible for Medicare, but not Medicaid and "pre-duals"—those who are at risk of spending down to Medicaid based on health status and/or income limitations. Targeting healthy beneficiaries before they become frail or disabled would reduce long-run Medicare and Medicaid costs by preventing or delaying health care decline and the need for costly medical or long-term care services. Your amendment also would offer CHP a mechanism to serve non-special needs beneficiaries as a strategy for expanding our membership, preventing our risk through a more representative cross-section of Medicare beneficiaries in West Central Wisconsin.

Your compassion for seniors, disabled and other special needs beneficiaries has been evident since you served as the Chair of the Senate Aging Committee in the State of Wisconsin. The amendment you are offering to the Senate Medicare bill only provides further evidence that you continue to be hard at work on behalf of Wisconsin’s most vulnerable populations. Thank you for all of your work on behalf of Wisconsin’s seniors.

Sincerely,
KAREN MUSSER,
CEO.

Mr. HATCH. Mr. President, I rise to speak on the Gregg-Schumer amendment which was adopted last week. This amendment was based on a piece of legislation, S. 1225, the Greater Access to Affordable Pharmaceuticals Act of 2003, reported by the HELP Committee on June 11th.

I want to take this opportunity to explain why I cast the lone vote against this amendment. It is my hope that when my colleagues consider my explanation that they might be making additional changes to this very important amendment as the process moves forward.

Let me start by commending Senators Gregg, Schumer, McCain, and Kennedy for their work in developing this provision which I believe is a significant improvement on legislation that was adopted by the Senate last Congress, S. 812.

The Gregg-Schumer amendment relates to a complex and often admittedly confusing law I coauthored with my friend, Representative Henry Waxman of California in 1984 the Drug Price Competition and Patent Term Restoration Act.

I voted against this amendment in May of 2001 that helped document some abuses that were occurring in the law. Since our last hearing on this issue, much has happened.

Both the Federal Trade Commission and the Food and Drug Administration played a constructive role in attempting to end several mechanisms by which some research-based and generic
drug firms were attempting to game the system put in place by the 1984 and subsequent court decisions to avoid competition in the marketplace.

The FTC succeeded in achieving several widely-publicized consent decrees with a variety of offending firms under the existing antitrust statutes.

In addition, the FTC conducted an exhaustive survey and study of how certain provisions of the 1984 Waxman-Hatch Act compete in the pharmaceutical industry.

The FTC study contained two major recommendations. The first addressed the use of the statutory 30-month stay granted by the 1984 law in situations where patents are challenged by generic competitors. The FTC recommended that the law:

- Permit only one automatic 30-month stay per drug product per ANDA to resolve patent infringement disputes over patent listed ... prior to the filing date of the generic applicant's ANDA.

This was precisely the position that I suggested in testimony before the HELP Committee on May 8, 2002 and argued during the Senate debate on the Edwards-Collins substitute amendment to the McCain-Schumer legislation.

I would note that the 30-month stay provision in the McCain-Schumer bill last year, S. 812, and in the Edwards-Collins substitute, were both at variance with this central recommendation of the FTC report.

The second major FTC recommendation responds to those situations in which generic firms were entering into agreements not to impede generic competition. The FTC recommended that Congress:

- Pass legislation to require brand-name and first generic companies applicants to provide copies of certain agreements to the Federal Trade Commission.

Senator LEAHY, working very closely with the FTC, developed legislation, the Drug Competition Act, S. 946, that squarely addressed this second recommendation.

During the 107th Congress, I worked with Senator LEAHY on refining that bill. I supported it in committee, and worked with him to pass it through the Senate late last year. In supported his efforts to have it attached to the Medicare vehicle earlier this week. I expect that the 108th Congress will adopt this measure.

The FTC study served an important purpose of cataloging the facts surrounding certain abuses of the 1984 act. In formulating public policy, the facts should matter and a legislative or regulatory response should be tailored to fit the problem.

Unfortunately, the timing of the issuance of FTC study did not allow the report to get the attention it deserved by the Senate. The FTC report was published only one day before the Senate adopted S. 812, the Greater Access to Affordable Pharmaceuticals Act of 2003, last July 31st.

The GAAP Act, developed by Senators MCCAIN and SCHUMER, was substantially altered by the Edwards-Collins substitute, with active involvement of Senator KENNEDY. While there is no question my colleagues were motivated by their goal of making drugs more affordable for seniors, and despite the fact that it garnered 78 votes in the Senate, there were significant shortcomings in the bill.

I let me briefly review a few of the most troublesome provisions of the Edwards-Collins substitute to S. 812. The proposed legislation would have created for the first time a private right of action in the Federal Food, Drug, and Cosmetic Act. The last thing the already overburdened FDA staff needs is a bunch of trial lawyers bringing the agency to a screeching halt by second-guessing its judgment calls.

The bill that passed last year would have resulted in the waiver of patent rights apparently against even third parties—if pioneer drug firms did not file its patents with the FDA and, if challenged by a generic drug applicant, pursue expensive litigation within tight time frames.

In sharp contrast to the FTC recommendation, S. 812 basically made any patents listed with the FDA after a month from the date the pioneer drug application was approved by the FDA ineligible for the 30-month stay. In my view, this is at least forty years earlier than what I and the FTC recommended—freezing the Orange Book to patents listed before a generic drug application was filed.

The American Intellectual Property Law Association opposed S. 812. The patent-dependent biotech industry worked against the bill. The Patent and Trademark Office found that “S. 812 would forfeit unnecessarily the core right of patent holders—the right to exclude others from practicing the inventions for the entire patent term. After years of research and development and significant investment, the patent right is extinguished for the mere failure to satisfy an administrative task or respond in a timely manner.”

Here is what the July 18, 2002 Statement of Administration Policy said about the Edwards-Collins-McCain-Schumer legislation:

the Administration opposes S. 812 in its current form because it will not provide lower drug prices. S. 812 would unnecessarily encourage litigation around the initial approval of a drug and duplicate the process of filing and protecting patents on new drugs. The resulting higher costs and delays in making new drugs available will reduce access to new breakthrough drugs. Moreover, the new cause of action is not necessary to address patent process abuses.

Clearly, the bill would benefit from consideration by the Senate's experts on Hatch-Waxman law on the Judiciary Committee, the proper committee of jurisdiction for this bill.

While S. 812 passed by a very wide margin, it was certainly not without its critics.

Comes now S. 1225. This bill emerged from the HELP Committee. Once again, it is entitled the Greater Access to Affordable Pharmaceuticals Act. Once again, it is cosponsored by Senators MCCAIN, SCHUMER, and KENNEDY.

Due in large part to the leadership of Chairman GREGG, there are significant changes in the bill compared with last year’s legislation.

While I have significant concerns over certain aspects of S. 1225 as adopted in its amended form on June 19, 2003, I must acknowledge Chairman GREGG and Majority Leader FRIST for their role in working with the cosponsors of last year’s bill to make substantial improvements in the legislation.

Likewise, I commend Senators SCHUMER, MCCAIN and KENNEDY for abandoning many of the troublesome features of a bill that garnered 78 votes last Congress.

I can only believe that the factual presentation, analysis, and recommendations contained in the FTC report and subsequent public notice and comment process surrounding the recent issued FDA final rule on patent listings and the application of the statutory 30-month stay both played a constructive role in helping to form the basis of the Gregg-Schumer legislation.

It is appropriate to recognize the efforts of the Bush administration for tackling the problem of multiple, successive 30-months stays through rulemaking. Secretary Thompson, Commissioner McClellan, and FDA Chief Counsel Dan Troy testified for their roles in so promptly completing a rulemaking regarding patent listing that generally embraced the one-and-only-one 30-month stay policy recommended in the FTC Report. Chairman Muris and the FTC staff deserve credit for a report that helped shape a more carefully targeted policy response.

There can be no doubt that this year’s vehicle, S. 1225, is superior to S. 812. This new Gregg-Schumer bill, S. 1225, embraces every one-and-only-one 30-month stay policy that I suggested to the HELP Committee last May, argued for on the floor last July, and was ultimately recommended by the FTC.

The Gregg-Schumer legislation, S. 1225 in the form adopted by the Senate, also addresses some problems that the FDA rule perhaps did not resolve satisfactorily. As FDA Chief Counsel Dan Troy stated at the June 17th Judiciary Committee hearing:

We tried as best we could to cut down on all opportunities for gaming. We did not succeed in cutting down all opportunities for gaming, because nothing, no legislation is so perfect that the rule could not be cut down all opportunities for gaming. Because there are unforeseen circumstances and unintended consequences.

I think Mr. Troy is correct about the nature of the inherent limitations of regulatory and legislative approaches for complex problems where there are powerful incentives to game the system to gain financial advantage. We need to
I have requested the Department of Justice for its formal views on this language. At this point, I think it premature to embrace this language. It is my understanding that the bill that the House will take up does not contain the controversial case or controversy language and prepared to work with the sponsors of the amendment, DOJ and others on this important issue.

Yet another improvement of S. 1225 over the patent infringement action within a year relates to the manner in which the 180-day rule is addressed. In short, I am pleased that the policy embraced last year, the rolling exclusivity policy, was replaced in favor of a “use it or lose it” approach. I have long stated a preference for the consumer-friendly “use it or lose it” rule over the too-open-ended rolling exclusivity.

The Waxman-Hatch law provides an incentive for generic firms to challenge patents. To encourage generic competitive action, the law is based on the failure to bring a suit challenging a patent. The matter, but Mr. Sheldon Bradshaw, Deputy Assistant Attorney General, Office of the United States Trade Representative if USTR finds that the legislation raises any concerns for international trade and intellectual property under the TRIPS provisions.

It is my understanding that FDA and FTC staff provided a great deal of what is known as “technical assistance” on the Gregg-Schumer amendment, a good deal of it between the markup on June 11th and the time the amendment was offered on June 19th. I am not aware whether PTO or USTR were consulted. I think that the PTO and USTR should understand that this is a fast moving train, so they should be prepared to give us any comments they may have in short order. President Bush and the congressional leaders have said it plain that they expect the conference report on the Medicare bill to be completed as soon as possible.

One special area of concern to me as Chairman of the Judiciary Committee is that one provision of the amendment overwhelmingly adopted by the Senate raises significant issues with respect to civil justice policy, including a constitutional concern. Specifically, proposed section 271(e)(5) of title 35, would make the failure of a patentee to file a patent infringement action within a specified time frame sufficient to establish “an actual controversy” for the purpose of establishing subject matter jurisdiction for a declaratory judgment action by a generic drug firm challenging a patent.

Whether the Congress can, or should, by statute grant subject matter jurisdiction for a declaratory judgment action by a generic drug firm challenging a patent? I believe that re-instating the successful defense requirement may prove preferable than intentionally sanctioning a first-filer regime. Frankly, I am uncertain of the policy justification for S. 1225’s retention of granting the 180-day reward to the first-filer rather than the first successful defendant. I believe that there is a lot to be said for giving the reward to the actual winner in court or the first to be sued, not just the first one to enter the Parklawn Building with an application.

The amendment places a high premium on being a first filer. At our hearing last week, FTC Chairman Muris characterized the rush to be a first filer as “the shantytown problem” for US. I stand on the record that a first-filer, or a group of first-filers, to expire before the non-infringing firm could enter the market. Such an outcome only hurts consumers by needlessly delaying introduction of the non-infringing generic product for many years.

Unlike a determination of patent invalidity, a finding of non-infringement does not accrue to third parties. It is important to understand that there are two ways for a generic firm to challenge a patent: it may be barred from the 180-day exclusivity under the current law, or the generic challenger can show that the pioneer’s patent is invalid. And second, the generic challenger can demonstrate

keep this in mind as we analyze further the amendment the Senate adopted last week.

As I stated at the June 17th hearing, it was unfortunate that the PTO was unable to present a witness. Admittedly, the PTO was issued short notice. I have asked PTO for its formal comments on the Gregg-Schumer amendment. I would also be interested in the PTOs comments on whatever language the House adopts. We would also like to hear from the Office of the United States Trade Representative if USTR finds that the legislation raises any concerns for international trade and intellectual property under the TRIPS provisions.

I am concerned that the language that passed the Senate could allow some unintended and, in fact, counterproductive, results. Changes in current law with respect to the court decision and commercial marketing triggering mechanisms for the 180-day exclusivity provision demand careful attention and analysis. The amendment does not appear to adopt all the FTC recommendations in this area.

Other questions should be raised. What if, for example, the generic applicant that successfully challenges the validity of the patent is not also a first filer? Why should such a non-first-filing but successful invalidity challenger not be granted the 180 days exclusivity? Stated another way, why should the first-filer—or rather Muris’ “shantytown” situation, a whole group of first-filing, exclusivity-sharing, first-filers, gain while the actual successful challenger waits out the 180-days? I am not sure that such an outcome is fair and consistent national policy. The system may not result in the most efficient or aggressive pursuit of patent challenges.

One thing is for sure: You can expect a lot more first filers to appear at the door of the FDA building on the first day that successful drugs become eligible for patent challenges. As I pointed out at the Judiciary Committee hearing, some have already suggested that the first to file system might result in an increase in willful infringement cases. In fact, there was a decision last month by a Federal court in Chicago that ruled against a generic firm which filed a generic drug challenge before obtaining the opinion of outside counsel on either non-infringement or invalidity.

Another type of potential problem could arise, and frankly I am not certain how it can be avoided, if a non-first-filing generic drug challenger wins a court decision on grounds of non-infringement. Unless I am wrong in my understanding of the Gregg-Schumer amendment, a generic challenger that prevailed on a non-infringement theory would have to wait for the 180-day period granted to the first filer, or a group of first-day, first-filers, to expire before the non-infringing firm could enter the market. Such an outcome only hurts consumers by needlessly delaying introduction of the non-infringing generic product for many years.

Unlike a determination of patent invalidity, a finding of non-infringement does not accrue to third parties. It is important to understand that there are two ways for a generic firm patent challenger to be barred from the 180-day exclusivity under the current law, or the generic challenger can show that the pioneer’s patent is invalid. And second, the generic challenger can demonstrate
that its product will not infringe a pioneer's patent.

These are two very different theories. Al Engelberg, a highly successful and highly respected attorney engaged by generic drug firms to attack pioneer patents, has characterized the following controversy about the difference between invalidity and non-infringement challenges:

In cases involving an assertion of non-infringement, an adjudication in favor of one challenge may immediately benefit any other challenger and does not lead to multisource competition. Each case involving non-infringement is decided on the specific facts relating to that challenger's expert and provides no direct benefit to any other challenger. In contrast, a judgment of patent invalidity or enforceability creates an estoppel against any subsequent attempt to enforce the patent against any party. The drafters of the 180-day exclusivity provision failed to consider this important distinction.

As one of the drafters of the 1984 law, I must embrace a measure of responsibility for this problem. It is not clear, however, that S. 1225 has addressed this issue in a satisfactory fashion. The language adopted in the Gregg-Schumer amendment does not appear to solve the problem created by the 1998 Mova decision that effectively eliminated the successful defense requirement.

Frankly, I think we need further thought on how best to address the implications of the distinction between invalidity and non-infringement claims in the Hatch-Waxman context of non-infringement challenges and 180-day exclusivity awards. Specifically, I question the propriateness of continuing to group together patent invalidity and patent non-infringement challenges, particularly in light of the fact that the latter may in practice extend longer than the purported 180-day award. From what I know now, there are strong arguments to prefer the reinstatement of the successful defense requirement.

Let me close by once again commending Senators Gregg, Schumer, McCain, and Kennedy for all their hard work in reaching the compromise amendment that was so overwhelmingly adopted by the Senate. The Gregg-Schumer amendment represents significant improvement over the legislation passed by the Senate last year. I am pleased that the amendment adopts the stand-alone 30-month stay policy that I, and the FTC, advocated last year.

I am also pleased that the Senate has adopted Senator Leahy's Drug Competition Act, which also addressed a major recommendation of the FTC. I have worked with Senator Leahy to perfect and pass this measure.

As a co-author of the 1984 Drug Price Competition and Patent Term Restoration Act, I support efforts to bring affordable and innovative drugs to America. While I support the spirit and much of the letter of the Gregg-Schumer amendment, for the reasons I have set forth, I was unable to fully support this measure at this time.

Mr. BUNNING. Mr. President, during consideration of S. 1, an amendment was introduced by Senators Santorum and Schumer dealing with payments to the Medicare+Choice program. This amendment paid for the program by adding payments to the M+C plans over the next 2 years, to make sure they are still viable when the Medicare Advantage program takes effect in 2006.

I regret to inform you that this amendment was withdrawn because of the lack of funding in the Senate bill, but it is still an important issue I would like to lend my support to.

The Medicare+Choice program already provides a good prescription drug benefit to many seniors across the county, and gives these seniors another option to the Medicare fee-for-service program.

Unfortunately, many Medicare+Choice plans are pulling out of the program because their reimbursement levels are too low. This is leaving many seniors scrambling for a new Medicare+Choice plan or having to go back into fee-for-service Medicare which doesn't offer them the same type of benefit and M+C plan.

In fact, it seems like every year, more and more Medicare+Choice plans leave the market.

I am concerned if we do not provide these plans with enough funding over the next 2 years while the MedicareAdvantage program is being implemented, these M+C plans will continue to leave the program and more seniors will be left in the lurch.

This isn't fair to our seniors. I had hoped we could provide some additional funding for the Medicare+Choice plans over the next 2 years so the plans currently in the program will remain and we might actually attract new plans to other areas that have not been served.

In Kentucky, we have a limited number of Medicare+Choice plans. In fact, only seniors in certain counties in Northern Kentucky and around Louisville have access to these plans. With higher payments to Medicare+Choice plans, we might actually get some more plans to come into our state and cover more counties.

We shouldn't give up on the Medicare+Choice plans, or the seniors who depend on them. I urge this committee to resolve the issue we can resolve during the conference with the House, and I commend Senators Santorum and Schumer for bringing this issue before the Senate.

Mr. LEAHY. Mr. President, I am pleased that late last night the Senate again supported lowering drug prices and maintaining a fair generic drug approval process by adding the Drug Competition Act of the Prescription Drug and Medicare Improvement Act of 2003, S. 249, to the Senate by unanimous consent. On Monday, Senator Grassley and I, along with Senators Cantwell, Durbin, Feingold, Kohl, and Schumer, offered our bill as an amendment to the larger Medicare bill. I hope that in this Congress it is actually enacted into law as part of the larger effort to improve the health care of millions of Americans. Prescription drug prices are rapidly increasing, and this new measure will help slow down the costs concern to many Americans, especially senior citizens and families. Generic drug prices can be as much as 80 percent lower than the comparable brand-name drugs.

While the Drug Competition Act is small in terms of length, it is large in terms of impact. It will ensure that law enforcement agencies can take quick and decisive action against companies that are driving up prescription drug prices. This is practice that hurts American families, particularly senior citizens, by denying them access to low-cost generic drugs, and further inflating medical costs.

Last July, the Federal Trade Commission released a comprehensive report on barriers to the entry of generic drugs into the pharmaceutical marketplace. The FTC had two recommendations to improve the current situation and to close the loopholes in the law that allow drug manufacturers to manipulate the timing of generics' introduction to the market. One of those recommendations was simply to enact our bill, as the most effective solution to the problem of "sweetheart" deals between brand name and generic drug manufacturers that keep generic drugs off the market, thus depriving consumers of the benefits of quality drugs at lower prices. Indeed, at a hearing just yesterday in the Judiciary Committee, Chairman Timothy Muris of the FTC praised the Drug Competition Act in his testimony and urged its passage. In short, this bill enjoys the unqualified endorsement of the current FTC, which follows on the support by the Clinton administration's FTC during the initial stages of our formulation of this bill. We can all have every confidence in the commonsense approach that our bill takes to ensuring that our law enforcement agencies have the information they need to take quick and decisive action if necessary to protect consumers from drug companies that abuse the law.

Under current law, the first generic manufacturer that gets permission to sell a generic drug before the patent on the brand-name drug expires, enjoys protection from competition for 180 days—a head start on other generic companies. That was a good idea, but the unfortunate loophole exploited by a few is that secret deals can be made that allow the manufacturer of the generic to have a 180-day period to block other generic drugs from entering the market, while at the same time, getting paid by the brand-
name manufacturer not to sell the generic drug.

Our legislation closes this loophole for those who want to cheat the public but keeps the system the same for companies engaged in true competition. It is important that Congress not to overreact and throw out the good with the bad. Most generic companies want to take advantage of this 180-day provision and deliver quality generic drugs at much lower cost for consumers. We should not eliminate the incentive. Instead, we should let the FTC and Justice look at every deal that could lead to abuse, so that only the deals that are consistent with the intent of that law will be allowed to stand. The Drug Competition Act accomplishes precisely that goal, and helps ensure effective and timely access to generic pharmaceuticals that can lower the cost of prescription drugs for seniors, for families, and for all of us.

The effects of this amendment will only benefit the effort to bring quality health care at lower costs to more of our citizens. The Drug Competition Act enjoyed the unqualified support of the Senate last year, and I am pleased that my colleagues have recognized that it fits well within the framework of the Prescription Drug and Medicare Improvement Act of 2003. It is a good complement to the larger bill and does nothing to disrupt the bill's balance. I sincerely hope that this common-sense legislation is a part of any final agreement with the House on the larger Medicare prescription drug bill.

(At the request of Mr. Daschle, the following statement was ordered to be printed in the RECORD.)

Mr. KERRY. Mr. President, I wish to express my enthusiastic support for the amendment Senators SCHUMER and SANTORUM offered to increase funding for the Medicare+Choice Program in 2004 and 2005. This amendment addresses a critically important issue that has far-reaching implications affecting the health care benefits of millions of low-income and minority seniors. I am pleased to be a cosponsor of this amendment to ensure that this urgently needed funding increase is included in the Medicare bill.

I believe we must take bold action to address the fact that Congress has not provided adequate funding for the health care benefits that senior citizens who select HMOs and other private sector health plans. In many parts of Massachusetts, and in other parts of the country, funding for Medicare+Choice plans has been limited to annual increases of only 2 percent in most years since 1998. These increase are inadequate at a time when health care costs are rising by 8 to 10 percent annually. This level of inadequate funding is unfair to the 170,000 Medicare beneficiaries in Massachusetts who have select Medicare+Choice plans. It makes it impossible for a strong supporter of the wonderful health plans we have in Massachusetts—Harvard, Tufts, Blue Cross/Blue Shield, and Fallon Community Health Plan. We must step up to the plate to help these plans—nonprofit plans in my State—in their time of need.

The Schumer-Santorum-Kerry amendment takes important steps to address the problem of providing funding now to stabilize existing private health plan options for Medicare beneficiaries, we can help ensure that the proposed Medicare Advantage Program will be successful in the future. Our amendment lays the groundwork for success by trying to provide beneficiaries with high-quality health care choices.

As the Senate continues to debate changes in Medicare, it is important for us to remember that, for more than 4.5 million Medicare beneficiaries across America, Medicare+Choice is an essential program that provides high-quality, comprehensive, affordable coverage that is not always available, or affordable under the Medicare fee-for-service program. The seniors and disabled Americans have voluntarily chosen to receive their health coverage through Medicare HMOs and other private sector plans because they recognize the value they offer.

Seniors in Delaware and across the country, funding for Medicare+Choice plans.

These additional benefits are valued by all seniors, but they are particularly important to low-income seniors who cannot afford other Medicare supplementary plans that might provide them such benefits but at a greater cost.

As the Medicare debate moves forward, it is important for Congress to remember that Medicare+Choice serves as a vital safety net for many of our Nation's most vulnerable seniors. For millions of beneficiaries who cannot afford to purchase a Medigap policy, Medicare+Choice is their only hope for obtaining comprehensive health coverage.

The Schumer-Santorum-Kerry amendment focuses on protecting this important option for seniors who have nowhere else to turn for quality health care they need. I urge my colleagues to support the additional funding that is urgently needed to strengthen the Medicare+Choice Program for seniors. This should be among our highest priorities in this year's Medicare debate.

Mr. CARPER. Mr. President, when I ran for the U.S. Senate, I promised Delawareans that I would work in a bipartisan fashion to provide a Medicare prescription drug benefit for our Nation's seniors. I pledged that I would seek consensus around what is right with competing Republican and Democratic plans. Along with my Democratic colleagues, I would support voluntary coverage that is available and affordable for all seniors. Along with my Republican colleagues, I would support choice and competition to constrain costs. And to the extent we found ourselves constrained by limited resources, I would ensure the greatest assistance to those with the greatest needs.

The bill before us today achieves some of that vision. It is bipartisan. It will provide seniors a bondable to all and to all beneficiaries a voluntary benefit. It will harness market forces to strengthen the integrity of the Medicare Program for the future. And it will provide comprehensive health security to our most vulnerable, low-income seniors.

Still, the bill we have before us today is not everything I would have hoped for. The overriding priority of the current majority here in Congress has been to make dramatic reductions in Federal revenue without corresponding reductions in Federal spending. As a result, there is insufficient money in the budget under which we are currently operating to provide the kind of comprehensive coverage that all seniors—not just low-income seniors—deserve. This is an unfortunate choice of priorities. I think, but it is the choice that this President and this Congress have made.

Unfortunately, the consequences of the majority's misguided priorities are reflected in this legislation. As the Senate continues to debate changes in Medicare, it is important for Congress to narrow the coverage gap by not allowing employer contributions to count towards the calculation of seniors' out-of-pocket
spending in the gap. To see how this works, we need to understand how the coverage gap works. Once seniors reach $4,500 in total drug costs, they fall into the coverage gap. They then have to spend a certain amount of their own money—$5,000, as I believe the Finance Committee it is $1,300—before their coverage resumes, or they get out of the coverage gap.

The effect of not allowing seniors to count the cost paid by their retiree health plans toward this out-of-pocket requirement is to ensure that seniors will remain in the gap longer and fewer will get out of it. This allows the level of spending at which the gap ends to be set at a lower level than would otherwise be possible for the same budgetary cost. The problem with this, however, is that it also provides an unintended incentive for employers to drop or scale back their retiree drug coverage.

The majority has made clear, however, that they could to solve problems and get solutions, I pledge to today to continue to work to build on these results. I continue to believe that we should provide our seniors with quality coverage without gaps or gaps. I will work to ensure that filling the gap of coverage that exists in the present bill is given greater priority in future budgets than it was in this year’s Republican budget. I also believe that it is a mistake to shun rather than welcome employer efforts to wrap around the new Medicare benefit, and I will work to rectify the mistake as we move toward implementation of this program over the next few years.

Mr. President, it is often said that politics is the art of the possible. The bounds of the possible are a bit narrower now than they need, thank you to our Republican friends. But, as the ranking member of the Senate Committee has said, this may be the best bill that could be written under the constraints of the Republican budget. For that reason, I support this compromise as an important, if limited, first step toward addressing what clearly is a pressing priority, not just for our elderly population, but for our Nation as a whole.

Mr. JEFFORDS. Mr. President, as we debate the Prescription Drug and Medicare Improvement Act, I would like to take a few minutes today to speak in support of the overall bill, but I would also like to highlight several provisions in the bill that are of particular importance to me and my State of Vermont.

Over the last several days, we have focused much of our discussion on the aspects of this bill related to prescription drugs and the Medicare Advantage Program. These are clearly among the most important items in this bill and these issues warrant the attention and debate they are receiving. I especially appreciate the close relationship this bill has to last year’s bipartisan effort—which effectively is the parent of the current bill. Last year, my friends—Senators GRASSLEY, SNOWE, HATCH, and BREAUX—and I set out to design a bill that provided a prescription drug benefit along with other improvements, what we called “enhancements,” to the basic operations of the Medicare Program. That legislation was good legislation—something all of its original cosponsors were very proud to work on together.

This year, I am pleased to say that the Grassley-Baucus bill is even better than our effort from last year, and I commend Chairman GRASSLEY and Ranking Member BAUCUS for their leadership and initiative in bringing it to the Senate floor.

One of the most important reasons that the Prescription Drug and Medicare Improvement Act is stronger than the tripartisan plan from last year is because it includes that begin to resolve longstanding inequities in payments to rural doctors, hospitals, and other providers. This problem can be stated simply. Rural health care providers are paid less than providers in more densely populated areas for the same exact services. Earlier this year, I joined with my colleagues, Senators HATCH, GRASSLEY, LINCOLN, and BINGAMAN, in introducing the legislation that addressed geographic inequities in the Medicare’s services by changes to the physician reimbursement formulas.

As many of our colleagues are aware, Senator GRASSLEY fought to include rural provisions to the Prescription Drug and Medicare Improvement Act. I want to thank Chairman GRASSLEY and Senator BAUCUS, among others—for their work. I urge my colleagues to support this compromise as an important, if limited, first step toward addressing what clearly is a pressing priority, not just for our elderly population, but for our Nation as a whole.

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Grassley and Ranking Member Baucus for including this provision in this bill.

I became concerned about the issue of health care quality after reading the work of Dr. Jack Wennberg of Dartmouth. He showed that higher levels of Medicare spending do not lead to better health outcomes. Let me repeat this finding. Higher levels of medical spending do not lead to better health outcomes. Instead, spending tends to vary by region—generally reflecting the availability of physicians and hospitals—rather than the health or needs of the population.

I have followed Dr. Wennberg's work for a very long time. One of his early studies looked at rates of surgical procedures at Vermont hospitals. He found that communities in Vermont that had many more medical procedures were not necessarily healthier. I saw how this result led Vermont health care providers to join with the business community to improving high quality and supportive outcomes. I also saw how our State government used this effort to improve health care across our State. Today, I am happy to say that Vermonters enjoy some of the highest quality health care in the United States, at a cost that is among the lowest in the country.

As we prepare to vote for the bill before us, I think it is critically important for us to consider some of the lessons learned from Vermont. Some of my colleagues have expressed concern about the costs of the bill before us. Others have expressed concern that the bill does not go far enough. The quality demonstration program in this bill will give us some of the answers we need to these funding questions.

The need for these demonstrations is critical. RAND Health published a study today in the New England Journal of Medicine that describes the problems with overuse and underuse of needed medical care services in the United States. The RAND study will make it clear that every American is at risk—not only for failing to receive needed medical care, but also for receiving care that is not needed and may even be harmful. This is a problem that belongs to each and every one of us, and we must find ways to fix it.

The legislation before us closes a significant gap in the health benefit package available to our Nation's seniors. However, providing coverage for health care services is not enough. We must do a better job of ensuring that people are getting the care they need, and also that they need the care they get.

In closing, I would like to urge my colleagues from both sides of the aisle to support this bill as we move forward. This bill will establish a drug benefit that is universal, comprehensive, affordable, and sustainable. This bill restores necessary and long-needed funding for Medicare providers in rural areas. And, the bill will improve the quality of care offered under Medicare.

Mr. DORGAN. Mr. President, over the last 2 weeks the Senate has debated the most significant changes to the Medicare Program since it was created in 1965. Today, we passed this legislation by a vote of 76 to 21, and I would like to take a few minutes to explain why I supported it.

This bill will, for the first time, provide the option of modest prescription drug coverage for nearly 30 million Medicare beneficiaries, including about 100,000 beneficiaries in North Dakota. It is also intended to give Medicare beneficiaries more choices of health plans. And it takes significant steps towards equalizing the Medicare payments that rural health care providers receive, compared to their urban counterparts.

There is no question that, if Medicare were being created today, it would include prescription drug coverage. Prescription medicines are a vital part of modern medicine. Last year alone, pharmaceutical companies introduced 26 new prescription medicines into the marketplace. But these advancements in medicine mean little if Americans cannot afford to access them. That is especially true for senior citizens who have reached their declining income years.

For years now, Congress has been debating proposals to add a prescription drug benefit to Medicare. Unfortunately, however, in past years we have not been able to reach agreement on just how to do this. With each passing year, older Americans continue to struggle to pay for their medicine. In North Dakota, about 48,000 Medicare beneficiaries have no prescription drug coverage, and many more have limited drug coverage. I hear from North Dakota seniors regularly who tell me that they have to choose between taking the medicines their doctor prescribed for them and other necessities such as food and shelter.

These older North Dakotans say that they want and need Medicare drug coverage, and they want and need it now. If Congress doesn't enact legislation this year, chances are that several more years will go by before there is another serious opportunity to consider this issue. In other words, we could pass the legislation before the Senate today or we could do nothing for yet another year. In my judgment, doing nothing is not an option.

The prescription drug benefit in this bill is not as helpful to seniors as I would like or as generous as I think Medicare beneficiaries deserve—but it is a start.

Frankly, I think our budget priorities have been wrong. If I had my way, Congress would have reduced the size of the tax cuts for the very wealthy and instead set aside more money for improving and modernizing Medicare. During the Senate's debate earlier this year on the budget, I offered an amendment to set aside a total of $620 billion over the next 10 years for a Medicare prescription drug benefit. This is the amount of funding I felt was needed to provide a more generous and reliable benefit. Unfortunately, the majority in the Senate rejected my amendment, so we are limited to a package of just $400 billion over 10 years. When you consider that Medicare beneficiaries are now at risk—not only for failing to spend prescription drugs over the next 10 years, it is impossible to develop a robust benefit within the $400 billion budget constraint, in my judgment.

The benefit provided for in this legislation is better than that which President Bush proposed in several key respects. Most importantly, this bill will not force seniors to leave the traditional Medicare Program—and the doctors they depend on—in order to get the prescription drug coverage they also need. I could not support a bill that coerces seniors out of the traditional Medicare Program that virtually all of North Dakota's Medicare beneficiaries rely on.

In addition, this bill provides extra assistance above the basic drug benefit for those older or disabled beneficiaries who have low incomes or very high drug expenses. Medicare beneficiaries with incomes below about $14,400 for individuals and $19,400 for couples—about 40 percent of North Dakota's beneficiaries—would qualify for extra assistance. And those with the highest drug costs—totaling more than about $5,800—would qualify for the catastrophic drug coverage. About 7 percent of North Dakota Medicare beneficiaries would qualify for this threshold.

Despite these improvements over the President's proposal, there are other concerns that I worked to address during the Senate's debate. In some instances, we were able to make changes to address these concerns, and in other cases, those efforts were rejected. In those instances where concerns still exist, I intend to continue working to fix them in conference with the House of Representatives.

For instance, as I have already mentioned, I am concerned that this coverage is not as generous as it should be, and in fact, there are some holes in the coverage. Under this benefit, seniors will have to reach a $275 deductible before their Medicare drug coverage starts. In addition, seniors whose drug expenses reach $4,500 will have to pay 100 percent of their drug costs between $1,501 and $5,800. Then, when their drug spending reaches $5,800, the catastrophic drug coverage will kick in and Medicare will pay 90 percent of their drug expenses after that. This means that there could be periods—in some cases as much as 3 months—when Medicare beneficiaries will have paid a premium for drug coverage but will be getting no benefit.

That makes no sense to me. No other insurance plans that I am aware of in the country that are supported various amendments on the Senate floor to close these coverage gaps or at least ensure that seniors
don’t have to pay premiums for the periods when they aren’t receiving coverage. Regrettably, however, those efforts were rejected.

I am also concerned that rural Medicare beneficiaries may not receive a benefit that is as stable or as generous as other beneficiaries receive. This bill envisions that seniors will basically have two options for receiving drug coverage. First, this bill creates a new Medicare Advantage Program through which beneficiaries could choose to get their drug coverage, as well as the rest of their medical care, through an HMO or a PPO. Frankly, however, I am very skeptical that HMOs or PPOs will want to serve rural areas, and even if they do, I don’t think most North Dakota beneficiaries will want to leave the traditional Medicare Program.

Those seniors who want to remain in the traditional Medicare Program will be able to do so and get their prescription drug coverage through private “drug-only” Medicare Advantage plans. Budget experts estimate that Medicare beneficiaries who sign up for these drug-only plans will pay an average monthly premium of about $35. However, this is only an estimate, and the actual premium they may pay could vary substantially from area to area. That is already the case in the current Medicare HMO program—for instance, a Medicare HMO with drug coverage currently charges $99 per month in Connecticut and only $26 in Florida. I am worried that it would be rural seniors who would pay the highest premiums, even though they paid the same Medicare payroll taxes as other beneficiaries.

To address this concern, I supported an amendment by Senator Daschle that would have limited the variation in premiums to only 10 percent above the national average, no matter where beneficiaries live. In other words, insurance costs could charge beneficiaries a lower premium but they couldn’t charge them more than 10 percent above the national average. Unfortunately, however, Senator Daschle’s amendment was rejected.

In areas where there are not at least two private drug-only plans offered to Medicare beneficiaries in any given year, Medicare would step in and ensure that there is a “fallback” plan available. This is a vital guarantee for beneficiaries in rural States like North Dakota where I believe it is unlikely that there will be two stable drug-only plans available. But even with this fallback plan, seniors could still be bounced back and forth between different plans, depending on how private plans move in and out of an area.

I supported an amendment that would have addressed this concern by allowing all Medicare beneficiaries to choose the fallback option, no matter how many private plans are available where they live. When that amendment failed, I cosponsored an amendment with Senator Conrad that would at least allow seniors who have the fallback option to remain in that plan for 2 years, not just 1 year. That amendment was also rejected.

Even though this bill doesn’t require Medicare beneficiaries to leave traditional Medicare, I know there are some concerns among Medicare beneficiaries who will be getting their drug coverage through private plans. I, too, would strongly have preferred that all seniors be able to choose from a Medicare-administered benefit.

However, let me say this if I felt that by structuring the drug coverage the way it is in this bill, we were undermining the entire underlying Medicare Program, I would not support it. Medicare has been a wonderful success, and in our efforts to modernize it, we should exercise extreme caution not to undermine it. However, virtually all of the major Medicare prescription drug proposals would have used a private entity in some way to provide the drug benefit. Indeed, the traditional Medicare Program for the bulk of its medical care has been a wonderful success, and it would make little sense to cut off Medicare beneficiaries in any given year, Medicare would step in and extend the Medicare Advantage option, so it seems clear that the vast majority of seniors will continue to rely on the traditional Medicare Program for the bulk of their medical care.

One area where we had some success in improving the bill during the Senate’s debate is in the area of reducing drug costs. This bill relies largely on private insurance companies to negotiate lower drug prices. However, we have seen from prior experience that insurance companies have not been able to keep drug spending from increasing by nearly double digits every year. Yet, in 2001, 18.8 percent in 2000, and 16 percent in 1999.

To help put downward pressure on drug prices, I offered an amendment that was passed by the Senate by a 62-to-28 vote to allow for the reimportation of lower-priced, FDA-approved medicines from Canada. As many North Dakotans know first hand, the same FDA-approved prescription drug that costs $1 in the United States costs only 62 cents in Canada, even though it is the exact same drug, in the same bottle, made by the same manufacturer.

It is not my intention with this amendment to require Americans to go to Canada in order to get lower drug prices. Rather, by allowing U.S. licensed pharmacists and drug distributors to do the importing for them, Americans can stay at home, and by breaking the monopoly that the drug companies currently have on drug pricing in this country, we will force a re-pricing of drugs here in the United States.

I also supported an amendment that will help to make more affordable generic drugs more readily available. Generic drugs are safe, effective, and lower priced alternatives to heavily advertised brand-name prescription drugs. Unfortunately, however, some of the big brand-name drug companies use loopholes in the patent laws to keep generic drugs off the market for longer than intended. The bill, which passed the Senate by a 94-to-1 vote, will close these loopholes and thereby speed consumers’ access to generic medicines.

I am also pleased that this bill improves Medicare’s coverage of preventive services, especially by including a provision that I authored to provide for a cholesterol screening benefit for Medicare beneficiaries. I have felt for a long time that Medicare needs to do a better job of preventing disease, rather than just paying to treat it. In the case of cholesterol screening in particular, high cholesterol is one of the major, high cholesterol is one of the major, changeable risk factors for heart attacks, stroke and other cardiovascular diseases. Yet when Americans turn 65 and enter the Medicare Program, their coverage for cholesterol screening stops unless they already have cardiovascular disease. That makes no sense, and I am glad the Senate has taken steps to provide this coverage.

Finally, I am very happy that this bill includes a range of provisions that will make Medicare reimbursement more fair and equitable for our rural hospitals, physicians, and other health care providers. It is right that Medicare has historically reimbursed urban health care providers at a much higher rate than their urban counterparts. This inequity in Medicare reimbursement has very real consequences for hospitals and clinics in rural States like ours. They have to reduce services, have greater difficulty recruiting staff, are less able to make capital improvements, struggle to give their patients access to the latest innovations in medical care, and in some instances, they even have to close.

I have been fighting for a long time to correct this inequity. In fact, some of the provisions in this bill are similar to legislation that I introduced in the Senate earlier this year, and I am glad they have been included in this bill.

I know there will be some who feel that this bill should have been rejected by the Senate because it relies too heavily on private plans and others believe that it does not put enough emphasis on enrolling seniors in private plans. Others will feel that the Medicare benefit is not generous enough, and some feel its coverage is too liberal. I agree that this legislation isn’t perfect—far from it, in fact. In the coming months and years, I will continue working to improve it. But it is a start in the right direction, and that is why I have supported it.

The House of Representatives is also expected to pass a version of the Medicare Modernization this week. The House and the Senate will now need to have a conference committee to work out the differences between the two bills. I
have some serious concerns about the House-passed bill. I hope these concerns and the concerns that I have with the Senate bill can be resolved in the final bill, so that we can send a bill to the President for his signature this year.

Mr. SARBANES. Mr. President, I rise today to speak on S. 1, the Prescription Drug and Medicare Improvement Act of 2003. I applaud my colleagues in working toward enactment of legislation to provide prescription drug coverage under Medicare. However, I am deeply concerned that the bill before us today would not ensure an affordable, guaranteed benefit that would cover seniors’ outpatient prescription drug expenses.

Under this legislation, the Secretary of the Department of Health and Human Services would temporarily issue prescription drug discount cards for seniors until the drug benefit begins in 2006. At that time, all Medicare beneficiaries would receive a standard prescription drug benefit whether they remained in traditional fee-for-service or in a private plan. For a $275 deductible and an estimated $35 per month, 50 percent of a beneficiary’s drug costs would be covered up to $4,500. A beneficiary would receive no coverage for drug costs between $4,501 and $5,800, though they are still responsible for paying the monthly premium during this coverage gap. Furthermore, any assistance by employer-sponsored plans or third parties on behalf of the beneficiary does not count toward the out-of-pocket costs. After drug expenses reach $5,801, the plan would cover 90% of drug expenses.

The bill creates a new Medicare Advantage program, which would replace Medicare+Choice, and create a new agency, the Center for Medicare Choices, CMC, with authority parallel to the existing Centers for Medicare and Medicaid Services. The CMC would administer the Medicare Advantage program and the prescription drug plans. The drug plans would be administered through private plans, but when no private plans exist, the government would provide a fallback plan for seniors in fee-for-service. However, if a new private plan decides to enter an area, beneficiaries would again be forced to receive their coverage through that plan.

It is no surprise that it is terribly confusing, it is. One hundred Senators and their staffs found it difficult to work through this bill and understand exactly how the benefit would work. Seniors who don’t sign up as soon as they are eligible are subject to a penalty similar to the penalty imposed on those who delay enrollment in Part B. It is unfair to expect seniors and their families to work through this web to make an informed decision.

The complexity of this drug plan is only one of numerous flaws with this bill. S. 1 does not provide a national fixed premium. The bill sets out an estimate of a $35 monthly premium, but there is no guarantee for seniors that they will not have to pay much more than that estimate.

The bill has the serious potential to cause a number of retirees to lose existing employer-sponsored prescription coverage. It is estimated that as many as 37 percent of Medicare beneficiaries would lose existing coverage. This is an unacceptable consequence of legislation that is supposed to make life easier for seniors. This serious deficiency is the number one concern of constituents who have called into my office about this bill.

The bill before us leaves a large gap in coverage and forces seniors to continue premium coverage during that gap period. Seniors may have to face months without any assistance, waiting to reach the limit where catastrophic coverage begins. The seniors who fall into this coverage gap are among the most ill, with severe chronic conditions and prescription needs. It is dishonest and immoral that this legislation would cease coverage for prescription drugs for seniors at the very time when it is needed most.

Finally, because this proposal relies on private plans to deliver the drug benefit, it would be too shift from plan-to-plan, year-to-year as they did when Medicare+Choice HMOs pulled out of the Medicare program a few years ago. In my own State of Maryland, insurance companies left the Medicare market, abandoning more than 100,000 seniors.

This legislation makes our Nation’s seniors the subject of an experiment to which none of us should be willing to subject our parents and grandparents. We don’t know what the benefit is under this bill. We don’t know how much it will cost. We don’t know how private plans will participate and make a profit. We don’t know how many seniors would lose existing coverage. What we do know is that we have prepared to spend approximately $400 billion over 10 years to create an inadequate drug benefit, a new bureaucracy, and subsidies for private insurance companies.

With modest additional resources, we could have closed the coverage gaps in this bill. Amendments offered by my colleagues to provide stability for seniors, move up the start data of the drug benefit, eliminate beneficiary premiums during the coverage gap period, and improve the quality of shortcomings have been defeated. We have lost so many opportunities to make this bill something all Medicare beneficiaries can support. I am hopeful that in the future we can improve upon this and create a system that is easier for seniors to understand, more affordable, and more reliable than what is offered today.

I want to highlight one amendment that would have provided Medicare beneficiaries with a substantial, reliable and straightforward prescription drug benefit. I cosponsored and voted for this amendment offered by my colleague from Illinois, Senator DURBIN. His alternative would have provided a Medicare-delivered drug benefit that allows the Secretary of HHS to employ negotiating strategies used by the VA and other government entities to bring down drug prices. Under Senator DURBIN’s amendment, seniors would de-deductible, pay only 30 percent of costs until reaching the catastrophic limit, and face no coverage gap. In addition, employer contributions would count toward out-of-pocket limits so there would be much less risk of employers dropping retiree coverage. This was the proposal we should be working from today, but unfortunately the Durbin alternative was defeated by a vote of 56 to 43.

Those opposed to providing a richer benefit argue we don’t have the money. The selective amnesia of these so-called fiscal conservatives is baffling. Not too long ago, this body passed a tax cut that primarily benefited the wealthiest Americans. Where was their sense of fiscal responsibility then? As my colleagues Senators DURBIN and HARKIN noted yesterday, this is about priorities. I’m sure others have raised the very good point that we can risk greater budget deficits to give huge tax cuts to Americans who are already prospering, but we cannot provide the necessary resources for millions of Medicare beneficiaries to get an affordable, reliable drug benefit that they can understand?

I have long been a strong supporter of providing older Americans and disabled individuals who rely on Medicare an affordable, comprehensive, reliable and voluntary prescription drug benefit. However, I want to ensure we do so in a way that does not worsen the situation in which many seniors find themselves as they face rapidly rising drug costs. As we consider proposals to expand our Nation’s entitlement programs, it is appropriate to follow a guiding principle in the practice of medicine — do no harm. Our seniors deserve a drug benefit that is a real improvement, not a complex experiment that may cause more harm than it’s worth. We must not enact a law intended to help that might eventually harm millions. The American people deserve better.

Mrs. BOXER. Mr. President, for over 35 years, Medicare has been a savior for our seniors citizens. It has helped pay their doctor bills, their hospital bills, and their home health bills.

But it has not paid for their prescription drug bills, and millions of seniors across the country have been waiting a long time for the day when prescription drug coverage is offered through Medicare. That day is getting closer.

Our seniors are dropping coverage. And the Senate will soon pass — a Medicare prescription drug benefit.

Let me tell you why this is important. In California, four million people are enrolled in Medicare. Every day, far too many of them are forced into the difficult choice of paying for their prescriptions or putting food on the table.
I want to tell you a few of their stories. I recently heard from a California woman who told me she struggles to survive on $950 a month income. She cannot, she says, afford all of her prescription drugs. She is, unfortunately, all too typical.

A constituent from San Marcos, CA told me that her annual costs for prescription drugs this year will top $10,000.

Another constituent from Indio, CA told me that she has made five trips to Mexico over the last several years to purchase her prescriptions. She drives all day long to Mexico in order to purchase affordable heart medication. She wanted me to remind my colleagues that “thousands of seniors are forced to do this.”

A retired physician from Marina Del Rey told me that a pill he takes for his heart disease has gone up 600 percent from $15 per month to $95.

The story of all of our seniors—need and deserve to have Medicare help pay for their prescription drugs. We need to end this situation where seniors are cutting their pills in half or forgoing their medications altogether or skipping meals in order to pay for their prescription drugs. That is unacceptable.

Today, we are making a prescription drug benefit a part of Medicare. And that is why I am supporting this bill—because, at long last, it puts a Medicare prescription drug benefit on the books.

But, this bill is wanting. It has problems. And I have voted for amendment after amendment to fix those problems. I offered an amendment to close the benefit shutdown. Under this bill, even when seniors have paid and continue to pay premiums, Medicare stops covering prescription drugs, forcing seniors to pay the entire cost. When that failed, I offered an amendment to ensure that seniors with cancer would never have their benefit stopped.

I supported an amendment by Senator DASCHLE to limit the disparities in premiums so that seniors in different parts of the country are not paying different premiums for the same benefit.

These amendments would have made the Medicare drug benefit a better drug benefit for seniors. Unfortunately, none of them passed.

But we should not—and I will not—stop trying to make it the best benefit it can be.

The good news is that Medicare will soon, for the first time ever, cover prescription drugs. The better news will be when we fix the problems with this bill and improve the coverage for our seniors. I look forward to the day when enough of my colleagues will join me in that effort.

Finally, let me say that I hope the conference report on this bill—the final version of this bill before it goes to the President—does not come back to the Senate in a way that would provide even less help to seniors or in a way that would undermine the entire Medicare program.

Mr. MIKULSKI. Mr. President, senior citizens are facing a crisis—a crisis in affording health care and a crisis in affording prescription drugs.

I have been in communities all over Maryland. Listening to seniors who are desperate. Listening to their families in the diners—who want to help their parents, yet face stresses of their own. Listening to the employers in the boardrooms—who want to help their retirees, but can no longer afford to.

Here is what they tell me. They say: We need a prescription drug benefit in Medicare. We need a safety net for seniors and families. Congress must enact a Medicare prescription drug benefit, and must do it soon.

I absolutely agree. It is time Congress made Medicare prescription drug coverage a national priority.

For so many years, Congress has talked about prescription drugs and Medicare. That, you can’t talk yourself out of high cholesterol; you need Lipitor. You can’t talk your way out of diabetes; you need insulin.

The problem with the Senate is—when all gets said and done—more gets said than gets done. Finally—the Congress is acting.

Here are my principles. These principles are the yardstick by which I measure any proposal. The benefit must be for seniors, not for insurance companies. That means the cornerstone must be Medicare. This bill does that. It does not force seniors to give up the Medicare they love to get the drugs they need.

It must be meaningful. It must be accessible. It must be affordable. I am not so sure. I am concerned about the significant deductible—$275 a year and the average premiums—$400 plus.

It also has a coverage gap. Once you spend $4,500 a year—you get no help until you spend $5,800. This will cost too much. That is why I supported the Durbin amendment, which would have provided a better benefit at less cost to seniors.

It must be accessible. It must be available to all seniors, regardless of where they live. This bill does that; it must be meaningful. It must cover the kind of drugs your doctor says you need, not what an insurance executive thinks you should get. This bill does that by creating a medical necessity override. This means your doctor has the final say on which drugs you get, not an insurance company. I feel pretty good about that.

I tried to improve the bill. I voted for amendments to improve the bill. For example: For the Durbin substitute which would have created a stronger, more comprehensive benefit at a lower cost to seniors.

For an amendment to get rid of the coverage gap. This would guarantee that seniors would have continuous coverage for their prescription drug costs.

For an amendment to provide seniors with a guaranteed prescription plan that is under Medicare. This would allow seniors to stay in a prescription drug plan that is operated by Medicare and not have to move in and out of private plans and a Medicare fallback plan that is only available when the private plans leave the market.

For amendments to protect the benefits of retirees who already have drug coverage. These amendments would help employers to continue to be able to offer quality health care to their retirees.

For an amendment to implement the drug benefit next year—instead of waiting until 2006 to start these benefits.

I am sorry all these amendments failed on party line votes.

This legislation is a beginning. It is something we can build on. What it comes down to is will it help the majority of seniors in Maryland? The answer is, yes; it will help over 394,000 people. For people who spend at least $1,110 a year on prescription drugs—it will help. For someone who is facing a catastrophic disease like cancer and has very high drug costs—it will help. So I will vote for this bill. It is not the bill I want. Yet we can’t let the perfect be the enemy of the good. We can’t do nothing—as seniors struggle to pay for the drugs they need.

But let me be very clear, this is as far as I will go. If this bill comes back from conference and it is a benefit for insurance companies more than to my vote. If it increases costs for seniors, say goodbye to my vote. If it cuts benefits, say goodbye to my vote.
So I will vote for this legislation tonight because I don’t want to say goodbye to this opportunity to provide a Medicare prescription drug benefit for seniors.

Mr. HOLLINGS. Mr. President, I rise today in opposition to the Prescription Drug and Medicare Improvement Act of 2003.

The Senate has spent the last 2 weeks debating how to help our Nation’s senior citizens afford their prescription drugs. The Kaiser Family Foundation estimates that average annual out-of-pocket drug spending for Medicare beneficiaries grew from $544 3 years ago to $999 this year and will reach $1,454 by the time this bill takes effect in 2006. As a result, 25 percent of seniors without drug coverage declined to fill a prescription and 27 percent of seniors without drug coverage skipped doses to make their prescriptions last longer. This is unacceptable. These citizens deserve affordable, comprehensive, and reliable drug coverage. Unfortunately, the legislation now before us fails to provide sufficient coverage.

From the outset this proposal will confuse seniors. Enrollees in private plans better not get too comfortable because their plans could be gone in 2 years if the HMOs find them unprofitable just like they have with Medicare+Choice in my state of South Carolina. The same goes for enrollees in fallback plans. They will be kicked out of the system as early as a year if enough private plans enter their area. This volatile system could force seniors to move in between three separate plans, with three separate formularies, in 3 years. This bill should create a sense of stability in the system and reduce the confusion over coverage. That is why I supported first the Stabenow amendment and then the Lincoln-Conrad amendment, which would have extended the availability of fallback plans to ensure that seniors will have access to stable drug coverage.

Senior citizens will need to hire an accountant just to comprehend the benefits available to them under this legislation. Once seniors select their Medicare drug plan, they will have to maneuver a maze of premiums, deductibles and copayments for benefits that contain huge gaps in coverage. On top of their premiums, which will vary region to region and plan to plan, seniors will get no help for the first $275 of their drug costs, pay half of costs from $276 to $4,500, pay all the costs from $4,501 to at least $5,813, and then pay a tenth of costs above $5,828. With a break-even point of $1,115, many healthier Medicare beneficiaries will opt not to participate. With a coverage gap of $1,302, many of the sickest patients will still have to continue paying premiums even though they may have to resort to rationing their care until they can spend their way out of the “doughnut.”

Once again, the Senate defeated a number of amendments that I supported that would have brought much needed simplicity and fairness to the bill including the Boxer amendment, which would have closed the coverage gap for all seniors, and the Daschle amendment, which would have limited the regions that could afford premiums to 110 percent of the national average. Finally, we chose to provide $13 billion in new subsidies to PPOs and HMOs instead of using that money to reduce premiums or fill in the coverage gap for senior citizens. All in all, the bill provides Medicare beneficiaries with a benefit valued at about $1,000 less than the drug coverage available to Federal employees.

This is a plan only Washington could dream up. It should come as no surprise that the authors of this convoluted mess and their friends in the White House have decided to wait until after the 2004 election before allowing Medicare beneficiaries to see what they are in for.

I should also note that this Nation is more than $6.6 trillion in debt. This bill is part of budget resolution and economic plan that will run up an average deficit of $600 billion a year for the next 10 years. Make no mistake about it, we will borrow every red cent to pay for this program. And what do we get in return? Massive subsidies for HMOs, spotty drug coverage for senior citizens, and a lack of attention to the factors driving the rapid increase of health care costs in this country. If we are going to borrow from future generations to pay for this benefit, we should get it right.

Now that we have disposed of all amendments and final passage appears imminent, I have concluded taxpayers and Medicare beneficiaries would be better served if we go back to the drawing board. We should come back with a proposal with affordable premiums and cost sharing requirements with no gaps in coverage that is administered in a manner that gives seniors the same sense of security they receive under the current Medicare system. I have heard many of my colleagues say this is an important first step and it is important that we get something on the books. Nonsense. Thirty months will pass before the first beneficiary receives coverage. That was enough time to draft and ratified the Constitution. It was enough time to complete the Manhattan Project. Thirty months should be more than enough time for us to create a real meaningful prescription drug benefit for our senior citizens.

I hope this body will have the wisdom to vote no and do this right.

Mr. PEINGOLD. Mr. President, I will vote for passage of the Medicare prescription drug bill. But I do so, however, with great reservations about many of the provisions in the bill. I am voting for this measure for two principal reasons.

First, I believe that we owe our seniors a Medicare prescription drug benefit. I believe such a benefit is long overdue for our Nation’s seniors. For years we have promised them we would give them the crucial help they need with their skyrocketing prescription drug costs. And I believe that it is finally time to deliver on that promise.

I am pleased that key provisions of the Gregg-Schumer-McCain-Kennedy amendment, which I was proud to co-sponsor and support, which will bring more competition to the prescription drug market by preventing pharmaceutical companies from blocking generic drugs from entering the market. This amendment is one of the only provisions that will help bring cost savings to seniors.

Second, I believe this measure is an important first step. This legislation will give our seniors a sense of stability and predictability in their health care costs in this country. If we are going to borrow from future generations to pay for this benefit, we should get it right.

This amendment is one of the only provisions that will help bring cost savings to seniors.
By adopting Senator Dorgan's amendment relating to the reimportation of prescription drugs from Canada, the Senate will help seniors obtain affordable prescription drugs. This legislation helps both consumers who buy prescription drugs and businesses which sell them. I supported this provision, both in its earlier legislative form and in this amendment, because it is the right thing to do. Our seniors and other Americans in need of affordable prescription drugs deserve no less.

I also supported Senator Enzi's amendment, which passed overwhelmingly, that will make sure that community pharmacies, like the ones in my home State of Wisconsin, can still operate within this new prescription drug program. Smaller pharmacies will be protected from being shut out by larger pharmacies through this amendment, and that means helping seniors to access the prescription drugs they need in their own communities.

I also worked with Senator Allard on an amendment to provide regulatory relief for home health care providers. This amendment was adopted. The Medicare Program is already full of bureaucratic red tape, often creating barriers for seniors looking for basic information about their health care options. This prescription drug benefit is the biggest expansion of the Medicare Program since its inception in 1965. We are adding an entire new part to the program, and we need to help guide our seniors through it.

My amendment is simple. It establishes a Medicare Beneficiary Advocate Office within the Department of Health and Human Services, with the sole function of providing clear information to beneficiaries. The office will serve as a one-stop information source on all of Medicare for our seniors.

This new office will provide a toll-free phone number, a regularly updated website and regional publications that will give our seniors all of the information they need to make informed health care decisions.

Thus the three new offices. But as I said earlier, I have many reservations about this bill. This is not the bill I would have proposed.

This bill does not go far enough to deliver the prescription drug benefit that seniors need. Instead, it imposes a high deductible on seniors a meaningful prescription drug benefit. It fails to provide any assistance after a senior's prescription drug costs total $3,450, until they spend another $1,850. And it adds insult to injury by making beneficiaries continue to pay a premium even during the time they receive no benefit.

I am also troubled that this bill does not provide clear, uniform benefits and premiums for all seniors. Many aspects of the benefits provided in the bill remain uncertain, and will continue to remain uncertain until the plan goes into effect. Under this bill, the premiums for the Medicare prescription drug plan will be dictated by the private insurers who will offer the plans. The only thing we know for sure is that the Congressional Budget Office estimates that the national average for premiums will be $35. However, those premiums may vary dramatically. Just look at Medicare HMO premiums. Medicare HMO premiums in Connecticut are $99, but in Florida they are only $16.

Who will offer the plans is also uncertain. There is no guarantee that plans will be offered in regions where there may not be enough profit. History again shows us that private companies do not always find rural and smaller urban areas profitable enough to move into.

Furthermore, understanding is that this plan only offers a guaranteed Medicare-administered plan, or "fall-back plan," if there are less than two private plans in a region. This means that, if only one private plan offers a prescription drug benefit in the region that includes Almena, WI, a Medicare beneficiary living in Almena may instead choose the Medicare-administered fall-back plan. While on the fall-back plan, my Almena constituent would become familiar with the medications that are included in their formulary and the cost of their premiums. If a second private plan subsequently decides to move into that region, my understanding is that my constituent will be dropped from the Medicare fall-back plan, and forced to join one of the private plans even if those plans have higher premiums that do not include their prescriptions in their formularies.

Further, my Almena constituent can be forced to leave the plan that he or she has come to know, if that plan leaves the region. This leads to instability and uncertainty for seniors.

Benefits are also uncertain under this proposal. Again, benefit packages will be determined by the private insurers who offer the plans. And we can assume, from experience with the Medicare-Choice Program, that the benefits will vary widely. I am concerned about what this may mean for States like my home State of Wisconsin, States that have had a difficult time attracting and keeping private Medicare plans. If Medicare prescription drug plans may be able to offer more brand name drugs at a lower cost to beneficiaries, while others in less profitable areas may limit the amount of brand name drugs they can offer at all.

I fear that as with Medicare HMOs, Wisconsin seniors may be faced with little choice with Medicare prescription drug plans.

And I am concerned that the uncertainty in this bill regarding monthly premiums, the possible differences in benefits packages and the stability of private plans that will deliver these benefits may lead to more inequity for Wisconsin seniors.

I was disappointed that Senator Durbin's amendment, the MediSave Act, was not adopted in the Senate. Senator Durbin's amendment, which I strongly supported, would have fixed most of the errors that exist in this bill. The MediSave Act would have made this benefit one that would truly help all seniors with all of their prescription drug benefit. Senator Durbin's proposal offered a meaningful, enhanced prescription drug benefit that would have covered all seniors regardless of whether their prescription drug costs are high, low, or somewhere in between.

Finally, I am pleased that an amendment to give seniors a meaningful prescription drug benefit was adopted. Under this bill, the pre

ortion of working with my colleagues over the next 2 years to improve this bill and finally deliver on our promise to give seniors a meaningful prescription drug benefit. Mr. Jeffords. Mr. President, this bill is a landmark piece of legislation. It is a major accomplishment on the path toward enacting a prescription drug benefit for our seniors. It is the result of years of bipartisan, I might even say tripartisan, effort and it puts in place many long-sought changes. It has many significant features for the citizens of my home State of Vermont. It provides a sustainable, universal, and comprehensive prescription drug benefit. It guarantees access to traditional Medicare for all beneficiaries. It allows Medicare beneficiaries to participate, if they choose, in new systems of care that will be based on today's dynamic health care environment. The bill recognizes the high cost of providing quality care in rural settings and closes the reimbursement gap.

Mr. President, this bill is a landmark piece of legislation. It is the most significant modernization of the Medicare Program since its inception in 1965. Its passage by the Senate is a major accomplishment on the path toward enacting a prescription drug benefit for our seniors. It is the result of years of bipartisan, I might even say tripartisan, effort and it puts in place many long-sought changes. It has many significant features for the citizens of my home State of Vermont. It provides a sustainable, universal, and comprehensive prescription drug benefit. It guarantees access to traditional Medicare for all beneficiaries. It allows Medicare beneficiaries to participate, if they choose, in new systems of care that will be based on today's dynamic health care environment. The bill recognizes the high cost of providing quality care in rural settings and closes the reimbursement gap.
gap between rural providers and their urban counterparts. Finally, it contains a provision that will allow us to better understand how to provide quality health care—not care driven by using more and more resources, but instead one based on ensuring quality patient outcomes.

Over the past 2 weeks, I have applauded the work of my colleagues who have labored over this bill. Today, I have the pleasure of congratulating them on their success and thanking them for their efforts. I have worked for more than 3 years with my good friends, Chairman Grassley and Senators Snowe, Breaux, and Hatch. In many meetings over many months, we delved into the details of what came to be called the Tripartisan Bill. This has been one of the finest experiences of my many years in Congress. I am very proud to have been a part of that group and that our efforts led the way to our success today.

I especially want to salute the efforts of Senator Baucus and Senator Kennedy without whose hard work and commitment to working through an agreement we would not have accomplished the possible victory, and they deserve our accolades.

A bill such as this is the result of great effort on the part of many different people who are not elected to this body, but upon whom we all rely. I would like to recognize the staff members who have worked so hard on this bill and deserve much of the credit for its successful passage.

On Senator Grassley’s staff: Ted Tottman, Linda Fishman, Colin Roskey, Mark Hayes, Jennifer Bell, and Leah Kegler, and on Senator Baucus’ staff Jeff Forbes, Liz Fowler, Jon Blum, Pat Bouslaman, Kate Kirschgraber, and Andrea Cohen deserve considerable recognition for their tireless efforts. Gene Pinley, Tom Geter, and Carolyn Holmes from my friend Senator Snowe’s staff; Patricia DeLoatche and Trecia Knight of Senator Hatch’s office; and most especially Senator Breaux’s legislative director Sarah Walters deserve enormous credit for this bill. Finally, we would not be claiming a victory today if it were not for the contributions of Senator Kennedy’s staff, especially, David Nenon and Michael Meyers.

On my staff, I particularly want to recognize the contributions of Paul Harrington during the last Congress, and most especially the work of Sean Donohue who took up that effort on the tripartisan bill and who has continued to see it through to today’s success, with the recent assistance of David Crimmins, our Robert Wood Johnson Health Policy Fellow. Each and all have worked tirelessly to gather the input, analyze the issues, and build a consensus toward achieving this final product.

Mr. LEVIN. Mr. President, I support making a prescription drug benefit available to seniors. Most Members of the Senate do. However, there are honest disagreements about how to get it done and whether the bill before us will strengthen or weaken Medicare.

My principles are simple. The benefit should be voluntary, guaranteed, universal, and permanent, when they are finally enacted.

Perhaps my greatest concern with the bill before us is the effect its passage is likely to have on retirees who currently have prescription drug coverage provided by their former employers. Many retirees currently enjoy good prescription drug coverage from their former employer. However, the Congressional Budget Office has indicated that if we adopt the legislation before us approximately 37 percent of retirees who are currently receiving prescription drug coverage from their former employers will lose that coverage. Specifically, on June 12, the Director of the Congressional Budget Office, CBO, Mr. Douglas Holtz-Eakin, who previously served as chief economist for President Bush’s Council of Economic Advisers, testified at a Finance Committee markup that 37 percent of retirees would be dropped from their former employers’ coverage at that time. That Administrator of HHS’ Center of Medicare and Medicaid Services, CMS, Mr. Tom Scully, stated that for current retirees “who have employer-sponsored insurance, our estimate is consistent with 37 percent having their coverage dropped.”

During the markup, Members on both sides of the aisle made strenuous efforts to strengthen incentives for employers to maintain their prescription drug coverage for their retirees. Also very troubling is what I call the yo-yo effect. To participate in the proposed plan, a senior in any service area where two or more private plans are offered, no matter what the premium, would only have the option of purchasing private insurance. The reason is that only if there are not two private plans available in the so-called Medicare fallback plan available. So let’s assume that there are two plans offered in 2006 in a particular service area and a senior opts in. Assume further that in 2008, one of the two insurance companies pulls out of the service area and the so-called Medicare fallback plan is then available. So the senior opts for the Medicare fallback plan. However, if two private plans become available a later time, the second plan is no longer available to the senior and she would then be required to again enroll in one of the private plans to retain coverage. This yo-yo effect could be repeated forcing seniors to deal again and again with different programs and different benefits and lots of paperwork. This is totally unacceptable. Seniors want stability and continuity in their Medicare Program. They want a program on which they can trust and rely.

In addition, the legislation we are considering has a large gap in the prescription drug coverage. Once a senior’s total drug spending reaches $4,500 for the year, she will have to pay 100 percent of the cost of their prescriptions until her total drug spending reaches $5,800. This has come to be called the donut hole. This coverage gap will leave many seniors to pay the full cost of their prescriptions at a time when they most need assistance. I know of no other insurance program that is so unfairly structured in that way. There is a gaping hole in coverage but no gap in the requirement to pay premiums. That obligation continues even during the period that benefits are halted.

The bill before the Senate also has an unspecified premium that could fluctuate from service area to service area as well as from year to year. Premium amounts are left up to the insurance companies. I believe there should be a cap on those premiums. The effort to adopt one failed.

Adding a prescription drug benefit to Medicare is one of the most important things Congress can do this or any other year. We spend more on prescription drugs than we do on hospital costs. Members of Congress have been working for years to finally pass a Medicare prescription drug benefit for seniors. The only way to assure that the benefit will be available reliably and without complications to our seniors is to make it a guaranteed part of Medicare. The Medicare prescription drug benefit from their former employer are going to lose the benefit because of this legislation, that is real harm.

I hope the major flaws of this bill are somehow corrected in conference so I can vote for a conference report. But I cannot vote for the version before us.

Ms. COLLINS. Mr. President, I was pleased to join my colleagues, Senators Boxer, Coleman, Landrieu, Kohl & Murray in offering to authorize a Medicare demonstration project on pancreatic islet cell transplantation to help advance this tremendously important research that holds the promise of a cure for more than 1 million Americans with Type 1 or juvenile diabetes.

As the founder and cochair of the Senate Diabetes Caucus, I have learned a great deal about this serious disease and the difficulties and heartbreak that it causes for so many Americans and their families as they await a cure. Earlier this week, I had the privilege of chairing a hearing featuring young delegates from the Juvenile Diabetes Research Foundation’s Children’s Congress who had traveled to Washington from every State in the country to tell Congress what it is like to have diabetes, just how serious it is, and how important it is that we find a cure.

Diabetes is a devastating, lifelong condition that affects people of every age, race, and nationality. It is
leading cause of kidney failure, blindness in adults, and amputations not related to injury. Moreover, a study released by the American Diabetes Association earlier this year estimates that diabetes cost the Nation $132 billion last year and that health spending for people with diabetes is 26 percent higher than for people without it—that’s $530 billion over 10 years.

The burden of diabetes is particularly heavy for people with juvenile diabetes. Juvenile diabetes is the second most common chronic disease affecting children. Moreover, it is one that they never outgrow.

In individuals with juvenile diabetes, the body’s immune system attacks the pancreas and destroys the islet cells that produce insulin. While the discovery of insulin was a landmark breakthrough in the treatment of people with diabetes, it is not a cure, and people with juvenile diabetes face the constant threat of developing life-threatening complications as a result of diabetes.

Thankfully, there is good news for people with diabetes. We have seen some tremendous breakthroughs in diabetes research in recent years, and I am convinced that diabetes is a disease that can be cured and will be cured. I am encouraged by the development of the Edmonton Protocol, an experimental treatment developed at the University of Alberta involving the transplantation of insulin-producing pancreatic islet cells, which has been hailed as the most important advance in diabetes research since the discovery of insulin in 1921. Of the 257 patients who have been treated using variations of the Edmonton Protocol, all have seen a reversal of their life-disabling hypoglycemia, and 80 percent have maintained normal glucose levels without insulin shots for more than 1 year. Amazingly, many of the transplant recipients have even reported a reversal of some of their complications, such as improved vision and less pain from neuropathy.

Earlier this year, I joined with my colleague from Wisconsin, Senator Patty Murray, as well as my colleagues in the Senate Diabetes Caucus, Senator John Breaux, in introducing the Pancreatic Islet Cell Transplantation Act of 2003, which will help fund this significant research that holds the promise of a cure for the more than 1 million Americans with juvenile diabetes. The amendment we are introducing today is based on one of the provisions of that bill, which currently has 43 Senate cosponsors.

Diabetes is the most common cause of kidney failure, accounting for 40 percent of new cases, and a significant percentage of individuals with Type 1 diabetes will experience kidney failure and become Medicare-eligible before they reach age 65. Medicare currently covers both kidney transplants and simultaneous pancreas-kidney transplants for these individuals. To help Medicare de-
to make up the Medicare shortfall. The bill before us changes many of Medicare’s payment systems, especially for rural areas, and a long way toward making Medicare fair for seniors and providers, no matter where they live. I am also pleased that the bill includes a provision to make generic drugs more available to all Americans. It will close loopholes in our current law that keep generics off the market and keep drug prices too high for too long. The CBO estimates that this provision will save Americans $60 billion over 10 years.

I hope, but don’t expect, that these two important provisions will survive the upcoming conference with the House of Representatives. And while I continue to hope that the conference will come back with a better Medicare drug benefit, I regret that it is unlikely to be the case. The House bill is in many ways even worse than the Senate bill before us.

Mr. President, I regret that none of the amendments that I supported during this debate prevailed. These amendments would have greatly improved this bill and provided a real prescription drug benefit to seniors—a benefit we left out in 1997. Instead, this bill is an empty promise to seniors and the disabled on Medicare. This is not the kind of plan they have been asking for or have a right to expect. We could and should have done better for our seniors—hence, we could and should be able to hold our work here to the standard set in the Hippocratic Oath: do no harm. And we have failed. I yield the floor.

Ms. COLLINS. Mr. President, I want to thank the chairman of the Finance Committee for including provisions in S. 1 that will provide a measure of relief to rural health care providers, and in particular to home health agencies serving patients in rural areas. I am concerned, however, that the under-lying bill does not go quite far enough and have filed an amendment with Senator BOND to increase the rural add-on payment for home health agencies to 10 percent. This was the amount of the payment prior to its expiration on April 1, and I believe it is the amount that is necessary to ensure that Medicare patients in rural areas continue to have access to the home health services that they need.

Home care has become an increasingly important part of our health care system. The kinds of highly skilled and often technically complex services that our nation’s home health agencies provide have enabled millions of our most frail and vulnerable older persons to avoid hospitals and nursing homes and stay just where they want to be—in the comfort and security of their own homes.

Surveys have shown that the delivery of home health services to rural areas can be as much as 12 to 15 percent more costly because of the extra travel time required to cover long distances between patients, higher transportation expenses, and other factors. Because of the longer travel times, rural caregivers are unable to make as many visits in a day as their urban counterparts. Saundra Scott-Adams, the executive director of the Visiting Nurses of Aroostook in Aroostook County, ME, where her agency covers 6,600 square miles with a population of only 72,000. Her costs are understandably much higher than the average agency due to the long distances her staff must drive to see clients. And, her staff is not able to see as many patients.

Agencies in rural areas are also frequently smaller than their urban counterparts, which means that their relative costs are higher due to smaller scale operations. Smaller agencies with fewer patients and fewer visits mean that fixed costs, particularly those associated with meeting regulatory requirements, are spread over a smaller number of patients and visits, increasing overall per-patient and per-visit costs.

Moreover, in many rural areas, home health agencies are the primary caregivers for homebound beneficiaries with limited access to transportation. These agencies have to provide more time and care than their urban counterparts, and are understandably more expensive for agencies to serve.

If the rural add-on payment is not reinstated, agencies may be forced to make decisions to accept rural patients with greater care needs, and access will suffer further.

The loss of the rural add-on has already caused many agencies to reduce their service areas. Some are eliminating services altogether in remote areas. There are some counties in Montana, for example, that have no home health services. And agencies in my home State of Maine have had to eliminate delivery of services to some of our outlying areas. If the 10 percent rural add-on payment is not restored, it will only put more pressure on rural home health agencies that are already operating on very narrow margins and could force more of these agencies to close. Many home health agencies operating in rural areas are the only home health providers in a vast geographic area. If any of these agencies are forced to close, the Medicare patients in that region will lose complete access to home care.

There is strong support in the Senate for restoring the rural add-on. Earlier this month, 55 Senators joined me in sending a letter to the chair and ranking member of the Senate Finance Committee urging that they extend the 10 percent rural add-on for home health agencies, and I ask unanimous consent that this letter be printed in the RECORD.

The chairman of the Finance Committee and his staff have been working with us to try to accommodate my amendment, and I am very appreciative of their efforts. I am hopeful that we will be able to work this out so that we will be able to ensure that Medicare patients in rural areas continue to have access to the home health services that they need.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

Hon. Charles E. Grassley, Chairman, Hon. Max Baucus, Ranking Member, Senate Committee on Finance, Dirksen Senate Office Building, Washington, DC,

Dear Senators Grassley and Baucus:

Home health has become an increasingly important part of our health care system. The kinds of highly skilled and often technically complex services that our nation’s home health agencies provide have enabled millions of our most frail and vulnerable older persons to avoid hospitals and nursing homes and stay just where they want to be—in the comfort and security of their own homes.

By the late 1980s, home health was the fastest growing component of Medicare spending. The rapid growth in home health spending understandably prompted the Congress and the Administration to cut back part of the Balanced Budget Act of 1997—to initiate changes that were intended to slow this growth in spending and make the program more cost-effective and accountable. These measures, however, produced cuts in home health spending far beyond what Congress intended. Home health spending dropped to $10 billion in FY 2002, nearly half the 1997 amount, and it is clear that the savings goals set for home health in the Balanced Budget Act have not only been met, but far surpassed.

According to the Congressional Budget Office (CBO), the post-Balanced Budget Act reductions in home health entitlements were more than $72 billion between fiscal years 1998 and 2002. This is over four times the $16 billion that the CBO originally estimated for that time period and is a clear indication that the Medicare home health cutbacks have been far deeper than Congress intended.

As a consequence of these cutbacks, over 3,000 home health agencies have either closed or stopped serving Medicare beneficiaries. Moreover, the number of Medicare patients receiving home health care nationwide has dropped more than one-third. Which points to the central and most critical issue—cuts of this magnitude simply cannot be sustained without ultimately affecting patient care, particularly for those Medicare beneficiaries with complex care requirements.

On October 1, 2002, home health agencies received an additional across-the-board cut in Medicare home health payments, and the Centers for Medicare & Medicaid Services has dramatically reduced projections for home health spending under the Medicare program over the next ten years. We are concerned that any further cuts for home health services simply cannot be sustained without affecting patient care, particularly for those Medicare beneficiaries with complex care requirements.

As you begin consideration of a Medicare modernization package, we urge you to avoid any further cuts in payments for home health services and provide a timely basket update for payments for home health services for 2004. In addition, we urge that you extend the 10 percent add-on payment for home health services that expired on April 1, 2003. Surveys have shown that the delivery of home health services in rural areas can be as much as 12 to 15 percent more expensive because of the extra travel time required to cover long distances between patients, higher transportation expenses, and
other factors. Extension of this add-on payment will therefore help to ensure that Medicare patients in rural areas continue to have access to the home health services they need.

Thank you for your consideration, and we look forward to working with you to ensure that the elderly and disabled Americans continue to have access to quality home health services.

Sincerely,

[Signature]

Mr. President, I rise today to speak in support of S. 1, the Prescription Drug and Medicare Improvement Act of 2003. However, I do so with great trepidation. While I intend to vote for the bill that is presently before the Senate, I believe that drastic changes are still necessary to make the benefit created by this legislation one that meets the needs of our senior citizens.

I am also deeply concerned that Members on the other side of the aisle—as well as those in the House of Representatives, and the administration—will attempt to move this bill in a direction during conference. Let me reiterate what I said in an earlier statement on this issue: we must not approve any Medicare reform measure that would force seniors to join private plans in order to receive a more generous prescription drug benefit. Such a measure would signal an end to the Medicare Program as we know it and should be rejected out of hand. I urge my colleagues to protect the Medicare that our seniors have come to rely on, and I urge the President to veto any bill that privatizes Medicare. If such changes are made, I will not hesitate to oppose the conference report.

Given these concerns, it is reasonable to ask why I am supporting this bill. The answer is simple. I believe in my home State of Connecticut and across the country that we have been waiting far too long for a prescription drug benefit under Medicare. And it is time that we in Congress heard them.

At these forums I heard from seniors who literally could not afford to fill prescriptions called for by their doctors. I heard from elderly Medicare beneficiaries forced to choose between purchasing groceries or filling their prescriptions. I heard from seniors who were forced to skimp on medications in an attempt to stretch their limited supplies of needed medicines. I heard from Medicare beneficiaries requiring more than 10 prescribed medicines a day unable to afford even half of these prescriptions. Clearly, what I heard from hundreds of Connecticut’s more than 500,000 Medicare beneficiaries is their grave concern over the present lack of a prescription drug benefit under the Medicare Program. I believe that the legislation about to be approved by this body offers an answer to those concerns. It is not the most complete answer, but it is a start—based on which we can improve the future of the Medicare program because it will make so many seniors better off than they are today. And that should be our ultimate goal as legislators—to make people’s lives better. Often this must be done incrementally, in steps. This bill is a positive first step.

What do I mean when I say that it will make people better off? In Connecticut, one-third of all Medicare beneficiaries have incomes below 160 percent of poverty. For many of these seniors, drug costs can be crippling. They are forced to choose between putting food on the table, and buying the medicines that they need to live healthy lives. With the passage of this bill, these seniors will have no more to worry about. The new Medicare prescription drug benefit will cover most, if not all, of their drug costs. I congratulate Senator GRASSLEY and Senator FORD for offering and supporting amendments designed to provide assistance with high prescription drug costs within the hole, especially those with lower incomes who can least afford any gap in coverage, that have failed to win support by the Senate. Failure to close this gap, in my view, constitutes a glaring failure, one that I hope can be reversed as this bill moves into conference.

I am also concerned that S. 1 fails to adequately protect Medicare beneficiaries. The new prescription drug benefit will cover the cost of prescription drugs for Medicare beneficiaries, senior Medicare beneficiaries with incomes below 160 percent of poverty. However, I believe that the majority will be helped by this passage even to meet their particular needs. For this reason, I offered an amendment to S. 1 that would have simply granted Medicare beneficiaries accessing the new prescription drug benefit. However, I fear that many Medicare beneficiaries will face great uncertainty as they seek to determine which plan fits their particular health care needs for the first time. I am fearful that many Medicare beneficiaries who spend more than $5,000 per year on prescription drugs would have difficulty in choosing the best plan for their particular needs. For this reason, I offered an amendment to S. 1 that would have simply granted Medicare beneficiaries navigating the intricacies of a brand-new program. Specifically, if enacted the underlying bill will require Medicare beneficiaries choosing a prescription drug plan to stay with that plan for a minimum of 1 year. With the enactment of such broad and sweeping changes to the Medicare program, I am fearful that many Medicare beneficiaries will face great uncertainty and may not be able to find the plan that will meet their particular needs. For this reason, I offered an amendment to S. 1 that would have simply granted Medicare beneficiaries navigating this new benefit for the very first time the ability to switch plans as they seek to determine which plan fits their particular needs. Unfortunately, this amendment was not agreed to and I reiterate that the new prescription drug benefit will not be unfairly locked into plans that do not meet their needs.

Mr. President, I am pleased that S. 1 represents a significant departure from
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previous plans supported by the administration that would have required Medicare beneficiaries to leave the traditional fee-for-service Medicare Program in order to receive coverage for their prescribed medicines. Such a move, I believe unconscionably, affects 49 percent of all Medicare beneficiaries today are in the traditional program. To force these beneficiaries to leave their present system of coverage, and most likely the doctor that they have come to know and trust, would not only imperil the future of Medicare, it would also for the first time since the program’s inception create a tiered benefit system under Medicare that would more greatly reward those who choose to join a private preferred provider organization, PPO, or health maintenance organization, HMO.

And while I am pleased that the bill before us soundly rejects a tiered benefit system, I am deeply concerned that the plan presently taking shape in the House of Representatives appears to rely on such a flawed plan. As I said earlier, such a measure should be soundly rejected.

So it is with great caution that we come to the final moments of debate on this important legislation. Medicare’s near 41 million beneficiaries clearly need assistance in affording their needed medicines. The result of our efforts over the past 2 weeks, and more importantly, the result of the coming conference, will greatly determine to what extent we assist our Nation’s Medicare beneficiaries to afford their needed medicines.

Clearly, a great opportunity is presently before us. As the underlying bill moves to conference committee, I look forward to working with my colleagues to ensure that we seize this opportunity by strengthening the underlying bill. With passage of the bill presently before us, we will have a choice. We can insist on the good start that we have made here with passage of S. 1, and work to strengthen its provisions. Or, conversely, we can accede to the House legislation that in my view unfairly jeopardizes the traditional Medicare Program by tilting the system in favor of risky privatization schemes and against seniors.

I ask my colleagues to join with me in working to ensure that any Medicare prescription drug legislation passed by this Congress is at least as strong as the bill we are about to vote on. A tilt toward the House-drafted language would signify not a strengthening of Medicare, but rather a weakening of this vital program’s foundation, and must be avoided at all costs.

Nearly 38 years ago on July 9, 1965, this body passed the legislation creating the Federal Medicare Program sending it to a conference committee with the House. On that day, President Lyndon Baines Johnson remarked, “This is a great day for older Americans. And it is a great day for America. For we have proved, once again, that the vitality of our democracy can shape the oldest of our values to the needs and obligations of today.” Nearly four decades later, we are on the cusp of a similar challenge. Let us move Medicare toward the future without threatening its proven ability to provide for the security of this Nation’s senior citizens.

Mr. COLEMAN. Mr. President, I am proud to mark this extraordinary day by coming to the floor of the Senate to celebrate the imminent passage of a bill to improve Medicare. This is a triumph not for a party or a President, but for America’s seniors and their families. This is an incredibly hopeful day for all Americans who long for a national government that can get things done for people.

Thirty-eight years ago Congress voted to create a health care program that would be the primary source of health insurance for this Nation’s seniors. Most people would agree that this program has worked for almost four decades. However, the practice of medicine has changed. Drug therapies, medical devices, and human genome research all hold great hope for breaking through physical limitations that hinder many of our seniors’ ability to enjoy the later years of life.

The question we now ask is what level of care are we going to provide our seniors and is the current system equipped to provide the type of care our seniors need and deserve? The benefits provided under Medicare, considered generous at its inception in 1965, pale in comparison to those enjoyed by Federal employees and most workers in the private sector today. A recent report submitted by the Joint Economic Committee found that Medicare has the least generous benefit package among leading forms of insurance. Medicare covers 56 percent of total health care expenses, while typical employment-based health insurance covers 70 percent.

Seniors need prescription drug coverage. Seniors need better access to preventative care and disease management. Seniors need more choices in their health care options than they have today. Without updating, it may take years to add this kind of care to the current program—after all, it has taken over 30 years to add a prescription drug benefit.

The Prescription Drug and Medicare Improvement bill is a step toward meeting the needs of this Nation’s seniors.

This bill provides a solid drug benefit that will provide assistance to every senior struggling to pay for prescription drugs as well as the security of knowing they are covered for unforeseen drug expenses. Under this plan, the average senior’s annual drug costs will be reduced by 53 percent each year. That amounts to $1,677 less each year in the pocket of our seniors. And seniors with the greatest needs will receive additional assistance through increased cost-sharing, and reduced or waived monthly premiums and deductible.

Equally important, this plan provides seniors with the security of knowing that they are covered in the event something happens and they find themselves facing extraordinary costs. At $3,700 in out of pocket drug costs, stop-loss coverage kicks in and the senior is only responsible for 10 percent of costs beyond this amount.

This bill is also about expanding options for this generation and future generations of seniors. The incremental improvements to the Medicare program have largely been the result of legislative action over the last 40 years. The legislative process is, however, not a quick process, and it is simply not possible to keep the program current in the first parcel environment we currently live.

The Medicare Advantage program included in this bill offers seniors the choice of receiving their health care benefits in a Preferred Provider Organization, PPO, the same type of health plan enjoyed by many families. Under this tiered benefit system—not mandate—seniors will have increased access to the latest advances in care such as desire management and better preventive screenings. Additionally, seniors who chose this option will also have a lower deductible for inpatient and hospital care than those in traditional Medicare.

This bill lays the foundation for a Medicare program that is better able to respond to an evolving health care system. This is the best we can do as we harness the efficiencies of the health care market, while preserving traditional Medicare for those seniors who are satisfied with their current coverage.

This bill is about expanding options for seniors so our parents and grandparents have access to the type of care best suited for them.

Is this bill everything everyone wants? Of course not. Are there decisions still to be made as it is implemented? Of course. And we should not actually works in the marketplace? Certainly. But this bill says we are not going to let the lack of perfection stop us from doing real good for people as soon and as effectively as we practically can.

I would be remiss if I didn’t express my appreciation to Senators GRASSLEY and BAUCUS for their leadership in including many provisions in this bill to strengthen rural health care.

The availability of quality medical care in rural areas in Minnesota is absolutely critical to the stability and viability of many communities.

The provisions in this bill to improve payments to hospitals in rural areas and reduce the geographic disparity in physician payments are critical to ensuring that these hospitals that threat not only seniors, but entire communities continued to receive care.

I am pleased that we did not allow perfect to be the enemy of good as we considered this package.

This is a substantial and dependable benefit for America’s seniors. Again,
it’s not everything everyone wants. There are still decisions to be made as it is implemented and we monitor how it works in the marketplace. But today we are delivering on a promise to provide quality care to our seniors.

I am glad to have bipartisan support this landmark legislation will pass the Senate and the House of Representatives by the July 4th holiday. When it does, there may not be any fireworks and parades but millions of seniors will be able to declare their independence about getting the prescription drugs they need to live a quality life.

Mr. BIDEN. Mr. President, after many years of preparation and deliberation, and following weeks of debate and discussion on the floor this year and last, we in the Senate are about to vote on a bill providing some prescription drug benefits for Medicare beneficiaries that is widely expected to pass.

Seniors have been demanding prescription drug coverage for many years now. They need it and they deserve it, and I believe what we should be passing here today is a bill that will bring the American people the type of prescription drug benefits they have been seeking—one that is easy to understand and use, one that covers a substantial portion of all their costs, and one that is affordable.

But to the many Medicare beneficiaries who will read the details of this bill and say, “there isn’t much here for me and it will cost me more than I am now paying for drugs,” I would say: I hear you. This bill is not enough, not nearly enough.

I have a lot of concerns about this bill. There is no uniformity from region to region in the benefit package or beneficiary payments. Senators in the East could be paying far higher premiums than their relatives in the Midwest.

The drug plan relies on private insurance companies to provide a type of insurance policy that they have already said they are unwilling to sell. I am skeptical that these private plans will stay, and that could mean seniors will have no stability in their coverage. The bill does allow traditional Medicare to step in and fill the gap but seniors might have to move back to a private drug plan if new ones come to the region.

There is also a gap in coverage which I think is unfair and will surprise a lot of people.

Finally, the bill falls short in its efforts to induce employers not to abandon their retiree prescription drug coverage. The situation that too many retirees have already faced in recent years.

In summary, I view this bill not as a situation where we would say that the glass is half full and half empty; to my thinking, the glass is only about one-quarter full. In 2003, prescription drugs are as important in medical care as surgery; consequently, it seems logical to me that if Medicare pays for the bulk of the cost of a heart bypass operation for all beneficiaries, it should similarly pay the bulk of the cost of the drugs used to lower the cholesterol, and which would prevent the need for the bypass operation, for all beneficiaries. This bill does not achieve that commonsense goal. Not even close.

But we need to start somewhere. This is the first step in gradually moving the health plan that covers nearly 40 million sex-cuts and disabled individuals into the 21st century. And it is, very frankly, the best that we can expect to pass this Congress and that the President will sign.

There are some good provisions in this bill. All Medicare beneficiaries will have access to a prescription drug plan. Individuals with low incomes, below 160 percent of Federal poverty level, will have access to prescription drug coverage at very little cost. Those with very high prescription drug expenditures of dollars, will have stop-loss protection to help protect them against catastrophic drug costs. And no one is forced to abandon the traditional Medicare Program for their basic health care, with which they are so familiar, in order to obtain prescription drug coverage.

During the Senate deliberation on this bill, I have voted for amendments that would improve the prescription drug coverage and decrease the cost to beneficiaries. If these amendments were not adopted, mostly with the rationale that there was not enough money. I do not feel constrained by any arbitrary $400 billion cost limit on this bill. I never agreed to such a limit. In fact, my sense of values tells me that prescription drug benefits are a high priority, and I would be willing to spend more than $400 billion for a good prescription drug plan, while cutting budget items of lower priority, such as cuts for the very wealthy.

In the end, I decided to vote for this bill, despite its severe limitations. Given the many past years of fruitless discussions on this matter, I feel it is critical to put something into law now that can serve as a starting point for development of a true prescription drug plan. But that is not to say that I will accept any lesser of a bill, and my colleagues should not count on my continued support, if the final version of this bill that comes out of negotiation of its amendments undercut the Medicare Program or moves toward reducing protections for beneficiaries.

We also need to remember, this bill comes with a warning to all of us: the public is a lot ammorer than they are sometimes given credit for, and if we do not work diligently to improve what we have begun, they will rightly take out their anger on us. We need to ensure that this bill is the first step, not the last step.

Mr. GRASSLEY. Mr. President, parliamentary inquiry. Are we now ready for third reading?
rate of more than 10 percent a year over the next decade. That is far faster than the cost of living. That means that without this legislation, seniors will need to devote larger and larger shares of their income to paying prescription drug bills.

So it is not a surprise that we are here to try to make prescription drugs more affordable for seniors. And we are here to extend coverage to the roughly 10 million seniors who have no prescription drug coverage at all.

Let me review what this bill would do.

This bill would make available prescription drug insurance to all seniors.

This bill would ensure that 44 percent of Medicare beneficiaries—those with the lowest incomes—would have truly affordable prescription drug coverage with minimal out-of-pocket costs. For these lower-income seniors, with incomes up to 160 percent of the poverty level, copayments would never exceed 20 percent of drug costs.

Let me take some examples. Let’s look at what this bill would do for beneficiaries with what will likely be average drug spending of $3,155 in 2006.

For seniors with average drug expenses with higher incomes, this bill would save them $1,677. That is a 40 percent savings in out-of-pocket costs.

The savings would be greater for lower income seniors. For an individual making $14,000 or a couple making $19,000 a year, with average drug spending, they would save $2,842. That is a 90 percent savings in out-of-pocket costs.

For an individual making $12,000 or couple making $16,000 a year with average drug spending, they would save $2,842. That is a 90 percent savings in out-of-pocket costs.

This bill would thus ensure that those who have been least able to receive the healing benefits of prescription drugs would now be able to do so. Millions of people would have a better quality of life. Lives would be saved.

This bill would create a strong Government fallback. Seniors would have access to at least two private plans for a prescription drug benefit, or else the Government would provide a standard fallback plan. If there is not true competition, then traditional Medicare would provide a fallback.

The Department of Health and Human Services would continue to oversee these plans. The plans would operate within tightly controlled limits. This bill includes strong consumer protections.

And this bill does not tilt the playing field. This bill does not make private plans a better deal than traditional Medicare.

This bill would make a nearly $400 billion expansion of a major entitlement program. This is a historic opportunity to make a fundamental change for the better for millions of Americans.

In so doing, this bill would finally do something that the overwhelming majority of industrialized nations have already done.

This is a broad compromise. This is not a bill of the left or a bill of the right. This is a weaving together of approaches, in the finest American tradition.

This is a historic opportunity. Let us finally seize that opportunity, and improve health care for our seniors. Let us finally seize the opportunity, and bring prescription drug coverage to all.

Mr. GRASSLEY, Mr. President, we are about to take a historical vote.

Since 1965, Medicare hasn’t covered prescription drugs. Now, 38 years later, we’re changing that—on a strong bipartisan basis.

Because of this bill, on January 1, 2004, seniors across America will have immediate help with prescription drug costs. Moreover, on January 1, 2006, seniors will have access to affordable, comprehensive drug coverage as a permanent part of Medicare.

No longer will seniors have to make hard choices when it comes to paying for prescription drugs.

This bill also strengthens and improves Medicare, giving seniors more choices and better benefits than they have today.

At the same time, it brings long overdue Medicare equity to the people of Iowa and to other rural States. We are on the verge of a major victory.

I urge my colleagues to support S. 1, Mr. BAUCUS, Mr. President, we are about to vote. I want to thank all Senators for their tremendous patience. It is not an easy task. I particularly thank the chairman of the committee but also all Senators.

Second, I thank the staff who have not had any sleep in the last two or three weeks, who don’t know how they are going to stand, a lot of people have been working on this bill. My thanks. I know I speak for all the Senators in thanking all the staff that worked so hard to help achieve this end.

The PRESIDENT pro tempore. The bill having been read the third time, the question is, shall it pass?

Mr. HOLLINGS, Mr. President, I ask for the yeas and nays.

The PRESIDENT pro tempore. Is there a sufficient second?

There is a sufficient second. The clerk will call the roll.

The legislative clerk called the roll. Mr. McCONNELL. I announce that the Senator from Oklahoma (Mr. INHOFE) is necessarily absent.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "nay".

The PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 76, nays 21, as follows:

NAYS—21

Mr. BAUCUS. Mr. President, I move to reconsider the vote.

The PRESIDENT pro tempore. The Chair, in my capacity as a Senator from the State of Alaska, moves to lay the motion on the table.

The motion to lay on the table was agreed to.

Mr. INHOFE. Mr. President, because of recent business back in my State of Oklahoma, I will be unable to be in attendance to vote on S. 1. It makes no difference, however, because I would have voted against it.

Last week, I addressed this Chamber regarding S. 1, the Prescription Drug and Medicare Improvement Act. At that time, I said I could not support the legislation in its current form and expressed my hope that it could be improved on the floor. Unfortunately, that has not occurred. I am restating my opposition to this legislation.

This is simply another Federal entitlement program designed to balloon past expected costs of $400 billion. For
example, in the past, Medicare expenses have soared nearly five times the projected costs. I remember that well because I remember in 1965 when it was passed. This trend will only escalate if we continue to add unfunded obligations without ensuring the long-term solvency of the entire program.

We must examine the necessity of such obligations prior to placing the burden on the backs of the future taxpayers. And is a full prescription drug benefit necessary? Currently, 76 percent of seniors already have some form of prescription drug coverage. A recent Zogby poll found that three-fourths of seniors thought the coverage offered under this plan would be no better than what they currently have. In fact, less than one-half would even purchase the option if given the choice. However, with the passage of S. 1, those individuals may not be given that choice. CBO estimates that one-third of Medicare beneficiaries with employer-sponsored coverage would lose those benefits once the bill takes effect. Seniors who currently have private coverage that they like will be forced to buy the Government-sponsored benefit simply because it is the only thing that will be available.

There is something wrong with that picture. The Government should not be replacing coverage that already exists. However, this legislation opens the door for continued Government intervention. In the inclusion of the fallback provision, this benefit has the potential to become fully federalized if private plans do not surface. Once again, we are placing more and more expense at the door of the taxpayers, our children, and our grandchildren.

I am concerned about the effect this bill could have on the future of the entire Medicare Program. I have worked with my colleagues to support improvements to this legislation. I and many of my colleagues have signed letters to former Speaker Gingrich and President Bush outlining the principles that need to be included in the final version of this bill. I also cosponsored an amendment with Senators Ensign, Hagel, and Lott to provide a more reasonable prescription drug benefit that does not create a massive entitlement program. I believe the House of Representatives is on the right track with this issue.

I am hopeful that with the passage of S. 1, the conferees will work to see that the final legislation adheres to the principles stated in the letters to President Bush and Senator Frist and the proposal supported by the House. At that time, I will look forward to supporting this legislation.

The PRESIDENT pro tempore.

The majority leader.

Mr. FRIST. Mr. President, for years Congress has debated providing prescription drug coverage to seniors and how and when to improve the Medicare Program. Tonight we have acted. Tonight America is one step closer to being a more caring society for millions of seniors and individuals with disabilities. Tonight seniors and individuals with disabilities, through this bill, will get relief from high prescription drug costs and outdated, often inadequate medical care. Tonight we are one step closer to providing real health care security to seniors all across the Nation.

We stand on the shoulders of many in this body and in the House of Representatives who fought mightily to improve the Medicare Program. We have reached this point of success because of the commitment of the leadership in the House as well as the Senate. Above all, we are indebted to the bold leadership of the President of the United States without whom we would not be transforming or improving the system.

Indeed, the bill we have just passed is nothing less than historic. By dramatically reducing prescription drug costs and outdated, often inadequate medical care, it offers genuine reform that will dramatically improve the quality of health care for all seniors. At the same time, the legislation preserves traditional Medicare so that those who wish can remain in traditional Medicare and keep exactly what they have today.

This bill combines the best of the public and private sectors and positions Medicare to evolve with the medical treatments of the future. It is entirely voluntary.

I am very pleased by the overwhelming majority of this body who tonight voted to move this legislation towards a cooperative private model but a partnership between the public and private sector.

I am also pleased that the amendment maintained the balance that has been so important in what I set out a few weeks ago, to be a truly bipartisan effort. This bill devotes increased resources and expands opportunities within the traditional Medicare Program for chronic care coordination, for disease management, for preventive care.

As many people have stated, it is not a perfect bill, but we will continue to move this legislation forward now to conference once, later in the evening or in the hours of the morning, after the House passes its legislation, we will have the opportunity to make the private sector provisions more flexible, indeed more competitive, and more like the Federal Employees Health Benefits Plan. I am familiar with the impressive record of that plan, the Federal employees plan. Every Member of Congress and over 8 million other Federal workers and retirees enjoy the ability to choose the plan that best suits their medical needs.

Indeed, as we go through conference and once the bill is signed by the President of the United States, all seniors will have that same opportunity to voluntarily choose the plan that best meets their medical needs.

I look forward to working with my colleagues on both sides of the aisle to improve this legislation and to make sure that it does not inadvertently displace good private health care coverage that exists today—options that are available to millions of Medicare beneficiaries, including employer-sponsored health care coverage.

Compromise and debate are the cornerstone of this great democratic system of government. I commend my colleagues for their admirable show of bipartisanship spirit. Thanks to the leadership of our colleagues in both Senate and the commitment of President Bush, America's seniors will finally receive the health coverage they need and the security they deserve.

I want to take a brief moment to thank all of my colleagues for their hard work and dedication over the last several weeks. It has been about 3 months ago that I set out that we would address Medicare for these 2 weeks—the 2 weeks prior to the July 4 recess. Many people said we were trying to do too much in too short a period of time. Others said it is something that has been debated for weeks and months, and indeed years, and that we had no way we could finish it before July 4.

Yet through the hard work of our colleagues—again, on both sides of the aisle—we have fulfilled that vision. Again, it is a first step, a step that will be improved in that conference before us. Nevertheless, we succeeded in what we set out to do with the legislation that is built upon the work of many Members of the Senate, as well as the House of Representatives and, in particular, the members of the Senate Finance Committee. I do want to thank especially Senators Hatch, Nickles, Lott, Snowe, Kyl, Thomas, Santorum, Smith, Bunning, and Breaux for their hard work and leadership.

In particular, of course, I thank Chairman Grassley and Senator Baucus, the managers, who for the last 2 weeks have so capably managed the bill on the floor. Their cooperation and their leadership have been invaluable. Without it, we would not be here so close to the finish line.

I would like to recognize all of the staff who have contributed to this effort:

First, I would like to thank my chief of staff, Lee Rawls; my policy director, Eric Ueland; and my health policy director, Dean Rosen. Paul Jacobson, Bob Stevenson, Nick Smith, Bill Hogeland, and Amy Simmons. My Leadership office also made important contributions. I also would like to recognize the other members of my health team who worked so hard to help make possible the passage of this legislation: Scammon, Norton, Susan Goelzer, Shana Chirstrup, Allison Winnike, and Jennifer Romans.

The Majority Whip's staff deserves special recognition, especially Kyle Simmons, Michael Solon, and Amy Swommer, for the long hours they put in and for the guidance they provided to our Finance Committee Chairman and our entire Republican leadership team.
As I have said, passage of this legislation was made possible in the United States Senate because of the genuine spirit of bipartisan cooperation. Both the Republican and Democratic staff of the Senate Finance Committee worked incredibly hard, long hours, these past several weeks and months. Their expertise, support, and stamina has been invaluable.

I would like to thank Kolan Davis, Ted Totman, Linda Fishman, Colin Roskey, Leah Kegler, Mark Hayes, Jennifer Roskey, Alicia Ziemiecki of Chairman Grassley’s staff.

And I would also like to thank Jeffrey Forbes, Elizabeth Fowler, Bill Dauster, John Blum, Pat Bousilman, Kate Kirchgraber, and Andrea Cohen of Senator Baucus’ staff for their contributions.

Hazen Marshall, Stacey Hughes, and Megan Hauck of the Senate Budget Committee staff are also commended for their efforts.

Thank you to you all.

I look forward to working with Chairman Grassley and our colleagues in the House of Representatives to produce a conference report that can pass both Houses and be signed by the President in a timely manner later this year.

Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

ORDER TO PRINT S. 1

Mr. FRIST. Mr. President, I ask unanimous consent that S. 1, as passed, be printed.

The PRESIDING OFFICER. Without objection, it is so ordered.

(This bill will be printed in a future edition of the RECORD.)

MORNING BUSINESS

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate proceed to a period for morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

INDEPENDENCE DAY

Mr. BYRD. Madam President, the Senate is poised to adjourn, but before we adjourn, I want to call us away from the onrushing press of Senate business and impending airline schedules to pay tribute to Independence Day. Next Friday is the glorious Fourth of July, that most patriotic and star-spangled of holidays. With the Fourth of July holiday, summer is at its Halycon best, with temperatures still enjoyable, skies richly blue, and trees and lawns still lush and green, and gardens coming into bewildering abundance. In fields and along the roadsides, wildflowers bloom in profusion, and wild blackberries earn our forgiveness for their thorns by offering the tender treasures of their glossy berries.

It is a golden period of enjoyment for students on summer holiday, the respite still feels luxuriously long, full of golden days of enjoyment.

The Fourth of July this year falls on a Friday, easily making a long weekend for summer pleasure. With luck, the Fourth will be clear and cooler, comfortable for marching bands and hometown parades, bathed in glorious sunshine for family picnics and perfect for evening symphonies and fireworks to compete with the glittering stars above.

If the weather is sweltering, however, then we might be better able to empathize with the Delegates to the Second Continental Congress, who met in Philadelphia in the spring and summer of 1776. In hot and muggy weather, their clothes that were designed for a cooler European summer, the Delegates debated and amended, reportedly fending off flies from a nearby stable that swarmed the Hall and bit the Delegates through the silk hose on their lower legs. But they persevered in their momentous task.

On June 7, 1776, Richard Henry Lee of Virginia offered a motion to declare independence from England. His resolution declared:

These United Colonies are and of right ought to be free and independent States.

His resolution passed on July 2 by a 12–0 vote, with New York temporarily abstaining.

The next day, on July 3, John Adams wrote to his wife, Abigail, rejoicing over the decision to secede. To Abigail, he wrote:

The 2nd of July will be a memorable epoch in the history of America. I am apt to believe that this will be celebrated by succeeding generations as the Great Anniversary Festival. He further suggested that it ought to be commemorated as the day of deliverance, by solemn acts of devotion to God Almighty. This is John Adams speaking. This is not some rustic boob like I was when I came to the House more than half a century ago. Listen to him again: It ought to be commemorated as the day of deliverance by solemn acts of devotion to God Almighty.

It ought to be solemnized with pomp, shows, games, sports, guns, bells, bonfires, illuminations, from one end of this Continent to the other, from this time forward, forever. How remarkably prescient. Adams was off on the date, as we celebrate the approval of the Declaration of Independence rather than of the adoption of the motion, but he certainly knew how Americans like to celebrate. As well, he accurately predicted the explosive growth of an embryonic nation into a continent-spanning colossus.

That vision took great courage, coming as it did on the eve of putting his signature to a document that could easily become his death warrant. Every signer of that Declaration of Independence committed treason against England, against the King of England, against the crown. Every signer would have been arrested, put in chains and sent by boat to England; tried, convicted, and hanged. The delegates to the Continental Congress had, with the act, committed treason against the crown and set their nascent nation-state on the road to war. After the failed Jacobite uprising against England in 1745 under Bonnie Prince Charles, only 31 years before the delegations met in Philadelphia, the Scottish leaders had been beheaded in public ceremonies.

One Delegate to the Congress, John Witherspoon, put it thus:

There is a tide in the affairs of men, a nick of time. We perceive it, now or never. To hesitate is to consent to our own slavery. That noble instrument upon your table, that insures immortality to its author, should be subscribed to this very session by every pen in this house. He that will not respond to its accents, and strain every nerve to carry into effect the provisions of this unworthy of the nation of free men. For my own part, property, I have some; of reputation, more. That reputation is staked, that property is pledged on the issue of this contract and although these grey hairs must soon descend into the sepulcher, I would infinitely rather that they descend thither by the hand of the executioner than desert at this crisis the sacred cause of my country.

What beautiful words. The signers knew full well what risks they were running.

The first anniversary of the adoption of the Declaration of Independence took place in a nation at war, with our battle fortunes at low ebb. But Americans still celebrated in Philadelphia, U.S. ships of war were decked in red, white, and blue. At 1 o’clock, each ship fired a volley of 13 cannon over the 13 States. Members of Congress dined in state with other civil and military dignitaries and made toasts to liberty and to fallen patriots. After dinner, the Members and officers of the Army reviewed the troops, followed by a ringing of bells and a show of fireworks.

In 1788, Philadelphia was serving as the U.S. Capital. On that year, not only was the Declaration of Independence celebrated, but also the U.S. Constitution, which had recently been ratified by 10 States. This July Fourth celebration included another new feature—a parade with horse-drawn floats. One float, that of an enormous eagle, carried the Justices of the Supreme Court in lieu of today’s beauty pageant queens.

In 1826, the Nation achieved a milestone when the 50th Independence Day celebration was being planned. The mayor of Washington wrote to invite the surviving ex-President and Signers of the Declaration to attend the festivities. The five men, John Adams, Thomas Jefferson, James Madison, James Monroe, and Charles Carroll.
were unable to attend. Why? Because of age or infirmity, or other reasons. Indeed, at 10 minutes before 1 o'clock on July 4, 1826, Thomas Jefferson, principal drafter of the Declaration, passed away.

John Adams, too, breathed his last on the same day. In his 90s and gravely ill, he had determined to hold on until the 50th anniversary of independence. That morning, he roused long enough to confirm to a servant that he knew that July 4 was the previous Fourth of July. "God bless it. God bless you all," before fading into unconsciousness. Rousing later that afternoon, he confided unknowingly as he passed on to that other shore that "Thomas Jefferson still survives." He did not know that Jefferson had died earlier that day.

James Monroe, who fought in the Revolutionary War and became the fifth President of the United States, also died on July 4. In 1831, James Madison, the fourth President, died a week before the 50th anniversary of Independence Day, on June 28, 1836.

The last living Signer of the Declaration of Independence, Charles Carroll, performed one of his last public acts on July 4, 1836. His participation in the ground-breaking ceremony initiating construction of the Baltimore and Ohio Railway, the first important railroad in the Nation. He died in 1832, at the age of 95. Also in 1828, President John Quincy Adams led an unusual 4th of July parade, up the Potomac River and the old Washington Canal to the site where construction was to start on the Chesapeake and Ohio Canal. These two acts underscore the vital link between the Declaration of Independence, the Constitution which followed it, and the vibrant economy which has made and kept the United States economy vibrant and strong for so many years.

Our Nation is a union of disparate States, each of which has considerable power and independence. But across those boundaries, linking the Union into a seamless web of bustling commerce and economic might, is the national infrastructure. Just as the Constitution provides for the common defense, so it promotes the common good by linking markets and people across States. Over the Years, Federal support for great infrastructure projects, from the Chesapeake and Ohio Canal to the National Highway System, have woven the country into a unified economic structure. Federal support for rural electrification and rural telephone and Internet access have spread opportunity and progress from border to border and coast to coast, just as John Adams foretold in 1776.

This 4th of July, as we all visit national parks, tour Federal monuments, drive on interstate highways, call friends and family around the country, and buy picnic goods grown all over the United States, we celebrate a national Federal holiday under the protective watch of the U.S. military and Federal law enforcement agencies—we unconsciously enjoy the benefits of the Federal Government and of belonging to a union that is the United States.

Each star on the flag, the flag beside the President Office's desk, we salute so proudly represents a single state, but only when they are aligned together do we feel the strength and the glory that were won for us, beginning on July 4, 1776. This Independence Day, we would all do well to read and cherish the Declaration of Independence. Even more, we would do well as a Nation to study and cherish our Constitution, by which our freedom, so dearly won and so cost- ly held, lives on.

Too often in recent years and months have I seen unwise attempts to erode the checks and balances of the Constitution, unknowing or unthinking efforts to dissolve the institutions and practices established to make our Nation the free and representative government by our Founding Fathers. Attacks on the United States from within or out are met with instant, unhesitating defense by all Americans, but we are not so knowledgable vigilant against the insidious weakening from within, even within the Chambers of 50 do we let the public and our votes, the last, best guardians of American freedom and independence. We lack only the weapons of knowledge and awareness.

I close with a poem by Henry Wadsworth Longfellow, entitled "O Ship of State."

Thou, too, sail on, O Ship of State! Sail on, O Union, strong and great! Humanity to it hath committed The Workmen wrought thy ribs of steel, Who made each mast and sail and rope, What anvil rings, what hammers beat, In what a forge and what a heat! Were shaped thy distant hope! Fear not each sudden sound and shock, 'Tis of the wave and not the rock; Were shaped the anchors of thy hope! Fear not each sudden sound and shock, 'Tis but the flapping of the sail, Fear not each sudden sound and shock, With all the hopes of future years, Is hanging breathless on thy fate! We know what Master laid thy keel! How many may be there who know Not what is in the toils of hope! Fear not each sudden sound and shock, 'Tis of the wave and not the rock; With all the hopes of future years, Is hanging breathless on thy fate! We know what Master laid thy keel! How many may be there who know Not what is in the toils of hope! Fear not each sudden sound and shock, 'Tis of the wave and not the rock; With all the hopes of future years, Is hanging breathless on thy fate! We know what Master laid thy keel! How many may be there who know Not what is in the toils of hope! Fear not each sudden sound and shock, 'Tis of the wave and not the rock; With all the hopes of future years, Is hanging breathless on thy fate! We know what Master laid thy keel! How many may be there who know Not what is in the toils of hope! Fear not each sudden sound and shock, 'Tis of the wave and not the rock; "O Ship of State," Thou, too, sail on.

Mr. President, I yield the floor and suggest the absence of a quorum. The PRESIDING OFFICER. The clerk will call the roll.
On the occasion of the 100th anniversary of Strom Thurmond's birth, it is a fitting tribute to the man who has served his country with distinction for nearly a century. Mr. President, my senior on the Judiciary Committee, Strom Thurmond left an indelible mark on the Constitution. His service to the Senate spanned a century of progress. From the automobile to the Internet, literally every invention, innovation, and advancement of the last century has passed through its doors. The technological advancements he witnessed, from the automobile to the airplane to the Internet, are the direct result of the laws that came out of the Senate. With these and so many other accomplishments over the years, he has appropriately been referred to as “an institution within an institution.”

In 1902, the year Strom Thurmond was born, life expectancy was 51 years—and today it is 77 years. Strom Thurmond lived longer than any other Senator in history. He was the longest serving Senator in both parties and the longest serving member of any branch of Congress. He was also the oldest serving Senator, having been the oldest Senator when he passed away. He was my mentor. As my senior on the Judiciary Committee, he taught me that, by any measure, he was anything but average.

He saw so much in his life. To provide some context, let me point out that during his lifetime, Oklahoma, New Mexico, Alaska and Hawaii gained Statehood, and 11 amendments were added to the Constitution. The technological advancements he witnessed, from the automobile to the airplane to the Internet, literally spanned a century of progress. Conveniences we have come to take for granted today were not always part of Strom Thurmond’s world. Perhaps this explains why, during Judiciary Committee hearings, he was often heard asking witnesses who were too far away from the microphone to “please speak into the machine.” The story of his remarkable political career truly could fill several volumes.

I must admit, he came a long way in his political career, given that he originally ran on the “Dixiecrat” ticket against Harry Truman. I have often heard stories about how he and I were too far away from the microphone to “please speak into the machine.”

The story of his remarkable political career truly could fill several volumes. It began with a win in 1928 for the Edgefield County Superintendent of Schools. Eighteen years later, he was Governor of South Carolina. Strom was even a Presidential candidate in 1948, running on the “Dixiecrat ticket against Harry Truman. I must admit, he came a long way in his political career, given that he originally came to the Senate as a Democrat. I was happy to say that wisdom came within a short few years when Strom saw the light and joined the Republican Party.

When I first arrived in the Senate in January of 1977, he was my mentor. As my senior on the Judiciary Committee, it was him who helped me find my way and learn how the committee functioned. He was not only a respected colleague, but a personal friend.

During his tenure as chairman of the Judiciary Committee, Strom Thurmond left an indelible mark on the committee and the laws that came through it. He became known and respected for many fine qualities and positions—his devotion to the Constitution, his toughness on crime, his sense of fairness.

He was famous for his incredible grip. Many of us in this Chamber had the experience of Strom Thurmond holding our arm tightly as he explains a viewpoint and asked for our support. I might add that this proved to be a very effective approach.

Strom was also known to have a kind word for a gruff, hardworking colleague who came his way, and for being extremely good to his staff. Despite his power and influence, he never forgot the importance of small acts of kindness. For example, whenever he ate in the Senate dining room, he grabbed two fistfuls of sugar and placed them on the table for his colleagues. When Strom took over the Senate pages, unfortunately, it was usually melted into a keleidoscope of sugar by then. I have a feeling that the pages preferred it when Strom took them out for ice cream.

Strom Thurmond was truly a legend—someone to whom the people of South Carolina owe an enormous debt of gratitude for all his years of service. Clearly, the people of South Carolina recognized the sacrifices he made and are grateful for all he did for them. In fact, you cannot mention the name Strom Thurmond in South Carolina without the audience bursting into spontaneous applause. He truly was an American political icon.

Abraham Lincoln once said that “The better part of one’s life consists of friendships.” With a friend like Strom Thurmond, this sentiment could not be more true. I am a great admirer of Strom Thurmond, and I am proud to have called him my friend.

One final note about Strom Thurmond. He was a great patriot. A decorated veteran of World War II who fought at Normandy on D-day, Strom Thurmond loved this country. Let me close by saying that this country loved him, too.

A SALUTE TO PAUL GALIS

Mr. BYRD. Mr. President, the great State of West Virginia has produced numerous individuals who have dedicated their lives to the service of the Nation. These sons and daughters of West Virginia have contributed to the betterment of their communities, their State and their country. One such public servant is Paul L. Galis, who for 35 years has served admirably in the Federal Aviation Administration, and has contributed to the development of an aviation system unsurpassed in the world.

Mr. Galis retires in July as the Deputy Associate Administrator for Airports in FAA. In this position as well as his previous position of Director of the Office of Airport Planning and Program, Mr. Galis has overseen the planning and development of over 3,000 airports in the national plan for airports. This has been no small task and Mr. Galis has served with distinction.

All of us in the State of West Virginia salute Mr. Galis for his career and wish him the best in his future endeavors. Our country is better for the work he has done and the example of public service he has provided. His able leadership and steady hand will be missed.

OREGON’S TANF WAIVER

Mr. WYDEN. Mr. President, on June 12, 2003, I published a notice in the CONGRESSIONAL RECORD of my intent to object to moving to H.R. 2350, a bill to extend the Temporary Assistance for Needy Families, or “TANF,” our Nation’s welfare program. My good friend from Oregon, Senator SMITH, joined in this effort because the legislation does not contain a provision critical to Oregon’s welfare program: a waiver of certain provisions that gives Oregon flexibility to operate a successful welfare program. Because of its waiver, which expires on June 30, 2003, Oregon has reduced its welfare rolls nearly 60 percent since 1994. It is clear that the waiver has allowed Oregon to meet local needs and craft what has been heralded as one of the best welfare programs in the country.

Since Senator SMITH and I announced our public holds, the distinguished chairmen of the Finance Committee, Senator GRASSLEY, and the ranking member, Senator BAUCUS, have worked closely with us to find a way so that Oregon can continue to operate under its waiver until TANF is fully reauthorized. They have helped obtain a letter from Department of Health & Human Services Secretary Tommy Thompson to Oregon Governor Ted Kulongoski, myself and Senator SMITH assuring us that Oregon can continue to operate without penalty under its waiver. I believe this letter provides Oregon the assurances necessary to continue to operate as if the waiver were still in place, and ask unanimous consent to insert the letter in the RECORD.

Mr. SMITH. I join Senator WYDEN in expressing deep pride in Oregon’s TANF program and in thanking the chairman and ranking member of the Finance Committee, on which I serve, for their cooperation. I share his assessment that this letter will enable Oregon to maintain its TANF program without penalty until the program is reauthorized.

I also express my appreciation to Senators GRASSLEY and BAUCUS for their efforts on TANF reauthorization. We have been working together for months to ensure that all TANF proposals, including those elements which have made Oregon’s TANF program so successful, are carefully considered as we move toward TANF reauthorization.

Oregon’s TANF program, often called the Oregon Option, works because it recognizes local barriers to work and works with individuals to assess their needs and get them onto a path toward independence. For example, Oregon allows individuals with severe substance abuse problems to seek treatment. This helps people address the root of their problems—not just the symptoms. The
Oregon Option has put people into real work situations—not just make work—and this has helped Oregon move people off the welfare rolls and into real, sustainable jobs. I believe the Senate can learn from the lessons of Oregon’s program, and I will continue to work with my colleagues to ensure that all state TANF programs have the flexibility they need to operate successfully.

Mr. GRASSLEY. Mr. President, I understand the concerns of the Senators from my colleagues to look forward to working with them to reauthorize the TANF program in the coming months. I appreciate their concern for the need for Oregon to retain flexibility in TANF. I hope the Senator from Montana will agree that the Finance Committee, on both sides of the aisle, should discuss this issue as we move to reauthorize the TANF program.

Mr. BAUCUS. I agree with the chairman and look forward to moving on these issues. My home State of Montana is currently operating under a waiver that expires on December 31st of this year. I know that Montana, like Oregon, has been able to craft a successful TANF program because of its waiver, and I look forward to working with my distinguished colleagues to see that it is retained.

RECOGNIZING SENATOR TED STEVENS, THE RECIPIENT OF THE ARLEIGH BURKE AWARD FROM THE CENTER FOR STRATEGIC AND INTERNATIONAL STUDIES

Mr. INOUYE. Mr. President, our distinguished colleague, the Honorable Ted Stevens, was presented with the Arleigh Burke Award on June 11, 2003, by the Center for Strategic and International Studies. The award, named after the famed Admiral, who was the longest serving Chief of Naval Operations, recognizes Senator Stevens’s leadership in the fields of strategy, resource management affairs, as well as his hard work and selfless dedication to promote public service and the ideals of freedom.

When Senator Stevens accepted the Burke Award, he delivered a thoughtful speech that underscored Admiral Burke’s convictions that duty to country is more important than duty to the Commander-in-Chief, and that we should oppose the concentration of power.

I ask unanimous consent that Senator Stevens’s speech be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

SPEECH BY SENATOR TED STEVENS AT THE ARLEIGH BURKE MEMORIAL DINNER ON JUNE 11, 2003, IN WASHINGTON, DC

Good evening. Thanks to my good friend and colleague Senator Warner for that warm introduction.

My congratulations to General Keene, the Army’s new Acting Chief of Staff. I wish him success in the coming months.

It is a tremendous honor to receive an award named after Admiral Burke. Like many of you, I am familiar with the Admiral’s distinguished life of dedication, service, and achievement. Involved in the Navy during World War II, he was an admiral in the Navy, and the battles that made him one of that war’s greatest combat leaders were with well-known commanders.

I met Admiral Burke during the Eisenhower Administration. I was working on statehood for Alaska and Hawaii in the Department of Interior in those days. Admiral Burke was the Chief of Naval Operations. Like everything he did, Admiral Burke served as CNS with tremendous distinction. He was the longest serving CNS in history, and during his tenure he fought for technologies and strategies that continue to form the foundation of our Armed Services.

To refresh my memory of Admiral Burke’s accomplishments, I went back to E.B. Potter’s book about him.

Potter reported in January of 1958, the year Alaska’s Statehood Bill was enacted, Burke opposed the Gaither Report, which recommended streamlining and centralization of defense. At the National Press Club in the same year, he warned all he was, forces by “one man, a military Solomon.”

Notwithstanding that position of the CNS, in April 1958, and I quote from Potter’s book on Arleigh Burke:

“This . . . Eisenhower sent to Congress a special message on reorganization of the Department of Defense. Its chief recommendations were (1) to presume Chiefs from the operation chain of command; (2) to restrict Service Secretaries to administration, relieving them of responsibility for military operations; (3) to restrict duties of Joint Chiefs of Staff mainly to advising the Secretary of Defense; (4) to enlarge the Joint Staff; and (5) to limit control of operating forces to the President and the Secretary of Defense.”

Eisenhower sent word through Secretary of Defense McNary that he wanted all senior officers and officials to support his plan.

Arleigh was called before the Senate Armed Services Committee. As Potter related, Admiral Burke “put duty to country over duty to the Chief of Navy” and opposed this concentration of power in the Secretary of Defense.


To his great credit, Ike appointed Admiral Burke to a third term as CNS in August 1959. It is my hope that in reviewing the current proposals from D.D.O. before Congress, senior officers and officials of D.D.O. and all members of Congress will follow the great traditions Admiral Burke upheld.

Arleigh Burke lived his life by principles which guided him through the perils of World War II and still pertain today. He once described his philosophy as:

“A old-time philosophy—a philosophy of realism. You must always ask yourself the question, ‘What is important in life?’ . . . I don’t think it’s very important to be remembered. . . . The ideas I stood for should be remembered.”

Admiral Burke demonstrated his loyalty to the men under his command. The spirit of Admiral Burke’s commitment to his sailors is reflected in the steps the Congress has taken to support our troops and honor our promises to our veterans.

Admiral Burke was a hero and a visionary, and I do not think it is an honor to be your guest at this evening’s event. Thanks again for this award.

LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Mr. President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Act, a bill that would codify current federal hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred in New Bedford, Massachusetts. In June 2000, Mr. Arleah Bhalerao, a 24-year-old graduate student, was ambushed by four men and savagely beaten when the assailants mistook the student for a Muslim. Mr. Bhalerao, a Hindu Indian, works part-time as a pizza delivery man. One of the suspects placed a phone order at the local pizzeria where Mr. Bhalerao is employed. When Mr. Bhalerao arrived with the order, two men shoved him into the apartment and pushed him to the floor. After Mr. Bhalerao was lying on the floor, the attackers kicked and beat him. At one point, one suspect hit him with a kitchen chair. The perpetrators also burned Mr. Bhalerao’s beard and let him suffer. After hissing to court documents, one of the attackers told Mr. Bhalerao to “Go back to your own country.” Mr. Bhalerao eventually escaped from the trunk of an assailant’s car after he managed to loosen the fisherman’s rope binding his hands and feet. He is currently in the intensive care unit at a local hospital.

I believe that Government’s first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

NOMINATION OF JOSHUA BOLTEN TO BE DIRECTOR OF THE OFFICE OF MANAGEMENT AND BUDGET

Mr. CONRAD. Mr. President, I rise in support of Joshua Bolten as Director of the Office of Management and Budget, and to urge Mr. Bolten to do everything within his power to help put the Federal budget back on sound footing.

The position of OMB Director is always one of the most demanding posts in our Government, but it is especially so right now. The tax cuts pushed through by the President over the last 2½ years, combined with the continuing economic slowdown and increased spending to respond to the September 11 terrorist attacks and prosecute the military efforts in Afghanistan and Iraq, have pushed the budget deep into deficit. And despite the fact that we desperately need to get our fiscal house in order to be ready for the imminent retirement of the baby-boom population, this administration and its allies in Congress have not yet accepted that the policies they have advocated are leading us in the wrong direction.
I support the nomination of Joshua Bolten as OMB Director because I believe he is a very capable and honorable man, with a distinguished record both in public service—including service as a Senate staffer—and in the private sector. I expect that he will do the job of taking to heart the duty of the OMB Director to be an advocate for fiscal responsibility—to be willing to present the President with the facts where the budget is heading even if those facts are unpleasant, and to recommend policies that are unpalatable but are necessary and manageable within the overall context of our economy.

I hope when Mr. Bolten assumes his post as head of OMB, he recognizes the reality of the budget situation and leads the administration to reassess that position. That reality is that the deficit we are currently facing is enormous by any standard. According to CBO, the total deficit will exceed $400 billion this year, more than $100 billion higher than the all-time record deficit of $250 billion recorded in 1992. As a percentage of GDP, the deficit will be about 4 percent, a level that has been reached only eight times in the 57 years since the end of World War II. More troubling, when Social Security is excluded from the calculation, this year's deficit is likely to total about 5.5 percent—a level reached only twice in the last 57 years.

I hope Mr. Bolten accepts how serious the budget situation is and how important it is that we do not delay beginning the situation. I hope that he will advise the President to work with the Congress in a truly bipartisan way to reach agreement on and enact policies that will put the budget back on track.

COMBATING TORTURE AND ASSISTING VICTIMS OF TORTURE

Mr. CAMPBELL. Mr. President, I rise to address the barbaric practices that constitute torture as we mark the United Nations Day in Support of the Victims of Torture. Astonishingly, an estimated 500,000 victims of torture live in the United States today, including in my home state of Colorado. The United States has provided vital leadership in the campaign to prevent torture around the world. The United States must not equivocate on preventing torture around the world. The United States has provided many in my home State of Colorado and around the world with hope that he will advise the President with the facts where the budget is heading even if those facts are unpleasant, and to recommend policies that are unpalatable but are necessary and manageable within the overall context of our economy.

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NEW HOMESTEAD ECONOMIC OPPORTUNITY ACT

Mr. SMITH. Mr. President, I rise today with great concern. As you are aware, President Bush named June National Homeownership Month 2003. I am proud that our President has seen fit to promote an aggressive homeownership campaign, and I support this administration's efforts to see more Americans reach the American Dream of homeownership. As a member of the Finance Committee, I have had the opportunity to learn of important ways that we can make that a reality. In January I introduced the New Homestead Economic Opportunity Act—better known as the Homeownership Tax Credit. This legislation will create a single-family housing tax credit for developers who build in low income areas, and allow more Americans to reach their dreams of homeownership. It will also encourage developers of single family units to invest in low income areas and improve our communities.

The Department of Housing and Urban Development has stated that one of its goals is to allow every citizen—regardless of race, creed, color, or place of birth—the opportunity to own their own home. To reach this goal, there must be affordable homes to purchase.

In his testimony before the Senate Committee on Banking, Housing, and Urban Affairs earlier this month, James Rayburn, the Vice President of the National Association of Home Builders stated that the Homeownership Dream seeks to close the gap in homeownership rates among Americans. While 82 percent of households earning 100 percent or more of the national median income now own homes, only 53 percent of households earning less than the national median are homeowners. The homeownership rate for families earning 80 percent or less of the national median is only 40 percent to 45 percent. Homeownership for whites is 75 percent, while the ownership rate for African Americans is just barely 48 percent and 48 percent for Hispanics.

We can all agree that the quality of life in distressed neighborhoods can be improved dramatically by increasing home ownership. Existing buildings in these neighborhoods often need extensive renovation before they can provide decent owner-occupied housing. It is also difficult for renovations to occur because the cost of renovation will be less than the property values sit vacant and neighborhoods remain devastated. The New Homestead Economic Opportunity Act seeks to close this gap between development costs and market prices and will revitalize these areas.

I would like to see every American given the opportunity to succeed at the goal of owning their own home. I am proud to be the sponsor of this legislation, and I plan to continue to work to see it become law. I urge my colleagues to join me in supporting the American Dream by supporting S. 198.

HONORING MAYNARD H. JACKSON, JR.

Mr. CHAMBLISS. Mr. President, as Atlanta’s first black mayor, Maynard Jackson dedicated his career and his life to making the real inequalities that surrounded him and ensuring that the city of Atlanta was a thriving, inclusive community.

Working to expand Hartsfield International Airport, Maynard fought for equal treatment for minority workers and businesses. He sought to bring diversity to government as well as Atlanta’s business community. Through the equality he sought for all racial groups, he was able to foster economic expansion and growth for Atlanta and greater equality for her citizens.

Working to secure the 1996 Olympics, Maynard ensured that Atlanta shined for the world and was recognized as a city that offered opportunity for everyone regardless of race or socio-economic class.

Serving as the president of the National Conference of Democratic Mayors and the National Black Caucus of Local Elected Officials, he became a role model for young African Americans hoping to someday make their mark on this world and worked tirelessly to improve interracial relationships in the South’s largest city.

His contributions and accomplishments are the framework for the teaching of American history and civics in our classrooms. From that discussion, we came up with the framework for the American History and Civics Act of 2003 that just passed the Senate.

The bill establishes summer residential academies for teachers and students to encourage and learning of American history and civics in a more inspired way than is happening today. We can’t expect our students to learn what it means to be an American if we don’t teach them.

I would also like to see students in every classroom across this Nation beginning each schoolday with the Pledge of Allegiance. That could be followed with a student or teacher explaining in his or her own words what it means to them to be an American.

In the days following the terrorist attacks of September 11, 2001, we saw how quickly we Americans could come together as one people, united in purpose, despite our

IN SUPPORT OF THE PLEDGE OF ALLEGIANCE

Mr. ALEXANDER. Mr. President, recently, I visited with Reverend Jacob Bazzel Mull and his wife, Elizabeth, in Knoxville, TN. They host the Mull Singing Convention, a popular gospel radio program.

Reverend Mull is a legend with an interesting story to tell. He was born in Lackawake, NC, into a musical family. When he was 11 months old, he lost his eyesight after falling into an open-pit fireplace. As a child, he played in a gospel group made up of his mother, father, brothers and sisters.

He began preaching in 1958 and hasn’t stopped since. In 1968, he moved to Knoxville to start his first radio program, and the rest is history. He became well-known nationwide during the 25 years he sold Chuck Wagon Gang Records on several 50,000-watt radio stations.

This year, all of his many accomplishments were recognized when he was honored by the Gospel Music Association for his ‘outstanding contribution to gospel music.’

During our visit in April, Reverend Mull gave me 2,000 letters and a number of petitions with thousands of names on them from Americans angry over the Ninth Circuit’s decision declaring the Pledge of Allegiance unconstitutional. Reverend Mull solicited these letters from his listeners across the country, and I was delighted to see the passion people across America have for the Pledge. It made me proud to answer all of those letters.

I believe the answer to how we do that lies with the people. In August of 2002, I spent the night with Jim Coley, a Tennessee Government high school teacher, and his family. One idea that came out of that visit was the importance of putting the teaching of American history and civics back into our classrooms. From that discussion, we came up with the framework for the American History and Civics Act of 2003 that just passed the Senate.

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In the days following the terrorist attacks of September 11, 2001, we saw how quickly we Americans could come together as one people, united in purpose, despite our
diverse backgrounds. Although we are almost 2 years removed from that time, there is no reason this sense of unity and purpose cannot continue as part of our lives every day. Americans have a reputation for being resourceful, resilient, and having common sense. These attributes are helping to bring out the best in the entire Nation.

I thank Reverend Mull for his commitment to this country, for inviting me to visit with him, and for sharing America’s outpouring of support in favor of our values and principles on which this Nation was founded. I also appreciate the opportunity to bring Reverend Mull’s good work to the attention of our country.

WELCOME BACK TO ALASKA, MR. CONSUL GENERAL

Ms. MURKOWSKI. Mr. President, next week the people of Alaska will welcome Mr. Yossi Amrani, the Consul General of the State of Israel for the Pacific Northwest, back to our State. He will begin his trip in Fairbanks, meeting with students and members of the community at the University of Alaska, visiting with members of Congregation Or Hatzafon, which has the northernmost synagogue building in the world, and speaking to the Greater Fairbanks Chamber of Commerce. He will also visit Anchorage on this trip and I look forward to meeting with him then.

This is not Mr. Amrani’s first visit to my State, but it is his first visit to Fairbanks, the “Golden Heart City.” Although the Fairbanks Jewish community is small in numbers, the fundamental Jewish values of tzedakah, charity; and chesed, kindness, are deeply ingrained in the Fairbanks culture, as they are in the culture of Alaska as a whole.

Like the Fairbanks Jewish community, the Alaska Jewish community is small in numbers, but large in spirit. In the late 1990s, Professor Bernard Reisman from Brandeis University visited Alaska on several occasions to learn more about our Jewish community. He concluded that in virtually all areas, the Alaska Jewish community has a higher level of identity than do American Jews generally. He found this to be true not only in places like Anchorage and Fairbanks, but also in the smaller communities, where “conveners” organize regular get togethers, especially on Jewish holidays.

Members of the Jewish community occupy a prominent role in the social, economic, cultural and political life of Alaska. A few weeks ago, I welcomed the internationally known Holocaust scholar, Dr. Michael Schudler of the University of Alaska Fairbanks, to my office in Washington. Dr. Schudler discussed his work with the United States Holocaust Memorial. Another UAF scholar, Dr. Michael Krauss, has worked closely with the Alaska congressional delegation for many years in efforts to preserve Alaska Native languages. And let us not forget the many contributions of the Gottstein family to virtually every aspect of Alaska’s fabric.

This is not a new phenomenon. The beautiful municipal library in Anchorage is named for Zachary J. Loussac, a Russian Jewish immigrant, who served as Mayor of Anchorage. The Girl Scout camp in Fairbanks is named for Jessie Bloom, who along with her husband Robert, are regarded as the founding leaders of the Fairbanks Jewish community. In 1926, Jessie started the first Girl Scout troop in Alaska, while Robert was a founder of what was later to become the University of Alaska. Our striking new courthouse in Fairbanks is named for Jay Rabinowitz who served for many years on the Alaska Supreme Court.

The survival of the State of Israel is important to the people of Alaska as it is to the American Jewish community and the American people. In Washington, I stand shoulder to shoulder with my colleagues in praying for peace in the Middle East while standing firm on the principle that terrorism is morally and politically unacceptable. Terrorism will not undo Israel’s future. When the Senate returns in July, it will consider comprehensive energy legislation and I am hopeful that my amendment to guarantee that Israel will have a secure source of petroleum in the event it cannot independently acquire it due to an embargo will be in the bill when it passes the Senate.

During this visit to Alaska, as on previous visits, the Consul General will encounter the vast natural beauty of our state. But he will also discover, as in previous visits, that it is the people of Alaska that make this place truly special. Shalom, Mr. Consul General. I hope that you will visit with Alaskans often.

Mr. President, I ask unanimous consent that the message of Consul General Yossi Amrani be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

MESSAGE OF CONSUL GENERAL YOSSI AMRANI TO THE PEOPLE OF ALASKA

The friendship and alliance between the United States and Israel have many varied faces, moral, political, economic and strategic. The partnership is on the federal and state level alike. Jews, who make up a small percentage of the population of Alaska, thousands of miles apart, the Consulate General of Israel to the Pacific Northwest region works with state leaders and the Jewish community bringing the two nations together in sharing the values, ideals and concerns of both people. The Consulate provides seminars and speaking engagements in different communities and schools to educate public opinion on the complexity of the situation in the Middle East and the importance of the U.S. role in that region. The Consulate also promotes Israeli culture and business opportunities. Mutual values are the corner stones of the relationship and interaction between the people of Alaska and Israel. As we maintain U.S. support for Israel’s existence and well being, we aspire to continue building stronger relations.

HONORING THE LATE DAVID BRINKLEY

Mrs. DOLE. Mr. President, I am honored today to talk about a pioneer for North Carolina in the field of journalism . . . the late David Brinkley. David died on June 12, at the age of 82, from complications resulting from a fall. He was laid to rest in his beloved home, Wilmington, North Carolina . . . beside his father—William Graham Brinkley and mother—Mary MacDonald West Brinkley.

David was born in Wilmington . . .

He attended high school at New Hanover High School. While there . . . and after several long hours pouring over books in the Wilmington Library . . .

David got an itch for journalism. He didn’t wait. He took a part-time job while still in high school, working for the Wilmington Morning Star and its afternoon edition, the Wilmington News. He said he made about $11 a week.

But the young boy, who once made extra money by changing light bulbs and running a soft-drink stand at Wrightsville Beach’s Lumina Pavilion, went on to become an icon for millions of viewers who watched him each night. He and co-anchor Chet Huntley had the highest rated news program on American television during the 1960’s with “The Huntley-Brinkley Report.”

Many of us still remember their familiar sign-off of “Good night, Chet.”

“Good night, David.”

David went on to host “This Week With David Brinkley,” until he retired in 1996.

Mr. President, at a time when we often get news that is too short, too sensationalized and sometimes too slanted, David Brinkley was the consummate newscaster. He knew the issues, and his intelligence, quick wit and thirst for answers kept us all glued to the television.

I had the pleasure of personally knowing David Brinkley, and in addition to sharing a distinctive Southern twang, we shared a fondness for our home state. David wrote about Wilmington in his 1995 memoirs and even with all this success, all his fame, David and his wife, Susan, returned to his home in North Carolina often and supported his hometown. He was an ardent supporter of downtown Wilmington preservation. The University of North Carolina at Wilmington presented him with an honorary Doctor of Laws degree in 1974. He was added to Wilmington’s Walk of Fame in 2001.

As much as David loved North Carolina—North Carolina loved him, too.
His life has been a model for so many North Carolinians—the local boy doing good . . . remembering his roots.

We will forever be indebted to David Brinkley for solid Washington reporting and his wry sense of humor. The Senatepraak a rapt audience, which I would appreciate, hearing the life accomplishments of David Brinkley. May his legacy live on and inspire those who follow in his footsteps.

In an interview 11 years ago, David said this of his profession, ‘People go and do things, and happen to be there when they then tell what they have seen. That’s all a reporter ever did. I think it’s a very honorable thing to do.’

Indeed, it is, David, indeed, it is.

Mr. President, I send out my heartfelt condolences—and those of all North Carolinians—to Susan and to David Brinkley’s family.

ADDITIONAL STATEMENTS

WIND RIVER INDIAN RESERVATION’S 140TH ANNIVERSARY

Mr. THOMAS. Mr. President, I rise today to recognize the 140th Anniversary of the Wind River Reservation.

On July 2, 1863, the U.S. Government and the Shoshone people signed the Fort Bridger Treaty, creating the Shoshone Reservation, which included over 44 million acres. In what is now Colorado, Utah, Idaho, and Wyoming. This area was reduced to roughly 3 million acres by the second Fort Bridger Treaty of July 3, 1868, and was later renamed the Wind River Reservation during the 1930s. Today, the reservation is roughly more than 2 million acres, one of the largest in the country, and is located in central Wyoming’s beautiful Wind River Basin. It remains the contemporary home of the Eastern Shoshone and Northern Arapaho tribes.

Chief Washakie, a distinguished statesman of the Shoshone people, was one of the few Indian leaders to successfully negotiate with the U.S. Government in determining the reservation’s location. For centuries, American Indians who traveled through this area referred to it the Warm Valley of the Wind River because of surrounding hot springs. Renowned for his courage on the battlefield, and talent in diplomacy, the people of Wyoming selected Chief Washakie to represent our State, in the U.S. Capitol Building, as one of our two contributions to Statuary Hall.

The northern band of Arapahos began to make the Wind River Reservation a more permanent home during the last 1870s, though they were not signatories to either of the Fort Bridger Treaties. Under the leadership of men such as Black Coal, Sharp Nose, Little Wolf and White Horse, the Northern Arapahos settled in Wyoming, while the eastern band of Arapahos moved to a reservation in western Oklahoma. Wind River country encompasses mountains, streams, lakes and forests, and was favored by the Northern Arapahos over the hot and arid Oklahoma landscape.

The Wind River Indian Reservation is one of Wyoming’s greatest historical, cultural, and natural treasures. A grave site for Sacajawea, the young Shoshone woman who helped guide the Lewis and Clark expedition through Shoshone lands in the early 1800s, can be visited on the reservation. Both tribes continue to celebrate each other during the spring and summer months, which describes the Treaty Days Powwow.

As we look back on the past 140 years, I would like to pay tribute to the important contributions American Indians have made to our history and our culture. Throughout my time in Congress, I have had the pleasure to work with members of both tribes on the Wind River Reservation. I would like to thank Vernon Hill, chairman of the Eastern Shoshone Business Council and Burton Hutchinson, Sr., chairman of the Northern Arapaho Business Council, as we work to ensure the prosperity of the Wind River Reservation for future generations.

A GREAT MONTANAN—ANTHONY J. PREITE

Mr. BAUCUS. Mr. President, I rise today in celebration of a great Montanan and American, Anthony J. Preite.

Today, Mr. Preite, the director of the Denver Regional Office of the U.S. Department of Commerce Economic Development Administration is retiring. I have known Tony Preite for about 30 years, and my family has known Tony and his wife Betty all the best I thank him for more than 35 years of public service. Good luck, Tony, and welcome back to Montana!

AL BRAIMAN: DEPAUL UNIVERSITY CLASS OF 2003

Mr. DURBIN. Mr. President, I rise today to honor Al Braiman, graduate of DePaul University’s Class of 2003. Al was the oldest graduate of DePaul’s Class of 2003 when he graduated on June 14. Al completed a degree in liberal studies at DePaul’s University New Learning with a grade point average of 3.92 out of a possible 4.0.

Born in Kiev, Russia, in 1920, Al immigrated to the United States at the age of one. His family took up residency in Chicago, where he lived most of his life. After high school, Al turned down an academic scholarship for college to support his family. Al joined the Army and served with distinction in World War II, spending most of his time on Guadalcanal.

After leaving the Army, Al owned and operated Lakeview Grocerland until the mid-1960s when he became an insurance salesman with Equitable Life
Insurance Company. He became a certified life underwriter and chartered financial consultant. Al won many awards in the industry, including induction into the Equitable Hall of Fame.

After retiring in 1985, Al decided to earn a college degree, something he promised his mother earlier in his life. Al's interest in politics led him to take many political science and history courses at DePaul University. One of his favorites included a class on American presidents and a course on race relations. He also enjoyed learning many new things such as use of the Internet, photography, and art. Al has proven that it is never too late to learn and we could all learn a great deal from his perseverance.

I know my fellow Senators will join me in congratulating Al Braiman, DePaul Class of 2003. His story contains the elements of a great American life and I am honored to share it with you in my colleagues in the Senate.

HONORING SUPERINTENDENT GERALD WAYNE COBB, ED.D.

Ms. LANDRIEU. Mr. President, every session in Congress we spend a large amount of time discussing education in this country. Debates range from accountability to school construction to teacher recruitment. While our discussions are of the utmost importance, it is the implementation of our decisions by the individuals within the education system that changes how our children learn. I rise to honor a man who had dedicated his life to improving education for children in Louisiana, Dr. Gerald Wayne Cobb.

In 1960, Dr. Cobb received his bachelor's degree in health and physical education from Louisiana Tech University. Since that time he has been a crucial part of school improvements within the Lincoln Parish School System. Dr. Cobb has served as principal of Hillcrest High School, Simsboro High School, and Ruston High School. He has worked as visiting associate professor at Louisiana State University and Louisiana Tech University.

Dr. Cobb has also served in the Louisiana Department of Education, working as the director of secondary education, the executive director of academic programs, and the executive assistant to the superintendent. While with the Louisiana Department of Education, he has been instrumental in developing the Compensatory Education Program in Louisiana which provided remediation for students not meeting the passing scores on the State's Basic Skills Testing Program. Dr. Cobb also published *Basic Skills Testing Manual*, which is the Louisiana Handbook for School Administration and served as the basis for the State's accreditation program. Dr. Cobb worked to increase in-service training for principals by co-authoring the *Louisiana Academy for School Administrators Program* and representing Louisiana at the Leadership Training for Principals.

After working with the Department of Education and serving as principal for schools throughout Lincoln Parish, Dr. Cobb continued his public service in the area of education by serving as superintendent for the Lincoln Parish School System. For the past 15 years, Dr. Cobb has helped the 14 schools and 6,865 students in the Lincoln Parish School System. During his tenure, Dr. Cobb helped to construct the Lincoln Parish Secondary Alternative School at no cost to local taxpayers. Although the students in Lincoln Parish receive the highest ACT scores throughout the State in 1996. In 2000, Ruston High School graduated seven National Merit Finalists, the most of any public, nonmagnet high school in the State.

The gifts that Dr. Cobb has given the Lincoln Parish School System and all of Louisiana go far beyond those that I have named above. Dr. Cobb has spent the past 43 years giving his kindness, his leadership, and his service. It is to educators like Dr. Cobb that we owe many of the successes of our education policy. My best wishes are with Dr. Cobb and his family as he enters retirement.

HONORING LOUIS AND LUJUANNA CARNEY

Mr. CRAPO. Mr. President, I rise today to congratulate my good friend, Louis Carney and his wife LuJuanna. Just last week, the Carneys, who live near my family's home in Idaho Falls, celebrated their 50th wedding anniversary. I am honored to know them and pleased that I was asked to join the celebration.

I can think of no better way to commemorate their 50 years together than to mention that they are the proud parents of eight children, six who are still with us—Don, Nancy, Bob, Terry, Kevin, and Kenneth; and two who have rejoined their Heavenly Father—Laurie Ann and Jean Marie; the even prouder grandparents of fifteen; and the great grandparents of one. It speaks very highly of their commitment to each other and their family that so many of their family members were on hand to mark the occasion. Louis has been a very good friend to me over the years, and I appreciate his wisdom and guidance on many matters. He has been a strong supporter of the Boy Scouts of America program, and I share his enthusiasm for this program which can be so important in helping young men to learn new skills and achieve goals.

Louis and LuJuanna have been important members of our community. They are always available for those who are in need. They radiate happiness and contentment, and can be counted on by not only their friends, but so many others. I am proud to mark their anniversary, and even more pleased to call them friends.

TRIBUTE TO GARY R. COOPER

Mr. GREGG. Mr. President, I rise today to recognize and commend Gary R. Cooper upon his retirement after serving for 20 years as Executive Director of SEARCH, the National Consortium for Justice Information and Statistics.

SEARCH is a national organization dedicated to enhancing the use of information and identification technology in law enforcement. SEARCH provides invaluable no-cost technical assistance, training and support to criminal justice agencies all over the country. The organization's members are Governors appointees from each State and their common goal is to ensure that the criminal justice community has access to services that will allow them to use the best technology for communications, information sharing, and identification. SEARCH has been a tremendous asset to our Nation's law enforcement and this is due in no small part to the work of Gary Cooper.

Under Gary's leadership over the past 20 years, SEARCH has truly become a leader in encouraging States to participate in national information and identification technology programs. For instance, under Gary's leadership, SEARCH made a profound contribution to the States' effective participation in the Interstate Identification Index and the National Fingerprint File, and the National Crime Information Center 2000 (NCIC 2000) program.

Through SEARCH, Gary has also helped to implement his retirement on the national level. While Gary has headed SEARCH, it has made a profound contribution to the development and implementation of the National Criminal Background Check System. SEARCH also played a pivotal role in the development and enactment of the Crime Identification Technology Act which today creates the legal and funding platform for the Federal/State criminal justice technology partnership. Because of Gary, SEARCH was, and is, the primary State voice in support of the successful and ongoing national adoption of the Interstate Identification Index and Privacy Compact and the development of the Compact Council.

At every important moment in the past 20-year history of criminal justice information and identification technology, Gary Cooper has been a courageous leader, an untrusting champion and an influential national voice.

On the occasion of his retirement, I thank Gary R. Cooper for all that he has accomplished on behalf of criminal justice in the United States.
HONORING HUGH BRADY

Mr. CRAPO. Mr. President, I rise today to congratulate Mr. Hugh Brady of Boise Idaho who will be inducted into the Idaho High School Activities Hall of Fame on August 6th, 2003. In 1954 Mr. Brady started working at Idaho Sporting Goods, and he has been dedicating his young life in Idaho participate in athletics ever since. Mr. Brady, who later became the owner of the sporting goods store, has sponsored Little League baseball teams, football teams, basketball teams, softball teams, and bowling teams. He also took the time to coach many teams over the years.

Mr. Brady has demonstrated extraordinary support for athletics and the youth of Idaho. There have been numerous instances when a student could not afford the cost of equipment to participate in a sport and Mr. Brady made sure that they got it. Mr. Brady, you make Idaho proud.

For the past years, Mr. Brady has battled lung cancer. My wife, Susan, and I along with many Idahoans will keep in our thoughts and prayers.

HONORING VICTIMS OF GUN VIOLENCE

Mr. LEVIN. Mr. President, earlier this week, more than 35 dedicated cyclists, with People Pedaling Peace made the 200-mile trip from Hampton, VA, to Washington, DC, to honor and remember victims of gun violence. In partnership with the Alliance for Justice, the People Pedaling Peace cyclists rode not only in honor of the victims of gun violence, but for stronger, more sensible gun safety laws in America and to raise awareness of violence against children in this country.

Pedaling for Peace was started in 2001 by Sandra and Mike McSweeney whose young daughter Stephanie was killed while walking out of a roller rink in Hampton, VA. Mr. and Mrs. McSweeney, as well as several other individuals affected by gun violence and violence against children made the journey this year. Others who made the trip include Craig Scott, whose sister Rachel is a Columbine survivor; Amber Hensley, a student at Thurston High School in Eugene, OR, who witnessed the shootings; and Lorraine Reed, mother of two daughters whom was murdered and one of whom was seriously assaulted. Unfortunately, the total number of people like them who have lost family and friends to gun violence continues to grow.

According to the Centers for Disease Control and Prevention, the total number of gun deaths in the United States has been dropping since 1993, when it peaked at nearly 40,000, to around 28,000 annually 1999 through 2001. However, guns still kill more young people in America than the most common diseases of our time. Thousands more children are injured, lose a loved one, or live in fear of gun violence.

I hope my colleagues will join me in commending all of the cyclists who pedaled for peace, and join me in supporting sensible gun safety legislation.

DELBERT L. LATTA POST OFFICE BUILDING

Mr. VOINOVICH. Mr. President, I rise today on behalf of a bill considered by the Senate, H.R. 985, to designate a post office in Bowling Green, OH, as the Delbert L. Latta Post Office Building. I strongly support this bill honoring a long-time member of the Ohio congressional delegation. Naming this post office after Del Latta is a fitting way to honor him. The building that houses this post office also served as a district office for Mr. Latta during his 30 years of service in Congress.

Delbert Latta is a native and lifelong resident of Ohio. Born in the small northwestern town of Weston, OH, Mr. Latta attended Bowling Green College and Ohio Northern University Law School.

Mr. Latta began his service to our Nation as a member of the Ohio National Guard. During World War II, Mr. Latta served with the U.S. Marine Corps Reserves.

After his military service, Mr. Latta practiced law in Bowling Green, but in 1953, he again answered the call to public service by running for the State legislature. Mr. Latta was elected to the Ohio State Senate. After serving three terms, Mr. Latta was elected by the people of Ohio’s fifth congressional district to the U.S. House of Representatives. During his long and distinguished career in Congress, Mr. Latta fought hard against wasteful government spending and to balance the Federal budget, a passion that I share.

During his 30 years in Congress, Mr. Latta earned prominent committee assignments in the House, including serving as the ranking member of the Budget Committee, and as a member of the powerful Rules Committee, and the Agriculture Committee.

Naming this post office the Delbert L. Latta Post Office Building is a wonderful tribute to a man who served Ohio and our Nation with distinction throughout his life.

I thank my colleagues for their consideration of this matter.

TRIBUTE TO ARTHUR G. STEPHENSON

Mr. SHELBY. Mr. President, I rise today to recognize the outstanding accomplishments and distinguished career of Mr. Arthur G. Stephenson upon his retirement as the Director of the NASA Marshall Space Flight Center. It has been a privilege for me to get to know Art. While retirement announcements are things that we do not like to hear when it involves someone who has been successful in an organization as Art has been to Marshall’s, I would like to say how much I have enjoyed working with Art and his staff during his tenure as the Director of the Marshall Space Flight Center.

As the Director of one of NASA’s largest field installations, with more than 6,500 civil service and contract employees and an annual budget in excess of $2 billion, Art successfully managed a very broad range of activities for the U.S. space program. Some of these critical NASA initiatives included development of new reusable launch vehicles, propulsion advanced space transportation systems, second and third generation propulsion technology development programs, research in microgravity, and science payload operations aboard the International Space Station. He also oversaw the establishment of the National Space Science Technology Center, a partnership with universities and Federal agencies to conduct cutting-edge research. Art also oversaw the planning and establishment of the Propulsion Research Laboratory, a world-class laboratory for research into future space transportation and propulsion technology. Art has led the Marshall Center in numerous successful space shuttle missions, which Marshall was responsible for all propulsion elements. Under Art’s direction, the Marshall Center has completed testing of the truss and pressurized modules for the International Space Station, and provided support for the construction and operation of the International Space Station, including Marshall’s Payload Operations Center which controls all the science experiments aboard the space station.

Art brought more than 35 years of experience in the space industry to NASA and used it to the great benefit of the Marshall Center and the U.S. space program. I could list many additional achievements and professional accomplishments, and I believe that much of his success is directly attributable to Art’s record as an extraordinary leader throughout his career.

Art has been an important and respected member of Huntsville community. I know that I speak for many people in Huntsville and everyone in the NASA family when I say that we all thank Art for his tireless commitment to NASA and to Marshall. We sincerely hope that he and his family will remain part of the Huntsville community for many years to come.

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In his remarks Lord Black spoke vividly and in detail about Depression-era America, and the “bold experimentation,” as he put it, of the New Deal years.

I ask unanimous consent that the text of Lord Black’s remarks be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

ADDRESS OF LORD BLACK AT FRANKLIN DELAWARE ROOSEVELT DISTINGUISHED PUBLIC SERVICE AWARD DINNER

On election night, 1932, unemployment stood at approximately 30%. There was minimal direct government relief for the 14 million or so unemployed. Their condition was alleviated by private sector charity, and by theft and begging.

The Soviet Union advertised in the United States for 6,000 skilled workers to go to Russia in 1932 for a period of several years; it’s New York office was swamped with 100,000 applications. The natives of West Africa sent New York office with more than half the poor. When the city of Birmingham, Alabama, advertised for 750 ditch-diggers to work ten-hour days for $2 per day, 12,000 applications arrived in two days.

In the coal-mining regions of Kentucky and West Virginia, over 90% of children were suffering from malnutrition. The country had spawned a depression of more than 20%. Millions of Americans faced the distinct possibility of death by starvation or exposure to the elements. Large numbers of people lived from the scraps and leftovers thrown out in the garbage by restaurants and hotels.

The volume of cheque transactions and of stock transactions in the United States had declined by 60% since 1929. The amount of new capital financing had declined by over 95% since 1929. The volume of new building contracts had declined by 75%. By inauguration day in March 1933, the Dow Jones Industrial Average was down by 90% from its high in September, 1929.

BANK FAILURES

There had been 5,500 bank failures in three years, wiping out nine million individual bank accounts. Steel production was under 20% of capacity, and United States Steel Corporation alone had 225,000 full-time employees in 1929, now had no full-time employees, apart from those in the executive offices.

Total non-agricultural production was less than half of its 1929 level. Manufacturing income has shrank by 65%. Agricultural production, while approximately equal in physical volume to that of 1929, had shrunk in production, while approximately equal in physical volume to that of 1929, had shrunk in agricultural production, was less than half of its 1929 level. Manufacturing income has shrank by 65%. Agricultural production, while approximately equal in physical volume to that of 1929, had shrunk in agriculture. The volume of cheque transactions and of stock transactions in the United States had declined by 60% since 1929. The amount of new capital financing had declined by over 95% since 1929. The volume of new building contracts had declined by 75%. By inauguration day in March 1933, the Dow Jones Industrial Average was down by 90% from its high in September, 1929.

Approximately 45% of the residential homes in America were in danger of being foreclosed by mortgage-holders. Through the first six months of 1933, 250,000 homes were foreclosed, well over a thousand per day, the families pitched out into the streets. The mortgage values to that of 1929, had shrunk in agriculture. The volume of cheque transactions and of stock transactions in the United States had declined by 60% since 1929. The amount of new capital financing had declined by over 95% since 1929. The volume of new building contracts had declined by 75%. By inauguration day in March 1933, the Dow Jones Industrial Average was down by 90% from its high in September, 1929.

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The money supply, deflation-adjusted, had declined by 25% in four years.

Many local and state governments, including Chicago and Georgia, could not pay their school teachers. Georgia closed over a thousand schools attended by 170,000 students. Most rural Alabama white schools were closed within months of its 50th anniversary.

On the day before inauguration day, 32 states had closed all their banks indefinitely. Six other states had closed almost all their banks. Ten states, including the District of Columbia, withdrawals were limited to 5% of deposits and in Texas to $10 per day. The U.S. financial system had reached the last extremity before it would collapse completely, taking the life’s savings of tens of millions of people and what was left of the international economic system with it.

American literature achieved a virtual golden age with writers such as John Steinbeck, Erskine Caldwell, Edmund Wilson, and John Dos Passos describing depression conditions.

FRANKLIN D. ROOSEVELT’S FIRST INAUGURAL ADDRESS

Over 400,000 people came out to hear Franklin D. Roosevelt’s famous first inaugural address; they covered 40 acres of lawns adjacent to the first time since the Civil War, soldiers in full combat gear and machine gun emplacements surrounded by sand-bags were visibly guarding the White House.

Roosevelt promised bold experimentation. In the Hundred Days of the spring of 1933, the Roosevelt administration reorganized and reopened the banks and guaranteed their deposits, a great monetary step as bank deposits now joined most definitions of the money supply.

The legislation of the Hundred Days incentivized price and wage increases, reduced the working week, cut government salaries, increased some marginal taxes, tolerated a degree of cartelism to raise prices and avoid over-production, encouraged collective bargaining, and engaged in massive workfare schemes that employed nearly half the unemployed in projects of conservation and public works.

The first year of these programs funded 500,000 miles of roads and 40,000 schools, 3,500 parks and 1,000 airfields were built or upgraded. The Civilian Conservation Corps, through the ‘thirties, thinned four million acres, produced one billion fish, and built 30,000 animal shelters.

Ordinary unemployment declined by four million through 1933, partly due to the reduction in the workweek. Farmers voted by category to approve production cutbacks, permitting farm price increases, and some of the agricultural surpluses were taken for distribution to the needy. The Tennessee Valley Authority was launched and great progress began on rural electrification, flood control, and drought control.

The Hundred Days also refinanced the nation’s mortgages, effectively departed the gold standard, exchanged embassies with the Soviet Union, and extended the Hawley-Smoot Tariff.

In the Hundred Days of the spring of 1933, the Roosevelt administration reorganized and reopened the banks and guaranteed their deposits, a great monetary step as bank deposits now joined most definitions of the money supply.

The legislation of the Hundred Days incentivized price and wage increases, reduced the working week, cut government salaries, increased some marginal taxes, tolerated a degree of cartelism to raise prices and avoid over-production, encouraged collective bargaining, and engaged in massive workfare schemes that employed nearly half the unemployed in projects of conservation and public works.

The first year of these programs funded 500,000 miles of roads and 40,000 schools, 3,500 parks and 1,000 airfields were built or upgraded. The Civilian Conservation Corps, through the ‘thirties, thinned four million acres, produced one billion fish, and built 30,000 animal shelters.

Ordinary unemployment declined by four million through 1933, partly due to the reduction in the workweek. Farmers voted by category to approve production cutbacks, permitting farm price increases, and some of the agricultural surpluses were taken for distribution to the needy. The Tennessee Valley Authority was launched and great progress began on rural electrification, flood control, and drought control.

The Hundred Days also refinanced the nation’s mortgages, effectively departed the gold standard, exchanged embassies with the Soviet Union, and extended the Hawley-Smoot Tariff.

The second New Deal, in 1934 and 1935, was built around Social Security and included the Labour Relations Act, the Securities and Exchange Commission, a comprehensive modernization of the Federal Reserve, and what was called, but was not really, a works program.

As in executive session the Presiding Officer laid before the Senate messages from the President of the United States which were referred to the appropriate committees.

(Messages printed today are printed at the end of the Senate proceedings.)

MESSAGES FROM THE HOUSE

At 11:59 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House had passed the following bill, without amendment.

S. 858. An act to extend the Abraham Lincoln Bicentennial Commission, and for other purposes.

The message also announced that the House had passed the following bills, in which it requests the concurrence of the Senate:

H.R. 1511. AN act to award a congressional gold medal to Prime Minister Tony Blair.

H.R. 2747. An act to authorize the Congressional Hunger Center to award Bill Emerson and Mickey Leland Hunger Fellowships for fiscal year 2003 and 2004.

H.J. Res. 49. A joint resolution recognizing the important service to the Nation provided by the Foreign Agricultural Service of the Department of Agriculture on the occasion of its 50th anniversary.

The message further announced that the House had agreed to the following concurrent resolution, in which it requests the concurrence of the Senate:

H. Con. Res. 49. Concurrent resolution expressing the sense of the Congress that the
sharp escalation of anti-Semitic violence within many participating States of the Organization for Security and Cooperation in Europe (OSCE) is of profound concern and efforts should be undertaken to prevent future occurrences.

At 6:19 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the bill to which the Committee requests the concurrence of the Senate:

H.R. 2559. An act making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes.

At 7:50 p.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 531. An act to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program (SCHIP).

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were read before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–2961. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Amendment to Class E Airspace: Windsor Locks, Bradley International Airport, Federal Aviation Regulations (FARs)" (RIN 2120-AA64) (2003–0002) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2962. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "IFR Altitudes: Miscellaneous Amendments (18)" (RIN 2120-AA64) (2003–0003) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2963. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Bombardier Model C1 600 2C10 Series Airplanes" (RIN 2120-AA64) (2003–0236) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2964. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Airbus Model A319 131, 132, and 253, and A321 251 Series Airplanes; Equipped with International Aero Engines V2500 A5 Series Engines" (RIN 2120-AA64) (2003–0230) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2965. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Dassault Model Mystere-Falcon 50 Series Airplanes" (RIN 2120-AA64) (2003–0248) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2966. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Raytheon Aircraft Company Model 390 Airplanes" (RIN 2120-AA64) (2003–0258) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2967. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: CPM International 'Purbach Engeines'" (RIN 2120-AA64) (2003–0247) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2968. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Dornier Weke GmbH Model DO 27Q-6 Airplanes" (RIN 2120-AA64) (2003–0246) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2969. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation transmitting, pursuant to law, the report of a rule entitled "Airworthiness Directives: Dowty Aerospace Propellers, Models R354, R375, R388, and R390 Propellers" (RIN 2120-AA64) (2003–0239) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

MEASURES REFERRED

The following bill and joint resolution were read the first and the second times by unanimous consent, and referred as indicated:

H.J. Res. 49. Joint resolution recognizing the 50th anniversary of the Organization for Security and Cooperation in Europe (OSCE) is of profound concern and efforts should be undertaken to prevent future occurrences.

The following bills were read the first and second times by unanimous consent:

H.R. 151. An act to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program (SCHIP).

MEASURES PLACED ON THE CALENDAR

The following bills were read the first and second times by unanimous consent, and placed on the calendar:

H.R. 2559. An act making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes.

H.R. 531. An act to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program (SCHIP).

MEASURES READ THE FIRST TIME

The following bill was read the first time:

S. 11. A bill to protect patients' access to quality and affordable health care by reducing the effects of excessive liability costs.

EC–2968. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives: Boeing Commercial Airplane Company Model 747–200B and 200F Series Airplanes Powered by Pratt and Whitney JT9D–70 Series Engines” ((RIN2120-AA64)(2003–0219)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2969. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives: Raytheon Model DH 125, HS 125, and BH 125 Series Airplanes, 800A, 800A (C–29A), 800A (U–125), 800B, 1000A, and 1000B Airplanes; and Models Hawker 800, 800 (including variant U–125A), and 1000, and 800 A10 and BR700–710 A2 2 Turbofan Engines’’ ((RIN2120-AA64)(2003–0227)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2970. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives: McDonnell Douglas Model MD 90 30 Airplanes” ((RIN2120-AA64)(2003–0226)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2971. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives: Bombardier Model CRJ 900 and 700 Series Airplanes” ((RIN2120-AA64)(2003–0225)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2972. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives: Schweizer Aircraft Corp Model SA 221 Helicopters” ((RIN2120-AA64)(2003–0224)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2973. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives: Cesna Aircraft Models 414 and 411 Series Airplanes” ((RIN2120-AA64)(2003–0223)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2974. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives: Rolls Royce Deutschland Ltd and Co KG Models B747 710 A10 and B747 710 A2 20 Turboprop Engines’’ ((RIN2120-AA64)(2003–0222)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2975. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives: Rolls Royce Deutschland Ltd and Co KG Models B747 710 A110 and B747 710 A2 20 Turbofan Engines’’ ((RIN2120-AA64)(2003–0221)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2976. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Airworthiness Directives: Rolls Royce Corporation 501–D Series Turboprop Engine” ((RIN2120-AA64)(2003–0220)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2977. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Modification of Class E Airspace; Eureka, KS’’ ((RIN2120-AA66)(2003–0103)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2978. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Modification of Class E Airspace; Atlantic Mackerel, Squid and Butterfish Fisheries; Framework Adjustment 3’’ (RIN0693–AB52) received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2979. A communication from the Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled “Establishment of Class E Airspace; Ridgely, MD’’ ((RIN2120-AA66)(2003–0109)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2980. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Modification of Class D Airspace; and Modification of Class E Airspace; Topeka Philip Billardunicia; Airport, KS’’ ((RIN2120-AA66)(2003–0108)) received on June 19, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2981. A communication from the Program Analyst, Federal Aviation Administration, Department of Transportation, transmitting, pursuant to law, the report of a rule entitled “Implementation of the Understanding Reached at the June 2002 Australia Group (AG) Meeting and the AG Intercessional Decision on Cross Border Transfrontier Chemical and Biological Weapons Controls in the Export Administration Regulations’’ ((RIN0694–AC70) received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2982. A communication from the Acting Director, Office of Sustainable Fisheries, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled “Fisheries Off West Coast States and in the Western Pacific; Pacific Coast Groundfishery; Annual Catch Limits for Pacific Coast Groundfishery; Amendment 66 to the 1999 Annual Catch Limit Adjustments” received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2983. A communication from the Council, National Institute of Standards and Technology, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled “Procedures for Implementation of the National Construction Safety Team Act’’ (RIN0695–AB52) received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2984. A communication from the Council, National Institute of Standards and Technology, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled “Procedures for Implementation of the National Construction Safety Team Act” (RIN0695–AB53) received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2985. A communication from the Deputy Assistant Administer–Fisheries, National Oceanic and Atmospheric Administration, Department of Commerce, transmitting, pursuant to law, the report of a rule entitled “Fisheries Off the Western United States; Atlantic Mackerel, Squid and Butterfish Fisheries; Framework Adjust ment 3’’ (RIN0693–AB52) received on June 24, 2003; to the Committee on Commerce, Science, and Transportation.

EC–2986. A communication from the Assistant Administrator–Fisheries, National Oceanic and Atmospheric Administration, Department of Commerce, transmitting, pursuant to law, the 1999 Annual Report regarding the Marine Mammal Protection Act of 1972; to the Committee on Commerce, Science, and Transportation.

EC–2987. A communication from the Chair man, National Marine Fisheries Service, Department of Commerce, transmitting, pursuant to law, a report relative to 700 MHz auctions, digital television,
and mobile communications services; to the Committee on Commerce, Science, and Transportation.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. WARNER, from the Committee on Armed Services:

S. 1025. An original bill to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes (Rept. No. 108–80).

By Mr. SPECTER, from the Committee on Appropriations, without amendment:

S. 1556. An original bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes (Rept. No. 108–82).

By Mrs. HUTCHISON, from the Committee on Appropriations, without amendment:


By Mr. GREGG, from the Committee on Health, Education, Labor, and Pensions, without amendment:

S. 888. A bill to reauthorize the Museum and Library Services Act, and for other purposes (Rept. No. 108–84).

By Mr. GREGG, from the Committee on Health, Education, Labor, and Pensions, with an amendment:

S. 650. A bill to amend the Federal Food, Drug, and Cosmetic Act to authorize the Food and Drug Administration to require certain research into drugs used in pediatric patients (Rept. No. 108–85).

By Mr. LUGAR, from the Committee on Foreign Relations, without amendment and with a preamble:

S. Res. 149. A resolution calling upon the Organization of American States (OAS) Inter-American Commission on Human Rights, the United Nations High Commissioner for Human Rights, the European Union, and human rights activists throughout the world to take certain actions in regard to the human rights situation in Cuba. By Mr. HATCH, from the Committee on Rules and Administration, without amendment.

S. Res. 138. A resolution to amend rule XXII of the Standing Rules of the Senate relating to the consideration of nominations requiring the advice and consent of the Senate.

By Mr. LUGAR, from the Committee on Foreign Relations, with an amended preamble:

S. Res. 174. A resolution expressing the sense of the Senate that the international response to the current need for food in the Horn of Africa remains inadequate.

By Mr. HATCH, from the Committee on the Judiciary, without amendment and with a preamble:

S. Res. 175. A resolution designating Thursday, November 20, 2003, as ‘‘Feed America Thursday’’.

S. Res. 176. A resolution designating the month of October 2003, as ‘‘Family History Month’’.

By Mr. LOTT, from the Committee on Rules and Administration, without amendment:

S. Res. 178. A resolution to prohibit Members of the Senate and other persons from removing art and historic objects from the Senate wing of the Capitol and Senate office buildings for personal use.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of committees were submitted:

By Mr. WARNER for the Committee on Armed Services:


Army nominations beginning Brigadier General George A. Alexander and ending Colonel Matthew J. Whittington, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nomination of Col. William J. Germann.

Army nomination of Col. William M. Jacobs.

Marine Corps nominations beginning Brig. Gen. John W. Bergman and ending Brig. Gen. John J. McCarthy, Jr., which nominations were received by the Senate and appeared in the Congressional Record on April 2, 2003.

Air Force nomination of Col. Thomas F. Deppe.

Navy nomination of Adm. William J. Fallon.


Marine Corps nomination of Lt. Gen. Wallace C. Gregson, Jr.

Navy nomination of Capt. Terry L. McCready.

Navy nominations beginning Capt. Martin J. Brown and ending Michael J. Lydon, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.


Air Force nomination of Col. Craig S. Ferguson.

Navy nomination of Vice Adm. Michael G. Mullen.


Mr. WARNER. Mr. President, for the Committee on Armed Services I report favorably the following nomination list which was printed in the RECORD on the date indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that this nomination lie at the Secretary’s desk for the information of Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

Army nomination of Kenneth S. Azarow.

Air Force nominations beginning Rebecca G. Abraham and ending Jeffrey Yuen, which nominations were received by the Senate and appeared in the Congressional Record on March 26, 2003.

Air Force nominations beginning Brian J. Austin and ending Anuli L. Anyachebelu, which nominations were received by the Senate and appeared in the Congressional Record on March 26, 2003.

Air Force nominations beginning Paul M. Barzler and ending Charles W. Williamson III, which nominations were received by the Senate and appeared in the Congressional Record on March 26, 2003.

Air Force nominations beginning James R. Burkhart.

Air Force nominations beginning Charles M. Belisle and ending Brett A. Wyrick, which nominations were received by the Senate and appeared in the Congressional Record on May 20, 2003.

Air Force nominations beginning Glenn D. Addison and ending Daniel J. Zachman, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nomination of Thomas K. Hunter, Jr.

Air Force nominations beginning Jeffrey J. King.

Air Force nominations beginning Dan B. Dorval and ending Gary M. Walker, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nomination of Richard J. Delorenzo, Jr.

Air Force nomination of Gerald M. Schneiders.

Air Force nomination of Jane B. Taylor.

Air Force nominations beginning Darrell A. Jones and ending Norbert S. Walker, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nominations beginning Thomas C. Barnett and ending Jean A. Vargo, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nomination of Edward C. Callaway.

Air Force nomination of H. Michael Tenneman.

Air Force nomination of Steven E. Ritter.

Air Force nomination of Bryan A. Keeling.

Air Force nomination of Robert L. Zabel, Jr.

Air Force nominations beginning Darryl G. Elrod, Jr. and ending Kevin R. Vanvalkenburg, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Air Force nomination of Drew Y. Johnston, Jr.

Air Force nomination of Rachel L. Beck.

Air Force nomination of Larry J. Martin.

Air Force nominations beginning Robert L. Daugherty, Jr. and ending Charles V. Rath, Jr., which nominations were received by the Senate and appeared in the Congressional Record on June 16, 2003.

Army nominations beginning Craig M. Anderson and ending Diane M. Zierhoffer, which nominations were received by the Senate and appeared in the Congressional Record on May 20, 2003.

Army nominations beginning Anuli L. Anyachebelu and ending Donald G Zuger, which nominations were received by the Senate and appeared in the Congressional Record on May 20, 2003.

Army nominations beginning Doreen M. Agin and ending Bonnita D. Wilson, which nominations were received by the Senate and appeared in the Congressional Record on May 20, 2003.

Army nominations beginning Kenneth B. Barzler and ending Charles W. Williamson III, which nominations were received by the Senate and appeared in the Congressional Record on March 26, 2003.

Air Force nominations beginning Brian J. Austin and ending Jeffrey Yuen, which nominations were received by the Senate and appeared in the Congressional Record on March 26, 2003.
nominees were received by the Senate and appeared in the Congressional Record on January 1.

Army nominations beginning Kevin R. Armstrong and ending Nancy Vincentjohnson, which nominations were received by the Senate and appeared in the Congressional Record on May 20, 2003.

Army nomination of James A. Deming.

Army nomination of Timothy H. Sughre.

Army nominations beginning Leslie J. Miktos, Jr. and ending Berrie D. Samples, which nominations were received by the Senate and appeared in the Congressional Record on June 5, 2003.

Army nominations beginning Patricia J. Modan and ending Nicholas K. Stravelakis, which nominations were received by the Senate and appeared in the Congressional Record on June 5, 2003.

Army nomination of Scott D. Kothenbeutel.

Army nomination of Glenn T. Bessinger.

Army nominations beginning Jane M. Anderholt and ending Jay A. Whitaker, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Army nominations beginning Rodney A. Armon and ending Mark W. Thackston, which nominations were received by the Senate and appeared in the Congressional Record on June 12, 2003.

Army nomination of Anthony Sullivan.

Army nomination of Bryan C. Sleigh.

Army nomination of Michael F. McDonough.

Navy nomination of Michael U. Rump.

Navy nominations beginning William A. Davies and ending Gary S. Tollerene, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Douglas W. Fenske and ending Michael J. Kautz, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Brian H. Miller and ending Perry T. Tuey, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Gerald W. Clouse and ending Mark A. Wilson, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Kenneth J. Brathwaite and ending Andrew H. Wilson, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Christopher M. Ballister and ending Carl M. M. Lee, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Jeffrey D. Adamos and ending Marcus K. Neeson, which nominations were received by the Senate and appeared in the Congressional Record on April 30, 2003.

Navy nominations beginning Danford S. K. Afong and ending Theodore A. Wyka, which nominations were received by the Senate and appeared in the Congressional Record on May 1, 2003.

Navy nominations beginning Scott F. Bohnenkamp and ending Christopher L. Wall, which nominations were received by the Senate and appeared in the Congressional Record on May 1, 2003.

Navy nominations beginning Charles L. Collins and ending Cynthia R. Sugimoto, which nominations were received by the Senate and appeared in the Congressional Record on May 1, 2003.

Navy nominations beginning Gregory S. Adams and ending Peter A. Withers, which nominations were received by the Senate and appeared in the Congressional Record on May 1, 2003.

Navy nominations beginning Bradford E. Aleson and ending Orlie R. Wilkins, which nominations were received by the Senate and appeared in the Congressional Record on May 5, 2003.

Navy nominations beginning Christopher A. Barnes and ending Scott M. Stanley, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Thomas M. Balestriere and ending Robert S. Wright, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Lisa L. Arnold and ending Peggy W. Williams, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Scott W. Bailey and ending Kevin R. Wheelock, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Matthew R. Beesley and ending John M. Wrisch, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Rebecca E. Brenton and ending Warren C. Graham III, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Kathy A. Baran and ending Margaret A. Taylor, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning William B. Adams and ending Daniel J. Zinder, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Evan A. Applequist and ending Richard D. Wright, which nominations were received by the Senate and appeared in the Congressional Record on May 8, 2003.

Navy nominations beginning Sherry L. Brown and ending Denise M. Shorey, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Craig E. Bundy and ending Cliff P. Watkins, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Christopher L. Allen and ending Frank G. Ussaggio II, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Eugene M. Avruch and ending Robert K. Zappas, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Judy L. Miller.

Navy nominations beginning Thomas W. Harrington and ending Robert L. Young, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Matthew O. Fenske and ending Frank G. Ussaggio II, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Craig E. Bundy and ending Cliff P. Watkins, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning William M. Arbaugh and ending Richard E. Wolfe, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Bartley G. Christo, Jr. and ending James L. White, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Nancy J. Bates and ending Lloyd G. Wingfield, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Annemarie Adamowi and ending Mary A. White, which nominations were received by the Senate and appeared in the Congressional Record on May 14, 2003.

Navy nominations beginning Sherry L. Brown and ending Denise M. Shorey, which nominations were received by the Senate and appeared in the Congressional Record on June 16, 2003.

Navy nominations beginning Linsly G. M. Brown and ending Denise M. Shorey, which nominations were received by the Senate and appeared in the Congressional Record on June 16, 2003.

By Mr. LUGAR for the Committee on Foreign Relations.

*Marsha E. Barnes, of Maryland, a Career Member of the Senior Foreign Service, Class of Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Suriname.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: Marsha E. Barnes

Post: Paramaribo, Suriname.

Contributions, amount, date, and done: none.

1. Self, none.

2. Spouse, none. 
The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: Robert W. Fitts.
Contributions, amount, date, and donee:
1. Self, N/A.
2. Spouse, N/A.
4. Parents: N/A.
5. Grandparents: N/A.
6. Brothers and spouses: Gary Allen Fitts, $100, 2000, Nat Goldhaber (VP); James Andrew Fitts, $50, 2002, Craig Benson (NH Gov).
7. Sisters and Spouses, none.

*John E. Herbst, of Virginia, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Ukraine.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: John E. Herbst.
Post: Ukraine.
Contributions, amount, date, and donee:
1. Self, none.
2. Spouse, none.
4. Parents: Christopher Herbst, deceased; Mary Herbst, deceased.
5. Grandparents: John Herbst and Sadie Herbst, deceased; Egidio Vaccheli and Irene Vacchelli, deceased.
7. Sisters and spouses: Christine Herbst, none; Mitchell Stern, none.

*William B. Wood, of New York, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Colombia.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Post: Ambassador to Colombia.
Contributions, amount, date, and donee:
1. Self, none.
2. Spouse: Never married.
4. Parents: Both deceased more than 20 years.
5. Grandparents: Deceased more than 20 years.
7. Sisters and spouses: No sisters.

*Tracey Ann Jacobson, of the District of Columbia, a Foreign Service Officer of Class One, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to Turkmenistan.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee Tracey Ann Jacobson.
Post: COM, Ashgabat, Turkmenistan.
Contributions, amount, date, and donee:
1. Self, none.
2. Spouse, Lars Johansson, none.
5. Grandparents, none.
6. Brothers and spouses, none.
7. Sisters and spouses: Teri and Terry Dermody, none.

*George A. Krol, of New Jersey, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of Belarus.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: George Albert Krol.
Post: Minsk, Belarus.
Contributions, amount, date, and donee:
1. Self, none.
2. Spouse, none.
3. Children and spouses, none.
5. Grandparents, deceased.
7. Sisters, none.

*Greta N. Morris, of California, a Career Member of the Senior Foreign Service, Class of Minister-Counselor, to be Ambassador Extraordinary and Plenipotentiary of the United States of America to the Republic of the Marshall Islands.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: Greta N. Morris.
Post: Majuro.
Contributions, amount, date, and donee:
1. Self, none.
2. Spouse, Charles H. Morris, deceased, none.
3. Children and spouses, none.
4. Parents: Gretchen W. Nance, Kendall W. Nance, both deceased.
5. Grandparents: Willis and Augusta Noriega, both deceased.
7. Sisters and spouses: Ernestine D. Nance, both deceased.

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: George A. Krol.
Post: Minsk, Belarus.
Contributions, amount, date, and donee:
1. Self, none.
2. Spouse, none.
3. Children and spouses, none.
5. Grandparents, deceased.
7. Sisters, none.

*Rodger Francisco Noriega, of Kansas, to be an Assistant Secretary of State (Western Hemisphere Affairs).

The following is a list of all members of my immediate family and their spouses. I have asked each of these persons to inform me of the pertinent contributions made by them. To the best of my knowledge, the information contained in this report is complete and accurate.

Nominee: Rodger F. Noriega.
Post: Assistant Secretary of State for Western Hemisphere Affairs.
Contributions, amount, date, and donee:
1. Self, $250, 10/10/03, Bob Dole for President.
2. Spouse, N/A.
3. Children and spouses: N/A.
5. Grandparents: all deceased, none.
6. Brothers and spouses names: James P. Noriega, and Carlos R. Noriega, both deceased.
7. Sisters and spouses names: Rita and Michael Pramh, none; Rosalie and Douglas Jackson, none; Emilie Palmer, divorced, none.

Mr. LUGAR. Mr. President, for the Committee on Foreign Relations I report favorably the following nomination lists which were printed in the RECORDS on the dates indicated, and ask unanimous consent, to save the expense of reprinting on the Executive Calendar that these nominations lie at the Secretary's desk for the information of Senators.

The PRESIDING OFFICER. Without objection, it is so ordered.

Foreign Service nominations beginning Ali Abdi and ending Lawrence C. Mandel, which nominations were received by the Senate and appeared in the Congressional Record on May 22, 2003.

Foreign Service nominations beginning Beth A. Saleman and ending Peter H. Chase, which nominations were received by the Committee on Foreign Relations in the Congressional Record on June 3, 2003.

By Ms. COLLINS for the Committee on Governmental Affairs.
Fern Planagan Solider, of the District of Columbia, to be an Associate Judge of the Superior Court of the District of Columbia for the term of fifteen years.
Joshua B. Bolton, of the District of Columbia, to be Director of the Office of Management and Budget.
Judith Nan Macaluso, of the District of Columbia, to be an Associate Judge of the Superior Court of the District of Columbia for the term of fifteen years.

By Mr. CAMPBELL, for the Committee on Indian Affairs.

*John Richard Grimes, of Massachusetts, to be a Member of the Board of Trustees of the Institute of American Indian and Alaska Native Culture and Arts Development for a term expiring May 19, 2006.*

*Lisa Neighbors, of Alaska, to be a Member of the Board of Trustees of the Institute of American Indian and Alaska Native Culture and Arts Development for a term expiring October 18, 2004.*

*Georgianna E. Ignace, of Wisconsin, to be a Member of the Board of Trustees of the Institute of American Indian and Alaska Native Culture and Arts Development for a term expiring October 18, 2004.*

*Charles W. Grim, of Oklahoma, to be Director of the Indian Health Service, Department of Health and Human Services, for a term of four years.*

By Mr. HATCH for the Committee on the Judiciary.

Thomas M. Hardiman, of Pennsylvania, to be United States District Judge for the Western District of Pennsylvania.

Diann M. Stansberry, of Utah, to be Director of the Violence Against Women Office, Department of Justice.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate. (Nominations without an asterisk were reported with the recommendation that they be confirmed.)*

**INTRODUCTION OF BILLS AND JOINT RESOLUTIONS**

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. ENSIGN (for himself, Mr. Frist, Mr. McConnell, Mr. Kyi, Mr. Enzi, Mr. Specter, Mr. Voinovich, Mr. Hagel, Mr. Cornyn, and Mr. Inhofe):

S. 11. A bill to protect patients' access to quality and affordable health care by reducing the effects of excessive liability costs.

By Mr. LEVIN:

S. 138. A bill to decrease the matching funds requirement and authorize additional appropriations for Keweenaw National Historical Park in the State of Michigan; to the Committee on Energy and Natural Resources.

By Mr. BRRAUX (for himself and Mr. Roberts):

S. 139. A bill to amend title 5, United States Code, to provide for appropriate overtime pay for National Weather Service employees who perform essential services during severe weather events; to the Committee on Governmental Affairs.

By Mr. GRAHAM of Florida (for himself and Mr. Nelson of Florida):

S. 140. A bill to authorize additional judgeships in the middle and southern districts of Florida, and for other purposes; to the Committee on the Judiciary.

By Mrs. HUTCHISON (for herself and Mr. Cornyn):

S. 141. A bill to name the Department of Veterans Affairs Medical Center in Houston, Texas, as the 'Michael E. DeBakey Department of Veterans Affairs Medical Center'; to the Committee on Veterans' Affairs.

By Mrs. FEINSTEIN:

S. 1342. A bill to amend the Graton Rancheria Restoration Act to give the Secretary of the Interior discretion regarding taking lands into trust; to the Committee on Indian Affairs.

By Mr. EDWARDS:

S. 1343. A bill to amend section 112, United States Code, to provide for the avoidance of certain transfers, and the alternative prosecution of certain actions, relating to certain retirement benefits; to the Committee on the Judiciary.

By Mr. CORZINE (for himself, Mr. Schumer, Mr. Akaaka, and Mrs. Boxer):

S. 1344. A bill to amend the Electronic Fund Transfer Act to require additional disclosures relating to exchange rates in transactions involving international transactions, and for other purposes; to the Committee on Banking, Housing, and Urban Affairs.

By Mrs. MURRAY (for herself, Mrs. Boxer, Ms. Cantwell, Mrs. Clinton, Mr. Corzine, Mr. Edwards, Mrs. Feinstein, Mr. Kennedy, Ms. Lautenberg, Mr. Schumer, and Mr. Hollings):

S. 1345. A bill to extend the authorization for the ferry boat discretionary program, and for other purposes; introduced, read the first time, placed on the calendar.

By Ms. CANTWELL:

S. 1346. A bill to amend the Higher Education Act of 1965 to modify the computation of eligibility for certain Federal Pell Grants, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. SMITH (for himself and Mrs. Collins):

S. 1347. A bill to amend the Workplace Investment Act of 1998 to provide for strategic sectoral skills gap assessments, strategic skillset plans, and strategic training capacity enhancement seed grants, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

S. 1348. A bill to amend the Internal Revenue Code of 1986 with respect to the eligibility of veterans for mortgage bond financing, and for other purposes; to the Committee on Finance.

By Mrs. MURKOWSKI:

S. 1349. A bill to require Federal agencies, and persons engaged in interstate commerce, in possession of electronic data containing personal information, to disclose any unauthorized acquisition of such information; to the Committee on the Judiciary.

By Mr. Frist:

S. 1351. A bill to amend the Tennessee Valley Authority Act of 1933 to authorize the Tennessee Valley Authority to enter into agreements with the Alabama Power Company for the purpose of acquiring and operating navigable waterway and power projects; to the Committee on Energy and Natural Resources.

By Mr. WYDEN (for himself and Mrs. Feinstein):

S. 1352. A bill to expedite procedures for hazardous fuels reduction activities and restoration in wildland fire prone National Forests and for other purposes; to the Committee on Agriculture, Nutrition, and Forestry.

By Mr. BROWNBACK (for himself and Mr. DeWine):

S. 1353. A bill to establish new special immigrant categories; to the Committee on the Judiciary.

By Ms. MURkowski:

S. 1364. A bill to resolve certain conveyances and provide for alternative land selections under the Alaska Native Claim Settlement Act related to Cape Fox Corporation and Sealaska Corporation, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SMITH (for himself and Mr. Wyden):

S. 1358. A bill to authorize the Bureau of Reclamation to participate in the rehabilitation of the Wallowa Lake Dam in Oregon, and for other purposes; to the Committee on Energy and Natural Resources.

By Mr. SPECTER:

S. 1359. An original bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes; from the Committee on Appropriations; placed on the calendar.

By Mrs. HUTCHISON:

S. 1361. An original bill making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes; from the Committee on Appropriations; placed on the calendar.

By Mr. AKAKA (for himself, Mr. Grassley, Mr. Levin, Mr. Lautenberg, and Mr. Durbin):

S. 1362. A bill to authorize the Port of Seattle to be the port of call for a cruise ship for the purpose of promoting tourism in Alaska; to the Committee on Energy and Natural Resources.

By Mr. GRAHAM of Florida:

S. 1364. A bill to amend section 7015 of title 38, United States Code, to clarify the responsibilities for notifications for appellate review of Department of Veterans Affairs activities; to the Committee on Veterans' Affairs.

By Mr. SMITH:

S. 1364. A bill to amend the Internal Revenue Code of 1986 to provide that foreign base company shipping income shall include only income from aircraft and income from certain vessels transporting petroleum and related products; to the Committee on Finance.

By Mrs. BOXER:

S. 1362. A bill to authorize the Port Passenger Accelerated Service System (Port PAS) under the Alaska Native Claims Settlement Act, and for other purposes; to the Committee on the Judiciary.

By Mr. REID:

S. 1363. A bill to prohibit the study or implementation of any plan to privatize, divest, or sell any part of the national park, function, or responsibility of the National Park Service; to the Committee on Energy and Natural Resources.

By Mrs. MURkowski:

S. 1364. A bill to amend the Alaska National Interest Lands Conservation Act to authorize the payment of expenses after the death of certain Federal employees in the State of Alaska; to the Committee on Energy and Natural Resources.
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S8726

By Mr. MCCONNELL (for himself, Mr. KYL, and Mr. LEAHY):
S. 684. A bill to create an office within the Department of Justice to undertake certain specific steps to ensure that all American citizens harmed by terrorism overseas receive equal treatment by the United States Government regardless of the terrorists’ country of origin or residence, and to ensure that all terrorists involved in such attacks are pursued, prosecuted, and punished with equal vigor, regardless of the terrorists’ country of origin or residence.

S. 777

At the request of Mr. INHOFE, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of S. 777, a bill to amend the impact aid program under the Elementary and Secondary Education Act of 1965 to improve the delivery of payments under the program to local educational agencies.

S. 835

At the request of Ms. LANDRIEU, the name of the Senator from Mississippi (Mr. LOTT) was added as a cosponsor of S. 835, a bill to amend the Higher Education Act of 1965 to provide student loan borrowers with a choice of lender for loan consolidation, to provide notice regarding loan consolidation, and for other purposes.

S. 847

At the request of Mr. SMITH, the name of the Senator from South Dakota (Mr. JOHNSON) was added as a cosponsor of S. 847, a bill to require the Secretary of the Treasury to mint coins in commemoration of the 230th Anniversary of the United States Marine Corps, and to support construction of the Marine Corp’s Heritage Center.

S. 922

At the request of Mr. LANDRIEU, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. 922, a bill to declare, under the authority of Congress under Article I, section 8, of the Constitution to “provide and maintain a Navy”, a national policy for the naval force structure required in order to “provide for the common defense” of the United States throughout the 21st century.

S. 911

At the request of Ms. LANDRIEU, the name of the Senator from Louisiana (Mr. BREAUX) was added as a cosponsor...
of S. 953, a bill to amend chapter 53 of title 5, United States Code, to provide special pay for board certified Federal Employees who are employed in health science positions, and for other purposes.

S. 977

At the request of Mr. FITZGERALD, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. 977, a bill to amend the Public Health Service Act, the Employee Retirement Income Security Act of 1974, and the Internal Revenue Code of 1986 to require that employers and individuals with individual health insurance coverage and group health plans provide coverage from treatment of a minor child’s congenital or developmental deformity or disorder due to trauma, infection, tumor, or disease.

S. 982

At the request of Mrs. BOXER, the name of the Senator from Montana (Mr. BURNS) was added as a cosponsor of S. 982, a bill to halt Syrian support for terrorism, end its occupation of Lebanon, stop its development of weapons of mass destruction, cease its illegal importation of Iraqi oil, and hold Syria accountable for its role in the Middle East, and for other purposes.

S. 982

At the request of Mr. SANTORUM, the name of the Senator from Alabama (Mr. SESSIONS) was added as a cosponsor of S. 982, supra.

S. 984

At the request of Mr. DODD, the name of the Senator from West Virginia (Mr. ROCKEFELLER) was added as a cosponsor of S. 984, a bill to amend the Federal Law Enforcement Pay Reform Act of 1990 to adjust the percentage differentials payable to Federal law enforcement officers in certain high-cost areas, and for other purposes.

S. 1001

At the request of Mr. BIDEN, the names of the Senator from Wisconsin (Mr. BROWN) and the Senator from Massachusetts (Mr. KENNEDY) were added as cosponsors of S. 1001, a bill to make the protection of women and children who are affected by a complex humanitarian emergency a priority of the United States Government, and for other purposes.

S. 1004

At the request of Mr. STEVENS, the name of the Senator from Alaska (Ms. MURKOWSKI) was added as a cosponsor of S. 1004, a bill to amend the Communications Act of 1934 to preserve localism, to foster and promote the diversity of television broadcasting, to foster and promote competition, and to prevent excessive concentration of ownership of the nation’s television broadcast stations.

S. 1115

At the request of Mrs. MURRAY, the name of the Senator from New Jersey (Mr. LUTENBERG) was added as a cosponsor of S. 1115, a bill to amend the Toxic Substances Control Act to reduce the health risks posed by asbestos-containing products.

S. 1129

At the request of Mrs. FEINSTEIN, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 1129, a bill to provide for the protection of unaccompanied alien children, and for other purposes.

S. 1137

At the request of Mr. LOTT, the name of the Senator from Mississippi (Mr. COCHRAN) was added as a cosponsor of S. 1137, a bill to establish a Mississippi Gulf Coast National Heritage Area in the State of Mississippi, and for other purposes.

S. 1139

At the request of Mr. DeWINE, the name of the Senator from Washington (Ms. MURRAY) was added as a cosponsor of S. 1139, a bill to direct the National Highway Traffic Safety Administration to establish and carry out traffic safety law enforcement and compliance campaigns, and for other purposes.

S. 1196

At the request of Mrs. HUTCHISON, the name of the Senator from Nevada (Mr. ENSIGN) was added as a cosponsor of S. 1196, a bill to eliminate the marriage penalty permanently in 2003.

S. 1245

At the request of Ms. COLLINS, the names of the Senator from Nebraska (Mr. HAGET) and the Senator from Montana (Mr. BURNS) were added as cosponsors of S. 1245, a bill to provide for homeland security grant coordination and simplification, and for other purposes.

S. 1248

At the request of Mr. GREGG, the name of the Senator from Missouri (Mr. BOND) was added as a cosponsor of S. 1248, a bill to reauthorize the Individuals with Disabilities Education Act, and for other purposes.

S. 1293

At the request of Mr. LEAHY, the name of the Senator from Florida (Mr. NELSON) was added as a cosponsor of S. 1293, a bill to criminalize the sending of predatory and abusive e-mail.

S. 1299

At the request of Ms. SNOWE, the name of the Senator from Alaska (Mr. STEVENS) was added as a cosponsor of S. 1299, a bill to amend the Trade Act of 1974 to provide trade readjustment and development enhancement for America’s communities, and for other purposes.

S. 1315

At the request of Mr. CRAIG, the name of the Senator from Colorado (Mr. ALLARD) was added as a cosponsor of S. 1315, a bill to amend the Federal Land Policy and Management Act of 1976 to provide owners of non-Federal lands with a reliable method of receiving compensation for damages resulting from the spread of wildfire from nearby forested National Forest System lands or Bureau of Land Manage-
the occasion of its 350th anniversary, supporting the designation of an “American Jewish History Month”, and for other purposes.

S. CON. RES. 40

At the request of Mrs. Clinton, the name of the Senator from Florida (Mr. Nelson), the Senator from Illinois (Mr. Durbin) and the Senator from California (Mrs. Feinstein) were added as cosponsors of S. Con. Res. 40, a concurrent resolution designating August 7, 2003, as “National Purple Heart Recognition Day”.

S. RES. 62

At the request of Mr. Ensign, the name of the Senator from Wyoming (Mr. Enzi) was added as a cosponsor of S. Res. 62, a resolution calling upon the Organization of American States (OAS) Inter-American Commission on Human Rights, the United Nations High Commissioner for Human Rights, the European Union, and human rights activists throughout the world to take certain actions in regard to the human rights situation in Cuba.

S. RES. 153

At the request of Mrs. Boxer, the name of the Senator from New Mexico (Mr. Domenici) was added as a cosponsor of amendment No. 975 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 979

At the request of Mr. Akaka, the name of the Senator from Virginia (Mr. Allen) was added as a cosponsor of amendment No. 979 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 980

At the request of Mr. Akaka, the name of the Senator from New Mexico (Mr. Domenici) was added as a cosponsor of amendment No. 980 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 981

At the request of Ms. Collins, the name of the Senator from Missouri (Mr. Bond) was added as a cosponsor of amendment No. 981 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1001

At the request of Mr. Allard, the names of the Senator from Wisconsin (Mr. Kohl) and the Senator from Vermont (Mr. Leahy) were added as co-sponsors of amendment No. 1001 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1017

At the request of Mr. Allard, the names of the Senator from Wisconsin (Mr. Kohl) and the Senator from Vermont (Mr. Leahy) were added as co-sponsors of amendment No. 1017 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1031

At the request of Mr. Crafo, the name of the Senator from Montana (Mr. Burns) was added as a cosponsor of amendment No. 1031 intended to be proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1033

At the request of Mr. Mikulski, the names of the Senator from Maryland (Mr. Sarbanes), the Senator from Wisconsin (Mr. Kohl) and the Senator from California (Mrs. Boxer) were added as cosponsors of amendment No. 1033 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1040

At the request of Mr. Schumer, the name of the Senator from Minnesota (Mr. Coleman) was added as a cosponsor of amendment No. 1040 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1060

At the request of Mrs. Murray, her name was added as a cosponsor of amendment No. 1060 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1063

At the request of Ms. Collins, the names of the Senator from Washington (Mrs. Murray), the Senator from Minnesota (Mr. Coleman), the Senator from California (Mrs. Boxer), the Senator from Nebraska (Mr. Hagel), the Senator from Louisiana (Ms. Landrieu) and the Senator from Wisconsin (Mr. Kohl) were added as cosponsors of amendment No. 1063 intended to be proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1065

At the request of Mr. Graham of Florida, his name was added as a cosponsor of amendment No. 1065 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1073

At the request of Mr. Smith, the name of the Senator from Washington (Mrs. Murray) was added as a co-sponsor of amendment No. 1073 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

AMENDMENT NO. 1086

At the request of Mrs. Murray, her name was added as a cosponsor of
amendment No. 1086 proposed to S. 1, a bill to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

**STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS**

*By Mr. LEVIN.*

S. 1086—A bill to decrease the matching funds requirement and authorize additional appropriations for Keweenaw National Historical Park in the State of Michigan; to the Committee on Energy and Natural Resources.

Mr. LEVIN. Mr. President, I ask unanimous consent that the text of the Keweenaw National Historical Park bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1383

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

SECTION 1. FUNDING FOR KEWEENAW NATIONAL HISTORICAL PARK.

(a) MATCHING FUNDS.—Section 8(b) of Public Law 102–543 (16 U.S.C. 410y–9(a)) is amended—

(1) by striking ''$25,000,000'' and inserting ''$50,000,000''; and

(2) by striking ''$3,000,000'' and inserting ''$5,000,000''.

(b) AUTHORIZATION OF APPROPRIATIONS.—Section 10(a) of Public Law 102–543 (16 U.S.C. 410y–9(a)) is amended—

(1) by striking ''$25,000,000'' and inserting ''$50,000,000''; and

(2) by striking ''$1'' and inserting ''$3,000,000''.

Mr. GRAHAM of Florida. Mr. President, I rise today to introduce legislation that will authorize additional judgeships in the Middle and Southern Federal Judicial Districts of Florida.

Additional judgeships are needed in these two districts in order to deal with a large volume of filings, heavy pending caseload, the considerable number of senior judges, and a rapidly growing population. It is vital that we add two additional permanent and one temporary judgeship in the Middle District and four additional permanent judgeships in the Southern District of Florida.

Florida’s Middle District is one of the busiest Federal district courts in the Nation. In 2001 it was ranked fifth in the Nation for the number of criminal defense filings, and it is charged with fraud and drug related offenses among all district courts. It handles cases filed in three of the four largest cities in the State of Florida, Jacksonville, Orlando and Tampa, which comprise 60 percent of the State’s population.

In 1999 four judges were added to the Middle District of Florida. The number of weighted filings and pending caseload both decreased in 2000. However, numbers quickly rose again in 2001. A personal judgeship survey conducted in 2000 indicated that in 2001 there were 553 weighted filings in this district versus the national average of 490. In addition, the United States Department of Justice has identified Central Florida as a High Intensity Drug Trafficking Enforcement Area.

The Southern and Middle Districts are parallel in some of the challenges that they face. Despite the additional judgeships that were created in the Southern District in 2001, the amount of weighted filings continues to rise. Since 1994, civil and criminal filings per judgeship have stayed above the national average, with civil filings rising by 67 percent and criminal filings increasing by 52 percent. These increases in criminal filings are linked to the increase in fraud, drugs, firearms and immigration prosecutions.

The administration of justice will continue to be a challenge in Florida’s Federal courts unless adequate resources are committed. It is projected that by 2015 Florida may surpass third-ranked New York in population. As the population increases, so do the number of people seeking justice from the Federal courts in our State. I ask that my colleagues join me in supporting this important legislation.

By Mrs. FEINSTEIN:

S. 1342. A bill to amend the Graton Rancheria Restoration Act to give the Secretary of the Interior discretion regarding taking land into trust; to the Committee on Indian Affairs.

Mrs. FEINSTEIN. Mr. President, I rise today to introduce legislation to amend the Graton Rancheria Restoration Act to give the State of California and the local communities of Sonoma, Napa, and Marin counties the opportunity for input and review of the tribe’s plan for a major casino in the Bay Area.

I am offering this legislation because the Boards of Supervisors of the local communities impacted by this planned casino have asked me to amend the Graton Rancheria Restoration Act. The proposal for a casino in Sonoma, Marin, and Napa counties has each county and the local communities of Sonoma, Marin, and Napa counties the opportunity for input and review of the tribe’s plan for a major casino in the Bay Area.

Prior to today’s introduction I have met with the Presidents of the Sonoma and Marin Boards of Supervisors, the Graton tribe, and Senators CAMPBELL and INOUYE the Chairman and Ranking Member of the Indian Affairs Committee.

This week I had a very spirited and frank conversation with Graton Tribal Chairman Greg Sarris and representatives from the casino investors. During the meeting Chairman Sarris committed to work with the local Boards of Supervisors and he committed to look at alternative sites for the casino. Chairman Sarris also said the Tribe and the casino investors would conduct a successful environmental impact statement. The criteria laid out in the National Environmental Policy Act, NEPA, before a site is selected. These are positive signs and I have told both the Boards of Supervisors and the Tribe that I would like to see them continue to work together.

This legislation guarantees that the local and State officials have a voice in the process. Without this change to the Graton Rancheria Restoration Act they do not have that voice.

In 2000, Congress passed the Graton Rancheria Restoration Act to restore Federal recognition to the 355 members of the Federated Indians of the Graton Rancheria.

The Graton Tribe’s original Rancheria was in the northern Sonoma County town of Graton on land purchased by the Bureau of Indian Affairs, BIA, in 1920 for the “village home” of otherwise homeless Miwok and Pomo Indians. The Rancheria was terminated in 1958 when the BIA approved a plan to distribute the assets to resident Indians and remove the Rancheria from Federal trust.

The original version of the Graton restoration bill, H.R. 946, sponsored by Congresswoman LYNN WOOLSEY in the 106th Congress, passed the House of Representatives with a gaming restriction, to which the Tribal Committee agreed.

In testimony before the House Resources Committee in May 2000, and in other public comments, Graton Chairman Greg Sarris stated that the Tribe had no intention of conducting gaming. Therefore, before the Resources Committee, Chairman Sarris stated, “Many may think our motives for restoration have been influenced by the opportunity gaming affords some other recognized tribes. Because our local political constituency, both democratic and republican has opposed any sort of development for environmental reasons, we agreed with these local political forces to not develop a gaming complex. So, as proof, we voted as a tribe to include a non-gaming clause in our bill, stipulating that we will not be a gaming tribe.”

Furthermore, in an article in the Marin Independent Journal on September 21, 2000, Chairman Sarris said, “All we want is to be formally recognized as Indians and have the same rights that other Indians do for education and health care. We are not interested in gambling.” I ask unanimous consent to print a copy of this article in the RECORD.

There being no objection, the article was ordered to be printed in the RECORD, as follows:

[From the Marin Independent Journal, Sept. 21, 2000]

**GAMBLING DISPUTE THREATENS MIWOK BILL**

By Gannett News Service

WASHINGTON—Legislation to formally reestablish the identity and standing of Marin’s band of Coast Miwok Indians appears all but dead in the face of a House-Senate dispute over how tight guarantees must be that the tribe will never allow casino gambling.

“This is insane, this is frustrating, and I just don’t see how we can’t find a way out of this,” said Greg Sarris, the tribe’s chief who is an English professor at UCLA.
Rep. Lynn Woolsey, the Petaluma Demo-
crat who authored the original bill, said she
shares the frustration but sees little hope
other than the fact that “down the road there
are other possibilities.”

The problem is that the bill to restore the
all-but-vanquished tribe, approved by the
full House in June, included specific lan-
guage that guaranteed the tribe the right to
establish gaming on the tribe’s remaining
one-acre ancestral plot in the Sonoma Coun-
ty town of Graton.

Woolsey fought that waiver in agreement
with the tiny tribe. In hearings last spring and
summer, she and Sarris said the tribe was
happy with the waiver. They were not
interested in gaming, and the acreage was
too small even if they were interested.

Additionally, the fine print in a state-passed
referendum in California to divide gaming
revenue among tribes prevents them from
operating any kind of casino.

Adding a federal gaming ban on top of an
existing state ban was an easy and harmless
layer of extra insurance to reassure the com-
munity that the tribe would not be bringing
high-stakes bingo to Marin.

“All we want is to be formally recognized as
Indians and have the same rights that other
Indians do for education and health care,” said
Sarris, one of some 300 descend-
ants of the government de-
clared extinct in the 1950s. “We are not in-
terested in gambling.”

But when the bill reached the Senate and
its identical language was signed by Sen.
Barbara Boxer, D-Calif., numerous In-
dian advocates and the government’s Bureau of
Indian Affairs objected. The surrender of
sovereignty by the Miwoks, however well-inten-
tonated, would set a precedent that could be
used against other tribes in other states—in
effect a means to pressure tribes on the sensi-
tive issue of gambling.

“It’s not that we don’t have sympathy with
what the Miwoks want to do, or in this case
don’t want to do. It’s a question of erod-
ing the hard-won sovereignty that is the
legal basis for the gambling that has been an
important resource of many tribes,” said
John Sanchez, an expert on Indian so-
vereignty at Pennsylvania State University
and a member of the Apache tribe.

Boxer’s spokesman, David Sandretti, said
his boss was “highly sensitive,” but the kern-
elfaker on the issue is Sen. Daniel Inouye of
Hawaii, vice chairman of the Indian Affairs
Committee and long a powerful voice on be-
half of tribes and native Hawaiian.

Without his support, the bill wouldn’t
survive in the Senate, Sandretti said.

Inouye made it clear this week that the bill
is dead unless Woolsey agreed to drop the
gambling ban in her legislation.

“If you set that precedent, that creates a
lot of problems,” Inouye said. “I would pre-
fer to avoid the waiver, and if I do I’d be likely to support it.”

Inouye added that it’s a meaningless, sym-
boolic waiver to begin with, because the tribe is
already covered by opening a casino on
by state law. “I just don’t think this is some-
ting that the federal government should be
involved in,” he said.

Woolsey said she has no intention of agree-
ing to anything that doesn’t include the
anti-gaming clause as written.

“I just want it to be a whole, and now it’s in
the Senate, and I guess that’s just where it
is,” Woolsey said. “I’ve heard some proposals
for compromise, but I haven’t seen anything
that addresses the level of protection
against gaming that the community and the
6th Congressional District would be prepared
to accept.”

Gene Nevelot of Novato, vice chairman of
the Federated Indians of Graton Rancheria,
said his group is disappointed in Woolsey, be-
cause members believe she should allow the
bill to go forward without the clause.

“We’re disappointed, deeply disappointed
with Woolsey because she seems to be the
one who dropped the ball on this, not Bar-
bara Boxer,” he said. “It’s a shame that it’s
getting this far and that Woolsey is letting
it bog down like this.”

Sen. Dianne Feinstein, a former Marin resident now living in Daly
City, said she often visited her great aunt at
the Miwok’s Graton Rancheria in Sonoma
County.

“I’m really steamed, I’m just so upset that
this bill maybe will not pass,” Campbell
said. “Frankly, it was about time we got some recognition because we
have all these other issues to deal with.
Health issues, education issues, and we need
this recognition to move forward.”

The bill would make the tribe eligible for
a wide range of U.S. and California health,
education and housing grants and assistance
from various federal agencies, give the tribe
the right to establish a reservation and ex-
empt the tribe from some local, state, or fed-
eral taxes and local zoning ordinances on
reservation land.

If the bill is not passed by Oct. 5, when
the Senate recesses, a new restoration bill
would have to wait until the next Congress.

Campion said California’s law requires the
tribe to drop the redundant anti-gaming clause from the
Senate version as “unrelevent” and
“unreasonable.”

Mrs. FEINSTEIN. Senator BOXER
sponsored legislation identical to Con-
gresswoman WOOLSEY’s in the Senate,
but the gaming restriction was strick-
en when the bill was ultimately passed
as part of the Omnibus Indian Advance-
ment Act of 2002.

The day the legislation passed on De-
crease, 2001, Senator BOXER stated
on the Senate Floor that dropping the
gambling restriction was necessary be-
cause of opposition to the no-gaming
clause by Senator SANDRETTI, on In-
dian Affairs and the Clinton Adminis-
tration and because, according to Sen-
ator BOXER, “Senator INOUYE asserts
that the no-gaming clause is unneces-
sary because the Graton Rancheria
have no intention of conducting groom
playing.”

So what has changed one might ask?
Well, even though the Gratons volun-
tarily and repeatedly took a no-gaming
pledge while their restoration bill was
under consideration by Congress, on
April 23, 2003, the Tribe and its partner,
Stations Casinos of Las Vegas, an-
nounced plans to purchase approxi-
ately 2,000 acres of land in Southern
Sonoma County near Sears Point for
the development of a casino.

This site is located on environ-
mentally sensitive open space and San
Francisco—North Bay tidalands which have been the subject of a decades-long
conservation effort by environmentalists
and local residents.

This site is roughly 30 miles from
San Francisco—along the gateway to
Sonoma that leads thousands of trav-
elers into the beautiful wine country
each day.

The Tribe’s casino proposal has out-
raged local elected officials and resi-
dents who have sympathized with the
Tribe’s plight and supported their res-
toration on the condition that they not
seek to develop a casino. The Sonoma
and Marin County Boards of Super-
visors have each passed unanimous res-
solutions objecting to the Graton casino
proposal. In fact, even the Board of Super-
visors of neighboring Napa has also
passed a resolution against the casino
proposal.

I ask unanimous consent to print these resolutions and letters from the counties in the RECORD.

There being no objection, the mate-
rials were ordered to be printed in the
RECORD, as follows:

MARIK COUNTY, SAN RAFAEL, CA
AND SONOMA COUNTY, SANTA
ROSE, CA.


SENATE DIANNE FEINSTEIN,
U.S. Senate,
San Francisco, CA.

DEAR SENATOR FEINSTEIN: We write this
joint letter to request your assistance with
an urgent matter facing Marin and Sonoma
counties. As you are aware, the Graton
Rancheria Tribe has announced plans to ac-
quire lands adjacent to the San Pablo Bay
National Wildlife Refuge to construct a
major casino in partnership with Stations
Casinos of Las Vegas. The proposal came as
a shock to us since, at the time it sought res-
toration in 2000, the tribe represented to Congress that it would not engage in

gaming. It now appears that the Secretary of the Interior believes she must take into trust
land within our counties acquired by the

tribe, and that gaming will be permitted on
these lands without consultation with local
governments or discretionary review by the
Secretary.

We ask that you sponsor legislation to re-
quire that tribal trust land acquisitions be
subject to consultation with local govern-
ments by an appropriate administrative
review. We ask that restored tribal land ac-
quired for gaming be subject to the two part
test that it is not detrimental to the commu-

cy and is supported by the Governor. Fi-

ally, we ask that the Secretary be given
discretion with respect to accepting land
into trust for the benefit of the Graton tribe.

County Counsel from our two counties have
prepared a letter to you providing back-
ground and supporting details regarding our
proposals.

We know that you share our concern about
the proliferation of casinos in California, es-
pecially those which are close to metropoli-
tan areas or have impacts on sensitive lands.

We look forward to working with you to
bring about changes in the law which can ad-

vance the economic interests of tribes with-
out harm to the local community.

Very truly yours,

ANNETTE ROSE,
President, Marin
County Board of Su-
pervisors.

PAUL MANGELLY,
Chairman, Sonoma
County Board of Su-
pervisors.

RESOLUTION NO. 03-5612

Whereas, the agricultural lands and wet-
lands fronting the San Francisco Bay along
Highway 37 constitute one of the most envi-
ronmentally sensitive regions in the entire
Bay Area in light of their proximity to and
drainage directly into the Bay;

Whereas, the agricultural lands along
Lakeville Highway afford an invaluable agri-
cultural and scenic resource, mostly abut to
the people of Sonoma County but to the popu-
lace of the entire Bay Area;
Whereas, such lands provide one of the Bay Area’s most cherished community separators, and represent an important scenic gateway to Sonoma County;

Whereas, Graton Rancheria, a Federated Tribe, has small farms and wet lands that have been the focus of preservation and environmental efforts by environmentalists and local communities for many years;

Whereas, the impacts these agriculture and wet lands have been the focus of preservation and environmental efforts by environmentalists and local communities for many years;

Whereas, the Tribe was restored in 2000 based, in part, on its promise not to engage in Indian casino gaming;

Whereas, the federal legislation restoring the Tribe contains language that could be used to circumvent the normally required environmental review and administrative regulatory process for taking land into trust by the United States government on behalf of the Tribe;

Whereas, the Tribe’s gaming plans were announced without input from the affected local communities;

Whereas, the Board and Tribe have initiated legal challenges regarding the proposed casino but details regarding the project and siting have not yet been made available;

Whereas, the proposed project could overwhelm the local infrastructure in the area in which the casino project is proposed;

Whereas, the environmental impacts of the proposed casino potentially outweigh any benefits that they might bring to the local area, including causing damage to wetlands and other sensitive ecosystems; and

Whereas, the agricultural lands and wetlands fronting the San Francisco Bay along Highway 37 constitute one of the most environmentally sensitive regions in the entire Bay Area in light of their proximity to and drainage directly into the Bay; and

Whereas, the agricultural lands and wetlands fronting the San Francisco Bay along Highway 37 constitute one of the most environmentally sensitive regions in the entire Bay Area in light of their proximity to and drainage directly into the Bay; and

Whereas, the agricultural lands and wetlands fronting the San Francisco Bay along Highway 37 constitute one of the most environmentally sensitive regions in the entire Bay Area in light of their proximity to and drainage directly into the Bay; and

WHEREAS, the agricultural lands and wetlands fronting the San Francisco Bay along Highway 37 constitute one of the most environmentally sensitive regions in the entire Bay Area in light of their proximity to and drainage directly into the Bay; and

RESOLVED, That the Board of Supervisors of the County of Marin calls on Governor Davis, the U.S. Congress, and the U.S. Department of the Interior to take all necessary steps to protect the agricultural lands and wetlands that are presently in imminent danger of being withdrawn from public use and control and placed into trust for the purposes of casino development— including submitting comments to agencies involved in considering the trust application and casino proposal, requesting assistance from State and Federal elected representatives, proposing legislation, participating in administrative proceedings, and initiating proceedings to challenge the proposed casino development in Sonoma County complies with the county General Plan and meets all federal and state environmental, public health, and safety requirements that otherwise would apply to a non-Indian development project, and to require that any land proposed to be taken into trust goes through a thorough regulatory and environmental review process.

RESOLUTION NO. 2003–70

WHEREAS, the agricultural lands and wetlands fronting the San Francisco Bay along Highway 37 constitute one of the most environmentally sensitive regions in the entire Bay Area; and

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RESOLVED, That the Board of Supervisors of the County of Marin calls on its elected members of the United States Senate, DiANNE FEINSTEIN and Barbara Boxer, and its elected members of the House of Representa- tives, Lynn Woolsey, to assist the residents of Marin and the entire North Bay to preserve their environment by introducing legislation that would amend the Graton Rancheria Restoration Act and/or the Indian Gaming Regulatory Act to stop the unregulated creation of tribal lands and to subject any development on the newly acquired tribal lands by the Indian Gaming Regulatory Act.
that precludes the local community, the Governor, or the Secretary of the Interior from providing input on the suitability of this location for land taken into trust for gaming purposes. There is a problematic section of the Restoration Act states, “Upon application by the Tribe, the Secretary shall accept into trust for the benefit of the Tribe any real property located in Marin or Sonoma County . . . .” According to the Department of the Interior, this language removes any discretion by the Secretary as well as any tribal obligations for consultation with the surrounding community or environmental review, as required by the normal process under the Indian Gaming Regulatory Act (IGRA). But without the modest change made by this legislation, the Graton tribe will be allowed to develop an off-reservation casino outside the requirements of IGRA. The result of that change was that since the local communities are not infringing on Native American sovereignty. We are not even blocking the tribe, according to the view will take place.

I hope my colleagues will support this legislation and I look forward to working with the Chairman and Ranking Member of the Indian Affairs Committee to pass this legislation quickly. I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1342

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

SECTION 1. AMENDMENT TO GIVE SECRETARY DISCRETION CONCERNING LANDS TAKEN INTO TRUST.

(a) REVIEW.—Section 1404 of the Graton Rancheria Restoration Act (25 U.S.C. 1300n-2) is amended by adding at the end the following new subsection:

“(d) REVIEW.—No land taken into trust for the benefit of the Tribe shall be subject to the terms for an exception under section 20(b)(1)(B) of the Indian Gaming Regulatory Act (25 U.S.C. 2719(b)(1)(B)) to the prohibition on gaming on lands acquired by the Secretary in trust for the benefit of an Indian tribe after October 17, 1988, under section 20(a) of such Act (25 U.S.C. 2719(a)).”.

(b) LAND INTO TRUST.—Section 1405(a) of the Graton Rancheria Restoration Act (25 U.S.C. 1300n-3) is amended by striking “shall” and inserting “may”.

By Mr. CORZINE (for himself, Mr. SCHUMER, Mr. AKAKA, and Mrs. BOXER).

S. 1344. A bill to amend the Electronic Fund Transfer Act to require additional disclosures relating to exchange rates in transfers involving international transactions, and for other purposes. 

Mr. CORZINE. Mr. President, today, along with my distinguished colleagues Senators SCHUMER, AKAKA, and BOXER, I am introducing “The Money Wire Improvement and Remittance Enhancement Act” (The “Money WIRE Act”), legislation that will protect consumers who send cash remittances through international money transfer providers who not only charge consumers with an upfront charge for the money wire transfer service, but also hit them on the back end with hidden costs. Many of these charges are extracted when the dollars sent by the consumer are converted to the foreign currency value that is supposed to be paid out to the friend of the family member.

This exploitation is especially pervasive in Latin American and Caribbean countries, where much of these types of transactions occur. According to the Multilateral Investment Fund and the Inter-American Development Bank, Latin American and Caribbean immigrants sent a record $32 billion to their home countries in 2002—a dramatic increase compared with $23 billion in 2001. Many of these dollars were used to pay for basic needs, such as food, medicine, and schooling, and to alleviate the suffering of loved ones during a difficult economic year.

To bring this amount into even greater perspective, the remittances that flowed into Latin America and the Caribbean last year equaled roughly the amount of direct foreign investment that flowed into the region, and exceeded the amount of development aid to Latin America from all sources. For this decade alone, Latin America and the Caribbean could receive more than $300 billion. And experts believe that number is likely to grow significantly in coming years.

These large cash flows have proven to be a powerful incentive for greed in the case of some wire transfer companies. Customers wiring money to Latin America and elsewhere in the world lose billions of dollars annually to undisclosed “currency conversion fees,” and other service costs.

June 26, 2003
In fact, many large companies aggressively target immigrant communities, often advertising "low fee" or "no fee" rates for international transfers. But these misleading ads do not always clearly disclose the fees charged when the currency is exchanged.

While large wire service companies typically obtain foreign currencies at bulk rates, they charge a significant currency conversion fee to their U.S. customers. For example, customers wiring money to Mexico are charged an exchange rate that routinely varies from the benchmark by as much as 15 percent. These hidden fees create staggering profits, allowing companies to reap billions of dollars on top of the stated fees they charge for the wire transfer services.

Last year alone, immigrants who sent money to Latin America and the Caribbean paid approximately $4 billion in transaction costs to the money wire transmitting businesses that operate this business. In other words, for every $100 that an immigrant sent home, to help their family and loved ones, $12 was siphoned off by these businesses in order to "service" that transaction.

Thus, a $200-$300 average cost, occasionally it can be considerably more, for poor, hard-working folks for whom the typical remittance—around $250 to $300 a month—represents a significant percentage of their monthly income.

Multiplied by millions, these excessive charges constitute a significant major economic force. These millions could have otherwise been used to feed children, house a family, or invest in a small business—all of which markedly improve overall quality of life.

The "Money WIRE Act" would require money wire transmitting businesses to disclose to senders, and receivers, of international money wire transfers the exchange rate used in association with the transaction; any surcharges, commissions or fees charged to the customer for the service; and the exact amount of the foreign currency to be received by the recipient in the foreign country.

It also requires that that rate and fee information be prominently displayed at the wire transmitting service location and on all receipts associated with the money wire transaction—and it ensures that these disclosures occur in the same language as that primarily used by the business to advertise its money transmitting services, if that language is other than English.

The bill also requires Federal banking regulators and the Department of Treasury to conduct a study, and submit a report to Congress, of the fees and fees disclosure at traditional financial institutions compared to those that occur at money transmitting businesses for money wire transactions.

Finally, the Act includes a provision that expands the "field of membership" definition for credit unions to give non-members, particularly unbanked and immigrant communities, access to credit unions for international money transfer, money order, and check cashing services, where the costs for these services are significantly less.

This legislation does more than merely provide better information to consumers—it actually helps them and their families financially. Consumers will see increased competition among wire transfer service providers because they are better-informed and more knowledgeable. This competition will result in lower fees for the wire transfer services that will free up a greater portion of these cash remittances to go to the friends and families that they were originally intended for.

In short, this is sound public policy that empowers those who do their part to help America's economy move forward.

I hope that my colleagues will support this legislation and I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1344
Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.
This Act may be cited as the “Money Wire Improvement and Remittance Enhancement Act of 2003” (or the “Money WIRE Act of 2003”).

SEC. 2. DISCLOSURE OF EXCHANGE RATES IN CONNECTION WITH INTERNATIONAL MONEY TRANSFERS.
(a) IN GENERAL.—The Electronic Fund Transfer Act (15 U.S.C. 1691 et seq.) is amended—
(1) by redesignating sections 918, 919, 920, and 921 as sections 919, 920, 921, and 922, respectively; and
(2) by inserting after section 917 the following new section:

SEC. 919. DISCLOSURE OF EXCHANGE RATES IN CONNECTION WITH INTERNATIONAL MONEY TRANSFERS.
(a) DEFINITIONS.—
(1) INTERNATIONAL MONEY TRANSFER.—The term ‘international money transfer’ means any money transmitting service involving an international transaction which is provided by a financial institution or a money transmitting business.

(2) MONEY TRANSMITTING SERVICE.—The term ‘money transmitting service’ has the meaning given to such term in section 5330(d)(2) of title 31, United States Code.

(3) MONEY TRANSMITTING BUSINESS.—The term ‘money transmitting business’ means any business that the Act describes.

(A) provides check cashing, currency exchange, or money transmitting or remittance services, or issues or redeems money orders, travelers’ checks, and other similar instruments; and

(B) is not a depository institution as defined in section 513(k) of title 31, United States Code.

(4) DISCLOSURES IN LANGUAGES OTHER THAN ENGLISH.—The disclosures required by this section shall be in English and in the same language as that principally used by the financial institution or money transmitting business, or any of its agents, to advertise, solicit, or negotiate, either orally or in writing, at that office if other than English.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect at the end of the 6-month period beginning on the date of the enactment of this Act.

SEC. 3. STUDY ON FEE DISCLOSURES FOR MONEY WIRE TRANSMISSIONS.
(a) STUDY.—The Federal banking agencies (as defined in section 3 of the Federal Deposit Insurance Act) and the Secretary of the Treasury shall jointly conduct a study on fees charged and fee disclosures for money wire transmissions.

(b) COMPARISON OF PRICES.—The study required by subsection (a) shall compare the disclosures provided by federally insured depository institutions for money wire transmissions with disclosures provided by money transmitting businesses (as defined in section 5330(d)(1) of title 31, United States Code) for such transmissions.
Ferries are also the preferred, and the only feasible, method of commuting from home to work in places like Washington State, New York/New Jersey, North Carolina, Hawaii and Alaska.

Finally, in many States—like my home State of Washington—they are an important part of the tourism industry and represent a part of our cultural identity.

The symbol of ferries moving people and vehicles on the waterways of the Puget Sound is as much a part of our cultural identity as computers, coffee, commercial aircraft and the Washington Apple.

Ferry use is growing.

In Washington State our ferry system—the Nation's largest—currently transports 26 million passengers each year and carries 11 million vehicles.

Other systems that serve New York/New Jersey, North Carolina, San Francisco, and Alaska also have significant numbers of passengers using the ferries.

The Nation's six largest ferry systems carried 73 million people and 13 million vehicles last year.

The growth projection for ferry use is very strong. For the six ferry systems, it is projected that by 2009 there will be a 14-percent increase in passengers and a 17-percent increase in vehicles being carried by ferries compared to 2002.

In San Francisco, that projection is a 46-percent increase.

It is clear that many people are using ferries and more will be using them in the future.

This is all with very little help from the Federal Government.

Our investment in ferries pails in comparison to the Federal investments in highways and other forms of mass transit.

Our bill would provide the needed funding for these growing systems for new ferry boat construction, for ferry facilities and terminals, and for maintenance facilities.

The bill also would make ferries eligible under the Clean Fuels Program.

Like buses, ferries are a form of mass transit that is environmentally cleaner than mass use of cars and trucks. Making them eligible for the Clean Fuels Program will encourage boat makers to design cleaner and more efficient vessels in the future.

This will make ferry travel an even more environmentally friendly means of transportation than it already is today.

Finally, setting up a Ferry Joint Program Office, keeping track of ferry statistics, and establishing a National Ferry Institute will increase the profile of ferries as part of our Nation's infrastructure and provide a method to analyze and research ways to improve their use.

In the end, I hope this proposal can be included in the TEA-21 Reauthorization.

Ferries are an important part of our Nation's transportation infrastructure.
This bill recognizes their importance by providing the resources and support they need to grow and serve passengers. I urge the Senate support this bill, and I look forward to working with my colleagues to see it passed.

By Ms. CANTWELL: S. 1346. A bill to amend the Workforce Investment Act of 1998 to provide for strategic sectoral skills gap assessments, strategic skills gap action plans, and strategic training capacity enhancement seed grants, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

By Ms. CANTWELL: S. 1347. A bill to amend the Workforce Investment Act of 1998 to provide for training service and delivery innovation projects; to the Committee on Health, Education, Labor, and Pensions.

By Ms. CANTWELL: S. 1348. A bill to amend the Higher Education Act of 1965 to modify the computation of eligibility for certain Federal Pell Grants, and for other purposes; to the Committee on Health, Education, Labor, and Pensions.

Ms. CANTWELL. Mr. President, I come to the floor today to discuss a topic that I believe is critical to our Nation's economic growth and future competitiveness—the training of our workforce.

We are living in tough economic times. The economy of the State of Washington and the Nation at large are suffering through a recession where jobs are scarce and workers are scrabbling to pay the bills. The most recent employment data available from the Bureau of Labor Statistics have offered little comfort in Washington where the unemployment rate is 7.3 percent. Washington, along with the other Pacific Northwest States of Oregon and Alaska, continues to have among the highest unemployment rates in the nation.

Just a month ago, the Senate moved quickly to extend the temporary extension of unemployment compensation program, so that approximately four million workers across this country will not lose their Federal extended unemployment benefits. I am proud that the Senate acted quickly to extend this important program. This means that over 100,000 unemployed workers in Washington State will receive 26 weeks of Federal extended benefits. I am disappointed, however, that we were not able to pass coverage for the estimated 1.1 million unemployed workers who have entirely exhausted their State and Federal benefits. Therefore, I am fighting to pass a bill that would extend coverage to the long-term unemployed, so that help is available to the hardest hit workers in this weak economy.

Nonetheless, our efforts should not stop with an unemployment insurance extension. We must continue to pursue long-term strategies for a sustained economic recovery. The fundamental strength of our economy lies in the working men and women of this Nation whose innovation and hard work propelled the massive economic expansion of the past decade.

The competitive edge that will keep our workers ahead in this changing global economy is their skills. Our economy is global, linked by international trade and communications networks. The sustained success of U.S. companies depends on adaptability and innovation, which means that workers themselves need to remain flexible and continually update their job skills.

Even in this time of high unemployment, businesses throughout the country cannot find workers with the skills they need. According to a study completed by the Heldrich Work Trends Survey, American employers are finding it difficult to find qualified workers. Nearly half, 46 percent, of American businesses say they have had trouble finding workers with the necessary skills. At the same time, over three million workers are laid off each year, yet many workers want to sort through years of training to learn the skills demanded by those businesses that face worker shortages. Job training is an answer to meeting those skill demands and bridging the skills gaps that persist. However, it will not occur widely without a strong financial commitment from the Federal Government to ensure access to job training programs, and ongoing efforts to maximize the effectiveness of those funds that we already invest.

Investment in job training must be our first priority. As we decide to invest in our workers, will pay off many times over in the form of stronger local economies, healthier communities, and improved quality of life.

But the reality is that we are delivering a trickle of funding while faced with a tidal wave of need. I have traveled across my state, from Olympia to Kelso, Vancouver to Bellingham, the Tri-city's to Spokane and received a great deal of feedback from Washingtonians who are seeking training, are providing it, or are serving as employers who need to hire skilled workers. Businesses, especially in these critical areas for economic growth, are experiencing a dramatic decrease in income. My legislation would explicitly provide the authority for educational institutions, after taking sufficient precautions to prevent fraud, to consider current or past financial aid data in determining Pell Grant eligibility for student aid at a time when the workers' families are experiencing a dramatic decrease in income. My legislation would explicitly provide the authority for educational institutions, after taking sufficient precautions to prevent fraud, to consider current or past financial aid data in determining Pell Grant eligibility for student aid at a time when the workers' families are experiencing a dramatic decrease in income. My legislation would explicitly provide the authority for educational institutions, after taking sufficient precautions to prevent fraud, to consider current or past financial aid data in determining Pell Grant eligibility for student aid at a time when the workers' families are experiencing a dramatic decrease in income. My legislation would explicitly provide the authority for educational institutions, after taking sufficient precautions to prevent fraud, to consider current or past financial aid data in determining Pell Grant eligibility for student aid at a time when the workers' families are experiencing a dramatic decrease in income. My legislation would explicitly provide the authority for educational institutions, after taking sufficient precautions to prevent fraud, to consider current or past financial aid data in determining Pell Grant eligibility for student aid at a time when the workers' families are experiencing a dramatic decrease in income. My legislation would explicitly provide the authority for educational institutions, after taking sufficient precautions to prevent fraud, to consider current or past financial aid data in determining Pell Grant eligibility for student aid at a time when the workers' families are experiencing a dramatic decrease in income. My legislation would explicitly provide the authority for educational institutions, after taking sufficient precautions to prevent fraud, to consider current or past financial aid data in determining Pell Grant eligibility for student aid at a time when the workers' families are experiencing a dramatic decrease in income.

The second bill addresses issues of distance-learning and delivery of training to hard to reach areas in a comprehensive manner. While many distance-learning technologies have been developed in recent years, those technologies have not necessarily reached many of those who are most in need of training.

Last year, my office released a study of this apparent shortfall in capacity of training systems in my State, and the results of that study were staggering to me. There are over 110,000 dislocated workers in my state, the majority of whom want to upgrade their skills but cannot do so because of budgetary limitations that prevent institutions from offering enough courses, and the limited numbers of available training vouchers.

To make things worse, this year, the State of Washington received approximately 40 percent less in Workforce Investment Act, WIA, funding compared to last year. This drastic cut in WIA funding means that services will be cut back at a time when the demand is at an all time high. It is imperative that during this time of State deficits, States receive additional help from the Federal Government for important services such as education and job training.

As my colleagues know, the Workforce Investment Act is up for reauthorization this year. The WIA system is clearly the central Federal job training programs. It provides a one-stop delivery system designed to meet a broad range of worker needs, and it emerged from years of bipartisan work by Congress to consolidate over 300 Federal programs into a system for delivering employment and training services.

Today, I am introducing three bills that are designed to build upon the existing workforce structure to expand opportunities for training and improve its effectiveness.

The first piece of legislation would change the Pell Grant program to make certain that student financial aid is available to recently laid off workers. Under current law, the standard practice in the determination of Pell Grant eligibility for student aid is to base grant awards upon the applicant's income during the previous year. The use of tax forms for this purpose, in my view, is the most appropriate and easiest administrative method of obtaining a clear and official statement of financial need. But, as a result, many recently laid-off workers are not eligible for critical financial assistance at a time when the workers' families are experiencing a dramatic decrease in income. My legislation would explicitly provide the authority for educational institutions, after taking sufficient precautions to prevent fraud, to consider current or past financial aid data in determining Pell Grant eligibility for student aid at a time when the workers' families are experiencing a dramatic decrease in income.
training may not be aware of online distance learning opportunities and may not be able to take advantage of them even if they do know about them. I believe, it is not enough to create a distance learning curriculum and passively distribute it through an educational institution website. Rather, comprehensive solutions need to be developed that integrate curriculum innovations, technological access, and the promotion and linkage of workers in need of training with such opportunities, especially to help workers in rural areas. That’s why my bill encourages the local workforce development boards to plan a comprehensive approach to improve access to and delivery of employment training services by using technology and online resources to connect workers with the information and tools they need to upgrade their skills.

The third bill that I am introducing today is designed to help local workforce development boards better understand regional labor market dynamics and improve system performance by identifying emerging sectors and industries with chronic worker shortages. My legislation encourages local workforce development boards to target employment and training resources so that workers can get training in occupations where employers need workers.

My legislation provides new resources for this purpose so that states can direct funding down to the local workforce development boards to form partnerships with employers, unions, service providers and other key players in order to develop a strategic plan for addressing regional industry and workforce needs.

I want to make clear that this legislation is not intended to reinvent the wheel for areas that are already developing sectoral approaches within existing workforce development systems. In fact, the Washington State is a leader in sector approaches: in 2000, the Washington State Legislature enacted legislation to support industry skills panels known as the “Skills Initiative.” The Skills Initiative provides grants to local workforce development councils to engage business and industry in strategies to close the skill gaps in my State. My legislation emphasizes this work by providing funding to support these partnerships.

This is a step on a long journey as we work to improve Federal job training systems, and it is critical, now more than ever, that Congress increase funding for the job training programs under the Workforce Investment Act. By providing the necessary resources, we send a strong message to the American public that our government must invest in our greatest resource—the American worker. Each of these bills is an important component of that broader strategy, and I look forward to working with my colleagues we begin to look at the reauthorization of WIA and the Higher Education Act this year and next.

Mr. President, I ask unanimous consent that the text of each bill be printed in the RECORD.

There being no objection, the bills were ordered to be printed in the RECORD, as follows:

SEC. 134(d)(3).

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

SECTION 1. SHORT TITLE. — This Act may be cited as the “Sectoral Market Assessment for Regional Training Enhancement and Revitalization Act”.

SEC. 2. FINDINGS. — Congress makes the following findings:

(1) More than 1/3 of the Nation’s current workforce lacks the basic skills necessary to succeed in today’s labor market.

(2) Globalization of the economy is leading to losses of jobs in key domestic industries, as well as challenges to competitiveness and productivity in other domestic industries.

(3) To remain economically vital and competitive, the Nation must invest in generating jobs and train a workforce skilled enough to contribute productively to the United States economy.

(4) Strategic planning that links workforce development and economic development, and the targeting of resources to industries that can build strong regional economies and create jobs with living wages for workers, need to be priorities for the workforce investment system.

(5) States and local workforce investment boards can play lead roles in guiding a more strategic process for achieving economic growth through workforce development.

SEC. 3. SKILLS GAP CAPACITY ENHANCEMENT GRANTS. —

Subtitle B of title I of the Workforce Investment Act of 1998 (29 U.S.C. 2811 et seq.) is amended —

(a) PURPOSES.—The purposes of this section are —

(1) to assist States and local boards in better focusing funds provided under this title on activities and programs that address labor shortages and meet the emerging demand for skills in high-quality jobs in area industries;

(2) to enhance the efficiency of the one-stop delivery systems and providers of training services;

(3) to establish and improve partnerships between local boards, industry sectors, economic development agencies, providers of training services (including secondary schools, postsecondary educational institutions, community-based organizations, business associations, and providers of joint labor-management programs), providers of supportive services, and other related public and private entities;

(4) to strengthen planning of workforce development strategies and economic development strategies in States, local areas, and labor markets;

(5) to retain vital industries in the local areas and regions involved, avoid displacement of workers, and strengthen the competitiveness of key industries; and

(6) to encourage the development of career ladders and advancement efforts in local industries.

(b) DEFINITIONS.—In this section—

(1) Consortium means a consortium of local boards, established as described in subsection (d)(3).

(2) Region.—The term ‘region’ means 2 or more local areas that comprise a common labor market for an industry sector or group of related occupations.

(3) Training services.—The term ‘training services’ means services described in section 134(d)(4).

(c) GRANTS TO STATES.—

In general.—The Secretary shall make grants to States, to enable the States to assist local boards and consortia in carrying out the activities described in subsection (e).

(d) GRANTS TO LOCAL BOARDS.—

(1) In general.—A State that receives a grant under subsection (c)—

(A) shall use the funds made available through the grant to make grants to local boards and consortia to carry out the activities described in subsection (e); and

(B) may use not more than 15 percent of the funds made available through the grant, at the election of the State, to prepare strategic sectoral skills gap assessments, as described in subsection (e)(2), in the local areas or regions involved, or to provide technical assistance to local boards, consortia, or partnerships described in subsection (e)(3).

Consideration.—In making the grants, the State may take into account the size of the workforce in each local area or region.

(2) Consortium.—States shall encourage local boards to aggregate, to the maximum extent practicable, into consortia representing regions, for purposes of carrying out activities described in subsection (e). Nothing in this paragraph shall be construed to require local boards to aggregate into such consortia.

(e) APPLICATIONS.—To be eligible to receive a grant under this section, a local board or consortium shall submit an application to the State, at such time and in such manner as the State may require, containing—

(A) information identifying the members of the partnership described in subsection (e) that will carry out the activities described in subsection (e); and

(B) an assurance that the board or consortium will use, or ensure that the partnership uses, the funds to carry out the activities described in subsection (e).

(f) USE OF FUNDS.—

(1) In general.—A local board or consortium that receives a grant under this section—

(A) shall ensure that the partnership described in paragraph (3) uses the funds made available through the grant to—

(i) prepare a strategic sectoral skills gap assessment, as described in paragraph (2), unless the State elects to prepare the assessment;

(ii) develop a strategic skills gap action plan, as described in paragraph (4); and

(iii) provide strategic training capacity enhancement assistance grants to providers of training services specified in subsection (a)(3), one-stop operators, and other appropriate intermediaries, as described in paragraph (3); and

(B) may use funds made available through the grant to ensure that activities carried
out under this subtitle are carried out in accordance with the strategic skills gap action plan.

(2) STRATEGIC SECTORAL SKILLS GAP ASSESSMENTS.

(A) IN GENERAL.—Except as provided in subparagraph (E), the local board or consortium (or, at the election of the State, that State) shall prepare a strategic sectoral skills gap assessment, which shall—

(i) identify areas of current and expected demand for labor and skills in a specific industry sector or group of related occupations that is—

(I) producing high-quality jobs in the local area or region involved; and

(II) developing emerging jobs in that area or region; or

(III) suffering chronic worker shortages;

(ii) the current and expected supply of labor and skills in that sector or group in the local area or region; and

(iii) identify gaps between the current and expected demand and supply of labor and skills in that sector or group in the local area or region.

(B) SPECIFIC CONTENTS.—The assessment shall contain current (as of the date of preparation of the assessment) information including specific information from multiple employers in the sector or group described in subparagraph (A)(i), labor organizations, and others connected to the businesses and workers in that sector or group, to illuminate others connected to the businesses and workers in that sector or group.

(C) INFORMATION.—The assessment shall contain current (as of the date of preparation of the assessment) information including specific information from multiple employers in the sector or group described in subparagraph (A)(i), labor organizations, and others connected to the businesses and workers in that sector or group, to illuminate others connected to the businesses and workers in that sector or group.

(D) SURVEY.—The assessment shall contain the results of a survey or focus group interviews of employers and labor organizations in the local area or region; and

(E) EXCEPTION.—If a State shall not be required to use the funds made available through a grant received under this section, to prepare an assessment described in this paragraph.

(i) LOCAL BOARD OR CONSORTIUM.—A local board or consortium shall not be required to use the funds made available through a grant received under this section, to prepare an assessment described in this paragraph if—

(A) representatives of the local boards for the local area or region involved;

(B) representatives of multiple employers for a specific industry sector or group of related occupations involved; or

(C) representatives of economic development agencies for the local area or region;

(D) representatives of providers of training services described in subsection (a)(3) in the local area or region;

(E) representatives nominated by State labor federations or local labor federations; and

(F) other entities that can provide needed supportive services tailored to the needs of workers in the sector or group.

(3) STRATEGIC SKILLS GAP ACTION PLAN.—The partnership shall develop a strategic skills gap action plan, based on the assessment, that—

(A) identifies specific barriers to adequate supply of labor and skills in demand in a specific industry sector or group of related occupations that is producing high-quality jobs in the local area or region involved; and

(B) identifies activities (which may include the provision of needed supportive services) that will remove or alleviate the barriers described in clause (i) that could be undertaken by providers of training services described in subsection (a)(3);

(C) specifies how the local board or consortium and economic development agencies in the partnership will integrate the board’s or consortium’s workforce development strategies with local or regional economic development strategies in that sector or group; and

(D) identifies resources and strategies that will be used in the local area or region to address the skill gaps for both unemployed and incumbent workers in that sector or group.

(4) STRATEGIC TRAINING CAPACITY ENHANCEMENT SEED GRANTS.—

(A) IN GENERAL.—The local board or consortium, after consultation with the partnership, shall make grants to providers of training services described in subsection (a)(3), one-stop operators, and other appropriate intermediaries to pay for the Federal share of the cost of—

(i) developing curricula to meet needs identified in the assessment described in paragraph (2) and to overcome barriers identified in the process described in paragraph (4);

(ii) identifying the providers of training services offered by the providers in order to match those needs and overcome those barriers;

(iii) operating pilot training efforts that demonstrate new curricula, or modifications to curricula, described in clause (i);

(iv) expanding capacity of providers of training services in sectors or groups described in paragraph (2)(A)(i); and

(v) reorganizing service delivery systems to better serve the needs of employers and workers in the sectors or groups;

(B) FEDERAL SHARE.—

(i) IN GENERAL.—The Federal share of the cost described in subparagraph (A) shall be 75 percent.

(ii) NON-FEDERAL SHARE.—The non-Federal share of the cost may be provided in cash or in kind, fairly evaluated, including plant, equipment, real property, or services.

SEC. 4. AUTHORIZATION OF APPROPRIATIONS.

Section 138 of the Workforce Investment Act of 1998 (29 U.S.C. 2872), as redesignated by section 3(1), is amended by adding at the end the following:

(d) SKILLS GAP CAPACITY ENHANCEMENT GRANTS.—In addition to any amounts authorized to be appropriated under subsection (a), (b), or (c), there are authorized to be appropriated to carry out section 137 such sums as may be necessary for fiscal years 2004 through 2007.

SEC. 5. CONFORMING AMENDMENTS.

(a) TABLE OF CONTENTS.—The table of contents in section 1(b) of the Workforce Investment Act of 1998 is amended by striking the items relating to section 137 and inserting the following:

‘‘Sec. 137. Skills gap capacity enhancement grants.

‘‘Sec. 138. Authorization of appropriations.’’.

(b) REFERENCES TO AUTHORIZATION OF APPROPRIATIONS.—

(1) YOUTH ACTIVITIES.—Subsections (a) and (b)(1) of section 127 of the Workforce Investment Act of 1998 (29 U.S.C. 2862(a)(1)) are amended by striking ‘‘section 137(a)’’ each place it appears and inserting ‘‘section 138(a)’’.

(2) ADULT EMPLOYMENT AND TRAINING ACTIVITIES.—Sections (a)(3), (b)(2), and (b)(2)(A)(i) of section 132 of the Workforce Investment Act of 1998 (29 U.S.C. 2862) are amended by striking ‘‘section 137(b)’’ and inserting ‘‘section 138(b)’’.

(3) DISLOCATED WORKER EMPLOYMENT AND TRAINING ACTIVITIES.—Subsections (a)(2) and (b)(2)(A)(i) of section 132 of the Workforce Investment Act of 1998 (29 U.S.C. 2862) are amended by striking ‘‘section 137(c)’’ each place it appears and inserting ‘‘section 138(c)’’.

S. 1347

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ‘‘Federal Pell Grant Eligibility Clarification Act of 2003’’.

SEC. 2. CONSIDERATION OF CURRENT YEAR CIRCUMSTANCES.

Section 480(a) of the Higher Education Act of 1965 (20 U.S.C. 1070c(a)) is amended—

(1) in paragraph (1), by striking ‘‘paragraph (2)’’ and inserting ‘‘paragraphs (2) and (3)’’; and

(2) by adding at the end the following:

‘‘(3) CONSIDERATION OF CURRENT YEAR CIRCUMSTANCES FOR CERTAIN PELL GRANT AWARDS.—

(A) IN GENERAL.—If a student is a resident of a State that is in an extended benefit period (within the meaning of section 203 of the
Temporary Extended Unemployment Compensation Act of 2002 (Public Law 107–147), then for purposes of calculating total income under paragraph (1) for a student seeking assistance under subpart 1 of part A, the Secretary shall reduce the student’s total income by an amount by which—

(i) the adjusted gross income plus untaxed income derived for the preceding tax year minus any exclusion for income (as defined in subsection (e)), exceeds

(ii) the projected gross income plus untaxed income derived for the current tax year minus the projected exclusion for income (as defined in subsection (e)).

(3) ANTI-FRAUD PROCEDURES.—The Secretary shall establish procedures to ensure that computations made pursuant to subparagraph (A) are not fraudulent.

By Mr. SMITH (for himself, Mr. KOHL, Mrs. BOXER, Mr. CORNYN, Mr. FEINGOLD, Mrs. HUTCHISON, Ms. MURKOWSKI, and Mr. WYDEN):

S. 1349. A bill to amend the Internal Revenue Code of 1986 with respect to the eligibility of veterans for mortgage bond financing, and for other purposes; to the Committee on Finance.

Mr. SMITH. Mr. President, on behalf of myself and my colleagues, Mr. KOHL of Wisconsin, Mrs. BOXER of California, Mr. CORNYN of Texas, Mr. FEINGOLD of Wisconsin, Mrs. HUTCHISON of Texas, Ms. MURKOWSKI of Alaska, and Mr. WYDEN of Oregon, I ask unanimous consent that the text of the bill, the “Veterans American Dream Home Ownership Act” be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1349

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

SECTION 1. ALL VETERANS ELIGIBLE FOR STATE HOME LOAN PROGRAMS FUNDED BY QUALIFIED VETERANS’ MORTGAGE BONDS.

(a) IN GENERAL.—Section 143(3)(d) of the Internal Revenue Code of 1986 (defining qualified veteran) is amended—

(1) by striking “at some time before January 1, 1977” in subparagraph (A), and

(2) by striking subparagraph (B) and inserting the following:

“(B) who applied for the financing before the date 30 years after the last on which such veteran left active service.”;

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to bonds issued after December 31, 2003.

SEC. 2. REVISION OF STATE VETERANS LIMIT.

(a) IN GENERAL.—Subparagraph (B) of section 143(3)(d) of the Internal Revenue Code of 1986 (relating to volume limitation) is amended to read as follows:

“(B) STATE VETERANS LIMIT.—A State veterans limit for any calendar year is the amount equal to—

(i) $425,000,000 for the State of Texas,

(ii) $337,000,000 for the State of California,

(iii) $200,000,000 for the State of Oregon,

(iv) $200,000,000 for the State of Wisconsin, and

(v) $200,000,000 for the State of Alaska.”;

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to bonds issued after December 31, 2003.

SEC. 3. ELECTIVE CARRYFORWARD OF UNUSED LIMITATION.

(a) IN GENERAL.—Section 143(1)(b) of the Internal Revenue Code of 1986 (relating to volume limitation) is amended by adding at the end the following:

“(d) ELECTIVE CARRYFORWARD OF UNUSED LIMITATION.—

(i) IN GENERAL.—If—

(I) a State veterans limit for any calendar year after 2002, exceeds

(II) the aggregate amount of qualified veterans’ mortgage bonds issued by such State,

such State may irrevocably elect to treat such excess as a carryforward for qualified veterans’ mortgage bonds issued during the 3 calendar years following the calendar year in which the carryforward arose shall not be taken into account under subparagraph (A) to the extent the amount of such bonds does not exceed the amount of the carryforward so elected.

(ii) USE OF CARRYFORWARD.—

(I) IN GENERAL.—If a State elects a carryforward under clause (i), qualified veterans’ mortgage bonds issued during the 3 calendar years following the calendar year in which the carryforward arose shall not be taken into account under subparagraph (A) to the extent the amount of such bonds does not exceed the amount of the carryforward so elected.

(II) ORDER IN WHICH CARRYFORWARD USES TO BE APPLIED.—In case of a State electing the option under clause (ii), the Secretary shall establish procedures to ensure that computations made pursuant to subparagraph (A) are not fraudulent.

By Mrs. FEINSTEIN:

S 1350. A bill to require Federal agencies, and persons engaged in interstate commerce, in possession of electronic data containing personal information, to disclose any unauthorized acquisition of such information; to the Committee on the Judiciary.

Ms. FEINSTEIN. Mr. President, I rise to introduce the Notification of Risk to Personal Data Act of 2003. This legislation will require that individuals are notified when their most sensitive personal information is stolen from a corporate or government database.

Specifically, the bill would require government or private entities to notify individuals if a data breach has compromised their Social Security number, driver’s license number, credit card number, debit card number, or financial account numbers.

In most cases, if authorities know that someone is a victim of a crime, the victim is notified. But that isn’t the case if an individual’s most sensitive personal information is stolen from an electronic database.

Unfortunately, data breaches are becoming all too common. Consider the following incidents which have compromised the records of hundreds of thousands of Americans.

On April 5, 2002, a hacker broke into the electronic records of Steven P. Teale Data Center, the payroll facility at TriWest Health Care Alliance, a company that provides health care coverage for military personnel and their families, was burglarized at its Phoenix, AZ offices. Thieves hacked into a mainframe and stole laptop computers and computer hard drives containing the names, addresses, telephone numbers, birth dates and Social Security numbers of 562,000 military service members, dependents and retirees, as well as medical claims records for people on active duty in the Persian Gulf.

In February 2003, a hacker gained access to 10 million Visa, MasterCard, American Express Card and Discovery Card numbers from the databases of a credit processor, DPI Merchant services of Omaha, NE. Company officials maintained that the intruder did not obtain any personal information for these card numbers such as the account holder’s name, address, telephone number or Social Security number. However, at least one bank canceled and replaced 8,800 cards when it found out about the security breach.

And in March of this year, a University of Texas student was charged with hacking into the university’s computer system and stealing 55,000 Social Security numbers.

These are just some examples of the types of breaches that are occurring today. Except for California, which has a notification law going into effect in July, no State of Federal law requires companies or agencies to tell individuals of the misappropriation of their personal data.

I strongly believe Americans should be notified if a hacker gains access to their most personal data. This is both a matter of principle and a practical measure to curb identity theft.

Let me take a moment to describe the proposed legislation.

The Notification of Risk to Personal Data Act will set a national standard for notification of consumers when a data breach occurs.

Specifically, the legislation requires a business or government entity to notify an individual when there is a reasonable basis to conclude that a hacker or other criminal has obtained unencrypted personal data maintained by the entity.

Personal data is defined by the bill as an individual’s Social Security number, State identification number, driver’s license number, financial account number, or credit card number.

The legislation’s notification scheme minimizes the burdens on companies or agencies that must report a data breach.

In general, notice would have to be provided to each person whose data was compromised in writing or through e-mail. But there are important exceptions.

First, companies that have developed their own reasonable notification policies are given a safe harbor under the
bill and are exempted from its notification requirements.

Second, encrypted data is exempted.

Third, where it is too expensive or impractical, e.g., contact address information is incomplete, to notify every individual who was harmed, the bill allows entities to send out an alternative form of notice called “substitute notice.” Substitute notice includes posting notice on a website or notifying major media.

Substitute notice would be triggered if any of the following factors exist: 1. the agency or person demonstrates that the cost of providing direct notice would exceed $250,000; 2. the affected class of subject persons to be notified exceeds 500,000; or 3. the agency or person does not have sufficient contact information to notify people whose information is at risk.

The bill has a tough, but fair enforcement regime. Entities that fail to comply with the bill will be subject to fines by the Federal Trade Commission of $5,000 per violation or up to $25,000 per day while the violation persists. State Attorneys General can also file suit to enforce the statute.

Additionally, the bill would allow California’s new law to remain in effect, but preempt conflicting State laws. It is my understanding that legislators in a number of States are developing bills modeled after the California law. Reportedly, some of these bills have requirements that are inconsistent with the California legislation. It is not fair to put companies in a situation that forces them to comply with database notification laws of 50 different States.

I strongly believe individuals have a right to be notified when their most sensitive information is compromised—because it is truly their information. Ask the ordinary person on the street if he or she would like to know if a criminal had illegally gained access to their personal information from a database—the answer will be a resounding yes.

Enabling consumers to be notified in a timely manner of security breaches involving their personal data will help combat the growth scourge of identity theft. According to the Identity Theft Resources Center, a typical identity theft victim takes six to 12 months to discover that a fraud has been perpetrated and it is too late to prevent further unauthorized disclosure.

As Linda Foley, Executive Director of the Identity Theft Resources Center, puts it: “Identity theft is a crime of opportunity and time is essential at every junction. Every minute that passes after the breach until detection and notification increases the damage done to the consumer victim, the commercial entities, and law enforcement’s ability to track and catch the criminals. It takes less than a minute to fill out a credit application and to start an action that could permanently affect the victim’s life. Multiply that times hundreds of minutes, hundreds of opportunities to use or sell the information stolen and you just begin to understand the enormity of the problem that the lack of notification can cause.”

If individuals are informed of the theft of their Social Security numbers or other sensitive information, they can take immediate preventative action.

They can place a fraud alert on their credit report to prevent crooks from obtaining credit cards in their name; some companies offer credit reports to see if unauthorized activity has occurred; they can cancel any affected financial or consumer or utility accounts; they can change their phone numbers if necessary.

I look forward to working with my colleagues to pass this vitally needed legislation. This bill will give ordinary Americans more control and confidence about the safety of their personal information. Americans will have the security of knowing the threat should a breach occur, they will be notified and be able to take protective action.

I ask unanimous consent that the text of the bill be printed in the Record.

There being no objection, the bill was ordered to be printed in the Record, as follows:

SEC. 1. SHORT TITLE. This Act may be cited as the “Notification of Risk to Personal Data Act”.

SEC. 2. DEFINITIONS. In this Act, the following definitions shall apply:

(1) AGENCY.—The term “agency” has the same meaning given such term in section 551(1) of title 5, United States Code.

(2) BREACH OF SECURITY OF THE SYSTEM.—The term “breach of security of the system” means the compromise of the security, confidentiality, or integrity of computerized data that results in, or there is a reasonable basis to believe has resulted in, the unauthorized acquisition of and access to personal information maintained by the person or business; and

(3) TIMELINESS OF NOTIFICATION.—Except as provided in paragraph (4), all notifications required under paragraph (1) or (2) shall be made in a reasonable manner and without unreasonable delay following—

(A) the discovery by the agency or person of the breach of security of the system; and

(B) any measures necessary to determine the scope of the breach, prevent further disclosures, and restore the reasonable integrity of the data system.

SEC. 3. DATABASE SECURITY.

(1) DISCLOSURE OF SECURITY BREACH.—

(a) IN GENERAL.—Any agency, or person engaged in interstate commerce, that owns or licenses electronic data containing personal information shall, following the discovery of a breach of security of the system containing such data, notify the owner of the United States whose unencrypted personal information was, or is reasonably believed to have been, acquired by an unauthorized person.

(b) NOTIFICATION OF OWNER OR LICENSEE.—Any agency, or person engaged in interstate commerce, in possession of electronic data containing personal information that the agency does not own or license shall notify the owner or licensee of the information if the personal information was, or is reasonably believed to have been, acquired by an unauthorized person through a breach of security of the system containing such data.

(c) TIMELINESS OF NOTIFICATION.—Except as provided in paragraph (4), all notifications required under paragraph (1) or (2) shall be made in a reasonable manner and without unreasonable delay following—

(A) the discovery by the agency or person of the breach of security of the system; and

(B) any measures necessary to determine the scope of the breach, prevent further disclosures, and restore the reasonable integrity of the data system.

SEC. 4. NOTIFICATION OF INCURRED DAMAGE.

(1) IN GENERAL.—If a law enforcement agency determines that the notification required under this subsection would impede a criminal investigation, such notification may be delayed until such law enforcement agency determines that the notification will no longer compromise such investigation.

(2) NOTIFICATION TO VICTIM.—An agency, or person engaged in interstate commerce, shall, in compliance with this subsection if it provides the resident, owner, or licensee, as appropriate, with—

(A) written notification;

(B) e-mail notification, if the person or business has an e-mail address for the subject person; or

(C) substitute notice, if the cost of providing direct notice would exceed $250,000; or

(D) notice in any manner that demonstrates that the cost of providing direct notice would exceed $250,000; or

(E) the affected class of subject persons to be notified exceeds 500,000; or

(F) the agency or person does not have sufficient contact information for those to be notified.

(3) ALTERNATIVE NOTIFICATION PROCEDURES.—Notwithstanding any other obligation under this subsection, an agency, or person engaged in interstate commerce, shall be deemed to have complied with the requirements of this subsection if the agency or person—

(A) maintains its own reasonable notification procedures as part of an information security policy for the treatment of personal information; and

(B) notifies substitute persons in accordance with its information security policy in the event of a breach of security of the system.

(4) REASONABLE NOTIFICATION PROCEDURES.—As used in paragraph (6), with respect to a breach of security of the system involving personal information described in section 2(4)(C), the term “reasonable notification procedures” means procedures that—

(A) use a security program reasonably designed to block unauthorized transactions before they are charged to the customer’s account;
(B) provide for notice to be given by the owner or licensee of the database, or another party acting on behalf of such owner or licensee, after the security program indicates that the operation of the system has resulted in fraud or unauthorized transactions, but does not necessarily require notice in other circumstances; and

(C) is subject to examination for compliance with the requirements of this Act by 1 or more Federal functional regulators (as defined in section 599 of the Gramm-Leach-Bliley Act (15 U.S.C. 8909)), with respect to the operation of the security program and the notification procedures.

4. PENALITIES.—Any agency, or person engaged in interstate commerce, that violates this section shall be subject to a fine of not more than $25,000 per day while such violations persist.

5. EFFECTIVE DATE.—This Act shall take effect on the expiration of the date which is 6 months after the date of enactment of this Act.

By Mr. FRIST:

S. 1351. A bill to amend the Tennessee Valley Authority Act of 1933 (16 U.S.C. 831 et seq.) to modify provisions relating to the Board of Directors of the Tennessee Valley Authority, and for other purposes; to the Committee on Environment and Public Works.

Mr. FRIST. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

SEC. 1. CHANGE IN COMPOSITION, OPERATION, AND DUTIES OF THE BOARD OF DIRECTORS OF THE TENNESSEE VALLEY AUTHORITY.

(a) IN GENERAL.—The Tennessee Valley Authority Act of 1933 (16 U.S.C. 831 et seq.) is amended by striking section 2 and inserting the following:

"SEC. 2. MEMBERSHIP, OPERATION, AND DUTIES OF THE BOARD OF DIRECTORS OF THE TENNESSEE VALLEY AUTHORITY.

(a) MEMBERS.—

(1) APPOINTMENT.—The Board of Directors of the Corporation (referred to in this Act as the 'Board') shall be composed of 9 members appointed by and with the advice and consent of the Senate, who shall be legal residents of the service area.

(2) CHAIRMAN.—The members of the Board shall select 1 of the members to act as chairman of the Board.

(b) QUALIFICATIONS.—

(1) IN GENERAL.—To be eligible to be appointed as a member of the Board, an individual—

(A) shall be a citizen of the United States;

(B) shall have widely recognized experience or applicable expertise in the management of or decisionmaking for a large corporate structure;

(C) shall not be an employee of the Corporation;

(D) shall have no substantial direct financial interest in—

(i) any public-utility corporation engaged in the business of distributing and selling power to the public; or

(ii) any business that may be adversely affected by the success of the Corporation as a producer of electric power;

(E) shall profess a belief in the feasibility and wisdom of this Act.

(2) VACANCIES.—A member appointed to fill a vacancy occurring before the expiration of the term for which the predecessor of the member was appointed shall serve for the remainder of that term.

(c) REAPPOINTMENT.—

(A) IN GENERAL.—A member of the Board that was appointed for a full term may be reappointed for 1 additional term.

(B) APPOINTMENT TO FILL VACANCY.—For the purpose of subparagraph (A), a member appointed to serve the remainder of the term of a vacating member for a period of more than 2 years shall be considered to have been appointed for a full term.

(d) COMPENSATION.—

(A) IN GENERAL.—A member of the Board shall be entitled to receive—

(i) a stipend of $30,000 per year; plus

(ii) compensation, not to exceed $10,000 for any year, at a rate that does not exceed the daily equivalent of the annual rate of basic pay prescribed under level V of the Executive Schedule under section 5316 of title 5, United States Code, for a day the member is engaged in the actual performance of duties as a member of the Board at meetings or hearings; and

(iii) travel expenses, including per diem in lieu of subsistence, in the same manner as persons employed intermittently in Government service under section 5703 of title 5, United States Code.

(b) ADJUSTMENTS IN STIPENDS.—The amount of the stipend under paragraph (A) shall be adjusted by the same percentage, at the same time and manner, and subject to the same limitations as are applicable to adjustments under section 5318 of title 5, United States Code.

(c) DUTIES.—

(1) IN GENERAL.—The Board shall—

(A) establish the broad goals, objectives, and policies of the Corporation that are appropriate to carry out the purpose and policies of the Corporation as set forth in the Act; and

(B) develop long-range plans to guide the Corporation in achieving the goals, objectives, and policies of the Corporation that are appropriate to carry out the purpose and policies of the Corporation as set forth in the Act.
for fundamental changes in the electric utilities industry;

"(C) ensure that those goals, objectives, and policies are achieved;

"(D) approve an annual budget for the Corporation;

"(E) establish a compensation plan for employees of the Corporation in accordance with subsection (i);

"(F) approve the salaries, benefits, and incentives for managers and technical personnel that report directly to the chief executive officer;

"(G) ensure that all activities of the Corporation are carried out in compliance with applicable law;

"(H) retain an audit committee, composed solely of Board members independent of the management of the Corporation, which shall—

(i) recommend to the Board an external auditor;

(ii) receive and review reports from the external auditor; and

(iii) make such recommendations to the Board as the audit committee considers necessary;

"(1) create such other committees of Board members as the Board considers to be appropriate;

"(2) conduct public hearings on issues that could have a substantial effect on—

(i) the electric rates charged by the corporation or area;

(ii) the economic, environmental, social, or physical well-being of the people of the service area;

"(K) establish the electricity rate schedule.

"(2) MEETINGS.—The Board shall meet at least 4 times each year:

"(h) CHIEF EXECUTIVE OFFICER.—The chief executive officer will appoint the Board, with the advice and consent of the Board, and without regard to the provisions of the Civil Service laws applicable to officers and employees of the United States, such managers, assistant managers, officers, employees, attorneys, and agents as are necessary for the effective operation of the Corporation.

"(i) recommend to the Board an external auditor.

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jointly select hazardous fuels reduction projects identified by the Implementation Plan of the Comprehensive Strategy. (c) CONSISTENCY WITH EXISTING FOREST MANAGEMENT AND ENVIRONMENTAL LAWS.—Any project carried out pursuant to this Act shall be consistent with the applicable forest plan, resource management plan, or other applicable plans or environmental laws except as specifically amended by this Act. (d) PRIORITY LANDS.—In implementing projects under this Act, the Secretaries of Agriculture and the Interior shall give highest priority to: (1) Wildland-urban interface: Condition class 3 or condition class 2 federal lands or, where appropriate, non-federal lands; (2) Municipal watersheds: Condition class 3 federal lands or, where appropriate, non-federal lands; (3) Fire Regimes I and II lands: Federal lands that are condition class 3; and (4) Fire Regimes III and III lands: Condition class 1 lands identified by the Secretary as an area where windthrow or blowdown, or the existence of disease or insect infestation, pose a significant threat to forest health and federal lands. (e) PUBLIC NOTICE AND PUBLIC RESPONSE.—(1) QUARTERLY NOTICE.—The Secretary shall provide quarterly notice of each hazardous fuels reduction project which uses the streamlined processes established by this Act. The quarterly notice shall be provided for projects in the Federal Register and on an agency website and in a local paper of record for local projects. The Secretary may combine this quarterly notice with other quarterly notices otherwise issued regarding federal lands fuels reduction projects. (2) CONTENT.—For each hazardous fuels reduction project for which the processes established by this Act are to be used; (a) a description of the project, including as much in-borough information on its geographic location as practicable; (b) the approximate date on which scoping for the project will begin and (c) a description of how interested members of the public can take part in the development of the project, including, but not limited to, project related public meeting notification. (3) PUBLIC MEETING.—Following public notice of each quarterly notice under paragraph (1), but before the beginning of scoping under section (d), the Secretary shall conduct a public meeting at an appropriate location in each administrative unit of the federal lands regarding hazardous fuels reduction projects contained in the quarterly notice that are proposed to be conducted in that administrative unit. The Secretary shall provide advance notice of the date and time of the meeting in the quarterly notice or using the same means described in paragraph (1). (4) PUBLIC RESPONSE TO NOTICE OF PROJECTS.—(a) IN GENERAL.—A federally formed resource advisory committee may petition, with supporting evidence, the Secretary to better define conditions of large trees or old growth stands to be protected under subsection (a)(1). (b) SECRETARIAL RESPONSE.—The Secretary shall provide a review of historic geographic conditions, forest type, present fuel loads, and determination of whether the area properly qualifies as priority lands under subsection (d). (c) DETERMINATION OF PETITION.—The Secretary shall provide notice by the same means described in paragraph (1) of any final agency action regarding a hazardous fuels reduction project for which the processes established by this Act are used. (1) PRIORITIES.—(A) Hazardous Fuels Reduction Funding.—The Secretary shall expend no less than 70 percent of funds under this Act on projects within the wildland-urban interface, forest type, present fuel loads, and determination of whether the area properly qualifies as priority lands under subsection (d). (B) Final Agency Action.—The Secretary shall provide notice by the same means described in paragraph (1) of any final agency action regarding a hazardous fuels reduction project for which the processes established by this Act are used. (2) LIMITATIONS.—In implementing hazardous fuels reduction projects under this Act the Secretary shall provide notice by the same means described in paragraph (1) of any final agency action regarding a hazardous fuels reduction project for which the processes established by this Act are used. (1) SCOPING.—(A) The Secretary may issue the environmental assessment is sufficient and use the procedures set forth in the Council on Environmental Quality’s “Guidance for Environmental Assessments of Forest Health Projects,” of December 9, 2002, or as amended. (B) ISSUANCE OF DOCUMENTATION AND SHORT-ENED APPEALS.—Notwithstanding the Appeals Reform Act, section 322 of the Department of the Interior and Related Agencies Appropriations Act, 1993 (Public Law 102–381; 16 U.S.C. 1612 note), or regulations pertaining to the Department of the Interior Office of Hearings and Appeals procedures, for projects implemented pursuant to this Act that are consistent with NEPA, whether an environmental assessment is sufficient and use the procedures set forth in the Council on Environmental Quality’s “Guidance for Environmental Assessments of Forest Health Projects,” of December 9, 2002, or as amended. (c) ENVIRONMENTAL ASSESSMENTS OUTSIDE THE WILDLAND-URBAN INTERFACE.—(1) IN GENERAL.—For hazardous fuels reduction projects implemented pursuant to this Act on priority lands identified in section 2(d), if a categorical exclusion does not apply, the Secretary shall provide notice, in accordance with the procedures established by this Act, for public comment, or the project had already undergone NEPA, or is a project that is included in the Comprehensive Strategy. (d) CATEGORICAL EXCLUSIONS.—(1) Section 3 of the National Environmental Policy Act of 1969 (42 U.S.C. 4332) and the Secretary need not make any findings as to whether the projects individually or cumulatively have a significant effect on the environment. (2) VARIED TREATMENTS.—The Secretary shall provide notice, in accordance with the procedures established by this Act, for public comment, or the project had already undergone NEPA, or is a project that is included in the Comprehensive Strategy. (e) RESPONSIBILITY OF SECRETARY.—The Secretary shall provide notice, in accordance with the procedures established by this Act, for public comment, or the project had already undergone NEPA, or is a project that is included in the Comprehensive Strategy. (f) RESPONSIBILITY OF SECRETARY.—The Secretary shall provide notice, in accordance with the procedures established by this Act, for public comment, or the project had already undergone NEPA, or is a project that is included in the Comprehensive Strategy. (g) RESPONSIBILITY OF SECRETARY.—The Secretary shall provide notice, in accordance with the procedures established by this Act, for public comment, or the project had already undergone NEPA, or is a project that is included in the Comprehensive Strategy. 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the map entitled and dated on file at the Forest Service office.

(2) MONITORING.—The Secretary shall require that any saline hazardous fuels reduction project conducted under this Act be subject to ecological and economic monitoring of its effects, including on-site evaluation and inspection. The Secretary shall be represented by a group with representation from independent scientists, industry representatives, environmentalists, community-based organizations, and other interested parties. Group selection shall be through the Western Governors Association Collaborative process. The group shall report to the public under section 4(b) on the ecological and economic effects of individual saline hazardous fuels projects.

SEC. 4. JUDICIAL REVIEW IN THE UNITED STATES DISTRICT COURTS.

(a) VENUE.—A hazardous fuels reduction project conducted under this Act shall be subject to judicial review only in the United States District Court for the district in which the federal lands to be treated by the hazardous fuels reduction project are located, notwithstanding 28 U.S.C. 1391 or any other applicable statutes.

(b) EXPEDITED COMPLETION OF JUDICIAL REVIEW.—Congress intends and encourages any court that files a lawsuit pursuant to this Act shall have the ability to expedite the conduct of any administrative review for any action concerning a project under this Act.

(c) DURATION OF INJUNCTION.—Any temporary injunctive relief granted regarding a project undertaken pursuant to this Act shall be limited to 60 days, with authority to renew such temporary injunction without limitation. For purposes of injunctive relief the parties shall present the court with updates on the status of the project.

(d) STANDARD OF REVIEW.—Nothing in this section shall change the standards of judicial review for any action concerning a project authorized under this Act.

SEC. 5. CONTRACTING.

(a) BEST VALUE CONTRACTING.—The Secretary shall use best value contracting criteria in awarding at least fifty percent of contracts and agreements for hazardous fuels reduction projects conducted under this Act. Best value contract criteria will include, but not be limited to:

(1) the ability of the contractor to meet the ecological goals of the project;
(2) the use of equipment that will minimize or eliminate impacts on soils; and (3) benefit to local economies in performing the restoration to the public under section 5(b) on the ecological and economic effects of individual hazardous fuels projects.

(b) MONITORING.—The Forest Service shall monitor the business and employment impacts of hazardous fuels reduction projects including the total dollar value of contracts and agreements awarded to qualifying entities.

(c) PUBLIC LANDS CORPS.—

(1) CONTRACTS AND AGREEMENTS.—In implementing projects authorized under this Act, the Secretary is authorized to enter into contracts or cooperative agreements with a Public Lands Corps (i) to implement and complete projects prioritized by the Secretary, and (ii) to perform appropriate rehabilitation, enhancement, or beautification projects with the Department of Natural Resources, Department of Forestry or Department of Agriculture of any State.

(2) REPORT.—Such projects may also be carried out on Indian lands with the approval of the relevant Indian tribe.

(C) PREFERENCE.—The Secretary shall give preference to those projects which take place on lands identified as priorities in section 2(d) of this Act and can be planned and initiated promptly.

(D) SUPPORTIVE SERVICES.—The Secretaries are authorized to provide such services as the Secretaries deem necessary to carry out the purposes of this Act.

(E) TECHNICAL ASSISTANCE.—The Secretaries shall work with the National Association of Service and Conservation Corps to provide technical assistance, oversight, monitoring, and evaluation to the United States Departments of Agriculture and the Interior, State Departments of Natural Resources and Agriculture, and Corps.

(2) NONDISPLACEMENT.—The nondisplacement requirements of section 177 of the National and Community Service Trust Act of 1990 shall be applicable to all activities carried out under this Act by the Public Lands Corps.

(3) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of this subsection there are authorized to be appropriated $12,500,000 annually for 5 years after the enactment of this Act.

(4) DEFINITIONS.—For the purposes of this section—

(1) CONTRACTS AND AGREEMENTS.—The term "contracts and agreements" means service contracts, construction contracts, supply contracts, emergency equipment rental agreements, architectural and engineering contracts, cooperative agreements, and participating agreements.

(2) QUALIFYING ENTITY.—The term "qualifying entity" means:

(A) a local entity that meets the criteria to qualify for the Historically Underutilized Business Zone Program under section 32 of the Small Business Act (48 U.S.C. 1605 note);

(B) a Youth Conservation Corps or Public Lands Corps crew or related partnership with State, local and other non-federal conservation corps;

(C) an entity that will hire and train local people to complete the contract or agreement;

(D) an entity that will re-train non-local traditional forest workers to complete the contract or agreement; and

(3) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of this subsection, there are authorized to be appropriated $12,500,000 each fiscal year for 5 years after the date of enactment of this Act.

(4) DEFINITIONS.—For the purposes of this Act—

(A) the term "biomass" means pre-commercial thinning of trees and woody plants, or non-merchantable material, from hazardous fuels reduction projects.

(B) the term "green ton" means 2,000 pounds of biomass that has not been mechanically or artificially dried.

(5) INDIAN TRIBE.—The term "Indian tribe" has the meaning given the term in section 4(e) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(e)).

(b) BIOMASS COMMERCIAL UTILIZATION GRANT PROGRAM.

(1) IN GENERAL.—The Secretary may make grants to any individual, community, Indian tribe, small business or corporation, or non-profit organization to develop a proposal to offset capital expenses and costs incurred to purchase biomass for use by such eligible operation with priority given to operations using biomass from the highest risk areas.

(2) LIMITATION.—No grant provided under this subsection shall be paid at a rate that exceeds $20 per green ton of biomass delivered.

(3) RECORDS.—Each grant recipient shall keep such records as the Secretary may require to fully and completely document the use of the grant funds and all transactions involved in the purchase of biomass. Upon notice by the Secretary, the grant recipient shall provide the Secretary reasonable access to examine the inventory and records of any eligible operation receiving grant funds.

(d) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of this subsection, there are authorized to be appropriated $12,500,000 each fiscal year for 5 years after the date of enactment of this Act.

(c) IMPROVED BIOMASS UTILIZATION PROGRAM.

(1) IN GENERAL.—The Secretary shall make grants to persons in eligible communities to offset the costs of developing or researching biomass projects to improve the use of biomass or add value to biomass utilization.

(2) SELECTION.—Grant recipients shall be selected based on the potential for the proposal to—

(A) develop affordable thermal or electric energy resources for the benefit of an eligible community;

(B) provide opportunities for the creation or expansion of small businesses within an eligible community;

(C) provide new job opportunities within an eligible community; and

(D) reduce the hazardous fuels from the highest risk areas.

(3) LIMITATION.—No grant awarded under this subsection shall exceed $50,000.

(4) AUTHORIZATION OF APPROPRIATIONS.—For the purposes of this subsection, there are authorized to be appropriated $50,000 each fiscal year for the fiscal year after enactment of this Act.

(5) REPORT.—Not later than 3 years after the date of enactment of this Act, the Secretary of the Interior and the Secretary of Agriculture for each fiscal year for the purposes of this subsection shall exceed $500,000.

(6) ELIGIBILITY.—For the purposes of this subsection, there are authorized to be appropriated $12,500,000 each fiscal year for the fiscal year after enactment of this Act.

(7) ELIGIBLE COMMUNITY.—The term "eligible community" means any Indian reservation, or any county, town, township, municipality, or other similar unit of local government which has a population of not more than 50,000 individuals and is determined by the Secretary to be located in an area near federal or Tribal lands which is at significant risk of catastrophic wildfire, disease, or insect infestation or which suffers from disease or insect infestation.

(8) REPORT.—Not later than 3 years after the date of enactment of this Act, the Secretary shall submit a report to the Committee on Energy and Natural Resources of the Senate and the Committee on Energy and Commerce of the House of Representatives.
Agriculture shall jointly submit to the Congress a report that describes the interim results of the programs authorized under this section.

SEC. 7. FOREST STANDS INVENTORY AND MONITORING PROGRAM.

(a) In General.—The Secretary of Agriculture and the Secretary of the Interior shall, in conjunction with the Department of Transportation, implement a comprehensive program to inventory and assess forest stands on federal forest land and, with the consent of the owner, private forest land and, with the consent of the owner, private land and, with the consent of the owner, private property owners to reduce fire risk on private property.

(b) Location.—The facility for this program shall be located at the Ochoco National Forest Headquarters in Prineville, Oregon.

(c) Authorization of Appropriations.—For the purposes of this section, there are authorized to be appropriated $5,000,000 each fiscal year for the five years after enactment of this Act.

SEC. 8. EMERGENCY FUELS REDUCTION GRANTS.

(a) In General.—The Secretary of Agriculture shall establish an Emergency Fuels Reduction Grant program to provide State and local entities with financial assistance for hazardous fuels reduction projects addressing threats of catastrophic fire that have been determined by the United States Forest Service to pose a serious threat to human life.

(b) Eligibility.—Fuels reduction projects eligible for funding under the Emergency Fuels Reduction Grant program shall:

(1) be surrounded by or immediately adjacent to national forest boundaries;

(2) have been determined to be of paramount urgency by virtue of declarations of emergency by both local officials and the governor of the State in which they are located; and

(3) remove fuel loading determined to pose a serious threat to human life by the United States Forest Service.

(c) USE OF GRANT FUNDS.—Funds authorized under this section shall be limited to the following uses:

(1) removal of trees, shrubs or other potential fuels adjacent to primary evacuation routes;

(2) removal of trees, shrubs or other potential fuels adjacent to emergency response centers, fire communications facilities, or sites designated as shelter-in-place facilities; and

(3) evacuation drills and preparation.

(d) REVOLVING FUND.—For work done on private property and county lands, the grant recipients shall deposit into a revolving fund any proceeds from sale of the timber or biomass from the project, and fund assistance under this section. The revolving fund shall be used to assist with subsequent grants under this section.

(e) EMERGENCY FUELS REDUCTION GRANTS.—For the purposes of funding the Emergency Fuels Reduction Grant program under this Act, there are authorized to be appropriated $50,000,000 each fiscal year that this Act is in effect. Subject to section 13, amounts appropriated in one fiscal year and unobligated before the end of that fiscal year shall remain available for use in subsequent fiscal years.

SEC. 9. MARKET INCENTIVES FOR HOME PROTECTION.

It is the Sense of Congress that insurers should reduce premiums for homeowners in condition class 2 and condition class 3 areas within the following circumstances:

(1) clear brush and other flammable material in the vicinity of their homes;

(2) use noncombustible materials for roofs and other critical structures; or

(3) otherwise improve the defensibility of their homes against catastrophic fire.

SEC. 10. ON-SITE PROJECTS AND EXISTING AUTHORITIES.

Nothing in this Act shall affect projects begun prior to enactment of this Act or affect authorities otherwise granted to the Secretaries under existing law.

SEC. 11. PREFERENCE TO COMMUNITIES THAT HAVE ORDINANCES ON FIRE PREVENTION.

(a) In General.—In determining the allocation of funding for the Community and Private Land Fire Assistance Program (16 USC 2106c/PL–171 Sec. 10(a)(b)), the Secretary shall prioritize funding to those communities which have taken proactive steps through the enactment of ordinances and other means, including those that have developed a comprehensive fire protection plan encompassing all ownerships, to encourage property owners to reduce fire risk on private property.

(b) PRIVATE LANDS.—Nothing in this Act shall affect existing authorities to use appropriations authorized by this Act to carry out the provisions under this Act on non-federal lands with the consent of the land owner.

SEC. 12. SUNSET.

The provisions of this Act shall expire five years after the date of enactment, except that projects for which a decision notice has been issued by that date may continue to be implemented.

SEC. 13. AUTHORIZATION OF APPROPRIATIONS.

(a) NATIONAL FOREST SYSTEM LANDS.—For the purposes of planning and conducting hazardous fuels reduction projects under this Act on National Forest System lands, there are authorized to be appropriated to the Secretary of Agriculture $1,943,100,000 during the five-fiscal year period beginning October 1, 2003. Subject to section 12, amounts appropriated in one fiscal year and unobligated before the end of that fiscal year shall remain available for use in subsequent fiscal years.

(b) BLm LANDS.—For the purpose of planning and conducting hazardous fuels reduction projects under this Act on Federal lands managed by the Secretary of the Interior, there are authorized to be appropriated to the Secretary of the Interior $1,888,000,000 during the five-fiscal year period beginning October 1, 2003. Subject to section 12, amounts appropriated in one fiscal year and unobligated before the end of that fiscal year shall remain available for use in subsequent fiscal years.

SEC. 14. DEFINITIONS.

(a) LAND TYPES AND FIRE REGIME AREAS.—In this Act definitions of land types and fire regimes originate from the U.S. Forest Service Rocky Mountain Research Station, as follows:

(1) CONDITION CLASS 2.—The term ‘‘condition class 2’’ refers to lands on which—

(A) fire frequencies have been moderately altered and have departed from historic fire return intervals (decreased or increased) by one or more return interval, which results in moderate changes to fire size, frequency, intensity, severity or landscape pattern; and

(B) there exists a moderate risk of losing key ecosystem components; and

(C) vegetation attributes have been moderately altered from their historic range.

(2) CONDITION CLASS 3.—The term ‘‘condition class 3’’ refers to lands on which fire regimes have been significantly altered from their historic range, which results in dramatic changes to fire size, frequency, intensity, severity, or landscape pattern.

(3) There exists a high risk of losing key ecosystem components; and

(4) Vegetation attributes have been significantly altered from their historic range.

(b) FIRE REGIME.—The term ‘‘fire regime I’’ refers to lands on which historically fire recurred in 3–5 year intervals and burns with low severity.

(c) FIRE REGIME II.—The term ‘‘fire regime II’’ refers to lands on which historically fire recurred in 3–5 year intervals and replaces existing vegetation.

(d) FIRE REGIME III.—The term ‘‘fire regime III’’ refers to lands on which historically fire recurred in 35–100 year intervals and burns with mixed severity.

(e) At-Risk Community.—The term ‘‘at-risk community’’ means a geographic area designated by the Secretary of the Interior acting through the BLM, pursuant to section 15041 of title 43, Code of Federal Regulations, as a geographic area which has conditions conducive to large-scale wildland fire disturbance events, and for which a significant threat to human life exists as a result of wildland fire disturbance events.

(f) Best Value Contracting.—The term ‘‘best value contracting’’ means the contracting process described in section 15.101 of title 48, Code of Federal Regulations, which allows the inclusion of non-cost factors in the evaluation of proposals for public lands.

(g) Comprehensive Strategy.—The term ‘‘comprehensive strategy’’ means the Comprehensive Strategy for a Collaborative Approach for Reducing Wildland Fire Risks to Communities and the Environment, dated May 2002, including by reference the related Implementation Plan, which was developed pursuant to the conference report to accompany the Department of Interior and Related Agencies Appropriations Act, 2001 (House Report 106–416).

(h) Federal Lands.—The term ‘‘federal lands’’ means National Forest System lands and public forested lands administered by the Secretary of the Interior acting through the BLM.

(i) Local Preference Contracting.—The term ‘‘geographic feature’’ means a ridge top, road, stream, or other landscape feature which can serve naturally as a firebreak, staging ground for firefighting, or boundary affecting fire behavior.

(j) Hazardous Fuels Reduction Project.—The term ‘‘hazardous fuels reduction project’’ means a project—

(1) undertaken for the purpose of reducing the amount of hazardous fuels, and from the alteration of a natural fire regime as a result of fire suppression or other management activities; and

(2) accomplished through the use of prescribed burning or mechanical treatment, or a combination thereof.

(k) Inventario Roadless Areas.—The term ‘‘inventario roadless area’’ means one of the areas identified in the set of inventoried roadless area maps contained in the Forest Service Roadless Areas Conservation, Final Environmental Statement, Volume 2, dated November, 2000.

(l) Local Preference Contracting.—The term ‘‘local preference contracting’’ means a project which gives preference to local businesses described in section 333 of the Department of Interior and
First, the bill prioritizes our efforts. Many people believe that we should protect communities first. The bill does so. Seventy percent of the funding is directed to the wildland-urban interface near communities. Of course, conditions vary by State. The bill allows Governors to adjust the percentage of work that is to be done within the wildland—urban interface for their State, up to a maximum of 75 percent, or down to a minimum of 50 percent.

By way of contrast, H.R. 1904, which passed the House, includes no focus on protecting communities. All the money can be spent far from communities under H.R. 1904, even if the Governor of a State wishes otherwise.

Senator Wyden and I believe that in addition to protecting communities, there are some forest lands that should be thinned to ensure that catastrophic fires and eliminate habitat for the species that have there.

In the last century, Americans have rigorously suppressed fires, stamping them out wherever possible. In certain forests like ponderosa pine, these fires would naturally have cleared out the brush and small trees every 10 or 20 years or so.

In the absence of these fires, brush has grown into “downtown thickets” with dangerous levels of fuel loadings. When fires burn now in these forests, they will be so hot that they won’t just clear out the brush but will kill the large trees and often scorch the soil. Thus, these areas need us to focus our efforts. We thus target thinning projects to forests that are both Fire Regime I and Condition Class 3. Fire Regime I forests are those that used to have low-intensity, brush-clearing fires; and Condition Class 3 forests are the most altered from their natural condition. The combination of Fire Regime I and Condition Class 3 are the highest priority lands for treatment.

We also direct projects to municipal watersheds and diseased or windblown forests that are in Condition Class 3. If we don’t protect the municipal watersheds, catastrophic fires could strip off the tree cover that prevents soils from eroding into creeks and lakes. Municipalities’ water quality could suffer.

In contrast to our bill, H.R. 1904 fails to prioritize brush-clearing projects for the areas that need it the most. Instead, H.R. 1904 provides expedited processes for lands that are only moderately altered by fire suppression—Condition Class 2 lands in addition to Condition Class 3.

In many of the forests where H.R. 1904 would direct brush-clearing work, there naturally would have been severe fires that burned all the trees in the stand. After a thinning project, fires in these forests will still behave the same way, scorching and killing most of the trees. Thus, much of the thinning called for in H.R. 1904 would have little effect on the fire behavior or forest health.

Senator Wyden and I have also sped up the process for projects outside the immediate vicinity of communities. These projects are more controversial, so we want to make sure that the public has some opportunity for input.

In the past, the Forest Service and the Department of Interior have been able to conduct the majority of brush-clearing mechanical treatment following a National Environmental Policy Act process known as environmental assessments. Our bill simplified these environmental assessments in several ways.

The bill provides one round of public comment—the administrative appeal process—rather than two.

The bill shortens the time frame for administrative appeals from 90 to 60 days.

Finally, the appeal deciding offer can make necessary changes rather than having to send the project back to the original decisionmaker for further time-consuming review.

Together, these changes will likely speed up the process by a few months or more. We do all this without eliminating public comment or gutting core parts of the environmental analysis.

In contrast, the House-passed bill would include the requirement that the Forest Service consider alternatives to the proposed project as part of its environmental analysis. In other
words, the Forest Service doesn’t have to study other, less damaging ways of undertaking the project—it can just do the project the way it wants.

Many people think that public debate over alternatives is the core of the National Environmental Policy Act. Our bill does not eliminate this important environmental protection.

Another important part of our bill is its protection of magnificent old growth forests. The remaining groves of these trees provide a connection to nature untrammeled by human activity, a connection that many of us cherish.

Our bill would require full protection of these old growth stands. In addition, outside old growth stands, the bill focuses on small-diameter trees and protects large trees that promote fire-resistant stands and species diversity.

By way of contrast, H.R. 1904 provides no protection for these magnificent resources.

Let me now talk about judicial review. No one wants court cases to go on too long. In addition, people should not be able to tie up projects by gaming the system and picking and choosing the friendliest courts to hear their lawsuits.

Our bill addresses these problems. The bill encourages courts, to the maximum extent practicable, to resolve lawsuits over clearing projects quickly. These are important projects for the safety of our communities and our forests, and it is appropriate to give them some priority.

In addition, we require that potential litigants file suit in the same judicial district where a fuels reduction project takes place. No one can game the system by looking for a friendly judge somewhere else.

Finally, we limit temporary injunctions that are typically issued at the outset of a case to 60 days. They can be renewed if necessary—but the challengers to a project must submit updated explanations why the injunctions should be extended. This provision prevents projects from being held up any longer than is strictly necessary.

These changes will expedite the process—but they still respect our court system’s essential autonomy. As a member of the Judiciary Committee, I spend much of my time trying to make sure our court system is as fair as possible.

Americans count on a judiciary independent of the executive branch to preserve their liberties and to right any wrongs that their government commits. I think it is very important that we not interfere with the independence of our judiciary.

The House-passed bill would require the courts to give weight to certain findings by the Forest Service and the Department of the Interior. Even if projects had been found to violate the environmental laws, courts would be told to give weight to the agencies’ findings and allow many of the projects to go ahead anyway.

This is a dangerous provision for a bill to include, and I cannot support it.

I believe our bill includes more sensible provisions on judicial review that will help projects go forward quickly without compromising the independence of our judiciary.

Our bill includes several provisions to address health problems on private and State lands.

We authorize $50 million annually in emergency grants to States and localities where lives are at risk. The last few years have seen vast insect epidemics killing millions of trees in Southern California, Arizona, and elsewhere.

In places like Lake Arrowhead, Big Bear and Idyllwild in Southern California, communities are surrounded by dead and dying trees that are perfect kindling for a catastrophic fire. There is a real threat to people’s lives that we must address.

There is now no good funding source for clearing evacuation routes and clearing around schools and other emergency shelters that are on State and private lands. The emergency grants in the bill would authorize funds for these essential purposes.

The bill also includes two measures to encourage homeowners to clear brush and install non-flammable roofs. A study of Southern California fires by Forest Service researcher Jack Cohen has shown that these measures could reduce a blaze’s threat to homes by as much as 85 to 95 percent.

Our bill would encourage these home-saving practices in two ways:

The bill would prioritize grants to those communities that encourage brush-clearing and use of non-flammable roofs or develop comprehensive fire plans.

The bill would record the Sense of Congress that insurers should offer lower premiums to homeowners who take steps to protect their homes.

Our bill would also include grants to encourage the use of woody material, or biomass, for energy production. Biomass-to-energy plants serve multiple beneficial purposes: one, they are a clean and renewable source of energy; and two, they make brush-clearing projects more cost-effective, so we can protect more with the finite Federal dollars available.

Finally, our bill would also include contracting provisions to benefit rural communities. The Forest Service and the Department of the Interior would be required to use “best value contracting” for brush-clearing projects under the Act.

This contracting approach requires the agencies to consider other factors besides the price of the bid in awarding contracts. Bidders would be rewarded for such factors as their commitment to hire local workers, and their past record of environmental stewardship.

I would like to close by saying that this is truly a bipartisan issue. All of us, Democrat and Republican, have an interest in clearing out dangerous accumulations of brush in our national forests. All of us have an interest as well in protecting the magnificent old growth stands and species habitat that Americans cherish, and in upholding our environmental laws.

I look forward to working with my colleagues on both sides of the aisle to pass a bill as soon as possible.

By Mr. BROWNBACK (for himself and Mr. DEWINE):

S. 1353. A bill to establish new special immigrant categories to the Committee on the Judiciary.

Mr. BROWNBACK. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1353

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

SECTION 1. SHORT TITLE.

This Act may be cited as the “Widows and Orphans Acts of 2003”.

SEC. 2. NEW SPECIAL IMMIGRANT CATEGORY.

(a) CERTAIN CHILDREN AND WOMEN AT RISK ON HARBOR. —Section 101(a)(27) of the Immigration and Nationality Act (8 U.S.C. 1101(a)(27)) is amended—

(1) in subparagraph (L), by inserting a semicolon at the end;

(2) in subparagraph (M), by striking the period at the end and inserting “; or”; and

(3) by adding at the end the following:

(IV) subject to subsection (i), an immigrant who is not present in the United States—

(I) who is—

(aa) referred to a consular, immigration, or other designated official by a United States Government agency, an international organization, or recognized nongovernmental entity designated by the Secretary of State for purposes of such referrals; and

(bb) who faces a credible fear of harm related to travel or her age;

(cc) who lacks adequate protection from such harm; and

(dd) for whom it has been determined to be in his or her best interests to be admitted to the United States; or

(ii) who is—

(aa) a credible fear of harm related to her sex;

(bb) a lack of adequate protection from such harm; and

(c) STATUTORY CONSTRUCTION.—Section 101 of the Immigration and Nationality Act (8 U.S.C. 1101) is amended by striking the period at the end, and adding the following:

(2)(A) No alien who qualifies for a special immigrant status under subsection (a)(27)(N)(i) shall thereafter, by virtue of such parentage, be accorded any right, privilege, or status under this Act.

(2)(A) No alien who qualifies for a special immigrant visa under subsection...
(a)(2)(N)(I) may apply for derivative status or petition for any spouse who is represented by the alien as missing, deceased, or the source of harm at the time of the alien’s application and admission. The Secretary of Homeland Security may waive this requirement for an alien who demonstrates that the alien’s representations regarding the spouse were false.

“(b) An alien who qualifies for a special immigrant visa under subsection (a)(2)(N) may apply for derivative status or petition for any derivative or other family member under the age of 18 years or children under the age of 10 years of any such alien, if accompanying or following to join the alien. For purposes of this subparagraph, the age shall be made using the age of the alien on the date the petition is filed with the Department of Homeland Security.

“(c) An alien who qualifies for a special immigrant visa under subsection (a)(2)(N) shall be treated in the same manner as a refugee solely for purposes of section 212.

“(d) The provisions of paragraphs (4), (5), and (7)(A) of section 212(a) shall not be applicable to any alien seeking admission to the United States under subsection (a)(2)(N), and the Secretary of Homeland Security may waive any other provision of such section (other than paragraph 2(C) or subparagraph (A), (B), (C), or (E) of paragraph 3) with respect to such alien for humanitarian purposes, to assure family unity, or when it is otherwise in the public interest. Any such waiver by the Secretary of Homeland Security shall be in writing and shall be granted only on an individual basis following an investigation. The Secretary of Homeland Security shall provide for the annual reporting to Congress of the number of waivers granted under this paragraph in the previous fiscal year and a summary of the reasons for granting such waivers.

“(e) For purposes of subsection (a)(2)(N)(I)(II), a determination of age shall be made using the age of the alien on the date on which the alien was referred to the consular, immigration, or other designated official.

“(f) The Secretary of Homeland Security shall waive any application fee for a special immigrant visa for an alien described in section 101(a)(2)(N)(I).”

(c) ALLOCATION OF SPECIAL IMMIGRANT VISA.—Section 203(b)(4) of the Immigration and Nationality Act (8 U.S.C. 1153(b)(4)) is amended by striking “(A) or (B) thereof” and inserting “(A), (B), or (N) thereof”.

(d) EXPEDITED PROCESS.—Not later than 45 days after referral to a consular, immigration, or other designated official as described in section 101(a)(2)(N) of the Immigration and Nationality Act, as added by subsection (a), special immigrant status shall be adjudicated and, if granted, the alien shall be paroled to the United States pursuant to section 212(d)(5) of that Act (8 U.S.C. 1182(d)(5)) to apply for adjustment of status to permanent resident under section 245 of that Act (8 U.S.C. 1255) within 1 year of the alien’s arrival in the United States.

(e) REPORT TO CONGRESS.—Not later than 1 year after the date of enactment of this section, the Secretary of Homeland Security shall report to the Committees on the Judiciary of the Senate and the House of Representatives on the progress of the program, including—

(1) data regarding the number of placements of females and children at risk of harm; and

(2) data regarding the number of placements of males and children at risk of harm;

SEC. 2. FINDINGS.

Congress finds that:

(1) Cape Fox Corporation (Cape Fox) is an Alaska Native Village Corporation organized pursuant to the Alaska Native Claims Settlement Act related to Cape Fox Corporation and Sealaska Corporation, and for other purposes; to the Committee on Energy and Natural Resources.

By Ms. MURKOWSKI (for herself and Mr. STEVENS):

S. 1354. A bill to resolve certain conveyances and provide for alternative land selections under the Alaska Native Claims Settlement Act related to Cape Fox Corporation and Sealaska Corporation, and for other purposes; to the Committee on Energy and Natural Resources.

Ms. MURKOWSKI. Mr. President, I rise today to reintroduce a bill that passed the Senate with bipartisan support in the 107th Congress. This legislation addresses an equity issue for one of Alaska’s rural village corporations.

The Cape Fox Land Entitlement Act of 2003 will allow the agency to consolidate Forest Service holdings in the George Inlet area of Revilla Island. This will help rectify the long-standing inequities associated with restrictions placed on Cape Fox in ANCSA. It will also provide for the resolution of a long-standing land ownership problem with the Tongass National Forest. The predominant private landowner in the region, Sealaska Corporation, holds the subsurface estate on several thousand acres of National Forest System lands. This split estate poses a management problem which the Forest Service has long sought to resolve. Efforts to address this issue go back more than a decade. Provisions in the Cape Fox Land Entitlement Act of 2003 will allow the agency to consolidate its surface and subsurface estate and greatly enhance its management effectiveness and efficiency in the Tongass National Forest. I urge my colleagues to support this important legislation. I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1354

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

SEC. 1. SHORT TITLE.

This Act may be cited as the “Cape Fox Land Entitlement Adjustment Act of 2003”.

SEC. 2. FINDINGS.

Congress finds that:

(1) Cape Fox Corporation (Cape Fox) is an Alaska Native Village Corporation organized pursuant to the Alaska Native Claims Settlement Act (ANCSA) (48 U.S.C. 1601 et seq.) for the Native Village of Saxman.

(2) As with other ANCSA village corporations in Southeast Alaska, Cape Fox was limited to selecting 23,040 acres under section 16. However, unlike other village corporations, Cape Fox was further restricted from selecting lands within 6 miles of the boundary of the home rule city of Ketchikan. All other ANCSA corporations were permitted to select within 2 miles of such a home rule city.

The 6-mile restriction went beyond protecting Ketchikan’s watershed and damaged Cape Fox by preventing the corporation from selecting valuable timber lands, industrial sites, and other commercial property, not only in its core township, but in surrounding lands far removed from Ketchikan and its watershed. As a result of the 6-mile restriction, Cape Fox lost valuable lands and the value of those lands was nonproductive and of no economic value, was available for selection by the corporation. Cape Fox’s land selections were further limited by the fact that the Annette Island Indian Reservation is within its selection area, and those lands were unavailable for ANCSA selection. Cape Fox is the only ANCSA village corporation affected by this restriction.

Clearly, Cape Fox was placed on unequal economic footing relative to other village corporations in Southeast Alaska. Despite its best efforts during the years since ANCSA was signed into law, Cape Fox has been unable to overcome the disadvantage it built into its selection opportunities by this inequitable treatment.

To address this inequity, I have introduced the Cape Fox Land Entitlement Adjustment Act of 2003. This bill will address the Cape Fox problem by providing three interrelated remedies:

(1) The obligation of Cape Fox to select and seek conveyance of the approximately 160 acres of unusable land in the mountainous northeast corner of Cape Fox’s core township will be annulled.

(2) Cape Fox will be allowed to select and the Secretary of the Interior will be directed to convey 99 acres of timberland adjacent to Cape Fox’s current holdings on Revilla Island.

(3) Cape Fox and the Secretary of Agriculture will be authorized to enter into an equal value exchange of lands in Southeast Alaska that will be of mutual benefit to the Corporation and the U.S. Forest Service. Lands conveyed to Cape Fox in this exchange will not be timberlands, but will be associated with a mining property containing existing Federal mining claims, some of which are patented. Lands anticipated to be returned to Forest Service ownership will be of wildlife habitat, recreation and watershed values and will consolidate Forest Service holdings in the George Inlet area of Revilla Island.

The bill also provides for the resolution of a long-standing land ownership problem with the Tongass National Forest. The predominant private landowner in the region, Sealaska Corporation, holds the subsurface estate on several thousand acres of National Forest System lands. This split estate poses a management problem which the Forest Service has long sought to resolve. Efforts to address this issue go back more than a decade. Provisions in the Cape Fox Land Entitlement Act of 2003 will allow the agency to consolidate its surface and subsurface estate and greatly enhance its management effectiveness and efficiency in the Tongass National Forest. I urge my colleagues to support this important legislation. I ask unanimous consent that the text of the bill be printed in the RECORD.
(4) To protect the watersheds in the vicinity of Ketchikan, Cape Fox was restricted from selecting lands within six miles from the boundary of the home rule City of Ketchikan under section 22(1) of ANCSA (43 U.S.C. 1621(1)).

(5) The six mile restriction damaged Cape Fox by precluding the corporation from selecting its core township, and other commercial property, not only in its core township but in surrounding lands far removed from Ketchikan and its waterfront.

(6) As a result of the 6 mile restriction, only the remote mountainous northeast corner of Cape Fox’s core township, which is nonproductive known as the Annette Island watershed, was available for selection by the corporation. Selection of this parcel was, however, mandated by section 16(b) of ANCSA (43 U.S.C. 1615(b)).

(7) Cape Fox’s land selections were further limited by the fact that the Annette Island Indian Reservation is within its selection area, and those lands were unavailable for ANCSA selection. Cape Fox is the only ANCSA village corporation affected by this restriction.

(8) The settlement of Cape Fox’s selections and conveyances of land under ANCSA requires adjustment of Sealaska Corporation’s (Sealaska) lands and conveyances to avoid creation of additional split estate between National Forest System surface lands and Sealaska subsurface lands.

(9) Sealaska is the Alaska native regional corporation for Southeast Alaska, organized under the Alaska Native Claims Settlement Act (43 U.S.C. 1601 et seq.).

(10) There is an additional need to resolve existing areas of Sealaska/Tongass split estate, in which Sealaska holds title or conveyance rights to several thousand acres of subsurface mineral management of Tongass National Forest surface lands.

(11) The Tongass National Forest lands identified in this Act for selection by and conveyance to Cape Fox and Sealaska, subject to valid existing rights, provide a means to resolve some of the Cape Fox and Sealaska ANCSA land entitlement issues without significantly affecting Tongass National Forest resources, uses or values.

(12) Adjustment of Cape Fox’s selections and conveyances of land under ANCSA through enactment of this Act, and the related adjustment of Sealaska’s selections and conveyances hereunder, are in accordance with the purposes of ANCSA and otherwise in the public interest.

SEC. 3. WAIVER OF CORE TOWNSHIP REQUIREMENT FOR CERTAIN LANDS.

Notwithstanding the provisions of section 16(b) of ANCSA (43 U.S.C. 1615(b)), Cape Fox shall not be required to select or receive conveyance of approximately 160 acres of Federal subsurface mineral lands within Section 1, T. 75 S., R. 91 E., C.R.M.

SEC. 4. SELECTION OUTSIDE EXISTING SELECTION BOUNDARY.

(a) SELECTION AND CONVEYANCE OF SURFACE ESTATE.—In addition to lands made available for selection under ANCSA, within 24 months after the date of enactment of this Act, Cape Fox may select, and, upon receiving written notice of such selection, the Secretary of the Interior shall convey approximately 99 acres of the surface estate of Tongass National Forest lands outside Cape Fox’s current exterior selection boundary, specifically that parcel described as follows:

(1) Section 33: 5 acres.

(2) Section 35: SW portion of SE1/4: 3 acres.

(3) Section 35: NW portion of SE1/4: 13 acres.

(4) Section 36: SE1/4 of SE1/4: 40 acres.

(5) Section 36: SW portion of SE1/4: 8 acres.

(b) CONVEYANCE OF SUBSURFACE ESTATE.—Upon conveyance to Cape Fox of the surface estate to the lands identified in subsection (a), the Secretary of the Interior shall convey to Sealaska the subsurface estate to the lands.

(c) TIMING.—The Secretary of the Interior shall complete the interim conveyances to Cape Fox and Sealaska under this section within 180 days after the Secretary of the Interior receives the Cape Fox selection under subsection (a).

SEC. 5. EXCHANGE OF LANDS BETWEEN CAPE FOX AND THE TONGASS NATIONAL FOREST.

(a) GENERAL.—The Secretary of Agriculture shall offer, and if accepted by Cape Fox, select and agree to exchange 5 acres of Federal lands described in subsection (b) for lands and interests therein identified by Cape Fox under subsection (c) and, to the extent necessary, lands and interests therein identified under subsection (d).

(b) LANDS TO BE EXCHANGED TO CAPE FOX.—The lands to be offered for exchange by the Secretary of Agriculture are Tongass National Forest lands comprising approximately 2,683.9 acres in T. 36 S., R. 62 E., C.R.M. and T. 35 S., R. 62 E., C.R.M., as designated upon a map entitled ‘‘Project Kensington County Land Exchange’’, dated March 18, 2002, and available for inspection in the Forest Service Region 10 regional office in Juneau, Alaska.

(c) LANDS TO BE EXCHANGED TO THE UNITED STATES.—Cape Fox shall be entitled, within 60 days after the date of enactment of this Act, to identify in writing to the Secretaries of Agriculture and the Interior the lands and interests in lands that Cape Fox proposes to exchange for the Federal lands described in subsection (b). The lands and interests in lands shall be identified from lands previously conveyed to Cape Fox comprising approximately 2,683.9 acres as described as parcels A-1 to A-3, B-1 to B-3, and C upon a map entitled ‘‘Cape Fox Corporation ANCSA Land Exchange Proposal’’, dated March 15, 2002, and available for inspection in the Forest Service Region 10 regional office in Juneau, Alaska.

(d) VALUATION OF EXCHANGE LANDS.—The Secretary of Agriculture and the Interior shall determine whether the lands identified by Cape Fox under subsection (c) are equal in value to the lands described in subsection (b). If the lands identified under subsection (c) are determined to have insufficient value to equal the value of the lands described in subsection (b), the lands and interests therein identified under subsection (d) may be exchanged for the Federal lands described in subsection (b) and may adjust the amount of selected lands in order to reach agreement with Sealaska regarding equal value. The exchange conveyance to Sealaska shall be of the surface and subsurface estate underlying Tongass National Forest surface lands, described in Interim Conveyance No. 1673, and rights to be additional approximately 2,688 acres of subsurface estate was added to the Cape Fox surface estate and described in Exchange Agreement No. 26, dated February 26, 1991, at Schedule B, as modified on January 29, 1995.

(e) CONDITIONS.—The offer and conveyance of Federal lands to Cape Fox in the exchange shall, notwithstanding section 14(e) of ANCSA, be of the surface and subsurface estate, but subject to valid existing rights and all other provisions of section 14(g) of ANCSA.

(f) TIMING.—The Secretary of Agriculture shall, within 90 days after receipt of the selection of lands by Sealaska under subsection (b), enter into an agreement with Sealaska to consummate the exchange agreement consistent with this Act. The lands identified in the exchange agreement shall be exchanged by conveyance at the earliest possible date after the exchange agreement is signed. Subject only to conveyance from Cape Fox to the United States of all its rights, title and interests in the Cape Fox lands included in the exchange consistent with this title, the Secretary of the Interior shall complete the interim conveyance to Cape Fox and the Federal lands included in the exchange consistent with this title within 180 days after the execution of the exchange agreement by Cape Fox and the Secretary of Agriculture.

SEC. 6. EXCHANGE OF LANDS BETWEEN SEALASKA AND THE TONGASS NATIONAL FOREST.

(a) GENERAL.—Upon conveyance of the Cape Fox lands included in the exchange consistent with this title, the Secretary of Agriculture and the Interior shall convey to Sealaska in accordance with this title of the lands and interests in lands described in subsection (c) and may adjust the amount of selected lands to consummate the exchange consistent with this Act. The lands to be exchanged to Sealaska are to be selected by Sealaska from Tongass National Forest lands comprising approximately 9,329 acres in T. 36 S., R. 62 E., C.R.M., T. 35 S., R. 62 E., C.R.M., and T. 34 S., Range 62 E., C.R.M., as designated upon a map entitled ‘‘Proposed Corporation Land Exchange Kensington Land Selection Area’’, dated April 2002 and available for inspection in the Forest Service Region 10 Regional Office in Juneau, Alaska.

(b) TIMING.—The Secretary of Agriculture shall, within 180 days after the execution of the exchange consistent with this Act, to identify in writing to the Secretaries of Agriculture and the Interior the lands and interests in the Cape Fox exchange and the Tongass National Forest lands identified for exchange under subsection (b).

(c) LANDS TO BE EXCHANGED TO THE UNITED STATES.—Sealaska shall be entitled, within 60 days after the date of enactment of this Act, to identify in writing to the Secretaries of Agriculture and the Interior the lands and interests in the lands that Sealaska selects to receive in exchange for the Tongass National Forest lands described in subsection (c). The lands selected shall be in no more than two contiguous and reasonably compact tracts that adjoin the lands described for exchange to Cape Fox in section 5(b). The Secretary of Agriculture shall determine whether these selected lands are equal in value to the lands described in subsection (c) and may adjust the amount of selected lands in order to reach agreement with Sealaska regarding equal value.

(d) CONDITIONS.—The offer and conveyance of Federal lands to Cape Fox in the exchange shall, notwithstanding section 14(e) of ANCSA, be of the surface and subsurface estate, but subject to valid existing rights and all other provisions of section 14(g) of ANCSA.

(e) TIMING.—The Secretary of Agriculture shall, within 90 days after receipt of the selection of lands by Sealaska under subsection (b), enter into an agreement with Sealaska to consummate the exchange agreement consistent with this Act. The lands identified in the exchange agreement shall be exchanged by conveyance at the earliest possible date after the exchange agreement is signed. Subject only to conveyance from Cape Fox to the United States of all its rights, title and interests in the Cape Fox lands included in the exchange consistent with this title, the Secretary of the Interior shall complete the interim conveyance to Cape Fox and the Federal lands included in the exchange consistent with this title within 180 days after the execution of the exchange agreement by Cape Fox and the Secretary of Agriculture.
agreement by Sealaska and the Secretary of Agriculture.

(e) MODIFICATION OF AGREEMENT.—The executed exchange agreement under this section shall be subject to further modifications by the Secretary of Agriculture as necessary.

(f) SURVEY AND CONVEYANCE.—The Secretary of Agriculture shall convey and provide evidence of title satisfactory to the Secretary of Agriculture for their respective lands to be exchanged to the United States under this Act, subject only to any hazards in land solely as a result of any conveyance or transfer of the land or interests under this Act.

(g) EASEMENTS.—Notwithstanding section 17(b) of ANCSA, federal lands conveyed pursuant to ANCSA shall be subject only to the reservation of public easements mutually agreed to and set forth in the exchange agreements executed under this Act. The easements shall include easements necessary for access across the lands conveyed under this Act for use of national forest or other public lands.

(h) AGRICULTURAL LANDS.—The Secretary of Agriculture shall add an equal number of acres to old growth reserves on the Tongass National Forest as are transferred out of Federal Forest Service Split Estate Exchange Agreement, as ratified in section 17 of Public Law 102-40, October 13, 1991.

SEC. 7. MISCELLANEOUS PROVISIONS.

(a) EQUAL VALUE REQUIREMENT.—The exchanges described in this Act shall be of equal or greater value of the public lands conveyed pursuant to ANCSA. Nothing in this Act shall be construed to change the total acreage of land entitlement of Cape Fox or Sealaska under ANCSA. Cape Fox and Sealaska shall be charged for any lands they exchange under this Act and any lands conveyed pursuant to section 4, but shall not be charged for any lands received under section 4. Any exchanges described in this Act shall be considered, for all purposes, actions which lead to the issuance of conveyances to Native Corporations pursuant to ANCSA.

(b) TITLES.—Cape Fox and Sealaska shall remain charged for any lands exchanged under this Act and any lands conveyed pursuant to section 4. Cape Fox or Sealaska under ANCSA. Cape Fox and Sealaska shall have the opportunity to present to the Secretary of Agriculture estimates of value of exchange lands with supporting information.

(c) HAZARDOUS SUBSTANCES.—Cape Fox, Sealaska, and the United States each shall not be subject to liability for the presence of any hazardous substance in land or interests in land solely as a result of any conveyance or transfer of the land or interests under this Act.

(d) EFFORT ON ANCSA SELECTIONS.—Any conveyance of Federal forest or subsurface lands to Cape Fox or Sealaska under this Act shall be considered, for all purposes, land conveyed pursuant to ANCSA. Nothing in this Act shall be construed to change the total acreage of land entitlement of Cape Fox or Sealaska under ANCSA. Cape Fox and Sealaska shall be charged for any lands they exchange under this Act and any lands conveyed pursuant to section 4, but shall not be charged for any lands received under section 4. Any exchanges described in this Act shall be considered, for all purposes, actions which lead to the issuance of conveyances to Native Corporations pursuant to ANCSA.

(e) STATEHOOD SELECTIONS.—Lands conveyed to or selected by the State of Alaska under the Alaska Statehood Act (Public Law 85–508; 72 Stat. 339; 48 U.S.C. note preceding §21) shall not be eligible for inclusion as an exchange or conveyance under this Act without the consent of the State of Alaska.

(f) MAPS.—The maps referred to in this Act shall be considered a part of this record in the Forest Service Region 10 Regional Office in Juneau, Alaska. The acreages cited in this Act are approximate, and if there is any discrepancy between cited acreage and the land depicted on the specified maps, the maps shall control. The maps do not constitute an attempt to show ownership.

(g) ADMINISTRATIVE PROCEDURE.—The Secretary shall be subject to the provisions of chapter 23 of title 5, United States Code, to clarify the disclosure of information protected from prohibited personnel practices, require a statement in non-disclosure policies, forms, and agreements that such policies, forms, and agreements conform with certain disclosure protections, provide certain authority for the Special Council, and for other purposes; to the Committee on Governmental Affairs of the Senate.

(h) MR. AKAKA. Mr. President, I rise today to discuss the Federal Employee Protection of Disclosures Act. I offered legislation under this title earlier this month. I am modifying that measure, S. 1229, by introducing a new bill today which is cosponsored by Senators Grassley, Levin, Leahy, and Durbin. This bill, as with S. 1229, amends the Whistleblower Protection Act, WPA. These amendments are necessary to safeguard Federal employees from retaliation and protect American taxpayers from government waste, fraud, and abuse. Our bill follows S. 955 and S. 3070, the latter of which was favorably reported by the Governmental Affairs Committee in the 107th Congress. The bill we introduce today is the result of a bipartisan compromise to protect our federal whistleblowers.

Our bill would codify the repeated and unequivocal statements of congressional intent in federal policy that employees are to be protected when making "any disclosure" evidencing violations of law, gross mismanagement, or a gross waste of funds. The bill would also clarify the test that must be met to prove that a Federal employee reasonably believed that his or her disclosure was evidence of wrongdoing. The clear language of the WPA says that an employee is protected for disclosing information he or she reasonably believes evidences violations of law, gross mismanagement, or a gross waste of funds. The bill would also clarify the test that must be met to prove that a Federal employee reasonably believed that his or her disclosure was evidence of wrongdoing. The clear language of the WPA says that an employee is protected for disclosing information he or she reasonably believes evidences violations of law, gross mismanagement, or a gross waste of funds. The bill would also clarify the test that must be met to prove that a Federal employee reasonably believed that his or her disclosure was evidence of wrongdoing. The clear language of the WPA says that an employee is protected for disclosing information he or she reasonably believes evidences violations of law, gross mismanagement, or a gross waste of funds.

The measure would also provide independent litigating authority to the Office of Special Counsel, OSC. Under current law, OSC has no authority to request the Merit Systems Protection Board, MSPB, to reconsider its decision or to seek review of a MSPB decision by the Federal Circuit. The limitation undermines both OSC's ability to protect whistleblowers and the integrity of the WPA. As such, our bill would provide OSC authority to appear in any civil action brought in connection with the WPA and obtain review of any MSPB order where OSC determines that MSPB erred and the case will impact the enforcement of the WPA.

Our bill would codify an "anti-gag" provision that Congress has passed annually since 1988 as part of the appropriations process. The yearly appropriations language bars agencies from implementing or enforcing any non-disclosure policy, form, or agreement that does not contain specified language preserving open government statutes. In addition, the bill would make it a prohibited personnel practice to enforce a non-disclosure agreement that does not comply with open government statutes.

Enactment of the Federal Employee Protection of Disclosures Act will strengthen the rights and protections afforded to federal whistleblowers and encourage the disclosure of information vital to an effective government.

Following the events of September 11, we realized that whistleblowing is even more important when our national security is at stake. In many instances, the security of our Nation depends upon those who step forward to blow the whistle on significant lapses in our efforts to protect the United States against potential terrorist attacks. Congress should act quickly to assure whistleblowers that disclosing illegal activities and mismanagement within their agencies will not be met with retaliation. I urge my colleagues to join with me in protecting our federal whistleblowers.

I ask unanimous consent that the text of the bill be printed in the Record.

The Chair: There being no objection, the bill was ordered to be printed in the Record, as follows:

S. 1358

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

SECTION 1. PROTECTION OF CERTAIN DISCLOSURES OF INFORMATION BY FEDERAL EMPLOYEES.

(a) SHORT TITLE.—This Act may be cited as the "Federal Employee Protection of Disclosures Act of 2003."

(b) CLASSIFICATION OF DISCLOSURES COVERED.—Section 2302(b)(8) of title 5, United States Code, is amended—

(1) in subparagraph (A)—

(A) by striking "whistleblower" and inserting "employee or applicant reasonably believes evidences" and

(2) in clause (1), by striking "a violation" and inserting "an illegal activity or fraud, waste, or abuse."
(2) PROHIBITED PERSONNEL PRACTICE.—Section 2302(b) of title 5, United States Code, is amended—
  (A) in paragraph (11), by striking ‘‘or’’ at the end; and
  (B) in paragraph (12), by striking the period and inserting a semicolon; and
(C) by inserting after paragraph (12) the following:

  ‘‘(13) implement or enforce any nondisclosure policy, form, or agreement, if such policy, form, or agreement does not contain the following statement, under the caption ‘‘Security Clearances’’:

  ‘‘These provisions are consistent with and do not supersede, conflict with, or otherwise alter the employee obligations, rights, or liabilities established by Executive Order No. 12958, section 7211 of title 5, United States Code (governing disclosures to Congress); section 1034 of title 18, United States Code (governing disclosure to Congress by members of the military); section 2302(b)(8) of title 5, United States Code (governing disclosures of illegal, waste, fraud, abuse, or public health or safety threats); the Intelligence Identities Protection Act of 1962 (50 U.S.C. 421 et seq.) (governing disclosures that could expose confidential national security, including sections 641, 793, 794, 796, and 802 of title 18, United States Code (governing executive review by the Office of Special Counsel, or to the Inspector General, of any nondisclosure policy, form, or agreement that is incorporated into this agreement and are controlling.’’;

(3) BOARD AND COURT REVIEW OF ACTIONS RELATING TO SECURITY CLEARANCES.—
  (A) IN GENERAL.—Chapter 77 of title 5, United States Code, is amended by inserting after section 7702 the following:

  *7702a. Actions relating to security clearances*

  (a) In any appeal relating to the suspension, revocation, or other determination relating to a security clearance, the Merit Systems Protection Board or any reviewing court—
    (1) shall determine whether section 2302 was violated;
    (2) may order the President to restore a security clearance; and
    (3) subject to paragraph (2), may issue declaratory relief and any other appropriate relief.
  (b) If, in any final judgment, the Board or court declares that any suspension, revocation, or other determination was made with regards to a security clearance that was in violation of section 2302, the affected agency shall conduct a review of that suspension, revocation, or other determination, giving great weight to the Board or court judgment.
  (2) Not later than 30 days after any Board or court judgment declaring that a security clearance suspension, revocation, or other determination was made in violation of section 2302, the affected agency shall issue an unclassified report to the congressional committees of jurisdiction (with a classified annex if necessary), detailing the circumstances of the agency’s security clearance suspension, revocation, or other determination action. The report shall include any proposed agency action with regards to the security clearance.
  (c) An allegation that a security clearance suspension, revocation, or other determination relating to a personnel action for a protected disclosure shall receive expedited review by the Office of Special Counsel, the Merit Systems Protection Board, and any reviewing court.’’.

(4) EXCLUSION OF AGENCIES BY THE PRESIDENT.—Section 2302(a)(2)(C) of title 5, United States Code, is amended by striking clause (ii) and inserting the following:

  ‘‘(ii) the Federal Bureau of Investigation, the Central Intelligence Agency, the Defense Intelligence Agency, the National Imagery and Mapping Agency, the National Security Agency; and

(II) as determined by the President, any Executive agency or unit thereof the principal function of which is the conduct of foreign intelligence or counterintelligence activities, if the determination (as that determination relates to a personnel action) is made before that personnel action; or’’.

(5) ATTORNEY FEES.—Section 1204(m) of title 5, United States Code, is amended by striking ‘‘agency involved’’ and inserting ‘‘agency where the employee was employed or has applied for employment’’.

(6) DISCIPLINARY ACTION.—Section 1215 of the United States Code, is amended in subsection (a), by striking paragraph (9) and inserting the following:

  ‘‘(9) A final order of the Board may impose—

  (i) disciplinary action consisting of removal, reduction in grade, debarment from Federal employment for a period not to exceed 5 years, suspension, or reprimand; or
    (ii) an assessment of a civil penalty not to exceed $1,000; or

  (iii) any combination of disciplinary actions described under clause (i) and an assessment described under clause (ii).’’

(7) DISCLOSURES TO CONGRESS.—Section 2302(b) of title 5, United States Code, is amended by adding at the end the following:

  ‘‘(8) ‘These provisions are consistent with and are controlling.’’

  (8) REPRESENTATION OF SPECIAL COUNSEL.—Section 1212 of title 5, United States Code, is amended by adding at the end the following:

  ‘‘(a) No person shall be a party in any action relating to 7703 of title 5, United States Code, by adding at the end the following:
“(e)(1) Except as provided under paragraph (2), this paragraph shall apply to any review obtained by the Special Counsel. The Special Counsel may obtain review of any final order or decision by filing, within 60 days after the date the Director received notice of the final order or decision of the Board, a petition for judicial review in the United States Court of Appeals for the Federal Circuit if the Director determines, in his discretion, that the Board erred in deciding a case arising under section 2302(b)(8) or subchapter III of chapter 73 that the Board’s decision will have a substantial impact on the enforcement of section 2302(b)(8) or subchapter III of chapter 73. If the Special Counsel was not a party or did not intervene in a matter before the Board, the Special Counsel may not petition for review of a Board decision under this section unless the Special Counsel first petitions the Board for reconsideration of its decision, and such petition is denied. In addition to the named respondent, the Board and all other parties to the proceedings before the Board shall have the right to appear in the proceedings before the Court of Appeals. The granting of the petition for judicial review shall be at the discretion of the Special Counsel.

“(2) During the 5-year period beginning on the effective date of the Federal Employee Protection of Disclosures Act, any petition for judicial review shall be at the discretion of the Court of Appeals.

“(k) JUDICIAL REVIEW.—

(1) IN GENERAL.—Section 7703(b) of title 5, United States Code, is amended by striking paragraph (1) and inserting the following:

“(b)(1)(A) Except as provided in subparagraph (B) and paragraph (2) of this subsection, a petition to review a final order or decision of the Board shall be filed in the United States Court of Appeals for the Federal Circuit. Notwithstanding any other provision of this Act or of the Subversive Activities Control Act of 1950 (50 U.S.C. 783(b)), the definitions, requirements, obligations, rights, sanctions, and liabilities created by Executive Order No. 12938 of the Subversive Activities Control Act of 1950 (50 U.S.C. 783(b)), (l) NONDISCLOSURE POLICIES, FORMS, AND AGREEMENTS.—

(1) IN GENERAL.—Section 7703(b) of title 5, United States Code, is amended by striking subsection (b) and inserting the following:

“(d)(1) Except as provided under paragraph (2), this paragraph shall apply to any review obtained by the Special Counsel. The Director of the Office of Personnel Management shall have the right to appear in the proceedings before the Court of Appeals. The granting of the petition for judicial review shall be at the discretion of the Court of Appeals.

“(2) Review obtained by office of personnel management.—Section 7703(b) of title 5, United States Code, is amended by striking subsection (b) and inserting the following:

“(B) Enforcement.—Any nondisclosure policy, form, or agreement described under subparagraph (A) that does not contain the statement required under subparagraph (A) may not be implemented or enforced to the extent that the agreement is inconsistent with that statement.

“(2) PERSONS OTHER THAN GOVERNMENT EMPLOYEES.—Notwithstanding paragraph (1), a nondisclosure policy, form, or agreement that is to be executed by a person connected with the conduct of an intelligence or intelligence-related activity, other than an employee or officer of the United States Government, may contain provisions appropriate to the particular activity for which such document is to be used. Such form or agreement shall be the minimum that any person will disclose any classified information received in the course of such activity unless specifically authorized to do so by the United States Government. Such nondisclosure forms shall also make it clear that such forms do not bar disclosures to Congress or to an authorized official of an executive agency in the Department of Justice that are essential to reporting a substantial violation of law.

“(m) Clarification of Whistleblower Rights for Critical Infrastructure Information.—Section 214(c) of the Homeland Security Act of 2002 (Public Law 107–296) is amended by adding at the end the following:

“For purposes of this section a permissible use of independently obtained information includes the disclosure of such information under section 2302(b)(8) of title 5, United States Code.”

“(n) Effective date.—This Act shall take effect 60 days after the date of enactment of this Act.

Mr. LEVIN. Mr. President, I am pleased to join Senators AKAKA, GRASSLEY, LEAHY, and DURBIN today in introducing the Federal Employees Protection of Disclosures Act. This bill strengthens the law protecting employees who blow the whistle on fraud, waste, and abuse in federal programs.

Whistleblowers play a crucial role in ensuring that Congress and the public are aware of serious cases of waste, fraud, and mismanagement in government. Whistleblowing is never more important than when our national security is at stake. Since the terrorist attacks of September 11, courageous individuals have stepped forward to blow the whistle on significant lapses in our efforts to protect the United States against potential future attacks. Most notably, FBI Agent Coleen Rowley alerted Congress to serious institutional problems at the FBI and their impact on the agency’s ability to effectively investigate and prevent terrorism.

In another example, two Border Patrol agents from my State of Michigan, Marc Hall and Bob Lindemann, discarded their careers when they blew the whistle on Border Patrol and INS policies that were compromising security on
the Northern Border. Their disclosure led to my holding a hearing at the Permanent Subcommittee on Investigations in November 2001, that exposed serious deficiencies in the way Border Patrol and INS were dealing with aliens suspected while entering to the country illegally. Since the hearing, some of the most troublesome policies have been changed, improving the security situation and validating the two agents’ concerns. Despite the fact that their concerns proved to be dead on, shortly after they blew the whistle, disciplinary action was proposed against the two agents. Fortunately in this case, whistleblower protections worked. The Office of Special Counsel conducted an investigation and the decision to discipline the agents was reversed. However, that disciplinary action was proposed in the first place is a troubling reminder of how important it is for us to both strengthen protections for whistleblowers and discipline the Office of Special Counsel to discipline managers who seek to muzzle employees.

Agent Rowley, Mark Hall and Bob Lindermann are simply the latest in a long line of Federal employees who have taken great personal risks in blowing the whistle on government waste, fraud, and mismanagement. Congress has long recognized the obligation we have to protect a Federal employee when he or she discloses evidence of wrongdoing in the course of his or her duties. If an employee reasonably believes that a fraud or mismanagement is occurring, and that employee has the courage and the sense of responsibility to make that fraud or mismanagement known, it is our duty to protect the employee from any reprisal. We want Federal employees to identify problems so we can fix them, and if they fear reprisal for doing so, then we are not only failing to protect the whistleblower, but we are also failing to protect the taxpayer.

I sponsored the Whistleblower Protection Act in 1989 which strengthened and clarified whistleblower rights, as well as the bill passed by Congress to strengthen the law further in 1994. Unfortunately, however, repeated holdings by the United States Court of Appeals for the Federal Circuit have corrupted the intent of Congress, with the result that additional clarifying language was needed. The court of LaChance versus White represents perhaps the most notable example of the Federal Circuit’s misinterpretation of the whistleblower law.

In LaChance, decided on May 14, 1999, the court imposed an unfounded and virtually unattainable standard on Federal employee whistleblowers in proving their cases. In that case, John E. White was an education specialist for the Air Force who spoke out against a new educational system that purports to increase quality indicators for schools contracting with the Air Force bases. White criticized the new system as counterproductive because it was too burdensome and seriously reduced the education opportunities available on base. After making these criticisms, local agency officials reassigned White, relieving him of his duties and allegedly isolating him. However, after an independent investigation, the Air Force conducted an investigation, and the好像提出了White’s concerns, the Air Force canceled the program White had criticized. White appealed the reassignment in 1992 and the case has been in litigation ever since. The Administrative Judge initially dismissed White’s case, finding that his disclosures were not protected by the Whistleblower Protection Act. The MSPB, however, reversed the administrative judge’s decision and remanded the case back to the administrative judge, holding that since White disclosed information he reasonably believed evidenced gross mismanagement, this disclosure was protected under the Act. On remand, the administrative judge held that the Air Force had violated the Whistleblower Protection Act and ordered the Air Force to return White to his prior status; the MSPB affirmed the decision of the administrative judge. OPM petitioned the Federal Circuit for a review to determine whether the Federal Circuit subsequently reversed the MSPB’s decision, holding that there was not adequate evidence to support a violation under the Whistleblower Protection Act. The Federal Circuit held that White was a specialist on the subject at issue and aware of the alleged improper activities and that his belief was shared by other employees was not sufficient to meet the “reasonable belief” test in the law. The court held that “the board must look for evidence that it was reasonable to believe that the disclosures revealed misbehavior” by the Air Force. The court went on to say: “In this case, review of the Air Force’s policy was necessary. The QES standards might well show them to be entirely appropriate, even if not the best option. Indeed, this review would start out with a presumption that public officials perform their duties correctly, fairly, in good faith, and in accordance with the law and governing regulations. ** * * * And this presumption stands unless there is ‘irrefragable proof to the contrary’.”

It was appropriate for the Federal Circuit to hold that the MSPB to have it reconsider whether it was reasonable for White to believe that what the Air Force did in this case involved gross mismanagement. However, the Federal Circuit went on to impose a clearly erroneous and ex post facto standard that him to demonstrate his “reasonable belief” — requiring him to provide “irrefragable” evidence that the Air Force had engaged in gross mismanagement. Irrefragable means undeniable, incontestable, incontrovertible, incapable of being overthrown.” How can a Federal employee meet a standard of “irrefragable” in proving gross mismanagement? It is virtually impossible standard of proof to meet. Moreover, there is nothing in the law or legislative history that even suggests such a standard applies to the Whistleblower Protection Act. The intent of the law was not to make a federal employee an investigator and compile “irrefragable” proof that the Federal Government, in fact, committed fraud, waste or abuse. Rather, under the clear language of the statute, the employee had only to have “a reasonable belief” that there is fraud, waste or abuse occurring in order to make a protected disclosure. LaChance is only one example of the Federal Circuit misinterpreting the law. Our bill corrects LaChance and as well as several other Federal Circuit holdings. In addition, the bill strengthens the Office of Special Counsel and creates additional protections for federal employees who are retaliated against for blowing the whistle.

One of the most important issues addressed in the bill is to clarify again that the law is intended to protect a broad range of whistleblower disclosures. The legislative history supporting the 1994 Whistleblower Protection Act emphasized: “It also is not possible to further clarify the clear language in section 2302(b)(8) that protection for ‘any’ whistleblowing disclosure truly means ‘any’. A protected disclosure may be made as part of an employee’s job duties, may concern policy or individual misconduct, and may be oral or written and to any audience inside or outside the agency, without restriction to time, place, motive or content.”

Despite this clear Congressional intent that was clearly articulated in 1994, the Federal Circuit has acted to push a number of whistleblower disclosures outside the protections of the whistleblower law. For example, in Meuwissen versus Department of Interior, the Federal Circuit ruled that a whistleblower’s disclosures to co-workers or to the wrong-doer, or to a court ruled that a whistleblower’s disclosures to official in the agency chain of command or those made in the course of normal job duties were not protected. In Huffman versus Office of Personnel Management, the Federal Circuit reaffirmed Horton and Willis. And in Meuwissen versus Department of Interior, the Federal Circuit held that a whistleblower’s disclosures to co-workers or to the wrong-doer, or to a court were not protected. The MSPB’s decision in this case was reversed by the Court of Appeals for the Federal Circuit.
cover any disclosure of information without restriction to time, place, form, motive or context, or prior disclosure made to any person by an employee or applicant, including a disclosure made in the ordinary course of an employee's duties that the employee or applicant reasonably believes is credible evidence of any violation of any law, rule, or regulation.

The intent here, again, is to make it clear that when the WPA speaks of protecting disclosures by Federal employees “any” means “any.” The Federal Circuit’s repeated misinterpretations of the whistleblower law are unacceptable and demand Congressional action. In response to the court’s inexplicable and inappropriate rulings, our bill would suspend for five years the Federal Circuit’s exclusive jurisdiction over whistleblower appeals. It would instead allow a whistleblower to file a petition to review a final order or final decision of the MSPB in the Federal Circuit or in any other United States appellate court of competent jurisdiction and defined under 5 U.S.C. 7703(b)(2). In most cases, using another court would mean going to the federal circuit where the contested personnel action took place.

This five year period would allow Congress to evaluate whether other appellate courts would make important additions to the list of protected disclosures. First, it would subject certain disclosures of classified information to whistleblower protections and guide Congressional efforts to clarify the law if necessary.

In addition to addressing jurisdictional issues and troublesome Federal Circuit precedents, our bill would also make important additions to the list of protected disclosures. First, it would subject certain disclosures of classified information to whistleblower protections. However, in order for a disclosure of classified information to be protected, it would have to possess a reasonable belief that the disclosure was direct and specific evidence of a violation of law, rule or regulation, gross mismanagement, a gross waste of funds, an abuse of authority, a substantial and specified danger to public health or safety, or a false statement to Congress on an issue of material fact. A whistleblower must also limit the disclosure to a member of Congress or staff of the executive or legislative branch holding the appropriate security clearance and authorized to receive the information disclosed. Federal agencies covered by the WPA are also authorized to establish a whistleblower disclosure policy and a process to provide confidential advice to employees on how to lawfully make a protected disclosure of classified information to Congress.

Current law permits Federal employees to file a case at the MSPB when they feel that a manager has taken a personnel action against them in retaliation for blowing the whistle. The legislation would add three new personnel actions to the list of adverse actions that could be taken against whistleblowers for engaging in protected activity. These actions would include enforcement of any non-disclosure policy, form or agreement against a whistleblower for making a protected disclosure; suspension, reassignment, or other determinative action relating to a whistleblower’s security clearance; and an investigation of an employee or applicant for employment if taken due to their participation in whistleblowing activity.

It is important to note that, if it is demonstrated that a security clearance was suspended or revoked in retaliation for whistleblowing, the legislation limits the relief that the MSPB and reviewing court may issue declaratory and other appropriate relief but may not direct a security clearance to be restored. Appropriate relief may include back pay, an order to reinstate the employee, attorney fees, or any other relief the MSPB or reviewing court can order. The bill specifies that the MSPB or reviewing court may issue declaratory and other appropriate relief but may not direct a security clearance to be restored. Appropriate relief may include back pay, an order to reinstate the employee, attorney fees, or any other relief the MSPB or reviewing court can order.
the protection of federal employee whistleblowers.

As the head of the U.S. Office of Special Counsel (OSC), the independent federal agency that investigates complaints of whistleblower retaliation and prosecutes federal employees’ complaints of whistleblower retaliation, I share your recognition to ensure that the laws protecting whistleblowers are strong and effective. Federal employees are often in the best position to observe and identify official misconduct as well as dangers to the public health and safety, and the national security.

Now, perhaps more than ever before, our national interest demands that federal workers feel safe to come forward to bring appropriate attention to these conditions so that they can be fixed. Further, and even more than ever, the public now needs assurance that the workforce which is carrying out crucial operations is alert, and that its leaders become and encourage their constructive participation in making the government a highly efficient and effective steward of the public interest.

To these ends, Title VI contains a number of provisions that will strengthen the Whistleblower Protection Act (WPA) and close loophole coverage. This legislation would reverse the effects of several judicial decisions that have imposed unduly narrow and restrictive tests for determining whether the government had reason to believe the protecting the public interest.

Among other things, these decisions, among others, have held that employees are not protected against retaliation when they make disclosures in the line of duty or when they confront subject officials with their suspicions of wrongdoing. They have also made it more difficult for whistleblowers to force agencies to be held accountable for their decisions. The Court of Appeals for the Federal Circuit has called an “irrefragable” presumption that government officials perform their duties lawfully and in good faith.

In addition to reversing these rulings, Title VI would grant the Special Counsel independent litigating authority and the right to request judicial review of decisions of the Merit Systems Protection Board (MSPB). The act’s provisions are designed to parry the court’s decision, which would otherwise have the effect of weakening the whistleblowers’ ability to hold managers accountable and to request judicial review of decisions of the MSPB.

There are several other provisions of the amendments that would strengthen the Act’s coverage and remedies. These amendments, for example, would extend coverage of the WPA to circumstances in which an agency initiates an adverse personnel action against an employee or applicant in reprisal for whistleblowing or where an agency implemented an illegal non-disclosure form or policy. The amendments would also extend coverage to whistleblowers, among others, under other federal statutes.

Finally, Title VI contains a provision that would provide relief to employees who allege that their security clearances were delayed or revoked because of protected whistleblowing, without regard to the underlying authority of the President to make security clearance determinations. The amendment would allow employees to file OSC complaints alleging a violation of an adverse security clearance determination. OSC would be given the authority to investigate such complaints and the MSPB would have the authority to hold a hearing and determine the appropriate relief other than ordering the employee’s security clearance restored. Further, the Board found retaliation, the employing agency would be required to conduct its own investigation of the revocation and report back to Congress.

This amendment provides a balance resolution of the tension between protecting national security whistleblowers against retaliation and maintaining the President’s tradi.-

Thank you again for providing me with an opportunity to comment on these amendments, and for your continuing interest in the work of the Office of Special Counsel.

Sincerely,

ELAINE KAPLAN.

Mr. LEVIN. OSC currently has the authority to pursue disciplinary action against managers who retaliate against whistleblowers. However, Federal Circuit decisions, like LaChance, have undermined the agency’s ability to successfully pursue such cases. The Special Counsel has said that “change is necessary in order to ensure that the burden of proof in these cases is not so onerous as to make it virtually impossible to secure disciplinary action against retaliators.” In addition to it being difficult to win, if the OSC loses a disciplinary case, it has to pay the legal fees of those against whom it loses.

The amendment would shift liability for fees to the manager’s employing agency, where an award of fees would be in the interest of justice. The amendment would clarify the burden of proof for fees to the manager’s employing agency, where an award of fees would be in the interest of justice. The amendment also includes an award of fees against a government agency, the Federal Labor Relations Authority, under the Federal Service Labor Relations Act. The Federal Labor Relations Authority would be required to hold managers accountable. It is, more fundamentally, is a significant obstacle to our ability to use the important authority赋予 our investigation the duty to appropriate relief other than ordering the reinstatement of the employee’s security clearance.

Thank you for your attention to these problems by establishing a reasonable burden of proof for disciplinary actions and requiring the employing agency, the Federal Labor Relations Authority, to hold managers accountable. Our bill addresses these problems by establishing a reasonable burden of proof for disciplinary actions and requiring the employing agency, the Federal Labor Relations Authority, to hold managers accountable.

BLAKE KAPLAN.
June 26, 2003

CONGRESSIONAL RECORD — SENATE

S8755

critical infrastructure information program.

We need to encourage Federal employees to blow the whistle on waste, fraud and abuse in Federal Government agencies and programs. These people take risks and often face enormous obstacles in doing what they believe is right. The Congress and the country owe a particular debt of gratitude to those whistleblowers who put their careers on the line to protect national security. Since September 11, 2001, we have seen a number of examples of how crucial people like Coleen Rowley, Mark Hall and Bob Lindermann are to keeping our country safe. I request unanimous consent that a letter from Agent Rowley be printed in the Record. In the letter she says, "There are many more who do not benefit from the relative safety of public notoriety." It is to protect those responsible, courageous many that we offer this legislation. We need more like them.

I ask unanimous consent to print in the RECORD a section-by-section explanation of the bill.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

DEAR SENATORS: I have proudly served in federal law enforcement for over 21 years. Prior to my involvement in a very specific matter, I did not fully appreciate the strong disincentives that sometimes keep government employees from exposing waste, fraud, abuse, or other failures they witness on the job. Nor did I appreciate the strong incentives that do exist for agencies to avoid institutional embarrassment.

The decision to step forward with information that exposed my agency to scrutiny was one of the most difficult of my career. I did not come forward lightly. I attempted to warn my superiors through regular channels. Only after those warnings failed to bring about the necessary response and conditions were impractical did I go outside the agency with my concerns. I had no intention or desire to be in the public spotlight, so I did not go to the news media. I provided the information to Members of Congress with oversight responsibility. I felt compelled to do so because my responsibility is to the American people, not to a government agency.

Unfortunately, the cloak of secrecy which is necessary for the effective operation of government is not always in the public interest. These recent investigations and congressional hearings have highlighted the need for significant improvements in the current law. In 1989, while the 1989 WPA and its 1994 amendments strengthened and clarified whistleblower protections, Federal Circuit holdings have repeatedly undermined OSC's authority to protect whistleblowers and integrity of the WPA. The Federal Circuit's decision in 1997 that a whistleblower was not protected because the disclosure was made "but for" the whistleblower's protected activity was a "significant motivating factor" in the decision by the manager to take the adverse action, even if other factors also motivated the decision. This result would be equivalent of the Mt. Healthy standard.

Disclosures to Congress.—Section (j) would require agencies to establish a process to provide confidential advice to employees on how to lawfully make a protected disclosure of classified information to Congress. Authority of Special Counsel.—Under current law, OSC has no authority to require MSPB to reconsider a decision or seek appellate review of any MSPB decision. This limitation undermines OSC's authority to protect whistleblowers and integrity of the WPA. Section k would authorize OSC to appear in any civil action brought in connection with the whistleblower's protected disclosure and request appellate review of any final order or decision. This section would not empower MSPB to restore a security clearance decision and issue a report to Congress explaining it.

Attorney Fees.—The Office of Special Counsel, OSC, has authority to pursue disciplinary action against managers who retaliate against whistleblowers. Currently, if OSC loses a disciplinary case, it must pay the legal fees of those against whom it initiated the action. The amount involved could significantly deplete OSC's limited resources, section (m) would suspend the Federal Circuit's exclusive jurisdiction over whistleblower appeals in favor of a dual review by the Federal Circuit and any other federal circuit court of competent jurisdiction.

Notice.—Section (n) would require all federal nondisclosure policies, forms and agreements to contain specified language preserving the right of federal employees to disclose certain protected information. This section would codify the so-called anti-gag provision that has been included in federal administrative appeals fees.

Critical Infrastructure Information.—Section (o) would clarify that section 214(c) of
By Mrs. BOXER:

S. 1339. A bill to allow credit unions to provide international money transfer services and to require disclosures in connection with international money transfers from all money transmitting service providers; to the Committee on Banking, Housing, and Urban Affairs.

Mrs. BOXER. Mr. President, today, I am introducing the International Remittances Services Enhancement and Protection Act of 2003.

Remittances are the funds that immigrants send to their families abroad to help those relatives meet their basic needs. In the Latino community, 47 percent of all Latinos born outside the United States regularly send money to their country of origin. But, the World Bank estimates that 35 to 58 percent of those who send remittances abroad regularly do not have a bank account, much of their hard earned money is lost in fees paid to check cashing agencies and wire transfer companies. They rely on check cashing services to cash their paychecks at hefty fees and then pay another fee to send some portion of that money through a wire service to their relatives in Latin America and elsewhere at varying exchange rates.

This legislation will increase competition and transparency in the remittances market. It will provide immigrants with access to more choices for sending remittances by allowing credit unions to provide wire transfer and check cashing services to nonmembers. It will also provide immigrants with access to information in more than one language from all money transmitters about the exchange rates and fees they pay. That information will make it easier for consumers to compare the value of the services they can receive from different service providers.

The larger goal is to provide immigrant control over their finances. I believe this bill will encourage financial institutions to develop better services for immigrants and build stronger relationships with immigrant communities.

According to the Multilateral Investment Fund, immigrants living in the United States sent $23 billion to Latin America in 2001. More than $3 billion of that total was consumed in fees paid to money transfer agencies. If current growth rates in remittance transfers are maintained, cumulative remittances to Latin America could reach $300 billion by the 10-year period ending in 2010. We need to work to ensure that the benefits of international migration come together to lower the portion of those monies lost in fees and instead are used for productive purposes.

By Mr. GRAHAM of Florida:

S. 1360. A bill to amend section 7105 of title 38, United States Code, to clarify the requirements for notices of disagreement for appellate review of Department of Veterans Affairs activities; to the Committee on Veterans' Affairs.

Mr. GRAHAM of Florida. Mr. President, I introduce today a legislation that will remove a significant and arbitrary barrier to appellate review of veterans' benefits claims. In 1988, when Congress created judicial review for veterans' claims it intended to provide an opportunity for those aggrieved by VA decisions to have such decisions reviewed by a court. The purpose of this legislation is to remove an artificial barrier to judicial review for veterans' claims.

VA has promulgated regulations to implement section 7105. In Section 20.201 of title 38 of the Code of Federal Regulations, the Secretary defined a Notice of Disagreement (NOD) to not require special wording. The regulation does require that the NOD “must be in terms which can be reasonably construed as disagreement with the determination and a desire for appellate review.” The second component of that sentence—“a desire for appellate review”—is not required under the statute.

In 1997, Raymond Gallegos, a veteran, again filed an application for service connection for a psychiatric condition diagnosed as post-traumatic stress disorder that had been previously denied. VA medical evidence was not clear in limiting the requirement of a NOD to those in section 7105 of the United States Code, the document will be deemed a Notice of Disagreements with the rights and procedures that accompany that determination. It will also ensure that claimants whose NODs were found to be defective since the court decision will have the opportunity to have their NOD reevaluated under this new provision.

This is very significant because there are two key consequences of not having a valid, timely NOD. First, if a claimant fails to file a timely, valid NOD, the VA denial becomes final. The claimant will need to submit “new and material evidence” that VA erred in order to reopen the case. Second, the claimant will only be able to receive benefits dating to the beginning of the newly reopened claim, potentially losing years of retroactive benefits. This may affect a veteran’s ability to receive VA health care, a dependant’s ability to use educational benefits, and all the other benefits that flow from a finding of service-connection.

Second, if a claimant has not been deemed to file a NOD, there can be no appeal of the VA decision. A NOD is required to initiate an appeal. It is a prerequisite to review by the Board of Veterans’ Appeals and ultimately judicial review at the CAVC. This can create a VA decision that is not subject to review by the CAVC, for issue of the VA denial becomes final. This is very significant because there are two key consequences of not having a valid, timely NOD. First, if a claimant fails to file a timely, valid NOD, the VA denial becomes final. The claimant will need to submit “new and material evidence” that VA erred in order to reopen the case. Second, the claimant will only be able to receive benefits dating to the beginning of the newly reopened claim, potentially losing years of retroactive benefits. This may affect a veteran’s ability to receive VA health care, a dependant’s ability to use educational benefits, and all the other benefits that flow from a finding of service-connection.

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Mr. GRAHAM of Florida. Mr. President, I introduce today a legislation that will remove a significant and arbitrary barrier to appellate review of veterans' benefits claims. In 1988, when Congress created judicial review for veterans' claims it intended to provide an opportunity for those aggrieved by VA decisions to have such decisions reviewed by a court. The purpose of this legislation is to remove an artificial barrier to judicial review for congressional intent was not clear in limiting the requirements of a NOD to those in section 7105. Congress never intended to require that level of formality from veterans, in this uniquely pro-claimant system. Therefore, I offer legislation that would specify that if a claimant’s filing meets the criteria defined in section 7105 of title 38 of the United States Code, the document will be deemed a Notice of Disagreements with all the rights and procedures that accompany that determination. It will also ensure that claimants whose NODs were found to be defective since the court decision will have the opportunity to have their NOD reevaluated under this new provision.

This is very significant because there are two key consequences of not having a valid, timely NOD. First, if a claimant fails to file a timely, valid NOD, the VA denial becomes final. The claimant will need to submit “new and material evidence” that VA erred in order to reopen the case. Second, the claimant will only be able to receive benefits dating to the beginning of the newly reopened claim, potentially losing years of retroactive benefits. This may affect a veteran’s ability to receive VA health care, a dependant’s ability to use educational benefits, and all the other benefits that flow from a finding of service-connection.

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By Mr. GRAHAM of Florida:
“(3) A document that meets the requirements of the second sentence of paragraph (1) and the first sentence of paragraph (2) shall be recognized as a notice of disagreement under section 7105 of title 38, United States Code (as amended by this section), shall apply to any document—

(A) filed under section 7105 of such title on or after the date of the enactment of this Act; or

(B) filed under section 7105 of such title before the date of the enactment of this Act and not rejected by the Secretary of Veterans Affairs as a notice of disagreement pursuant to section 20.201 of title 38, Code of Federal Regulations, as of that date.

(2) In the case of a document described in paragraph (3) of this subsection, the Secretary shall, upon the request of the claimant or the Secretary’s own motion, order the document treated as a notice of disagreement under section 7105 of such title as if the document had not been rejected by the Secretary as a notice of disagreement pursuant to section 20.201 of title 38, Code of Federal Regulations.

(3) A document described in this paragraph is a document that—

(A) was filed as a notice of disagreement under section 7105 of such title during the period beginning on March 15, 2002, and ending on the date of the enactment of this Act; and

(B) the Secretary as a notice of disagreement pursuant to section 20.201 of title 38, Code of Federal Regulations.

(4) A document may not be treated as a notice of disagreement under paragraph (2) unless a request for such treatment is filed by the claimant, or a motion is made by the Secretary, not later than one year after the date of the enactment of this Act.

By Mr. SMITH.

S. 1361. A bill to amend the Internal Revenue Code of 1986 to provide that foreign base company shipping income shall include only income from aircraft and income from certain vessels transporting petroleum and related products, to the Committee on Finance.

By Mr. Oregon. Mr. President, today I am introducing legislation which would deal with a real problem facing our Nation, the decline of our U.S.-owned shipping fleet. A U.S. owned shipping fleet is essential as a matter of national and economic security. My bill would help make U.S. based shipping companies more competitive in the global market.

This is important to our country and to my state. Oregon plays a key role as a facilitator of international commerce. The Port of Portland is one of the most active ports in the world. It is a key link for trade between the United States and the Pacific Rim. In addition to its key role enabling global commerce, it has become a home to U.S.-owned shipping companies, shipyards, and numerous support businesses. As a result of tax-law changes enacted in 1975 and 1986, U.S. shipping companies must pay tax on income earned by subsidiaries overseas immediately rather than when such income is later brought back to the United States. This treatment represents a sharp departure from the generally applicable income tax principle of “deferral” and places U.S.-based owners of international fleets at a distinct tax disadvantage compared to their foreign-based competitors.

Controlled foreign corporations engaged in commerce were one of the only active businesses that are not eligible for general rule of deferral. My bill would amend the Internal Revenue Code to allow U.S. companies that own foreign-flagged ships to treat income earned by such controlled foreign corporations in the same manner as all other U.S. companies. In short, it would allow American shipping companies to defer the payment of tax on income that they derive from shipping activities outside the United States until that income is repatriated to the United States. Most foreign-based carriers pay no home-country taxes on income they earn abroad from international shipping. As a result of this competitive imbalance, U.S. companies now hold precious little share of the world shipping marketplace. Indeed, U.S. ownership of international shipping trades dropped precipitously in the aftermath of the 1975 and 1986 tax-law changes. Before 1975, the U.S. -owned share of the world’s open-registry shipping fleet stood at 26 percent. By 1986, the U.S. share had dropped to 14 percent. By 1996, the U.S. share had dropped to 5 percent.

Other security concerns also are raised by the decline in U.S. ownership of the international shipping trade. The U.S. military, in times of emergency, relies on the ability to requisition U.S.-owned foreign-flagged tankers, bulk carriers, and other vessels to carry oil, gasoline, and other materials in defense of U.S. interests overseas. These vessels comprise the Effective United States Control, EUSC, fleet. The sharp decline in the EUSC fleet following tax-law changes, and the resulting adverse strategic consequences, have been confirmed in a recent MIT study conducted for the Navy Department. The study recommended that in the short term, the most practical and cost-effective means of reversing this trend would be to “revise legislation to reflect tax deferment of income for some or all EUSC vessels.”

U.S. security also depends in no small part on our ability to maintain adequate domestic oil supplies in times of emergency. The United States consumes approximately 19.6 million barrels of oil per day, of which roughly 55 percent, mostly crude, is imported into the United States. It is estimated that 95 percent of all oil imported into the United States by sea is now imported on foreign-owned tankers. This means that one half of every gallon of oil consumed in the United States is carried on foreign-owned vessels. This growing dependence on foreign vessels—who may not be sympathetic to U.S. interests—to deliver our oil in times of global crisis is cause for potential alarm. In recent years, two of the largest American shipping companies have been purchased by foreign companies, thereby making their shipping operations more competitive than the remaining American companies.

The time has come for us to make changes in the tax law that will allow our domestic companies to compete fairly in the global marketplace. I urge my colleagues to join me to enact this needed legislation. I ask unanimous consent that the text of the legislation be printed in the Record.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1361

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

SECTION 1. SHORT TITLE.

This Act may be cited as the “RAFT (Re-store Access to Foreign Trade) Act of 2003”.

SEC. 2. ELIMINATION OF MOST VESSEL SHIPPING INCOME FROM FOREIGN BASE COMPANY INCOME.

(a) FOREIGN BASE COMPANY SHIPPING INCOME TO INCLUDE ONLY INCOME FROM AIRCRAFT AND PETROLEUM VESSELS.—Subsection (b) of section 964 of the Internal Revenue Code of 1986 (relating to foreign base company income) is amended—

(1) by inserting “petroleum” before “vessels” each place it appears, and

(2) by adding at the end the following new sentence: “For purposes of this subsection, the term ‘petroleum vessel’ means any vessel engaged in the carriage of petroleum or related products or bulk products or products of a controlled group (as defined in section 267(f)(1) without regard to section 1563(b)(2)(C) of the Internal Revenue Code of 1986) relating to petroleum or related products or byproducts.”.

(b) RETENTION OF SEPARATE FOREIGN TAX CREDIT BASKET FOR ALL SHIPPING INCOME.—Subparagraph (D) of section 904(d)(2) of the Internal Revenue Code of 1986 is amended by striking “as defined in section 954(f)” and inserting “, as defined in section 954(f), if references in such section to petroleum vessels included references to petroleum or related products or byproducts’’.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years of foreign corporations beginning after December 31, 2002, and to taxable years of United States shareholders (within the meaning of section 951(b) of the Internal Revenue Code of 1986) within which or with which such taxable years of such foreign corporations end.

By Mrs. BOXER.

S. 1362. A bill to authorize the Port Passenger Accelerated Service System (Port PASS) as a permanent program for land border inspection under the Immigration and Nationality Act, and for other purposes; to the Committee on the Judiciary.

Mrs. BOXER. Mr. President, today, I am introducing legislation that will strengthen national security, promote commerce, and provide assistance to our dedicated agents at the border. Thousands of San Diego and Tijuana residents cross the border every day as commuters, shoppers, or tourists. Unfortunately, our border infrastructure has not kept pace with the increasing
traffic volume, and travelers frequently encounter delays and congestion at the border.

The tragic events of September 11 further intensified these challenges along the border. Increased security measures severely over-extended inspection resources and resulted in longer waiting times for crossing the border.

The Secure Electronic Network for Traveler Rapid Inspection (SENTRI), program was created to help alleviate the congestion at the border.

SENTRI is a dedicated commuter lane program. It allows pre-screened travelers to move quickly through the inspection process at the United States-Mexican border. After participants pass a background check, they can move more quickly through a dedicated lane.

SENTRI accepts only travelers who pass both an extensive background check to verify their eligibility and a thorough inspection of their vehicle.

Delays at crossing the border were often an hour or more prior to SENTRI. But, with the program, the delays for participants are 5 to 15 minutes. Travelers in other lanes also benefit because the prescreen SENTRI crossers move swiftly through the border, reducing the number of motorists using general commuter lanes.

Expediting inspections through SENTRI is actually helping to improve border security, as Customs and Border Patrol agents can focus more attention on nonscreened drivers and passengers. Furthermore, SENTRI has been a victim of its own success. SENTRI needs a greater investment of resources to keep up with the current and future demand. Enrollment increased by more than 100 percent after September 11. Currently, prospective applicants must wait approximately 8 months to participate in the program.

For innovative programs, such as SENTRI, to work, we must provide them the tools and resources they need to succeed. This is why I am introducing the Secure and Fast Entry at the Border Act or SAFE Border Act.

The SAFE Border Act recognizes the contribution of SENTRI to border security and the agents who administer the program. My bill would extend the length of a SENTRI pass from 1 to 2 years—enabling border agents to process more new applicants and reduce the current enrollment wait. The SAFE Border Act recommends the appointment of dedicated SENTRI staff to expedite application processing, and encourages the creation of a dedicated commuter lane for prescreened, low-risk pedestrian crossers.

In addition, to ensure security at our borders, my legislation bans a person convicted of a felony or under active criminal investigation from participating in the program.

Our agents at the border shoulder an enormous responsibility every day. I believe we owe them the appropriate resources and support they need to carry out their duties.

Our Nation’s economic and overall security is heavily linked to smooth and secure border crossings. The SAFE Border Act provides a way for trusted travelers to cross the border securely and quickly.

By Mr. REID: S. 1363. A bill to prohibit the study or implementation of any plan to privatize, divest, or transfer any part of the mission, function, or responsibility of the National Park Service to: the Committee on Energy and Natural Resources.

Mr. REID. Mr. President, as thousands of families look forward to summer vacations at our beautiful national parks, we must address an issue that could one day ruin their experience: privatization of the National Park Service.

The Park Service has worked hard to preserve Nevada’s unique landscapes at the Great Basin National Park, Death Valley, and Lake Mead National Recreation Area. Instead of applauding the Park Service for a job well done, the Administration wants to study 1,800 jobs in the Park Service for privatization.

Many of these Park Service jobs have direct contact with visitors to our parks. They not only collect fees and maintain parks but also give directions, fight wildfires when necessary, and provide emergency medical assistance. They are not required to do these things; they are driven by a love for the parks and a commitment to public service that contractors lack.

Privatizing the Park Service would jeopardize our national parks. Members of the Park Service have a career-long interest in maintaining the parks and perform their jobs because they are dedicated to serving the public. They often go beyond the call of duty to fix a problem in the middle of the night or change a tire for an unlucky park visitor. Can we be sure that a contractor would do the same? No.

In addition, the Park Service receives tens of thousands of hours of volunteer work every year. At the Lake Mead National Recreation Area alone, volunteers provided 92,000 hours of work, the equivalent of 44 full-time employees. Will a contractor find volunteers to provide it with 92,000 hours of assistance for their profit?

Privatization will waste taxpayer money. Privatization studies cost about $3,000 per position studied, and privatization does not save money.

Nevadans visiting the national parks this summer want members of the Park Service, not profit-minded corporations, enriching their experience by directing them to the famous sites and best kept secrets of our parks.

I oppose privatizing the Park Service because it would hurt Nevadans, endanger our national parks, and waste taxpayer money.

This bill will keep our dedicated Park Service members running our national parks. It stops costly privatization studies and redirects the funds to address the maintenance backlog that President Bush promised to eliminate. I am committed to protecting our parks, and I am proud to introduce this bill that will ensure that the Park Service can preserve them for generations to come.

I ask unanimous consent that the text of the bill be printed in the Record, as follows:

S. 1363

Be enacted by the Senate and House of Representatives of the United States of America in Congress assembled.

SECTION 1. PARK PROFESSIONALS PROTECTION.

(a) SHORT TITLE.—This Act may be cited as the “Park Professionals Protection Act.”

(b) FINDINGS.—Congress finds the following:

(1) The National Park System is recognized throughout the world as a model for the conservation and enjoyment of natural, scenic, recreational, cultural, and historic resources.

(2) The National Park System would never have achieved such status, nor could the system maintain such status, without the professionalism, dedication, and passion of the men and women of the National Park Service.

(3) Current plans to privatize thousands of jobs within the National Park Service ignore the unique contributions made by the men and women of the National Park Service and threaten to undermine the entire National Park System.

(4) Scarc park operations and maintenance resources are being diverted to pay private consultants to study the current privatization scheme. According to the National Park Service, these studies cost approximately $300 per position proposed to be privatized.

(5) Despite the millions of taxpayer dollars diverted to these studies, not a single report has been published documenting any cost savings to be generated by the privatization of park operations.

(6) The current privatization scheme raises serious questions regarding the ability of temporary workers, provided by the lowest bidder, to adequately fulfill the responsibilities of professional National Park Service employees in the areas of conservation, interpretation, emergency fire and rescue, and homeland security.

(7) The current privatization scheme appears to affect minority employees disproportionately, threatening to significantly reduce the number of minority employees within the National Park Service.

(8) Pendency of the current privatization scheme is having detrimental impacts on the current and future number of minority employees struggling to encourage high quality candidates from applying for positions within the National Park Service.

(c) PROHIBITION.—Notwithstanding any other provision of law, the Secretary is prohibited from studying or implementing any plan to privatize, divest, or transfer any part of the Park Service, as of the date of the enactment of this section, the mission, function, or responsibility of the National Park Service.

(c) REALLOCATION OF FUNDING.—Notwithstanding any other provision of law, the Secretary shall withhold any funds currently available for the purpose of carrying out any plan to privatize the Park Service, as of the date of the enactment of this section, and reallocate those funds to the operations and maintenance accounts within the National Park Service.
van to ship the personal effects from South Naknek to Anchorage. There are no roads which connect the bush village of South Naknek to Anchorage. The personal effects need to be transported by air.

However, if the deceased employee is a local hire employee, the Federal Travel Regulation does not authorize the Federal Government to reimburse the surviving family members for their relocation cost because the deceased employee’s residence is deemed to be the local hire location. This works an inequity where, as in the present case, the deceased employee’s surviving spouse does not have ties to the duty station community, but rather to another community in Alaska. In this instance, the surviving spouse desires to relocate to Anchorage, which is Alaska’s largest city, and continue to raise her three children there.

The legislation that I am introducing today is intended to cure this inequity. It would amend ANILCA, the same legislation which contains the local hire authority, to provide that if a local hire employee dies in the line of duty, the Federal Government will reimburse the surviving immediate family for the cost of transporting the remains to a location in Alaska of their choosing and will also relocate the immediate family members to a community in the State of Alaska which is selected by the surviving head of household. I think that this is the least we can do for the survivors of local hire employees who go to work everyday in the harsh climate and conditions of bush Alaska but sadly sometimes do not return home.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1364

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

SECTION 1. PAYMENT OF EXPENSES AFTER THE DEATH OF CERTAIN FEDERAL EMPLOYEES IN THE STATE OF ALASKA.

Section 1008 of the Alaska National Interest Lands Conservation Act (16 U.S.C. 3188) is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following:

"(c) PAYMENT OF EXPENSES AFTER DEATH OF AN EMPLOYEE.

(1) DEFINITION OF IMMEDIATE FAMILY MEMBER.—In this subsection, the term "immediate family member" means a person related to a deceased employee that was a member of the household of the deceased employee at the time of death.

(2) PAYMENTS.—If an employee appointed under the program established by subsection (a) dies in the performance of any assigned duties on or after October 1, 2002, the Secretary may—

(A) pay reasonable expenses for the preparation and transportation of the remains of the deceased employee to a location in the State of Alaska which is selected by the surviving head of household of the deceased employee; and

"(d) PAY reasonable expenses for transporting immediate family members and the baggage and household goods of the deceased employee and immediate family members to a location in the State of Alaska which is selected by the surviving head of household of the deceased employee.

By Mr. MCCONNELL (for himself, Mr. KYL, and Mr. LEAHY):

S. 1365. A bill to provide increased foreign assistance for Cambodia under certain circumstances, and for other purposes; to the Committee on Foreign Relations.

Mr. MCCONNELL. Mr. President, today, along with my colleagues Senators KYL and LEAHY, I offer the ‘Cambodia Democracy and Accountability Act of 2003’. This Act is particularly timely, given that national elections are scheduled in that country on July 27th.

Cambodia is on its third round of parliamentary elections since the 1991 Paris Peace Accords, with previous elections having been sponsored by the United Nations in 1993 and by the Cambodian governments in 1998. Despite the billions of dollars spent on elections in that country—over $2 billion by the U.N. alone—there has yet to be a genuine election having the will of the Cambodian people.

My colleagues will remember that the U.N.-sponsored elections resulted in a large voter turnout—but also an unworkable power sharing deal brokered between the royalist FUNCINPEC party and the hard line Cambodian People’s Party, CPP, that quickly dissolved into open hostilities, including a bloody grenade attack against a peaceful, pro-democracy rally and a CPP sponsored coup d’etat in 1997.

The debilitating hangover from this coup—destroyed party offices, dead activists, and a palpable climate of fear and repression—undermined prospects for national elections having been funded by the U.N. alone—there has yet to be a genuine election having the will of the Cambodian people.

It is time that Prime Minister Hun Sen—as the self-proclaimed strongman of Cambodia—is held accountable for the murder of political activists, Buddhist monks, civilians, and students. There is no rule of law, if the leaders of the government are not subject to it.

A second "coalition" government between royalists and hard liners was cobbled together in the aftermath of the 1998 elections. This time, there was no pretext of power sharing, and for the past 5 years CPP has been firmly and completely in control of the country.

Nevertheless, in the months and weeks before the upcoming July elections, the political marriage between FUNCINPEC and CPP is fraying. In an
effort to harass and intimidate his opponents, in late January Prime Minister Hun Sen whipped up nationalist sentiment against Thailand, let loose the so-called Pagoda Boys, government-paid thugs, and destroyed $50 million worth of Thai public and private property in Phnom Penh.

Despite frantic pleas for assistance, the Thai ambassador and other diplomatic personnel escaped injury by scaling the embassy’s walls and scurrying to safety. In the aftermath of the riots, Hun Sen and intimidated students, independent broadcasters, and political activists. A senior opposition figure sought—and was granted—refuge in the U.S. Embassy.

In February, former royalist parliamentarian Om Radsady was gunned down in a mafia-style murder in Phnom Penh. Well liked and respected by his colleagues from all Cambodian political parties, Radsady’s assassination sent a not so subtle message that no one is immune from the black hand of CPP.

It is time Hun Sen is held accountable for his complicity in actions that grossly violate international and domestic laws, and the human rights and dignity of Cambodians.

The fundamental question facing the Cambodian people today is whether the July 27th elections will be a meaningful exercise in democracy, or another lost opportunity to chart a new course for the country.

Last week, Prime Minister Hun Sen assured Secretary of State Colin Powell that Cambodia would hold free and fair elections. Secretary Powell should not be duped by these hollow promises. A preponderance of evidence suggests that CPP is actively trying to steal the elections before July 27th: political activities continue to be murdered and intimidated, creating a chilling tone of fear and repression; the CPP continues to directly influence and manipulate the election machinery, with members of the National Election Commission, NEC, nominated in a closed manner by the co-Ministers of Interior and the NEC already failing to investigate allegations of election improprieties; and, opposition political parties continue to lack access to media, with several broadcast outlets in Cambodia unwilling to sell air time to CPP’s challengers.

Let me take a moment to describe what the Cambodian Democracy and Accountability Act does—and does not do.

The Act provides additional foreign assistance to Cambodia—an increase by half (or $21.5 million) over the fiscal year 2004 budget request of $46 million—if new leadership has been elected in free and fair elections, and if Hun Sen is no longer Prime Minister. It has been apparent to me that Hun Sen has long been part of Cambodia’s problems rather than part of the solution.

The Act does not preclude the Cambodian people from voting for the political party of their choice. Ballot secrecy must be ensured—as well as transparency in the process of vote counting and tabulation—in order that the will of the Cambodian people is accurately expressed. It is my fear that CPP pre-election chicanery may already have violated the integrity of the election process.

If I wanted to interfere with the elections I would have offered legislation that restricts all assistance to Cambodia unless a specific political party or parties was elected. This Act does not do this. It does not cut any assistance—not a single penny—to Cambodia included in the fiscal year 2004 budget request. It simply provides that if the major obstacle to democracy and development in the country—namely Prime Minister Hun Sen—is out of power, additional foreign aid will be forthcoming.

It is important to recall that Hun Sen’s coup resulted in severe restrictions on assistance to Cambodia—that continuing to provide continued opportunity through free and fair elections, the Cambodian people will make the right choices that will ensure a dawn for development in that country.

Why will they make the right choice? Over the many decades he has been in power, Hun Sen has ruled Cambodia through violence, fear and repression. Under his watch, the country has become a haven for sexual predators and pedophiles, the criminal underworld, and international terrorists. Hun Sen has repeatedly threatened the basic freedoms protected by the Cambodian Constitution, attacked his political position, and perpetuated a climate of impunity that stifles the advancement of freedom and free markets.

And he has never—not once—been held accountable for his actions.

In addition to increasing foreign assistance under certain conditions, the Act restricts assistance to a Khmer Rouge tribunal unless the President determined that the tribunal is supported by democratic Cambodian political parties and is not under the control or influence of the CPP. It also requires the Federal Bureau of Investigations to resume its investigations of the March 30, 1997, grenade attack against opposition leader Sam Rainsy that killed and injured scores of Cambodians.

I should remind my colleagues that American democracy worker Ron Abney was injured in this act of terrorism, reportedly carried out by the CPP. Ron—and all the victims of this attack—are still waiting for justice.

Secretary Powell wrote in a June 21 op-ed that Zimbabwean dictator Robert Mugabe’s “time has come and gone.” As democracy is similarly under siege in both Zimbabwe and Cambodia, dictator Hun Sen’s time has also come and gone.

By Mr. ALLARD (for himself, Mr. FEINGOLD, and Mr. CRAPO): S. 1366. A bill to authorize the Secretary of the Interior to make grants to State and tribal governments to assist State and tribal efforts to manage and control the spread of chronic wasting disease in deer and elk herds, and for other purposes; to the Committee on Environment and Public Works.

Mr. ALLARD. Mr. President, I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1366

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

SECTION 1. SHORT TITLE. This Act may be cited as the “Chronic Wasting Disease Financial Assistance Act of 2003.

SEC. 2. DEFINITION AND FINDINGS. (a) CHRONIC WASTING DISEASE DEFINED.—In this Act, the term “chronic wasting disease” means the animal disease affecting deer and elk that: (1) is a transmissible disease of the nervous system resulting in distinctive lesions in the brain; and (2) belongs to a group of diseases known as transmissible spongiform encephalopathies, which group includes scrapie, bovine spongiform encephalopathy, and Creutzfeldt-Jakob disease.

(b) FINDINGS.—Congress finds the following:

(1) The States retain undisputed primary and policy-making authority with regard to wildlife management, and nothing in this Act interferes with or otherwise affects the primacy of the States in managing wildlife generally, or managing, surveying, and monitoring the incidences of chronic wasting disease in animal populations.

(2) Chronic wasting disease is a fundamental threat to the health and vibrancy of deer and elk populations, and the increased occurrence of chronic wasting disease in the United States necessitates government action to manage and eradicate this lethal disease.

(3) As the States and tribal government move to manage existing incidence of chronic wasting disease and insulate non-infected wildlife populations from the disease, it is appropriate for the Federal Government to support their efforts with financial assistance.

SEC. 3. STATE CHRONIC WASTING DISEASE MANAGEMENT CAPACITY BUILDING GRANTS. (a) GRANTS AUTHORIZED.—The Secretary of the Interior shall make grants to State wildlife management agencies to assist States in developing and implementing long term management strategies to address chronic wasting disease in wildlife species.

(b) ELIGIBILITY.—A wildlife management agency of a State whose comprehensive wildlife conservation plan include chronic wasting disease management activities is eligible for a grant under this section.

(c) FUNDING PRIORITIES.—In determining the amount of grant funds to be provided to eligible applicants under this section, the Secretary shall prioritize applicants based on the following criteria:

(1) States in which chronic wasting disease has been detected and States located adjacent or in proximity to States in which chronic wasting disease has been detected.

(2) States that have expended State funds for chronic wasting disease management, monitoring, surveillance, and research, with additional priority given to those States
that have shown the greatest financial commitment to managing, monitoring, surveying, and researching chronic wasting disease.

(3) States with comprehensive and integrated policies and programs focused on chronic wasting disease management between involved State wildlife and agricultural and tribal governments with additional priority given to States that have integrated the programs and policies of all involved agencies related to chronic wasting disease management.

(4) States that are seeking to develop a rapid response capacity to address outbreaks of chronic wasting disease, whether occurring in chronic wasting disease is already found or States with first infections, for the purpose of containing the disease in any new area of infection.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $3,000,000 to carry out this section.

SEC. 6. ADMINISTRATION.

The Secretary of the Interior shall carry out this Act acting through the Director, United States Fish and Wildlife Service.

Funds appropriated to carry out this Act shall be administered through the Federal Assistance Program of the United States Fish and Wildlife Service. Not more than three percent of such funds may be expended for administrative expenses of the United States Fish and Wildlife Service to carry out this Act.

Mr. FEINGOLD. Mr. President, I am pleased to join with my colleague from Colorado, Mr. ALLARD, as a cosponsor of the Chronic Wasting Disease Financial Assistance Act of 2003. This legislation is similar to legislation, S. 1036, the Chronic Wasting Disease Support Act of 2003, that we introduced earlier this year.

The House Resources Committee held a hearing on June 19, 2003 on the issue of chronic wasting disease, or CWD. At that hearing, state agency representatives argued strongly that Congress should establish a program to provide assistance to states for the management of CWD. They also expressed an interest in having those funds distributed using an existing distribution mechanism. This legislation responds directly to those comments.

In total, the bill directs the U.S. Fish and Wildlife Service to provide $20.5 million in Federal grants to States and tribal governments for CWD management in wild deer and elk. $10.5 million more is included in this bill Senator ALLARD and I introduced earlier this year.

The bill creates three new Federal CWD grant programs. The first program is a new nationwide CWD capacity grant, authorized at a total of $7.5 million. This program would provide grants to States so that they can fund CWD management programs. Preference would be given to States with comprehensively planned chronic wasting disease management activities eligible for a grant under this section.

(c) FUNDING PRIORITIES.—In determining the amount of grant funds to be provided to eligible applicants under this section, the Secretary shall prioritize applicants based on the following criteria:

(1) State and tribal governments managing lands on which cervids with chronic wasting disease have been detected, or managing lands located adjacent or in proximity to lands on which cervids with chronic wasting disease have been detected.

(2) Tribal governments that have expended tribal funds for chronic wasting disease management, monitoring, surveillance, and research, with additional priority given to tribal governments that have shown the greatest financial commitment to managing, monitoring, and surveying chronic wasting disease.

(3) Tribal governments with cooperative arrangements with Federal and State wildlife agencies and State governments, with additional priority given to tribal governments that are working with other involved agencies on issues of chronic wasting disease management.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $3,000,000 to carry out this section.

SEC. 6. ADMINISTRATION.

The Secretary of the Interior shall carry out this Act acting through the Director, United States Fish and Wildlife Service.

Funds appropriated to carry out this Act shall be administered through the Federal Assistance Program of the United States Fish and Wildlife Service. Not more than three percent of such funds may be expended for administrative expenses of the United States Fish and Wildlife Service to carry out this Act.

Mr. FEINGOLD. Mr. President, I am pleased to join with my colleague from Colorado, Mr. ALLARD, as a cosponsor of the Chronic Wasting Disease Financial Assistance Act of 2003. This legislation is similar to legislation, S. 1036, the Chronic Wasting Disease Support Act of 2003, that we introduced earlier this year.

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(c) FUNDING PRIORITIES.—In determining the amount of grant funds to be provided to eligible applicants under this section, the Secretary shall prioritize applicants based on the following criteria:

(1) State and tribal governments managing lands on which cervids with chronic wasting disease have been detected, or managing lands located adjacent or in proximity to lands on which cervids with chronic wasting disease have been detected.

(2) Tribal governments that have expended tribal funds for chronic wasting disease management, monitoring, surveillance, and research, with additional priority given to tribal governments that have shown the greatest financial commitment to managing, monitoring, and surveying chronic wasting disease.

(3) Tribal governments with cooperative arrangements with Federal and State wildlife agencies and State governments, with additional priority given to tribal governments that are working with other involved agencies on issues of chronic wasting disease management.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $3,000,000 to carry out this section.

SEC. 4. GRANTS FOR STATES WITH CHRONIC WASTING DISEASE OUTBREAKS.

(a) GRANTS AUTHORIZED.—The Secretary of the Interior shall make grants to State wildlife management agencies to assist States in responding to chronic wasting disease outbreaks in wild cervids.

(b) ELIGIBILITY.—A wildlife management agency of a State whose comprehensive wildlife conservation plan includes chronic wasting disease management activities is eligible for a grant under this section.

(c) FUNDING PRIORITIES.—In determining the amount of grant funds to be provided to eligible applicants under this section, the Secretary shall prioritize applicants based on the following criteria:

(1) State and tribal governments managing lands on which cervids with chronic wasting disease have been detected, or managing lands located adjacent or in proximity to lands on which cervids with chronic wasting disease have been detected.

(2) Tribal governments that have expended tribal funds for chronic wasting disease management, monitoring, surveillance, and research, with additional priority given to tribal governments that have shown the greatest financial commitment to managing, monitoring, and surveying chronic wasting disease.

(3) Tribal governments with cooperative arrangements with Federal and State wildlife agencies and State governments, with additional priority given to tribal governments that are working with other involved agencies on issues of chronic wasting disease management.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $7,500,000 to carry out this section.

SEC. 5. TRIBAL CHRONIC WASTING DISEASE MANAGEMENT GRANTS.

(a) GRANTS AUTHORIZED.—The Secretary of the Interior shall make grants to tribal wildlife management agencies to assist Indian tribes in developing and implementing long term strategies to address chronic wasting disease in wild cervids.

(b) ELIGIBILITY.—A wildlife management agency of an Indian tribe whose comprehensive wildlife conservation plan includes chronic wasting disease management activities is eligible for a grant under this section.

(c) FUNDING PRIORITIES.—In determining the amount of grant funds to be provided to eligible applicants under this section, the Secretary shall prioritize applicants based on the following criteria:

(1) State and tribal governments managing lands on which cervids with chronic wasting disease have been detected, or managing lands located adjacent or in proximity to lands on which cervids with chronic wasting disease have been detected.

(2) Tribal governments that have expended tribal funds for chronic wasting disease management, monitoring, surveillance, and research, with additional priority given to tribal governments that have shown the greatest financial commitment to managing, monitoring, and surveying chronic wasting disease.

(3) Tribal governments with cooperative arrangements with Federal and State wildlife agencies and State governments, with additional priority given to tribal governments that are working with other involved agencies on issues of chronic wasting disease management.

(d) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $10,000,000 to carry out this section.

By Mr. McCONNELL (for himself, Mr. BAYH, and Mr. FITZGERALD):

S. 1367. A bill to amend the Richard B. Russell National School Lunch Act to establish programs to promote increased consumption of milk in schools and to improve the nutrition and health of children; to the Committee on Agriculture, Nutrition, and Forestry.

Mr. McCONNELL. Mr. President, I rise today to introduce a very important piece of legislation that could provide great benefits for the health of our young people while simultaneously strengthening the future viability of dairy producers throughout the United States.

My bill, the Child Nutrition Improvement Act of 2003, would provide incentives for schools to encourage the consumption of milk as part of the school lunch program and to greatly expand Flexibility for schools to offer a wide variety of milk products and flavors.

There is no doubt that the eating habits we develop when we are young affect our habits and nutritional choices for the rest of our lives. The school lunch program has provided a key tool in promoting healthy eating habits among young people, which have both health and educational benefits.

Milk has been a critical component of the school lunch program because it is the principal source of calcium and is a leading source of several other important nutrients in our diet. That was true when the federal program began in 1946 and it is still true today.

With 9 out of 10 teenage girls and 7 out of 10 teenage boys currently not getting enough calcium, milk’s important is perhaps greater today than ever before. Serving milk with the school lunch is a critical step in addressing the calcium crisis. Federal child health experts who are on the frontlines fighting the calcium crisis recognize milk’s central role in addressing the problem. Study after study, emphasize the need for growing children and teens to consume more milk for healthy bones, and the American Academy of Pediatrics has urged its members to recommend their patients get enough milk, cheese, yogurt and other calcium rich foods to help build bone mass.

As a result of these recommendations, we have seen a push for more and more school milk programs like vending machines and school stores. There’s a real concern about nutritional choices for school children, and many
local school districts and state legislatures are pushing to add more healthful beverage choices like milk. A large school vending test in 2001 demonstrated that kids will eagerly buy milk from vending machines in schools when offered. The plan was heralded by school nutritionists and helped stimulate nationwide interest in getting milk vending machines into more schools.

A pilot test conducted in 146 schools with 100,000 students showed dramatic increases in milk consumption—15 percent in elementary schools and 22 percent in secondary schools—when simple improvements were made in the way milk was packaged and presented to students. The milk was served colder and kids loved the addition of a third flavor, it was usually strawberry. No only did kids drink more milk, more kids ate in the cafeteria. That meant they not only got milk, they also got improved nutrition through greater intakes of vegetables, fruits and other nutritionally important foods.

Milk has an unsurpassed nutrient package for young children and teens. Milk has nine essential vitamins and minerals, including calcium, vitamins A, D, B12, niacin, thiamin, riboflavin, folic acid, and phosphorus. These nutrients are critical to good health and the prevention of chronic disease. In addition, it is the primary way that children get the calcium they need. In fact, according to the U.S. Department of Agriculture about 75 percent of the calcium in our food supply comes from milk and foods made with milk. By about age 20, the average young person has acquired about 98 percent of his or her skeletal mass. Building strong bones during childhood and adolescence is one of the best defenses against developing osteoporosis later in life.

In addition to the bone-building benefits of milk, research indicates that a diet rich in low-fat milk may help reduce the risk of high blood pressure and heart disease and help prevent breast cancer, colon cancer and even help in the fight against obesity. Milk’s role in a nutritious diet has long been noted by the nutrition and science community, including the American Academy of Pediatrics, the American Dietetic Association, the National Institute of Child Health and Human Development, the National Osteoporosis Foundation, the U.S. Department of Agriculture, and many other reputable health organizations.

As I have already mentioned, government statistics indicate that we have a calcium crisis among our children and youth. Nearly 90 percent of teenage girls and almost 70 percent of teenage boys fail to get enough calcium in their diets. During the teen years nearly half of all bone is formed and about 15 percent of your adult height is added. As a nation, with economic pressures, family growth and development, we need to be doing all we can to encourage our children and youth to drink milk, and that is the goal of the legislation I am introducing today.

I ask my colleagues for your support of this important piece of legislation. I ask unanimous consent that the text of the bill be printed in the Record.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1367
Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled:

SECTION 1. SHORT TITLE. This Act may be cited as the “Child Nutrition Improvement Act of 2003”.

SEC. 2. CONSUMPTION OF MILK IN SCHOOLS. (a) FLUID MILK.—(1) IN GENERAL.—Section (a) of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758(a)) is amended by striking paragraph (2) and inserting the following: “(2) FLUID MILK.—(A) IN GENERAL.—Lunches served by schools participating in the school lunch program under this Act—

(i) shall offer students milk as a flavored and unflavored milk, as determined by the school;

(B) FLUID MILK PRODUCTS.—A school or institution that participates in the school lunch program under this Act—

(i) may offer a la carte fluid milk products to be sold in addition to and at the option of the school, adjacent to fluid milk offered as part of a reimbursable meal; and

(ii) shall not directly or indirectly restrict the sale or marketing of fluid milk products by the school (or by a person approved by the school) at any time or any place.

(i) on the school premises; or

(ii) at any school-sponsored event.”.

(2) APPLICATION.—The amendment made by paragraph (1) applies to an agreement or contract entered into on or after the date of enactment of this Act.

(b) INCREASED CONSUMPTION OF MILK IN SCHOOLS.—Section 12 of the Richard B. Russell National School Lunch Act (42 U.S.C. 1758(a)) is amended by adding at the end the following:

“(q) INCREASED CONSUMPTION OF MILK IN SCHOOLS.—

(i) IN GENERAL.—To encourage healthier nutritional environments in schools and institutions receiving funds under this Act and the Child Nutrition Act of 1966 (42 U.S.C. 1771 et seq.) (other than section 17 of that Act (42 U.S.C. 1786)), the Secretary shall establish a program to provide grants to schools and institutions to tailor the plan to the customs and demographic characteristics of—

(I) the population of the school or institution; and

(ii) the area in which the school or institution is located; and

(iv) increased standard serving sizes for fluid milk consumed in middle and high schools.

(4) ACCEPTANCE OF FUNDS.—Notwithstanding any other provision of law, the Secretary may accept funds from any entity referred to in paragraph (3) solely for use in carrying out the program under this subsection.”.
SUBMITTED RESOLUTIONS

SENATE RESOLUTION 187—EX-Pressing the sense of the Senate regarding the centenary of Rhodes Scholarships in the United States and the establishment of the Mandela Rhodes Foundation

Mr. LUGAR (for himself, Mr. SARANKES, and Mr. FEINGOLD) submitted the following resolution; which was: S. Res. 188

Whereas the Rhodes Scholarships, the oldest international fellowships, were initiated after the death of Cecil Rhodes in 1902, and now bring outstanding students from the United States, Australia, Bangladesh, Bermuda, Canada, the Commonwealth Caribbean, Germany, Hong Kong, India, Jamaica, Kenya, Malaysia, New Zealand, Pakistan, Singapore, South Africa, Uganda, Zambia, and Zimbabwe to the University of Oxford;

Whereas the first American Rhodes Scholars were elected in 1904, and since that time distinguished American Rhodes alumni have included over 20 members of Congress, a President of the United States, 3 Supreme Court Justices, cabinet members, military leaders, 80 heads of colleges or universities, and prominent artists, scientists, and businesspeople;

Whereas the Mandela Rhodes Foundation, a partnership between the Rhodes Trust and the Nelson Mandela Foundation, was established in February, 2002;

Whereas after a lifetime of struggle against apartheid and the momentous challenge of governing the new South Africa as its first democratically elected President, Nobel Peace Prize laureate Nelson Rolihlahla Mandela continues to be devoted to building a society characterized by justice and opportunity for the Republic of South Africa;

Whereas President Mandela's efforts have manifested themselves in the work of the Nelson Mandela Children's Fund, established in the wake of President Mandela's pledge to devote 1/3 of his Presidential salary to life of South Africa's disadvantaged children; and

Whereas in Cape Town in February, 2002, President Mandela noted that the partnership between the Rhodes Trust and the new Mandela Foundation signals "the closing of the circle and the coming together of 2 strands in our history": Now, therefore, be it

Resolved, That the Senate—

(1) celebrates the centenary of the Rhodes Scholarships in the United States;

(2) welcomes the establishment of the Mandela Rhodes Foundation, which embodies the spirit of reconciliation and shared commitment that is one of South Africa's greatest assets;

(3) shares the Foundation's commitment to support initiatives aimed at increasing educational opportunities, fostering leadership, and promoting human resource development throughout Africa; and

(4) affirms the support of the United States for these worthy goals throughout the sub-Saharan region, and asserts that the pursuit of these goals is in the shared interest of the American and African people.

SENATE RESOLUTION 188—Hon-oring Maynard Holbrook Jackson, Jr. former mayor of the City of Atlanta, and extending the condolences of the Senate on his death

Mr. CHAMBLISS (for himself and Mr. MILLER) submitted the following resolution; which was:

Whereas the Honorable Maynard Holbrook Jackson, Jr. was born on March 23, 1938, in Dallas, Texas, and at the age of 14 entered Morehouse College as a Ford Foundation Early Admission Scholar;

Whereas the Honorable Maynard Holbrook Jackson, Jr. graduated cum laude from North Carolina Central University School of Law;

Whereas the Honorable Maynard Holbrook Jackson, Jr. became the first African-American Vice Mayor of the City of Atlanta;

Whereas the Honorable Maynard Holbrook Jackson, Jr. proved to be a gifted and brilliant political leader, and he later became the first African-American Mayor of the City of Atlanta;

Whereas, during his years in office, the Honorable Maynard Holbrook Jackson, Jr. was the catalyst for the design of a $400 million terminal at Atlanta's Hartsfield International Airport;

Whereas the Honorable Maynard Holbrook Jackson, Jr. helped to secure Atlanta's selection as the site of the 1996 Summer Olympics;

Whereas the Honorable Maynard Holbrook Jackson, Jr. served as president of the National Conference of Democratic Mayors and the National Black Caucus of Local Elected Officials;

Whereas the Honorable Maynard Holbrook Jackson, Jr. established the American Voters League, a nonpartisan organization committed to increasing voter turnout;

Whereas upon being elected Mayor of Atlanta, the Honorable Maynard Holbrook Jackson, Jr. became a great champion for diversity, inclusion, and fairness—just in government and business, but also in all areas of life;

Whereas the Honorable Maynard Holbrook Jackson, Jr. was a wonderful human being who never wavered from the principles that guided his life and career;

Whereas the results of the Honorable Maynard Holbrook Jackson, Jr. on behalf of the City of Atlanta and all Americans earned him the esteem and high regard of his colleagues;

Whereas the untimely death of the Honorable Maynard Holbrook Jackson, Jr. has deprived his community, the City of Atlanta, the state of Georgia, and the entire Nation of an outstanding leader: Now, therefore, be it:

Resolved: That the Senate—

(1) honors the life and accomplishments of the Honorable Maynard Holbrook Jackson Jr.; and

(2) recognizes the legendary compassion exhibited by the Honorable Maynard Holbrook Jackson, Jr. as a civil rights leader; and

(3) extends its condolences to the Jackson family and the City of Atlanta on the death of a remarkable man.

SENATE RESOLUTION 189—Elect-ing Doctor Barry C. Black, of Baltimore, Maryland, as chaplain of the United States Senate

Mr. FRIST (for himself and Mr. DACSHIE) submitted the following resolution; which was:

S. Res. 189

Resolved. That Doctor Barry C. Black, of Baltimore, Maryland, be, and he is hereby, elected Chaplain of the Senate, effective Monday, July 7, 2003.

SENATE RESOLUTION 190—Com-mending General Eric Shinseki of the United States Army for his outstanding service and commitment to excellence

Mr. AKAKA (for himself, Mr. INHOFE, Mr. WARNER, Mr. LEVIN, Mr. MURRAY, Mr. DODD, Ms. LANDRIEU, Mr. PHRYO, Mr. DACSHIE, Mr. BIDEN, Mr. KENNEDY, Mr. FEINGOLD, Mr. DURBIN, Mr. NELSON of Florida, Ms. DAVIS of Florida, Mr. REED, Mr. CHAMBLISS, Ms. CASTWELL, Mr. SARANKES, Mrs. CLINTON, Mr. ROBERTS, Mr. LAUTENBERG, Mr. LIEBERMAN, Mr. DAYTON, Ms. MURKOWSKI, Mr. INOUE, Mr. HAGEL, Ms. COLLINS, and Mr. STEVENS) submitted the following resolution; which was:

S. Res. 190

Whereas General Eric Shinseki, the Army’s 38th Chief of Staff, retired in June 2003, from active military duty after 37 distinguished years of service;

Whereas General Shinseki, a native of Hawaii, graduated from the United States Military Academy, West Point, in 1963 and served in a variety of assignments, including 2 combat tours in Vietnam, and was wounded twice in combat while serving his country;

Whereas General Shinseki has been awarded the Defense Distinguished Service Medal, Distinguished Service Medal, Legion of Merit (with oak leaf clusters), Bronze Star Medal (with “V” Device), Purple Heart (with oak leaf cluster), Meritorious Service Medal (with 2 oak leaf clusters), Air Medal, Army Commendation Medal (with oak leaf cluster), Army Achievement Medal, parachutist badge, ranger tab, office of the Secretary of Defense Identification Badge, Joint Chiefs of Staff Identification Badge, and the Army Staff Identification Badge;

Whereas General Shinseki has spent the last 4 years of his career in the highest position attainable in the Army and has proven himself a tremendous leader who has demonstrated selfless devotion to this Nation and the soldiers he leads;

Whereas General Shinseki focused the Army on improved readiness in preparation for war and transformed the Army into a lean, agile, lethal fighting force that achieved victories during Operations Enduring Freedom and Iraqi Freedom;

Whereas General Shinseki provided the vision to set the Army on a path of transformation that will provide the Nation with an Army that is more lethal, agile, deployable, and flexible; capable of fighting and winning this Nation’s wars in all future threats and environments;

Whereas General Shinseki exemplifies the trademark characteristics exhibited by all
great leaders and is a remarkable man of integrity, courage, and honor;

Whereas General Shinseki is an American hero who has been selfless in his service to his country by defend ing it through war, peace, and personal trial, and epitomizes the spirit of aloha; and

Whereas John F. Kennedy, the 35th President of the United States once said, “When at some future date the high court of history sits in judgment of each one of us—recording whether in our brief span of service we fulfilled our responsibilities, we will be measured by the answers to four questions—were we truly men of courage . . . were we truly men of judgment . . . were we truly men of integrity . . . were we truly men of dedication? When history looks back at the Army’s 34th Chief of Staff, it will be clear that this was truly a man of courage, judgment, integrity, and dedication. Now, therefore, be it:

Resolved,

SECTION 1. COMMENDATION.

The Senate—

(1) thanks General Eric Shinseki of the United States Army on behalf of a grateful Nation; and

(2) commends General Eric Shinseki for his extraordinary dedication to service to this great country and for his lifetime of commitment to excellence.

SEC. 2. TRANSMITTAL OF RESOLUTION.

The Senate directs the Secretary of the Senate to transmit an enrolled copy of this resolution to General Eric Shinseki.

Mr. AKAKA. Mr. President, I rise today to honor a great American hero, General Eric Shinseki, the Army’s 34th Chief of Staff. General Shinseki, a native of Hawaii, attained the Army’s highest position as the Army’s Chief of Staff in June 1999 and retired in June 2003.

Ric Shinseki graduated from the United States Military Academy, West Point, in 1965. He served two combat tours in Vietnam and was wounded twice in combat. Throughout his 37 years of service to this country, he has given his personal best, serving with great pride and dignity. His legacy to this Nation will live on for years to come.

Over the span of his career, I’ve watched his progress as a soldier and was privileged to participate in his promotion ceremony to Colonel. At that time, I thought he had a stellar career as a “soldier’s soldier.” I was very proud to witness his four years of service as the Army’s Chief of Staff. He was the perfect soldier to lead our Army into the 21st century.

This remarkable man and distinguished decorated soldier set a new standard for the Army. With extraordinary vision, he transformed the Army into an agile, lean, flexible, and lethal fighting force. This man of honor, integrity, and courage set a higher standard for all to follow, all while embodying the spirit of aloha. With his deep sense of pride and dedication to service, he made our Army stronger, one able to achieve swift victories during Operations Enduring Freedom and Iraqi Freedom.

As I quoted in the Senate Resolution, President John F. Kennedy once said, “When at some future date the high court of history sits in judgment of..."
Basilone and his men successfully repelled a Japanese assault. Other survivors reported that their success can be attributed to one man: “Manila John.” He crossed enemy lines to replenish a dangerously low stockpile of ammunition, repaired artillery pieces, and shielded his troops in the midst of torrential rain. He went several days and nights without food or sleep, and the U.S. military was able to carry the day. His exploits became Marine lore, and served as a patriotic inspiration to other facing daunting challenges in the midst of war.

For his courage under fire and profound patriotism, Basilone was the first enlisted Marine to be awarded the Congressional Medal of Honor. When he returned to the United States, he was heralded as a hero and quickly sent on tour around the country to help finance the war through the sale of war bonds. The Marine Corps offered to commission Basilone as an officer and station him far away from the frontlines.

But Basilone was not interested in riding out the war in Washington, DC. He was quoted as saying, “I ain’t no officer, and I ain’t no museum piece. I be riding out the war in Washington, DC.” In December 1944, he got his wish and returned to the frontlines.

General Douglas MacArthur called him “a one-man army,” and on February 19, 1945 at Iwo Jima, Basilone once again lived up to that reputation. Basilone destroyed an enemy stronghold, a blockhouse on that small Japanese island and commanded his young troops to move the heavy guns off the beach. Unfortunately, less than two hours into the assault on that fateful day in February, Basilone and four of his fellow Marines were killed when an enemy mortar shell exploded nearby.

When Gunnery Sergeant John Basilone died he was only 27, but he had already earned the Congressional Medal of Honor, the Navy Cross, the Purple Heart, and the appreciation of his Nation. Basilone is a true American patriot whose legacy should be preserved.

Now more than ever, the United States needs to honor and praise the courageous efforts put forth by the States needs to honor and praise the patriot whose legacy should be preserved.

Amendments Submitted & Proposed

SA 1094. Mr. SESSIONS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program.

SA 1113. Mr. GRASSLEY proposed an amendment to the bill S. 312, to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program.

SA 1114. Mr. Kyl submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.

SA 1115. Mr. Kyl (for himself, Mr. Hatch, and Ms. Murkowski) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes.
SA 1118. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1119. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 1120. Mr. DAYTON (for himself, Mr. COLEMAN, and Mr. SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1121. Mr. KYL (for himself, Mr. NICKLES, Mr. GREGG, Mr. THOMAS, and Mr. LOTTER) proposed an amendment to the bill S. 1, supra; which was ordered to lie on the table.

SA 1122. Mr. BROWNEBACK (for himself and Mr. NELSON, of Nebraska) submitted an amendment intended to be proposed by him to the bill S. 1, supra.

SA 1123. Mr. DEWINE submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1124. Mr. ROBERTS submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1125. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1126. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1127. Mr. DOLE (for herself and Mr. EDWARDS) submitted an amendment intended to be proposed by her to the bill S. 1, supra.

SA 1128. Mr. CHAMBLISS submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1129. Mr. SPECTER submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1130. Mr. KYL submitted an amendment intended to be proposed by him to the bill S. 1, supra; which was ordered to lie on the table.

SA 1131. Mr. SANTORUM proposed an amendment to the bill S. 1, supra.

SA 1132. Mr. GRASSLEY (for himself and Mr. BAUCUS) proposed an amendment to the bill S. 1, supra.

TEXT OF AMENDMENTS

SA 1094. Mr. SESSIONS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVII of the Social Security Act to provide for payment of customary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

On page 468, line 39, strike "no debt" and all that follows through line 5, and insert the following: "the sponsor of such an alien shall be responsible for paying 100 percent of the costs incurred in the provision of such assistance, unless the sponsor demonstrates that the sponsor has an extreme and unusual financial hardship that prevents the sponsor from paying such costs.

SA 1095. Mr. REID (for himself and Mr. COCHRAN) proposed an amendment to the bill S. 1, to amend title XVII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of subtitle A of title I, add the following:

SEC. 2. MEDICATION THERAPY MANAGEMENT PROGRAM.

(a) Establishment.—

(1) IN GENERAL.—The Secretary shall establish an assessment program to contract with qualified pharmacists for medication therapy management services to eligible beneficiaries who receive care under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) SITES.—The Secretary shall designate 6 geographic areas, each containing not less than 3 sites, at which to conduct the assessment program under this section. At least 2 geographic areas designated under this paragraph shall be located in rural areas.

(b) DURATION.—The Secretary shall conduct the assessment program under this section for a 1-year period.

(c) IMPLEMENTATION.—The Secretary shall implement the program no later than January 1, 2005, but may not implement the assessment program before October 1, 2004.

(d) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as an assessment site under subsection (a)(2) may participate in the assessment program under this section if such beneficiary identifies a qualified pharmacist who agrees to furnish medication therapy management services to the eligible beneficiary under the program.

(e) CONTRACTS WITH QUALIFIED PHARMACISTS.—

(1) IN GENERAL.—The Secretary shall enter into a contract with qualified pharmacists to provide medication therapy management services to eligible beneficiaries residing in the area served by the qualified pharmacist.

(2) NUMBER OF CONTRACTS.—The Secretary shall enter into contracts with no more than 3 qualified pharmacists at each site.

(3) DURATION.—The Secretary shall conduct the assessment program under this section for a 1-year period.

(f) BUDGET NEUTRALITY.—In conducting the assessment program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the assessment program under this section was not in effect.

(g) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.) if the Secretary determines that it may be necessary for the purpose of carrying out the assessment program under this section.

SEC. 3. MEDICATION THERAPY MANAGEMENT SERVICES.

(a) DEFINITIONS.—In this section:

(1) MEDICATION THERAPY MANAGEMENT SERVICES.—The term ‘‘medication therapy management services’’ means services or programs furnished by a qualified pharmacist to an eligible beneficiary, individually or on behalf of a pharmacy provider, which are designed—

(A) to ensure that medications are used appropriately by such individual;

(B) to enhance the individual’s understanding of the appropriate use of medications;

(C) to increase the individual’s compliance with prescription medication regimens;

(D) to reduce the risk of potential adverse events associated with medications; and

(E) to reduce the need for other costly medical services through better management of medication therapy.

(2) ELIGIBLE BENEFICIARY.—The term ‘‘eligible beneficiary’’ means an individual who is—

(A) entitled to (or enrolled for) benefits under part A and enrolled for benefits under part B of the Social Security Act (42 U.S.C. 1385 et seq.; 1395 et seq.); or

(B) not enrolled with a Medicare+Choice plan or a MedicareAdvantage plan under part C; and

(C) receiving, in accordance with State law or regulations, medication for—

(i) the treatment of asthma, diabetes, or chronic cardiovascular disease, including an individual on anticoagulation or lipid reducing medications; or

(ii) such other chronic diseases as the Secretary may specify.

(b) QUALIFIED PHARMACIST.—The term ‘‘qualified pharmacist’’ means an individual who is a licensed pharmacist in good standing with the State Board of Pharmacy.
SA 1096. Ms. MURKOWSKI (for herself and Mr. STEVENS) submitted an amendment intended to be proposed by her to the bill S. 1, to amend the title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

On page 529, between lines 8 and 9, insert the following:

SEC. 455. FRONTIER EXTENDED STAY CLINIC DEMONSTRATION PROJECT. (a) AUTHORITY TO CONDUCT DEMONSTRATION PROJECT.—The Secretary shall waive such provisions of the Medicare program as are necessary to conduct a demonstration project under which frontier extended stay clinics described in subsection (b) in isolated rural areas are treated as providers of items and services under the Medicare program.

(b) CLINICS DESCRIBED.—A frontier extended stay clinic is described in this subsection if the clinic—

(1) is located in a community where the closest short-term acute care hospital or critical access hospital is at least 75 miles away from the community or is inaccessible by public road; and

(2) is designed to address the needs of—

(A) seriously or critically ill or injured patients who, due to adverse weather conditions or other reasons, cannot be transferred to acute care referral centers; or

(B) patients who need monitoring and observation for a limited period of time.

(c) DEFINITIONS.—In this section, the terms "hospital" and "critical access hospital" have the meanings given such terms in subsections (e) and (mm), respectively, of section 1861 of the Social Security Act (42 U.S.C. 1395x).

SA 1097. Mr. MCCONNELL proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of subtitle A of title I, add the following:

SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES. (a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PAYMENTS ARE NECESSARY.—In section 1862(b)(2), (42 U.S.C. 1395y(b)(2)), (B) patients who need monitoring and observation for a limited period of time.

(b) CLARIFYING AMENDMENTS TO CONSIDERATION OF POPULATION DENSITY WITHIN POSTAL ZIP CODES.—With respect to ground ambulance services described in subparagraph (A), during the period described in that subparagraph, paragraph (9) shall be applied by substituting "as determined under an area classification system established by the Secretary that is based on population density within postal zip code areas" for "as determined in section 1886(d)(2)(D) or in a rural census tract or a metropolitan statistical area" as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725). Not later than December 31, 2003, the Secretary, taking into account the recommendations contained in the report submitted under section 369(c)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, shall implement the increase in payment required under subparagraph (B) and establish the classification system required by the application of this subparagraph.

(11) CONVERSION FACTOR ADJUSTMENTS.—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor."

SEC. 426A. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PAYMENTS ARE NECESSARY.—(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking "(as determined in accordance with regulations);" and

(B) in subparagraph (B) —

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

"(11) CONVERSION FACTOR ADJUSTMENTS.—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor."

SEC. 426C. INCREASE FOR GROUND AMBULANCE SERVICES. Section 183(h) (42 U.S.C. 1395m(h)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraphs:

"(10) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—(A) IN GENERAL.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by 21.5 percent.

(B) ADDITIONAL INCREASE FOR SERVICES FURNISHED IN RURAL AREA.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by 25 percent.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Act of 1984 (Public Law 98-369).

(b) CLARIFYING AMENDMENTS TO CONSIDERATION OF POPULATION DENSITY WITHIN POSTAL ZIP CODES.—With respect to ground ambulance services described in subparagraph (A), during the period described in that subparagraph, paragraph (9) shall be applied by substituting "as determined under an area classification system established by the Secretary that is based on population density within postal zip code areas" for "as determined in section 1886(d)(2)(D) or in a rural census tract or a metropolitan statistical area" as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725). Not later than December 31, 2003, the Secretary, taking into account the recommendations contained in the report submitted under section 369(c)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, shall implement the increase in payment required under subparagraph (B) and establish the classification system required by the application of this subparagraph.

(11) CONVERSION FACTOR ADJUSTMENTS.—The Secretary shall not adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor."
(1) in subparagraph (A), in the matter following clause (ii), by inserting the following sentence at the end: “An entity that engages in a business, trade, or profession shall be deemed to receive a payment from or to an insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.”

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: “A primary plan, or an entity that receives a payment from or to a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan’s responsibility for such payment may be constrained by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means.”; and

(B) in the final sentence, by striking ‘‘on the date such notice or other information is received’’ and inserting ‘‘on the date such notice or other information is received’’;

and

(3) in subparagraph (B)(iii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: “In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer, as the entity’s sponsor or contributor to a group health plan, or large group health plan, or otherwise) to make payment with respect to the same item or service (or any portion thereof) under a primary plan. The United States may, in accordance with paragraph (3)(A) collect double damages against any entity that has received payment from a primary plan or from the proceeds of a primary plan, or otherwise) to make payment with respect to such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan’s responsibility for such payment may be constrained by a judgment, a payment conditioned upon the recipient’s compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means.”; and

(4) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ‘‘such’’ before ‘‘paragraphs’’.

SA 1099. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 285 and insert the following:

SEC. 285. INCREASE FOR GROUND AMBULANCE SERVICES.

Section 1834(l) of the Social Security Act (42 U.S.C. §1395mm(i)), as amended by section 409(h)(2), is amended by adding at the end the following new paragraphs.

“(10) TEMPORARY INCREASE FOR AMBULANCE SERVICES.

“(A) GROUND AMBULANCE SERVICES.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004 and before January 1, 2007, for which the payment rate for mileage, shall provide that such rates otherwise established shall be increased by the higher of either 20 percent or the following:

“(C) Basing Rural Areas on Population Density by Postal Zip Codes.

(1) GROUND AMBULANCE SERVICES.—Notwithstanding any other provision of this subsection, the Secretary shall implement the system described in the amendment made by section 2(a)(1), by striking ‘‘(as defined in section 1860D–19(a)(3) of such Act)’’ and inserting ‘‘(as defined in section 1860D–19(a)(3) of such Act)’’.

(2) EFFECTIVE DATE.—The Secretary of Health and Human Services, taking into account the recommendations contained in the report submitted under section 221(b)(3) the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000, shall implement such adjustment in addition to the increase under subparagraph (A). The Secretary shall establish the classification system described in the amendment made by subsection (a)(1) not later than December 31, 2003. Such amendment shall apply to services furnished on or after such date, not later than 30 days after the establishment of such system, as the Secretary shall provide by regulation.

“(D) APPLICATION OF INCREASED PAYMENTS.

(1) IN GENERAL.—The increased payments under section 1834(l) of the Social Security Act (42 U.S.C. §1395mm(i)) is amended by adding at the end the following:

“(1) IN GENERAL.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004 and before January 1, 2007, for which the transportation originates in a rural area described in paragraph (10)(C), the fee schedule established under this section, with respect to the same item or service (or any portion thereof) under a primary plan. The Secretary shall implement the system described in paragraph (1) not later than December 31, 2003. Such amendment shall apply to services furnished on or after such date, not later than 30 days after the establishment of such system, as the Secretary shall provide by regulation.

“(D) IMPLEMENTATION OF PART D.—

“(1) IN GENERAL.—Notwithstanding section 1860D(3) of such Act or a qualifying individual (as defined in section 1860D–19(a)(4) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(1) of such Act, including the payment of—

(A) no deductible;
(B) no monthly beneficiary premium for at least one Medicare Prescription Drug plan available in the area in which the individual resides; and
(C) reduced cost-sharing described in subsection (D) of section 1860D–19(a)(1) of such Act.

SA 1100. Mr. DAYTON submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle A of title I, add the following:

SEC. 1. INCREASE IN DRUG BENEFIT.

Notwithstanding any other provision of law, there shall be $12,000,000,000 to improve the prescription drug benefit added under part D of title XVIII of the Social Security Act (as added by section 101) by eliminating premium gaps, reducing the premium or cost-sharing, or expanding subsidies for low-income beneficiaries in lieu of conducting any demonstration projects or making any increased payments to providers authorized under this Act or the amendments made by this Act.
(1) or (2) of section 1860D–17(a) of such Act; and
(3) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–16(a) of such Act.
(4) SUBSIDY-ELIGIBLE INDIVIDUALS WITH INCOME BETWEEN 135 PERCENT AND 150 PERCENT OF THE FEDERAL POVERTY LEVEL.—If the individual is a subsidy-eligible individual (as defined in section 1860D–19(a)(4)(D) of such Act) who is diagnosed with Alzheimer’s disease, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of
(A) for 2006, a deductible of only $50;
(B) only a percentage of the monthly premium (as described in section 1860D–19(a)(3)(A)(ii)); and
(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D–19(a)(3)(A).
(5) ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 150 PERCENT OF THE FEDERAL POVERTY LEVEL.—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3) of such Act, and is diagnosed with Alzheimer’s disease, such individual shall have access to qualified prescription drug coverage (as described in section 1860D–6a(1) of such Act) at a modest cost-sharing for residents.
(A) for 2006, a deductible of only $275;
(B) the limits on cost-sharing described in section 1860D–6c(1) of such Act for 2006, an initial coverage limit of $4,500; and
(C) for 2006, an annual out-of-pocket limit of $3,700 with 10 percent cost-sharing after that limit is reached.

SA 1103. Mr. DORGAN (for himself and Mr. PRYOR) proposed an amendment SA 1102 proposed by Mr. GRASSLEY (for himself and Mr. BAYH) submitted to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program and for other purposes; as follows:

In lieu of the matter proposed to be inserted, insert the following:

SEC. 6. ESTABLISHMENT OF PROGRAM TO PREVENT ABUSE OF NURSING FACILITY RESIDENTS.

(a) IN GENERAL.—
(1) SCREENING OF SKILLED NURSING FACILITY AND NURSING FACILITY PROVISIONAL EMPLOYEES.—(A) MEDICARE PROGRAM.—Section 1819(b) (42 U.S.C. 1395i–3(b)) is amended by adding at the end the following:
"(b) SCREENING OF SKILLED NURSING FACILITY WORKERS.—
"(1) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(i), after an individual is hired as an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status, shall, for this purpose be subject to the requirements of subsection (c) for purposes of section 1860D–21.
"(2) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after an individual is hired as an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status, shall, for this purpose be subject to the requirements of subsection (c) for purposes of section 1860D–21.

(b) SUBSIDY-ELIGIBLE INDIVIDUALS IN MONTHLY BENEFICIARY OBLIGATIONS.

Section 1860D–17, as added by section 101, is amended by adding at the end the following:
"(d) PROHIBITION IN MONTHLY BENEFICIARY OBLIGATIONS.—The Administrator shall, for each year, determine in a Medicare Advantage plan that provides qualified prescription drug coverage.5 This subsection shall not apply in determining the applicable percent under section (c) for purposes of section 1860D–21."

SA 1104. Mr. KOHL (for himself and Mr. BERNSTEIN) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. 6. ESTABLISHMENT OF PROGRAM TO PREVENT ABUSE OF NURSING FACILITY RESIDENTS.

(a) IN GENERAL.—
(1) SCREENING OF SKILLED NURSING FACILITY AND NURSING FACILITY PROVISIONAL EMPLOYEES.—(A) MEDICARE PROGRAM.—Section 1819(b) (42 U.S.C. 1395i–3(b)) is amended by adding at the end the following:
"(b) SCREENING OF SKILLED NURSING FACILITY WORKERS.—
"(1) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(i), after an individual is hired as an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status, shall, for this purpose be subject to the requirements of subsection (c) for purposes of section 1860D–21.
"(2) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after an individual is hired as an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status, shall, for this purpose be subject to the requirements of subsection (c) for purposes of section 1860D–21.

(b) SUBSIDY-ELIGIBLE INDIVIDUALS IN MONTHLY BENEFICIARY OBLIGATIONS.

Section 1860D–17, as added by section 101, is amended by adding at the end the following:
"(d) PROHIBITION IN MONTHLY BENEFICIARY OBLIGATIONS.—The Administrator shall, for each year, determine in a Medicare Advantage plan that provides qualified prescription drug coverage.5 This subsection shall not apply in determining the applicable percent under section (c) for purposes of section 1860D–21."

(b) SUBSIDY-ELIGIBLE INDIVIDUALS IN MONTHLY BENEFICIARY OBLIGATIONS.

Section 1860D–17, as added by section 101, is amended by adding at the end the following:
"(d) PROHIBITION IN MONTHLY BENEFICIARY OBLIGATIONS.—The Administrator shall, for each year, determine in a Medicare Advantage plan that provides qualified prescription drug coverage.5 This subsection shall not apply in determining the applicable percent under section (c) for purposes of section 1860D–21."

(c) QUALIFIED PROVISIONAL EMPLOYEES.—(A) MEDICARE PROGRAM.—Section 1819(b) (42 U.S.C. 1395i–3(b)) is amended by adding at the end the following:
"(b) SCREENING OF SKILLED NURSING FACILITY WORKERS.—
"(1) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(i), after an individual is hired as an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status, shall, for this purpose be subject to the requirements of subsection (c) for purposes of section 1860D–21.
"(2) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after an individual is hired as an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status, shall, for this purpose be subject to the requirements of subsection (c) for purposes of section 1860D–21.

(b) SUBSIDY-ELIGIBLE INDIVIDUALS IN MONTHLY BENEFICIARY OBLIGATIONS.

Section 1860D–17, as added by section 101, is amended by adding at the end the following:
"(d) PROHIBITION IN MONTHLY BENEFICIARY OBLIGATIONS.—The Administrator shall, for each year, determine in a Medicare Advantage plan that provides qualified prescription drug coverage.5 This subsection shall not apply in determining the applicable percent under section (c) for purposes of section 1860D–21."

(b) SUBSIDY-ELIGIBLE INDIVIDUALS IN MONTHLY BENEFICIARY OBLIGATIONS.

Section 1860D–17, as added by section 101, is amended by adding at the end the following:
"(d) PROHIBITION IN MONTHLY BENEFICIARY OBLIGATIONS.—The Administrator shall, for each year, determine in a Medicare Advantage plan that provides qualified prescription drug coverage.5 This subsection shall not apply in determining the applicable percent under section (c) for purposes of section 1860D–21."

(c) QUALIFIED PROVISIONAL EMPLOYEES.—(A) MEDICARE PROGRAM.—Section 1819(b) (42 U.S.C. 1395i–3(b)) is amended by adding at the end the following:
"(b) SCREENING OF SKILLED NURSING FACILITY WORKERS.—
"(1) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(i), after an individual is hired as an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status, shall, for this purpose be subject to the requirements of subsection (c) for purposes of section 1860D–21.
"(2) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after an individual is hired as an individual for a position as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status, shall, for this purpose be subject to the requirements of subsection (c) for purposes of section 1860D–21.
by a State agency under subsection (g)(1)(C) or a Federal agency that a skilled nursing facility worker has committed—

(i) an act of patient or resident abuse or neglect or misappropriation of patient or resident property; or

(ii) such other types of acts as the Secretary may specify in regulations.

(IV) SKILLED NURSING FACILITY WORKER.—The term ‘skilled nursing facility worker’ means any individual (other than a volunteer) that has access to a patient of a skilled nursing facility under an employment or other contract, or both, with such facility. Such term includes individuals who are licensed by the Secretary, including nurse aides, home health aides, personal care workers and attendants.”.

(B) MEDICAID PROGRAM.—Section 1919(b)(42 U.S.C. 1396n(b)) is amended by adding at the end the following new paragraph:

“(B) MEDICAID PROGRAM.—Section 1919(b) (42 U.S.C. 1396n(b)) (as added by this section) and shall implement changes, as necessary, based on available technology, to make the background check system more efficient and able to provide a more immediate determination for long-term care providers using the system.

(2) FEDERAL RESPONSIBILITIES.—(A) DEVELOPMENT OF STANDARD FEDERAL AND STATE BACKGROUND CHECK FORM.—The Secretary of Health and Human Services, in consultation with the Attorney General and representatives of appropriate State agencies, shall develop a model form that a provisioinal employee at a nursing facility may complete and Federal and State agencies may use to conduct the background checks required under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395l–1(b), 1396n(b)) (as added by this section).

(B) PERIODIC EVALUATION.—The Secretary of Health and Human Services, in consultation with the Attorney General, periodically shall evaluate the background check system imposed under sections 1819(b)(8) and 1919(b)(8) of the Social Security Act (42 U.S.C. 1395l–1(b), 1396n(b)) (as added by this section) and shall implement changes, as necessary, based on available technology, to make the background check system more efficient and able to provide a more immediate determination for long-term care providers using the system.

(3) no preemption of stricter state laws.—Nothing in section 1819(b)(8) or 1919(b)(8) of the Social Security Act (42 U.S.C. 1395l–1(b), 1396n(b)) (as so added) shall be construed to supersede any provision of State law that—

(A) specifies a relevant crime for purposes of prohibiting the employment of an individual at a long-term care facility (as defined in section 1122E(g)(6) of the Social Security Act (42 U.S.C. 1395l–1(b), 1396n(b)) (as so added) that is not included in the list of such crimes specified in such sections or in regulations promulgated by the Secretary of Health and Human Services to carry out such sections; or

(B) requires a long-term care facility (as defined in section 1122E(g)(6) of the Social Security Act (42 U.S.C. 1395l–1(b), 1396n(b)) (as so added) that is not included in the list of such crimes specified in such sections or in regulations promulgated by the Secretary of Health and Human Services to carry out such sections; or

(4) technical amendment.—Effective as if included in the enactment of section 941 of Bipartisan Budget Act of 2018 (114 Stat. 2763A–555, sections 1919(b) and 1919(b) (42 U.S.C. 1395l–1(b), 1396n(b)), as amended by redesignating the paragraph (8) added by such section as paragraph (9).
section 1128E.

(b)(8)(F)(i));

providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or $50. Such fees shall be available to the Attorney General, or in the Attorney General’s discretion, to the Federal Bureau of Investigation, until expended.

(b) SUPERVISION OF PROVISIONAL EMPLOYMENT.—

(1) IN GENERAL.—In addition to the Secretary’s authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee has not been updated to reflect changes in the provisional employee’s or employee’s criminal record.

(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a request by a nursing facility pursuant to subparagraph (B), the State shall—

(i) immediately report to the skilled nursing facility in writing the results of such review;

(ii) the disposition of such requests; and

(iii) the fee charged for conducting a search and exchange of records with respect to such individual as described in subparagraph (B).

(2) SEARCH AND EXCHANGE OF RECORDS BY MEDICAID.—Section 1919(e) (42 U.S.C. 1396r(e)) is amended by adding at the end the following:

(B) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON NURSING FACILITY EMPLOYEES.—

(A) In general.—Upon receipt of a request by a nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subparagraph (A) through (IV) of subsection (b)(8)(A)(ii), a State, after checking appropriate State records and finding no disqualifying information corresponding to the fingerprints and other positive identification information submitted, shall request the Attorney General and shall request the Attorney General to conduct a search and exchange of records with respect to such individual as described in subparagraph (B).

(B) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

(i) AUTHORITY TO CHARGE FEES.—(A) The Attorney General.—The Attorney General shall charge a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Attorney General, and for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the lesser of the actual cost of such activities or $50. Such fees shall be available to the Attorney General, or in the Attorney General’s discretion, to the Federal Bureau of Investigation, until expended.

(ii) PROHIBITION ON CHARGING.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

(E) REGULATIONS.

(i) IN GENERAL.—In addition to the Secretary’s authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General’s responsibilities under this paragraph and subsection (b)(8), including regulations regarding the security, confidentiality, accuracy, use, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

(ii) APPEAL PROCEDURES.—The Attorney General, in conjunction with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee has not been updated to reflect changes in the provisional employee’s or employee’s criminal record.

(P) REPORT.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

(i) the number of requests for searches and exchanges of records made under this section;

(ii) the disposition of such requests; and

(iii) the cost of responding to such requests.

SEC. 1897. (a) IN GENERAL.—The requirements of subsections (b)(8) and (e)(6) of section 1819 shall apply to any provider of services or any other entity that is eligible to be paid under this title for providing home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services to an individual entitled to benefits under part A or enrolled under part B of title XVIII of subchapter I of chapter 1 of title 18, U.S.C., who has a Medicare+Choice plan offered by a Medicare+Choice organization under part C (in this section referred to as a ‘‘medicare benefit plan’’), in accordance with the requirements of subsection (b)(1) of section 1857(o).
(bb) in clause (i), in the matter preceding subclause (I), by striking "a nurse aide" and inserting "an individual"; and

(cc) in clause (ii), by striking "an individual" and inserting "individual".

(e)(2)(A)(iii)" after "used by the facility";

(bb) in clause (i), in the matter preceding subclause (I), by striking "a nurse aide" and inserting "an individual"; and

(cc) in clause (ii), by striking "registration of all individuals" and inserting "a registry of (i) all individuals"; and

(ccc) in clause (iii), by striking "an individual".

(ii) In subparagraph (A), by striking "(aa)" and inserting "(aa)"; and

(bb) in clause (i), by striking "by no later than January 1, 1989, the" and inserting "The";

(bb) by striking "a registry of all individuals" and inserting "a registry of (i) all individuals"; and

(cc) by inserting before the period the following: 

"and (ii) other nursing facility employees with respect to whom the State has made a finding of patient neglect or resident of the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, including nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants) before the period.

(3) REPORTING BY LONG-TERM CARE FACILITIES OR PROVIDERS.—

(A) IN GENERAL.—Section 1128E(b)(1) (42 U.S.C. 1320a–7e(b)(1)) is amended by striking "health plan" and inserting "health plan, and long-term care facility or provider".

(B) CORRECTION OF INFORMATION.—Section 1128E(c)(2) (42 U.S.C. 1320a–7e(c)(2)) is amended by striking "health plan and" and inserting "health plan, and long-term care facility or provider".

(4) ACCESS TO REPORTED INFORMATION.—Section 1128E(d)(4) (42 U.S.C. 1320a–7e(d)(4)) is amended by striking "and health plans" and inserting "health plans, and long-term care facility or providers".

(5) MANDATORY CHECK OF DATABASE BY LONG-TERM CARE FACILITIES OR PROVIDERS.—

Section 1128E(d) (42 U.S.C. 1320a–7e(d)) is amended by adding at the end the following:

"(1) A long-term care facility or provider shall check the database maintained under this section prior to hiring under an employment contract, or both; (other than in a provisional status) an individual as an employee of such a facility or provider who will have access to a patient or resident of the facility or provider (including individuals who are licensed or certified by the State to provide services at the facility or through the provider, including nurse aides, home health aides, individuals who provide home care, and personal care workers and attendants)."

(2) REQUIREMENTS.—The regulations required under paragraph (1) shall provide the following:

(A) A survey of a provider of home care shall consist of ongoing, good faith, verifiable efforts by the supervisor of the provider of home care to conduct monitoring and oversight activities to ensure the safety of a Medicare beneficiary.

(B) For purposes of subparagraph (A), monitoring and oversight activities may include (but are not limited to) the following:

(i) Follow-up telephone calls to the Medicare beneficiary.

(ii) Unannounced visits to the Medicare beneficiary’s home while the provider employee is serving the Medicare beneficiary.

(iii) To the extent practicable, limiting the provider employee’s duties to serving only those Medicare beneficiaries in a home or setting where another family member or resident of the home or setting of the Medicare beneficiary is present.

(C) In promulgating such regulations, the Secretary shall take into account the staffing and geographic issues faced by small rural entities (as defined by the Secretary) that provide home health services, hospice care (including routine home care and other services included in hospice care under this title), or other long-term care services. Such services included in hospice care under this title, or long-term care services and with respect to such an entity, or other long-term care services.

(D) In subparagraph (A), by striking "nurse aide" and inserting "an individual".

(E) In clause (ii), by striking "an individual" and inserting "individual".

(F) In clause (iii), by striking "an individual" and inserting "individuals".

(G) In clause (iv), by striking "an individual" and inserting "individuals".

(H) In clause (v), by striking "an individual" and inserting "individuals".

(I) In clause (vi), by striking "an individual" and inserting "individuals".

(J) In clause (vii), by striking "an individual" and inserting "individuals".

(K) In clause (viii), by striking "an individual" and inserting "individuals".

(L) In clause (ix), by striking "an individual" and inserting "individuals".

(M) In clause (x), by striking "an individual" and inserting "individuals".

(N) In clause (xi), by striking "an individual" and inserting "individuals".

(O) In clause (xii), by striking "an individual" and inserting "individuals".

(P) In clause (xiii), by striking "an individual" and inserting "individuals".

(Q) In clause (xiv), by striking "an individual" and inserting "individuals".

(R) In clause (xv), by striking "an individual" and inserting "individuals".

(S) In clause (xvi), by striking "an individual" and inserting "individuals".

(T) In clause (xvii), by striking "an individual" and inserting "individuals".

(U) In clause (xviii), by striking "an individual" and inserting "individuals".

(V) In clause (xix), by striking "an individual" and inserting "individuals".

(W) In clause (xx), by striking "an individual" and inserting "individuals".

(X) In clause (xxi), by striking "an individual" and inserting "individuals".

(Y) In clause (xxii), by striking "an individual" and inserting "individuals".

(Z) In clause (xxiii), by striking "an individual" and inserting "individuals".

[1919(b)(8)(B)(ii) if the entity meets such requirements for supervision of provisional employees of the entity as the Secretary shall, by regulation, specify in accordance with paragraph (2).]
by this section shall take effect on the date that is the earlier of—
(A) 18 months after the effective date of final regulations promulgated to carry out this section; or
(B) January 1, 2007.

SA 1105. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:
On page 486, line 3, insert “and” after the semicolon at the end.
On page 486, line 4, insert “(I)” after “(I)”. On page 486, line 8, strike “(and)” and insert “or”. On page 486, line 9, strike “(iii)” and insert “(II)”.

SA 1106. Mr. HATCH (for himself and Mr. WYDEN) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of title VI, insert the following:
SEC. 601. HEALTH CARE THAT WORKS FOR ALL AMERICANS-CITIZENS HEALTH CARE WORKING GROUP.

(a) FINDINGS.—Congress finds the following:
(1) In order to improve the health care system, the American public must engage in an informed national public debate to make choices about the services they want covered, what health care coverage they want, and how they are willing to pay for coverage.
(2) More than a trillion dollars annually is spent on the health care system, yet—
(A) 41,000,000 Americans are uninsured;
(B) insured individuals do not always have access to essential, effective services to improve, maintain, and protect their health; and
(C) employers, who cover over 170,000,000 Americans, find providing coverage increasingly difficult because of rising costs and double digit premium increases.
(3) Despite increases in medical care spending that are greater than the rate of inflation, population growth, and Gross Domestic Product growth, there has not been a commensurate improvement in our health status as a nation.
(4) Health care costs for even just 1 member of a family can be catastrophic, resulting in medical bills potentially harming the economic stability of the entire family.
(5) Common life occurrences can jeopardize the ability of a family to retain private coverage or jeopardize access to public coverage.
(6) Innovations in health care access, coverage, and quality of care, including the use of technology, have often come from States, local communities, and private sector organizations, but more creative policies could tap this potential.
(7) Despite our Nation’s wealth, the health care system does not provide coverage to all Americans who want it.

(b) PURPOSES.—The purposes of this Act are—
(1) to provide for a nationwide public debate about improving the health care system to provide for an ability to obtain quality, affordable health care coverage; and
(2) to provide for a vote by Congress on the recommendations that result from the debate.

(c) ESTABLISHMENT.—The Secretary, acting through the Agency for Healthcare Research and Quality, shall establish an entity to be known as the Citizens’ Health Care Working Group referred to in this Act as the “Working Group”.

(d) APPOINTMENT.—Not later than 45 days after the date of enactment of this Act, the Speaker and Minority Leader of the House of Representatives and the Majority Leader and Minority Leader of the Senate (in this section referred to as the “leadership”) shall each appoint individuals to serve as members of the Working Group in accordance with subsections (e), (f), and (n).

(e) MEMBERSHIP CRITERIA.—

(1) APPOINTED MEMBERS.—The Speaker of the House of Representatives jointly with the Majority Leader of the House of Representatives, the Majority Leader of the Senate jointly with the Minority Leader of the Senate, shall each appoint 1 member of the Working Group described in subparagraphs (A), (G), (J), (K), and (N) of paragraph (2).

(B) The remaining appointments of the members in each of such subparagraphs shall be divided equally such that the Speaker of the House of Representatives, jointly with the Minority Leader of the House of Representatives, and the Majority Leader of the Senate jointly with the Minority Leader of the Senate shall each appoint an equal number of members.

(2) CATEGORIES OF APPOINTED MEMBERS.—Members of the Working Group shall be appointed as follows:
(A) 2 members shall be patients or family members of patients who, at least 1 year prior to the date of enactment of this Act, have had no health insurance.
(B) 1 member shall be a representative of children.
(C) 1 member shall be a representative of the mentally ill.
(D) 1 member shall be a representative of the disabled.
(E) 1 member shall be over the age of 65 and a beneficiary under the Medicare program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).
(F) 1 member shall be a recipient of benefits under the Medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.).
(G) 2 members shall be State health officials.
(H) 3 members shall be employers, including—
(i) 1 large employer (an employer who employed an average of at least 50 employees on business days during the preceding calendar year and who employed at least 50 employees on the first of the year);
(ii) 1 small employer (an employer who employed an average of at least 2 employees but less than 50 employees on business days in the preceding calendar year and who employed at least 2 employees on the first of the year); and
(iii) 1 multi-state employer.

(6) DEPARTMENT OF LONG-TERM CARE FACILITY OR PROVIDER.—Section 1128(e) (42 U.S.C. 1320a-7(e)(g)) is amended by adding at the end the following:
"(7) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated to carry out the amendments made by this subsection, $10,200,000 for fiscal year 2004.
(1) IDENTIFICATION AND TRAINING DEMONSTRATION PROJECT.—

(1) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish a demonstration program to provide grants to develop information on best practices in patient abuse prevention training (including behavioral health training and interventions) for managers and staff of hospital and health care facilities.

(2) ELIGIBILITY.—(To be eligible to receive a grant under paragraph (1), an entity shall be—
(A) a public or private nonprofit entity and prepare and submit to the Secretary of Health and Human Services an application at such time, in such manner, and containing such information as the Secretary may require.

(3) USE OF FUNDS.—(Amounts received under a grant shall be used to—
(A) examine ways to improve collaboration between State health care survey and provider certification agencies, long-term care ombudsmen programs, the long-term care industry, and local community members;
(B) examine patient care issues relating to regulatory oversight, community involvement, and the scope of care; and
(C) develop a patient abuse prevention training program by long-term care entities, including the training program developed by the National Association of Attorneys General, and the extent to which such programs are used.

(4) IDENTIFY AND DISSEminate—(To disseminate best practices for—
(A) examine abuse prevention training programs through medical bill potentially harming the economic stability of the entire family.

(5) COMMON LIFE OCCURRENCes—(Common life occurrences can jeopardize the ability of a family to retain private coverage or jeopardize access to public coverage.

(6) INNOVATIONS—(Innovations in health care access, coverage, and quality of care, including the use of technology, have often come from States, local communities, and private sector organizations, but more creative policies could tap this potential.

(7) DESPite—(Despite our Nation’s wealth, the health care system does not provide coverage to all Americans who want it.

(b) PURPOSES.—The purposes of this Act are—
(1) to provide for a nationwide public debate about improving the health care system to provide for an ability to obtain quality, affordable health care coverage; and
(I) 1 member shall be a representative of labor.
(II) 2 members shall be health insurance issuers.
(III) 1 member shall be health care providers.
(IV) 5 members shall be appointed as follows:
(i) 1 economist.
(ii) 1 academican.
(iii) 1 health policy researcher.
(iv) 1 individual with expertise in pharmacoeconomics.
(v) 1 health technology expert.
(M) 2 members shall be representatives of community leaders who have developed strategies or community solutions to the problems addressed by the Working Group.
(N) 1 member shall be a representative of a medical school.
(S) SECRETARY.—The Secretary, or the designee of the Secretary, shall be a member of the Working Group.
(F) PROHIBITED APPOINTMENTS.—Members of the Working Group shall not include members of Congress or other elected government officials (Federal, State, or local) other than those individuals specified in subsection (e).
To the extent such individuals appointed to the Working Group shall have used the health care system within the previous 2 years and shall not be paid employees or representatives of associations or advocacy organizations involved in the health care system.
(g) APPOINTMENT CRITERIA.—
(1) HOUSE OF REPRESENTATIVES.—The Speaker and Minority Leader of the House of Representatives shall make the appointments described in subsection (d) in consultation with the chairperson and ranking minority member of the following committees of the House of Representatives:
(A) The Committee on Ways and Means.
(B) The Committee on Energy and Commerce.
(C) The Committee on Education and the Workforce.
(2) SENATE.—The Majority Leader and Minority Leader of the Senate shall make the appointments described in subsection (d) in consultation with the chairperson and ranking minority member of the following committees of the Senate:
(A) The Committee on Finance.
(B) The Committee on Health, Education, Labor, and the Per diem equivalent of the rate provided under section 5315 of title 5, United States Code, for level IV of the Executive Schedule under the per diem equivalent of the rate provided under section 5315 of title 5, United States Code, for level IV of the Executive Schedule under the per diem equivalent of the rate provided under section 5315 of title 5, United States Code, for level IV of the Executive Schedule under the per diem equivalent of the rate provided under section 5315 of title 5, United States Code, for level IV of the Executive Schedule under the per diem equivalent of the rate provided under section 5315 of title 5, United States Code, for level IV of the Executive Schedule under the per diem equivalent of the rate provided under section 5315 of title 5, United States Code, for level IV of the Executive Schedule under the per diem equivalent of the rate provided under section 5315 of title 5, United States Code, for level IV of the Executive Schedule under the per diem equivalent of the rate provided under section 5315 of title 5, United States Code, for level IV of the Executive Schedule under the per diem equivalent of the rate provided under section 5315 of title 5, United States Code, for level IV of the Executive Schedule under the per diem equivalent of the rate provided under section 5315 of title 5, United States Cod.
(h) PERIOD OF APPOINTMENT.—Members of the Working Group shall be appointed for a term of 2 years. Such term is renewable and any vacancy shall affect the power and duties of the Working Group but shall be filled in the same manner as the original appointment.
(i) APPOINTMENT OF THE CHAIRPERSON.—Not later than 15 days after the date on which all members of the Working Group have been appointed under subsection (d), the leadership of the chairperson of the Working Group shall make the chairperson of the Working Group. If the leadership fails to make such designation within such time period, the Working Group Members shall, not later than 10 days after the end of such time period, designate a chairperson by majority vote.
(j) SUBCOMMITTEES.—The Working Group may establish subcommittees if doing so increases the efficiency of the Working Group in completing its tasks.
(k) DUTIES.—
(1) APPOINTMENT OF THE CHAIRPERSON.—Not later than 90 days after the date of appointment of the chairperson under subsection (i), the Working Group shall hold hearings to examine:
(A) the capacity of the public and private health care systems to expand coverage options;
(B) the cost of health care and the effectiveness of care provided at all stages of disease;
(C) innovative State strategies used to expand health care coverage and lower health care costs;
(D) local community solutions to accessing health care coverage;
(E) efforts by individuals currently eligible for public or private health care coverage;
(F) the role of evidence-based medical practices that can be documented as restoring, maintaining, or improving a patient's health, and the use of technology in supporting practices that improve quality of care and lowering costs; and
(G) strategies to assist purchasers of health care, including consumers, to become more aware of the impact of costs, and to lower the costs of health care.
(2) ADDITIONAL HEARINGS.—The Working Group may hold additional hearings on subjects other than those listed in paragraph (1) so long as such hearings are determined to be necessary by the Working Group in carrying out the purposes of this Act. Such additional hearings shall be completed within the time period specified in paragraph (1) but shall not delay the other activities of the Working Group under this section.
(3) THE HEALTH REPORT TO THE AMERICAN PEOPLE.—Not later than 90 days after the hearings described in paragraphs (1) and (2) are completed, the Working Group shall prepare and make available to health care consumers through the Internet and other appropriate public channels, a report to be entitled, "The Health Report to the American People". Such report shall be understandable to the general public and include—
(A) a summary of:
(i) health care and related services that may be used by individuals throughout their life span;
(ii) the cost of health care services and their medical effectiveness in providing better quality of care for different age groups;
(iii) the source of coverage and payment, including reimbursement, for health care services;
(iv) the reasons people are uninsured or underinsured and the cost to taxpayers, purchasers of health services, and consumers when Americans are uninsured or underinsured;
(v) the impact on health care outcomes and costs when individuals are treated in all stages of disease;
(vi) health care cost containment strategies; and
(vii) information on health care needs that need to be addressed;
(B) examples of community strategies to provide health care access;
(C) information on geographic-specific issues relating to health care;
(D) information concerning the cost of care in different settings, including institutional-based care and home and community-based care;
(E) a summary of ways to finance health care coverage; and
(F) the role of technology in providing future health care including ways to support the information needs of patients and providers.
(4) COMMUNITY MEETINGS.—
(A) IN GENERAL.—Not later than 1 year after the date of enactment of this Act, the Working Group shall initiate health care community meetings throughout the United States (in this section referred to as "community meetings"). Such community meetings may be geographically or regionally based and shall be completed within 180 days after the initiation of the first meeting.
(B) NUMBER OF MEETINGS.—The Working Group shall hold a sufficient number of community meetings in order to receive information that reflects—
(i) the geographic differences throughout the United States;
(ii) diverse populations; and
(iii) a balance among urban and rural populations.
(C) MEETING REQUIREMENTS.—
(i) FACILITATOR.—A State health officer may be the facilitator at the community meetings.
(ii) ATTENDANCE.—At least 1 member of the Working Group shall attend and serve as chair of each community meeting.
(iii) TOPICS.—The community meetings shall, at a minimum, address the following issues:
(I) The optimum way to balance costs and benefits so that affordable health coverage is available to as many people as possible.
(ii) The identification of services that provide cost-effective, essential health care services to maintain and improve health and which should be included in health care coverage;
(iii) The cost of providing increased benefits.
(iv) The mechanisms to finance health care coverage, including defining the appropriate financial role for individuals, businesses, and government.
(iv) INTERACTIVE TECHNOLOGY.—The Working Group may encourage public participation in community meetings through interactive technology and other means as determined appropriate by the Working Group.
(c) DURATION REQUIREMENTS.—Public community meetings may not last longer than 180 days after the date of completion of the community meetings, the Working Group shall prepare and make available to the public through the Internet and other appropriate public channels, an interim set of recommendations on health care coverage and ways to improve and strengthen the health care system based on the information and preferences expressed at the community meetings. There shall be a 90-day public comment period on such recommendations.
(d) RECOMMENDATIONS.—Not later than 120 days after the expiration of the public comment period described in subsection (k)(4)(D), the Working Group shall submit to the Congress and the President a final set of recommendations.
(m) ADMINISTRATION.—
(1) EXECUTIVE DIRECTOR.—There shall be an Executive Director of the Working Group who shall be appointed by the chairperson of the Working Group in consultation with the members of the Working Group.
(2) COMPENSATION.—While serving on the business of the Working Group (including travel time), a member of the Working Group shall be entitled to compensation at the rates provided equivalent to level IV of the Executive Schedule under section 5315 of title 5, United States Code, and while so serving away from home and the member's regular place of business, a member may be allowed travel expenses, as authorized by the chairperson of the Working Group.
(3) INFORMATION FROM FEDERAL AGENCIES.—The Working Group may secure directly from any Federal department or agency such information as the Working Group considers necessary to carry out this Act. Upon request of the Working Group, the head of such department or agency shall furnish such information.
monitoring system in cooperation with the CMS Mississippi Quality Improvement Organization, Information Healthcare, and the University of Mississippi.

SA 1108. Mr. DURBIN proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

SEC. 4. ADDITIONAL ASSISTANCE FOR CERTAIN ELIGIBLE BENEFICIARIES UNDER PART D.

Section 1860D-26, as added by section 101, is amended by adding at the end the following:

"(d) ADDITIONAL ASSISTANCE FOR CERTAIN ELIGIBLE BENEFICIARIES.—

(1) PROGRAM.—Subject to paragraph (2), the Administrator shall implement a program (for the period beginning on January 1, 2009, and ending on September 30, 2013) to provide additional assistance to applicable eligible beneficiaries who have reached the initial coverage limit described in section 1860D-6(c)(3) for the year but have not reached the annual out-of-pocket limit under section 1860D-6(b) for the year in order to reduce the cost-sharing requirement during this coverage gap.

(2) FUNDING LIMITATION.—The Administrator may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5318 of such title.

(p) ANNUAL REPORT.—Not later than 1 year after the date of enactment of this Act, and annually thereafter during the existence of the Working Group, the Working Group shall report to the President and make a public in- tailed description of the expenditures of the Working Group used to carry out its duties under this section.

(q) SUNSET OF WORKING GROUP.—The Working Group shall terminate when the report described in subsection (i) is submitted to Congress.

(r) ADMINISTRATION REVIEW AND COMMENTS.—Not later than 45 days after receiving the final recommendations of the Working Group submitted under subsection (i), the President shall submit a report to Congress which shall contain—

(1) additional views and comments on such recommendations; and

(2) recommendations for legislation and administrative actions as the President considers appropriate.

(s) REQUIRED CONGRESSIONAL ACTION.—Not later than 45 days after receiving the report submitted by the President under subsection (r), each committee of jurisdiction of Congress shall hold at least 1 hearing on such report and on the final recommendations of the Working Group submitted under subsection (i).

(t) AUTHORIZATION OF APPROPRIATIONS.—

(1) IN GENERAL.—There are authorized to be appropriated to carry out this Act, other than subsection (k)(3), $3,000,000 for each of fiscal years 2009 and 2008.

(2) HEALTH REPORT TO THE AMERICAN PEOPLES.—There are authorized to be appropriated for the preparation and dissemination of the Health Report to the American People described in subsection (k)(3), such sums as may be necessary for the fiscal year in which the report is required to be submitted.

SA 1107. Mr. COCHRAN submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, add the following:

SEC. 1. AUTHORIZATION OF APPROPRIATIONS TO CONTINUE THE EXISTING CMS MEDICATION MONITORING SYSTEM.

There are authorized to be appropriated such sums as are necessary to continue the Prescription Continuity of Care medication

SA 1114. Mr. KYL submitted an amendment intended to be proposed by
him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the appropriate place, insert the following:

**SEC. 2. SENSE OF THE SENATE CONCERNING MEDICARE PAYMENT UPDATE FOR PHYSICIANS AND OTHER HEALTH PROFESSIONALS.**

(a) FINDINGS.—The Senate makes the following findings:

(1) The formula by which Medicare payments are updated each year for services furnished by physicians and other health professionals is fundamentally flawed.

(2) The flawed physician payment update formula is causing a continuing physician payment crisis, and, without Congressional action, Medicare payment rates for physicians and other practitioners are predicted to fall by 4.2% in 2002.

(3) A physician payment cut in 2004 would be the fifth cut since 1991, and would be on top of a 5.5% cut in 2002, with additional cuts estimated for 2005, 2006, and 2007; from 1991-2003, payment rates for physicians and health professionals fell 14%; behind practice cost inflation as measured by Medicare’s own conservative estimates.

(b) SENSE OF THE SENATE.—It is the Senate’s sense that Medicare beneficiary access to quality care may be compromised if Congress does not take action to prevent cuts next year and the following result that from the SGR formula.

**SA 1116. Mr. DAYTON (for himself, Mr. COLEMAN, and Mr. SMITH) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:**

**SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES.**

Section 1337(a) (42 U.S.C. 1395m(a)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraph:

"(10) Temporary increase for ground ambulance services.—

(A) In general.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, for which the fee schedule established under this section with respect to such item or service promptly (as determined in accordance with regulations) otherwise established, shall be increased by 21.5 percent.

(B) Additional increase for services furnished in a rural area.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2007, for which the transportation originates in a rural area defined in accordance with regulations, the payment rate for mileage, shall provide that such rates otherwise established, shall be increased by 21.5 percent.

21.5 percent.

"(C) Determination of rural areas based on population density within postal zip code areas.

With respect to ambulance services described in subparagraph (B), during the period described in that subparagraph, paragraph (b) shall be applied by substituting in the definition of "rural census tract of a metropolitan statistical area" (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725)). Not later than December 31, 2003, the Secretary, taking into account the recommendations contained in the report submitted under section 221(b)(3) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, shall implement the increase in payment required under subparagraph (B) and shall establish the classification system required by the application of this subparagraph. The Secretary shall provide such increased payment for services furnished on or after the earlier of 30 days after the establishment of such classification system or December 31, 2003.

(2) Application of increased payments after 2007.—The increased payments under subparagraphs (A) and (B) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.

(3) Conversion factor adjustments.—

The Secretary shall adjust downward the conversion factor in any year because of an evaluation of the prior year conversion factor.

"(d) Technical Amendment Concerning Secretary’s Authority to Make Conditional Payment When Certain Primary Plans Do Not Pay Promptly.—

(1) in general.—Section 1832(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

* (A) in subparagraph (A)(ii), by striking "promptly (as determined in accordance with regulations)";

* (B) in subparagraph (B)——

* (i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

* (ii) by inserting before clause (ii), as so redesignated, the following clause:

"(1) Authority to make conditional payment. The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(i) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the provisions of subsection (b) of such section."

(2) Effective date.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

"(b) Clarifying Amendments to Conditional Payment Subsection.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is further amended—

(1) in subparagraph (A), in the matter following sentence at the end: "An entity that engages in a business, trade, or profession shall be
deemed to have a self-insured plan if it carries its own risk (whether by a failure to obtain insurance, or otherwise) in whole or in part.

(2) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B)—

(A) by striking the first sentence and inserting the following: ‘‘A primary plan, and an employer or other person payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to any item or service furnished by a Medicare Beneficiary if the appropriate Trust Fund demonstrates that such primary plan has or had a responsibility to make payment with respect to such item or service at the primary plan’s responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient’s compromise, waiver, settlement, or not (or a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means.’’;

and

(B) in the final sentence, by striking ‘‘on the date such notice or other information is received from the appropriate Trust Fund, or information related to, a primary plan’s responsibility for such payment or other information is received’’ and inserting ‘‘on the date such notice or other information is received from the appropriate Trust Fund, or otherwise’’;

(3) in paragraph (4)(A)—

(ii) in the clause beginning ‘‘the failure of the core health care safety net to continue their roles in the core health care safety net system to care for uninsured individuals’’ by striking ‘‘and Medicare beneficiaries, and other vulnerable populations’’ and inserting ‘‘and other vulnerable populations’’;

(4) in subparagraph (B)—

(i) by striking ‘‘a primary plan has or had a responsibility to make payment with respect to such item or service if it is demonstrated that such a failure on the community;’’;

(ii) by inserting at the end the following: ‘‘sequences of such failures and the impact of such a failure on the community;’’;

(5) in paragraph (8)—

(A) by striking ‘‘to document and analyze the effectiveness of changes in these programs on the core health care safety net programs (as described in paragraph (3)(C)) by—’’;

‘‘(A) monitoring each health care safety net program to document and analyze the effectiveness of these programs on the core health care safety net;’’;

‘‘(B) evaluating the impact of the Emergency Medical Treatment and Labor Act, the Health Insurance Portability and Accountability Act of 1996, the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999, the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, or any other law that affects the capacity of the core health care safety net to continue their roles in the core health care safety net system to care for uninsured individuals, Medicare beneficiaries, and other vulnerable populations;’’;

‘‘(C) monitoring existing data sets to assess the status of the core health care safety net and health outcomes for vulnerable populations;’’;

(D) wherever possible, linking and integrating existing data systems to enhance the ability of the core health care safety net to track changes in the status of the core health care safety net and health outcomes for vulnerable populations;

(6) in subparagraph (D)—

(i) by striking ‘‘(I) monitoring and providing oversight for the transition of individuals receiving supplemental security income benefits, medical assistance under title XIX, and other vulnerable populations;’’;

(ii) by inserting before ‘‘(II) monitoring and providing oversight’’ the following: ‘‘(i) the degree to which health plans have the capacity (including case management and management information system infrastructure) to manage the care of managed care services to such an individual;’’;

(iii) by inserting at the end the following: ‘‘(iv) the degree to which emergency department services are used by enrollees of these plans; and’’;

(iv) by inserting at the end the following: ‘‘(v) identifying and disseminating the best practices for more effective application of the lessons that have been learned. ’’;

(7) in paragraph (9)—

(A) by striking ‘‘a primary plan has or had a responsibility to make payment with respect to such item or service if it is demonstrated that such a failure on the community;’’;

(B) by inserting at the end the following: ‘‘sequences of such failures and the impact of such a failure on the community;’’;

(8) in subparagraph (b)—

(A) by striking ‘‘The Commission shall submit to the Comptroller General and the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.’’;

(B) by inserting at the end the following: ‘‘(2) DEFINITIONS.—In this section—’’;

(9) in paragraph (c)—

(A) by inserting at the end the following: ‘‘The term ‘core health care safety net’ means any health care program that the Commission determines to be appropriate.’’;

(B) by inserting at the end the following: ‘‘The term ‘vulnerable populations’ includes uninsured and underinsured individuals, low-income individuals, farm workers, homeless individuals, individuals with disabilities, individuals with HIV or AIDS, and such other individuals as the Commission may designate.’’

SA 1117. Mr. BAUCUS submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

At the end of title VI, add the following:

SEC. 1181. (a) ESTABLISHMENT.—There is hereby established the Safety Net Organizations and Patient Advisory Commission.

(b) REVIEW OF HEALTH CARE SAFETY NET PROGRAMS.—(1) ANNUAL REPORTS.—Not later than June 1 of each year, until 2005, the Commission shall, based on the review conducted under paragraph (1), submit to the appropriate committees of Congress a report on—

(i) the health care needs of the uninsured; and

(ii) the financial and infrastructure stability of the Nation’s core health care safety net.

(2) AGENDA AND ADDITIONAL REVIEWS.—

(A) AGENDA.—The Chair of the Commission shall consult periodically with the Chairpersons and Ranking Minority Members of the appropriate committees of Congress regarding the Commission’s agenda and progress toward achieving the agenda.

(B) ADDITIONAL REVIEWS.—The Commission shall conduct additional reviews and submit additional reports to the appropriate committees of Congress on topics relating to the health care safety net programs under the following circumstances:

(i) if requested by the Chairpersons or Ranking Minority Members of such committees.

(ii) if the Commission deems such additional reviews and reports necessary.

(iii) if the Commission deems such additional reviews and reports necessary.

(iv) if the Commission deems such additional reviews and reports necessary.

(v) if the Commission deems such additional reviews and reports necessary.

(vi) if the Commission deems such additional reviews and reports necessary.

(vii) if the Commission deems such additional reviews and reports necessary.

(viii) if the Commission deems such additional reviews and reports necessary.

(ix) if the Commission deems such additional reviews and reports necessary.

(x) if the Commission deems such additional reviews and reports necessary.

(xi) if the Commission deems such additional reviews and reports necessary.

(xii) if the Commission deems such additional reviews and reports necessary.

(xiii) if the Commission deems such additional reviews and reports necessary.

(xiv) if the Commission deems such additional reviews and reports necessary.

(xv) if the Commission deems such additional reviews and reports necessary.

(xvi) if the Commission deems such additional reviews and reports necessary.

(xvii) if the Commission deems such additional reviews and reports necessary.

(xviii) if the Commission deems such additional reviews and reports necessary.

(xix) if the Commission deems such additional reviews and reports necessary.

(xx) if the Commission deems such additional reviews and reports necessary.

(2) DEFINITIONS.—In this section—

(A) APPROPRIATE COMMITTEES OF CONGRESS.—The term ‘appropriate committees of Congress’ means the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committee on Finance, Education, Labor, and Pensions of the Senate.

(B) CORE HEALTH CARE SAFETY NET.—The term ‘core health care safety net’ means any health care program that the Commission determines to be appropriate.

(C) HEALTH CARE SAFETY NET PROGRAMS.—The term ‘health care safety net programs’ includes the following:

(i) SCHIP.—The State children’s health insurance program under title XXI.

(ii) MICHIGAN.—The medicaid program under title XIX.

(iii) SCHIP.—The State children’s health insurance program under title XXI.

(iv) SCHIP.—The State children’s health insurance program under title XXI.

(v) SCHIP.—The State children’s health insurance program under title XXI.

(vi) SCHIP.—The State children’s health insurance program under title XXI.

(vii) SCHIP.—The State children’s health insurance program under title XXI.

(viii) SCHIP.—The State children’s health insurance program under title XXI.

(ix) SCHIP.—The State children’s health insurance program under title XXI.

(x) SCHIP.—The State children’s health insurance program under title XXI.

(xi) SCHIP.—The State children’s health insurance program under title XXI.

(xii) SCHIP.—The State children’s health insurance program under title XXI.

(xiii) SCHIP.—The State children’s health insurance program under title XXI.

(xiv) SCHIP.—The State children’s health insurance program under title XXI.

(xv) SCHIP.—The State children’s health insurance program under title XXI.

(xvi) SCHIP.—The State children’s health insurance program under title XXI.

(xvii) SCHIP.—The State children’s health insurance program under title XXI.

(xviii) SCHIP.—The State children’s health insurance program under title XXI.

(xix) SCHIP.—The State children’s health insurance program under title XXI.

(xx) SCHIP.—The State children’s health insurance program under title XXI.

(3) REPORTS.—Each federal fund program under which a health center (as defined in section 330(c)(1) of the Public Health Service Act), a Federally qualified health center (as defined in section 1861(aa)(4), or a Federally-qualified health center (as defined in section 1865(2)(B)) receives funds.

(4) PAYMENT PROGRAMS.—Each federal fund program under which a rural health clinic (as defined in section 1861(aa)(4) or 1905(h)) receives funds.

(5) DISH PAYMENT PROGRAMS.—Each federal fund program under which a rural health clinic (as defined in section 1861(aa)(4) or 1905(h)) receives funds.

(6) VULNERABLE POPULATIONS.—The term ‘vulnerable populations’ includes uninsured and underinsured individuals, low-income individuals, farm workers, homeless individuals, individuals with disabilities, individuals with HIV or AIDS, and such other individuals as the Commission may designate.

(7) COMMITTEE.—The Chairpersons and Ranking Minority Members of such committees.
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“(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 13 members appointed by the Comptroller General of the United States (in this section referred to as the ‘Chair’). In composing the Commission, the Chair shall be subject to periodic audit by the General Accounting Office.

“(2) QUALIFICATIONS.—

“(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, health care safety net research and program management, actuarial science, health facility management, health plans and integrated delivery systems, management of health facilities, allopathic and osteopathic medicine (including emergency medicine), and other providers of health services, and other related fields.

“(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

“(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under the health care safety net programs shall not constitute a majority of the membership of the Commission.

“(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

“(3) TERMS.—

“(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that of the members first appointed, the Comptroller General shall designate—

“(i) four to serve a term of 1 year;

“(ii) four to serve a term of 2 years; and

“(iii) five to serve a term of 3 years.

“(B) ACCRUAL OF VACANCIES.—A vacancy shall be filled in the same manner in which the member whose term has expired was appointed.

“(C) APPOINTMENT.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member whose term has expired was appointed shall be appointed only for the remainder of that term.

“(D) TERMS.—A member may serve after the expiration of that member’s term until a successor has taken office.

“(4) COMPENSATION.—

“(A) IN GENERAL.—A vacancy in the Commission shall be filled in the same manner in which the member whose term has expired was appointed.

“(B) APPOINTMENT.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member whose term has expired was appointed shall be appointed only for the remainder of that term.

“(C) Terms.—A member may serve after the expiration of that member’s term until a successor has taken office.

“(5) MEETINGS.—The Commission shall meet at the call of the Chair or upon the written request of a majority of its members.

“(6) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General determines necessary to ensure the efficient administration of the Commission, the Commission may—

“(i) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out the duties of the Commission under this section.

“(ii) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes);

“(iii) six to serve a term of 2 years; and

“(iv) meet make advance, progress, and other payments which relate to the work of the Commission;

“(B) REQUEST OF CHAIR.—Upon request of the Chair, the head of that department or agency shall furnish that information to the Commission on an agreed-upon schedule.

“(2) DATA COLLECTION.—In order to carry out the duties of the Commission under this section, the Commission shall—

“(A) use existing information, both published and unpublished, where possible, collected or published by the Comptroller General or other arrangements made in accordance with this section;

“(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

“(C) adopt procedures allowing any interested party to submit information to the Commission’s use in making reports and recommendations.

“(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data that pertain to the work of the Commission, immediately upon request. The expectations of such information shall be borne by the General Accounting Office.

“(4) PERIOD OF AUDIT.—The Commission shall be subject to a routine audit by the Comptroller General.

“(5) APPLICATION OF FACA.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Commission.

“(6) AUTHORIZATION OF APPROPRIATIONS.—

“(A) IN GENERAL.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appropriations, but amounts appropriated for the Commission shall be separate from amounts appropriated for the Comptroller General.

“(B) EFFECTIVE DATE.—The Comptroller General of the United States shall appoint the initial members of the Safety Net Organizations and Patient Advisory Commission established under section 4106 of title 5, United States Code, governing appointments in the competitive service.

“(2) seek such assistance and support as may be required in the performance of the duties of the Commission under this section from appropriate Federal departments and agencies;

“(3) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes);

“(4) make advance, progress, and other payments which relate to the work of the Commission;

“(5) provide transportation and subsistence for persons serving without compensation; and

“(6) prescribe such rules and regulations as it deems necessary with respect to the internal organization and operation of the Commission.

“(e) POWERS.—

“(1) OBTAINING OFFICIAL DATA.—

“(A) IN GENERAL.—The Commission may secure directly from any department or agency of the United States information necessary for the Commission to carry the duties under this section.

“(B) REQUEST OF CHAIR.—Upon request of the Chair, the head of that department or agency shall furnish that information to the Commission on an agreed-upon schedule.

“(2) DATA COLLECTION.—In order to carry out the duties of the Commission under this section, the Commission shall—

“(A) use existing information, both published and unpublished, where possible, collected or published by the Comptroller General or other arrangements made in accordance with this section;

“(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

“(C) adopt procedures allowing any interested party to submit information to the Commission’s use in making reports and recommendations.

“(3) ACCESS OF GAO TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data that pertain to the work of the Commission, immediately upon request. The expectations of such information shall be borne by the General Accounting Office.

“(4) PERIOD OF AUDIT.—The Commission shall be subject to a routine audit by the Comptroller General.

“(5) APPLICATION OF FACA.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Commission.

“(6) AUTHORIZATION OF APPROPRIATIONS.—

“(A) IN GENERAL.—The Commission shall submit requests for appropriations in the same manner as the Comptroller General submits requests for appro-
SA 1119. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve drug benefit under the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

Strike section 443 and insert the following:

SEC. 443. MEDICARE COVERAGE OF CARE COORDINATION AND ASSESSMENT SERVICES.

(a) PART B COVERAGE OF CARE COORDINATION AND ASSESSMENT SERVICES.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking "and" at the end;

(2) in subparagraph (V)(iii), by adding "and" after the semicolon at the end; and

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

"(W) care coordination and assessment services (as defined in subsection (ww))."

(b) CARE COORDINATION AND ASSESSMENT SERVICES DEFINED.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

"Care Coordination and Assessment Services (ww)(1) The term 'care coordination and assessment services' means services that are furnished to an eligible individual (as defined in paragraph (2)) by a care coordinator (as defined in subsection (3)) under a plan of care prescribed by such care coordinator for the purpose of care coordination and assessment, which may include any of the following services:

(A) an initial assessment of an individual's medical status, functional capacity, and psychological needs and an annual assessment thereafter.

(B) management of transitions of care across practice settings and between providers.

(C) Coordination of, and referral for, medical and other health-related services, including—

(i) multidisciplinary care conferences;

(ii) coordination with other providers, including telephone consultations with physicians; and

(iii) monitoring and management of medications, with special emphasis on clients using specialty medications (including coordination with the entity managing benefits for the individual).

(D) Patient and family care-giver education and counseling (through office visits or telephone consultation), including self-management services and risk appraisal to identify behavioral risk factors through self assessment tools.

(E) Providing information about end of life care, including referral to hospice services, when appropriate, including patient and family education and counseling about hospice, and managing and facilitating transition to hospice when elected.

(F) Referral to and coordination with community resources.

(G) Such other services for which payment would not otherwise be made under this title as the Secretary shall determine to be appropriate including, but not limited to, activities to facilitate continuity of care and patient adherence to plans of care.

(2) PURPOSES.—For purposes of this subsection, the term 'eligible individual' means an individual who a care coordinator annually certifies that the individual has multiple chronic conditions that result in high use of Medicare services, high use of prescription medications, and high Medicare costs. Inability to manage one's own care due to cognitive impairment should be considered as an additional indicator of need for care coordination services.

(B) The average number of unique physician visits relative to geographic norms for all eligible beneficiaries.

(3) In general.—Section 1861(a)(1) of the Social Security Act (42 U.S.C. 1395l(a)(1)) is amended—

(A) by striking "and" before "(U)"; and

(B) by inserting after "(U)", "and (V) with respect to assessment services described in section 1861(a)(2)(W), the amounts paid shall be 100 percent of the lesser of the actual charge for the service or the amount determined under the payment basis determined under section 1848 by the Secretary for such service and an administrative fee shall be developed for care coordination services."

(2) PAYMENT UNDER PHYSICIAN PER SCHEDULE.—Section 1848(c)(3) of the Social Security Act (42 U.S.C. 1395l(a)(3)) is amended—

(A) by inserting after "(2)(W)," after "(2)(S)"); and

(B) by inserting after "(1)(A)" the following: 

"with respect to care coordination and assessment services (as defined in section 1861(ww)(1));"

(3) ELIMINATION OF CONSIDERATION OF SMS IN OUT-PATIENT HOSPITAL SETTINGS.—The third sentence of section 1861(a)(2)(A) of the Social Security Act (42 U.S.C. 1395l(a)(2)(A)) is amended by inserting after "(1)(A)" the following: 

"with respect to care coordination and assessment services (as defined in section 1861(ww)(1));"

(4) APPLICATION OF LIMITS ON BILLING.—Section 1842(b)(18)(C) of the Social Security Act (42 U.S.C. 1395l(b)(18)(C)) is amended by adding at the end the following new clause: 

"(VII) A care coordinator (as defined in section 1861(ww)(3)) that is not a physician;"

(5) EXCEPTION TO LIFE SUPPORT SERVICES.—Section 1877(b) of the Social Security Act (42 U.S.C. 1395n(mm)) is amended—

(A) by redesignating paragraph (4) as paragraph (5); and

(B) by inserting after paragraph (3) the following new paragraph:

"(4) PRIVATE SECTOR PURCHASING AND QUALITY IMPROVEMENT TOOLS FOR ORIGINAL MEDICARE.—In the case of a designated health service, if the designated health service is—

(A) a care coordination and assessment service (as defined in section 1861(ww)(1)); and

(B) provided by a care coordinator (as defined in paragraph (3)) that is not a physician, the Secretary shall define such terms
SEC. 426. TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.

Section 183(h)(4) (42 U.S.C. 1395m(h)(4)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraph:

"(10) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES.—

"(A) IN GENERAL.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2006, for which the transportation originates in—

"(i) a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section shall provide that the rate for the service otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent; and

"(ii) an area not described in clause (i), the fee schedule established under this section shall provide that the rate for the service otherwise established shall be increased by 2 percent.

"(B) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.

SA 1120. Mr. DAYTON (for himself, Mr. COLEMAN, and Mr. SMITH) submitted an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for voluntary prescription drug benefit for Medicare plans to provide the best quality health care to seniors at the most affordable price.

SECTION 1120. Provide that government contributions used to support Medicare Advantage plans are based on market principles beginning in 2008 to ensure the long-term solvency of such options for America's seniors.

Mr. SENATOR FROM MINNESOTA. It is the Sense of the Senate that Medicare reform legislation should:

(1) Ensure that prescription drug coverage is directed to those who need it most;

(2) Provide that government contributions used to support Medicare Advantage plans are based on market principles beginning in 2008 to ensure the long-term solvency of such options for America's seniors;

(3) Develop a payment system for the Medicare Advantage preferred provider organizations that is similar to the payment system used for the national preferred provider organizations in the Federal Employees Health Benefits Program has existed for 43 years with minimal changes from Congress;

(4) Incorporate private sector, market-based elements, that do not rely on the inefficient Medicare price control structure.

(5) Keep the cost of new unfunded obligations within the $400 billion provided for under the current Congressional Budget Resolution for implementing Medicare reform and providing a prescription drug benefit.

(6) Incorporate regulatory reform proposals to eliminate red tape and reduce costs.

(7) Restore the right of Medicare beneficiaries and their doctors to work together to provide services, allow private fee for service plans to set their own premiums, and permit seniors to add their own dollars beyond the government contribution.
SEC. 4. RURAL COMMUNITY HOSPITAL DEMONSTRATION PROGRAM.

(a) Establishment of Rural Community Hospital (RCH) Demonstration Program.—

(1) The Secretary shall establish a demonstration program to test the feasibility and advisability of the establishment of rural community hospitals that furnish rural community hospital services to Medicare beneficiaries.

(2) Designation of RCCHs.—

(A) Application.—Each hospital that is located in a demonstration area described in subparagraph (C) that desires to participate in the demonstration program under this section shall submit an application to the Secretary containing such information as the Secretary may require.

(B) Designation.—The Secretary shall designate any hospital that is located in a demonstration area described in subparagraph (C), submits an application in accordance with subparagraph (A), and meets the other requirements of this section as a rural community hospital for purposes of the demonstration program.

(C) Demonstration Areas.—There shall be four demonstration areas within this program. Two of these demonstration areas described in this subparagraph shall include Kansas and Nebraska.

(D) Duration.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(4) Implementation.—The Secretary shall implement the demonstration program not later than January 1, 2005, and may not implement the program before October 1, 2004.

(8) Removing Barriers to Establishment of Distinct Part Units by RCCH Facilities.—Notwithstanding section 1866(d)(1)(B) of the Social Security Act (42 U.S.C. 1395ww(d)(1)(B)), the Secretary shall permit rural community hospitals to establish distinct part units for purposes of applying such section.

(b) Amount of Payment Provided for Inpatient Hospital Services furnished by a qualified RCCH-based hospital for Medicare beneficiaries.

(1) In general.—The amount of cost-sharing that would apply to items or services furnished by a provider, or supplier, cost-sharing shall apply.

(2) For Inpatient Hospital Services.—The amount of payment under the demonstration program for inpatient hospital services furnished in a rural community hospital for payment of a hospital in the application referred to in subparagraph (a)(2)(A)—

(A) the reasonable costs of providing such services, without regard to the amount of the customary or other charge; or

(B) the amount of payment provided for under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww(d)(1)(U)); or

(c) Amount of Payment Provided for Outpatient Services furnished by a qualified RCCH-based hospital for Medicare beneficiaries.

(1) In general.—For purposes of paragraphs (1)(B), (2), and (3) of section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v)), the amount of cost-sharing determined under paragraph (8) of such section does not include any cost-sharing that would have paid if the demonstration program under this section did not apply.

(4) Exemption from 30 percent reduction in reimbursement for bad debt.—In determining the reasonable costs for rural community hospitals, section 1861(v)(1)(I) of the Social Security Act (42 U.S.C. 1395x(v)(1)(I)) shall not apply.

(5) Beneficiary cost-sharing for outpatient services.—The amounts of beneficiary cost-sharing for outpatient services furnished in a rural community hospital under the demonstration program shall be as follows:

(A) For items and services that would have been paid under section 1833(g)(1) of the Social Security Act (42 U.S.C. 1395f(bb)(1)) if furnished by a hospital, the amount of cost-sharing determined under paragraph (8) of such section.

(B) For items and services that would have been paid under section 1833(h) of such Act (42 U.S.C. 1395f(bb)(1)), subject to subparagraph (C), if furnished by a provider or supplier, no cost-sharing shall apply.

(6) For inpatient hospital services furnished in a rural community hospital for payment of a hospital in the application referred to in subparagraph (a)(2)(A)—

(A) the reasonable costs of providing such services, without regard to the amount of the customary or other charge; or

(B) the amount of payment provided for under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww(d)(1)(U)); or

(c) Inpatient hospital services furnished by a qualified RCCH-based hospital for Medicare beneficiaries.

(1) In general.—The amount of payment under the demonstration program for inpatient hospital services furnished in a rural community hospital, other than services furnished in a psychiatric or rehabilitation unit of the hospital which is a distinct part, is, at the election of the hospital, the amount of cost-sharing determined under paragraph (8) of such section.

(D) Inclusion of CAHS.—Nothing in this section shall be construed as prohibiting any hospital from qualifying as a rural community hospital if it is a critical access hospital from qualifying as a rural community hospital.

(E) Determination of hospital status.—For the purposes of paragraphs (1)(B), (2), and (3) of section 1861(v) of the Social Security Act (42 U.S.C. 1395x(v)), the amount of cost-sharing determined under paragraph (8) of such section does not include any cost-sharing that would have paid if the demonstration program under this section did not apply.

(F) Reporting.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, including with recommendations for legislative and administrative action as the Secretary determines to be appropriate.

(G) Definitions.—In this section:

(1) Rural Community Hospital.—The term ‘rural community hospital’ means a hospital (as defined in section 1861(g) of the Social Security Act (42 U.S.C. 1395x(e))) that is located in a rural area (as defined in section 1866(d)(2)(D) of such Act (42 U.S.C. 1395ww(d)(2)(D))) or treated as being so located pursuant to section 1866(b)(4)(E) of such Act (42 U.S.C. 1395ww(d)(4)(E));

(ii) subject to subparagraph (B), has less than 51 acute care inpatient beds, as reported in its most recent cost report;

(iii) makes available 24-hour emergency care services;

(iv) subject to subparagraph (C), has a provider agreement in effect with the Secretary and has been open to the public as of January 1, 2003; and

(v) applies to the Secretary for such designation.

(B) Treatment of Psychiatric and Rehabilitation Units.—For purposes of paragraph (1)(B), beds in a psychiatric or rehabilitation unit of the hospital which is a distinct part of the hospital shall not be counted.

(C) Types of Hospitals That May Participate.—Subparagraph (1)(D) shall not be construed to prohibit any hospital from qualifying as a rural community hospital.

(i) A replacement facility (as defined by the Secretary in regulations in effect on January 1, 2003) that was designated by the Secretary at such time, in such manner, and containing such information as the Secretary determines to be appropriate.

(j) A facility which has a binding written agreement with an outside, unrelated party for the construction, reconstruction, lease, sale, mortgage, or financing of a building as of January 1, 2003.

(K) Inclusion of Critical Access Hospitals.—Nothing in this subsection shall be construed as prohibiting a critical access hospital from qualifying as a rural community hospital if the critical access hospital meets the conditions otherwise applicable to hospitals under section 1861 of the Social Security Act (42 U.S.C. 1395x(e)) and section 1866 of such Act (42 U.S.C. 1395cc).

(2) Qualified RCCH-based Home Health Agencies.—The term ‘qualified RCCH-based home health agency’ is a home health agency that is a provider-based entity (as defined in section 906 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Public Law 106-554; Appendix F, 114 Stat. 2763A-506)) of a rural community hospital that is located in a demonstrated area and has been open to the public as of January 1, 2003; or

(j) Waiver Authority.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purposes of carrying out the demonstration program under this section.
(B) at least 35 miles from any main or branch office of another health agency.  

SEC. 500. SHORT TITLE.  

(a) Sense of the Senate.—It is the sense of the Senate that medicare beneficiaries should have a choice among multiple types of health plans under the MedicareAdvantage program, including regional preferred provider organizations and local health maintenance organization plans in markets where such plans naturally occur.  

(b) Establishment of Standards.—The Secretary shall establish standards with respect to the participation of private health plans in the MedicareAdvantage program under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w–21 et seq.) that—  

(1) encourage fair competition among such plans;  

(2) ensure that beneficiaries who desire to elect health benefits coverage under such a plan provided with benefits that are actuarially equivalent to the benefits provided under other beneficiary options for health benefits coverage available under the medicare program; and  

(3) equally apply incentives to promote health plan participation to all plans desiring to participate in the MedicareAdvantage program.  

(c) Sense of the Senate.—It is the sense of the Senate that medicare beneficiaries should have a choice among multiple types of health plans under the MedicareAdvantage program, including regional preferred provider organizations and local health maintenance organization plans in markets where such plans naturally occur.  

(d) Encourage fair competition among such plans;  

(e) Ensure that beneficiaries who desire to elect health benefits coverage under such a plan provided with benefits that are actuarially equivalent to the benefits provided under other beneficiary options for health benefits coverage available under the medicare program; and  

(f) Equally apply incentives to promote health plan participation to all plans desiring to participate in the MedicareAdvantage program.  

SEC. 1125. Mr. HATCH submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the medicare program and to strengthen and improve the medicare program, and for other purposes; which was ordered to lie on the table; as follows:  

At the end of subtitle B of title IV, add the following:  

SEC. 500. ADDITIONAL TITLE.  

Subtitle A—Regulatory Reform  

This title may be cited as the “Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003”.  

SEC. 5001. ADDITIONAL TITLE.  

(a) Sense of the Senate.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as necessary for the purpose of carrying out the demonstration program under this section.  

(b) Return on equity.—In general.—Notwithstanding subparagraph (P)(i) and (S)(i) of section 1861(v)(1) of the Social Security Act (42 U.S.C. 1395x(v)(1)), the Secretary shall permit consolidated billing under section 1886 of the Social Security Act (42 U.S.C. 1395x(v)(1)) and section 1886(g) of such Act (42 U.S.C. 1395ww(g)(2)), in determining the reasonable costs of the services described in subparagraph (P)(i) of such Act (42 U.S.C. 1395x(v)(1)), the Secretary determines to be appropriate.
SEC. 501. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) No Retrospective Application of Substantive Changes.—

(1) In general.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

"(d) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied retroactively (or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

"(i) such retroactive application is necessary to comply with statutory requirements; or

"(ii) failure to apply the change retroactively would be contrary to the public interest.

(2) Effective date.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) Timeliness for Compliance with Substantive Changes.—

(1) In general.—Section 1871(d)(1), as added by subsection (a), is amended by adding at the end the following:

"(B) An application may be made against a provider of services, physician, practitioner, or other supplier with respect to noncompliance with such a substantive change for items and services furnished on or after the effective date of the change.

"(C)(i) Except as provided in clause (ii), a substantive change may not take effect until not earlier than the date that is the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

"(ii) The Secretary may provide for a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a statement of reasons for such finding.

(2) Effective date.—The amendment made by paragraph (1) shall apply to substantive actions undertaken on or after the date of the enactment of this Act.

SEC. 502. REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.

Section 1871 (42 U.S.C. 1395hh), as amended by section 501(a)(1), is amended by adding at the end the following new subsection:

"(e) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and a statement of inconsistencies or conflict among the various provisions under law and regulation.

 SEC. 511. SUBMISSION OF PLAN FOR TRANSFER OF RESPONSIBILITY FOR MEDICAID APPEALS.

(a) Submission of Transition Plan.—

(1) In general.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XIX) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Department of Health and Human Services.

(2) Contents.—The plan shall include information on the following:

(A) Workload.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated increase in filings, the current and anticipated growth in the caseloads, and the case load projections necessary to make such calculations.

(B) Cost Projections and Financing.—Funding levels required for fiscal year 2004 and subsequent fiscal years to carry out the functions transferred under the plan and how such transfer should be financed.

(C) Transition Timetable.—A timetable for the transition.

(D) Regolutions.—The establishment of specific regulations to govern the appeals process.

(E) Case Tracking.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case information and the specific steps necessary to provide for the support staff and other resources necessary for the administration of the plan.

(F) Process for Decision Making.—The specific regulations to govern the appeals process to give decisions of the Departmental Appeals Board, in the Department of Health and Human Services, addressing broad legal issues binding on all levels of the Department.

(G) Access to Administrative Law Judges.—The feasibility of—

(i) filing appeals with administrative law judges electronically;

(ii) conducting hearings using tele- or video-conference technologies.

(H) Independence of Judges.—The specific regulations to govern the appeals process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services, addressing broad legal issues binding on all levels of the Department.

(I) Geographic Distribution.—The specific regulations to govern the appeals process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services, addressing broad legal issues binding on all levels of the Department.

(j) Hiring.—The specific regulations to govern the appeals process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services, addressing broad legal issues binding on all levels of the Department.


(c) Transition Report.—

(1) Effect of law.—The administrative law judge functions that are transferred under the plan with respect to timelines for decisions in cases under title XVIII.

(d) Report to Congress.—

(1) Effect of law.—The feasibility of the Secretary entering into such arrangements with the Commissioner of Social Security as may be appropriate with respect to the administration of the plan.

(2) Effect of law.—The effectiveness of the plan with respect to timelines for decisions in cases under title XVIII.

SEC. 512. EXPEDITED ACCESS TO JUDICIAL REVIEW.

(a) In general.—Section 1869(b) (42 U.S.C. 1395hh(b)) is amended by adding at the end the following:

"(1) in paragraph (1)(A), by inserting , subject to paragraph (2), before "to judicial review of the Secretary's final decision"; and

"(2) before paragraph (3) the following:

"(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain a determination by the Secretary at any time with respect to a question of law or regulations established under section 1869 of the Social Security Act (as amended by section 521 and 522 of BIPA (114 Stat. 2763A-534) and this Act)

(b) Shared Resources.—The Comptroller General of the United States shall—

(1) review the plan submitted under subsection (a); and

(2) not later than 6 months after such submission, submit to Congress a report on such review.
(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that the Departmental Appeals Board does not have authority to decide.

(ii) fails to make such determination within the period provided under subparagraph (B); then the appellant may bring a civil action as described in this subparagraph.

(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

(D), within 60 days of the date of the determination described in such clause; or

(ii) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supply has exhausted its administrative remedies pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as described in subparagraph (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the provider.

(D), by adding at the end the following new paragraph:

"(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, the term ‘review entity’ means an entity of up to 3 qualified reviewers drawn from existing appeals levels other than the determination level.”

(b) APPLICATION TO PROVIDER AGREEMENT TERMINATION.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395cc(b)(1)) is amended—

(i) by inserting “(A)” after “(B)”; and

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

“(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this paragraph as described in subparagraph (A) in the same manner as providers of services, suppliers, and beneficiaries may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.”

(c) CONFORMING AMENDMENT.—Section 1869(b)(2) (42 U.S.C. 1395cc(b)(2)(B)(iii)) is amended to read as follows:

“(ii) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For the provision relating to expedited access to judicial review, see paragraph (2).”

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after January 1, 2004.

SEC. 515. COST REPORT REFORM.

(a) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Secretary shall submit to the Committee on Ways and Means and Energy and Commerce of the House of Representa-

tives a report recommending specific ways to modernize the cost reporting system under the Medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.). Such report shall be consistent with the recommendations of the Secretary’s Advisory Committee on Regulatory Reform, including the use of Generally Accepted Accounting Principles.

(b) CONSULTATION.—In developing the report submitted under subsection (a), the Secretary shall consult with representatives of the hospital industry, the Medicare Payment Advisory Commission, the General Accounting Office, and such other individuals and entities as the Secretary determines to be appropriate.

SEC. 514. EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT TERMINATION ACTIONS.

(a) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—

(1) IN GENERAL.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which—

(A) the remedy of termination of participation has been imposed;

(B) a sanction described in clause (i) or (ii) of section 1869(b) (42 U.S.C. 1395cc(b)) has been imposed, but only if such sanction has been imposed on an immediate basis;

(C) the Secretary has required a skilled nursing facility to suspend operations of a nurse aide training program.

(2) PRIORITY FOR CASES OF TERMINATION.—Under the process described in paragraph (1), priority shall be provided in cases of terminations described in subparagraph (A) of such paragraph.

(b) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to the Secretary such sums for fiscal year 2004 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges (and their staffs) at the Departmental Appeals Board of the Department of Health and Human Services and to educate such judges and staff on long-term care issues.

SEC. 515. REVISIONS TO MEDICARE APPEALS PROCESSES.

(a) TIMEFRAMES FOR THE COMPLETION OF THE RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)(1)), as amended by section 512(a)(2), is amended by striking at the end the following new paragraph:

“(3) TIMELY COMPLETION OF THE RECORD.—

(A) DEADLINE.—Subject to subparagraph (B), the deadline for the record in a hearing before an administrative law judge or a review by the Departmental Appeals Board is 90 days after the date the request for review of the hearing is filed.

(B) EXTENSIONS FOR GOOD CAUSE.—The person filing a request under subparagraph (A) may request an extension of such deadline for good cause. The administrative law judge, in the case of a hearing, and the Departmental Appeals Board, in the case of a review, may extend such deadline based upon the finding of good cause specified by the judge or Board, as the case may be.

(C) DELAY IN DECISION DEADLINES UNTIL COMPLETION OF RECORD.—Notwithstanding any other provision of law, the deadlines otherwise established under section 1869(b) for the making of determinations in hear-

ings or review under this section are 90 days after the date on which the record is complete.

(D) COMPLETE RECORD DESCRIBED.—For purposes of this paragraph, a record is complete when the administrative law judge, in the case of a hearing, or the Departmental Appeals Board, in the case of a review, has reviewed—

(i) written or testimonial evidence, or both, submitted by the person filing the request;

(ii) written or oral argument, or both;

(iii) the decision of, and the record for, the prior level of appeal, and

(iv) the evidence, or other evidence, as such judge or Board, as the case may be, determines is required to make a determination on the request.

(b) REVISIONS TO APPEALS TIMEFRAMES.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended by adding at the end the following new paragraph:

“(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination of an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall be provided in printed form and written in a manner to be understood by the beneficiary and shall include—

(A) the reasons for the determination, including, as appropriate—

(i) upon request in the case of an initial determination, the provision of the policy, manual, or regulation that resulted in the determination;

(ii) upon request, in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination as appropriate;

(B) the procedures for obtaining additional information concerning the determination or redetermination; and

(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended to read as follows:

“(E) EXPLANATION OF DECISION.—Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing in a manner to be understood by the beneficiary and shall include—

(i) to the extent appropriate, an explanation of the decision as well as a discussion of the pertinent facts and applicable regulations cited in making such decision;

(ii) a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section; and

(iii) in the case of a determination of whether an item or service is reasonable and
necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A) an explanation of the decision.

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)) is amended—
(A) in the heading, by inserting "; Notice" after "SECRETARY"; and
(B) by adding at the end the following new paragraphs:

"(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner to be understood by the beneficiary or the entity or organization, as defined in section 1152).

(4) PREPARATION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) is amended by striking "such information as is required for an appeal" and inserting "the record for the appeal".

(e) QUALIFIED INDEPENDENT CONTRACTORS.—
(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c) (42 U.S.C. 1395ff(c)) is amended—
(A) in paragraph (2)—
(i) by inserting "(except in the case of a utilization control peer review organization, as defined in section 1152)" after "means an entity or organization"; and
(ii) by striking the period at the end and inserting a semicolon;

"(B) the entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the programs involved) and sufficient staffing to carry out duties of a qualified independent contractor under this section on a timely basis.

"(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

"(C) the entity or organization meets such other requirements as the Secretary provides by regulation.

"(B) INDEPENDENCE REQUIREMENTS.—
(i) Subject to clause (ii), an entity or organization meets the independence requirements of this subparagraph with respect to any case if the entity—

"(I) is not a related party (as defined in subsection (g)(5));

"(II) does not have a material familial, financial, or professional relationship with such a party that is involved in the case under review; and

"(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

"(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—
(i) prohibit a related party, solely on the basis of a related party designation, from serving as a reviewing professional if—

"(I) a nonaffiliated individual is not reasonably available;

"(II) the affiliated individual is not involved in the provision of items or services in the case under review;

"(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized representative) and another party objects;

"(IV) the affiliated individual is not an employee of the intermediary, carrier, or other contractor, from serving as a reviewing professional if—

"(A) the individual (or authorized representative) provides services at issue;

"(B) the individual is not qualified to serve as a reviewing professional under this section.

(2) ELIGIBILITY REQUIREMENTS OF REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—
(A) in subsection (c)(3)(B), by striking "a panel of health care professionals" and inserting "a physician or another appropriate health care professional";
(B) by striking subsection (c)(3)(D) and inserting the following:

"(D) QUALIFICATIONS OF REVIEWERS.—The requirements of subsection (g) shall be met respecting a reviewing professional if—

"(i) The entity or organization meets the independence requirements of subsection (c)(3)(B) and conducted by a qualified independent contractor shall ensure that—

"(A) each individual conducting a review shall meet the qualifications of paragraph (2);

(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

"(C) in the case of a review described in subsection (c)(3)(B) and conducted by a physician or another health care professional (each in this subsection referred to as a 'reviewing professional') that the reviewing professional meets the qualifications described in paragraph (4).

"(2) INDEPENDENCE.—
(A) In general.—Subject to subparagraph (B), each individual conducting a review in a case shall—

"(i) not be a related party (as defined in paragraph (5));

"(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

"(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

"(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—
(i) prohibit an individual, solely on the basis of affiliation with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

"(I) a nonaffiliated individual is not reasonably available;

"(II) the affiliated individual is not involved in the provision of items or services in the case under review;

"(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized representative) and another party objects;

"(IV) the affiliated individual is not an employee of the intermediary, carrier, or contractor, from serving as a reviewing professional if—

"(A) the individual (or authorized representative) provides services at issue;

"(B) the individual is not qualified to serve as a reviewing professional under this section.

(3) QUALIFICATIONS OF REVIEWERS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking "12" and inserting "4".

(e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—
(1) DELAY IN CERTAIN BIPA REFORMS.—Section 521(d) of BIPA (114 Stat. 2763A–543) is amended to read as follows:

"(1) IN GENERAL.—Except as specified in paragraph (2), the amendments made by this section shall apply with respect to initial determinations made on or after January 1, 2005.

"(2) EXPEDITED PROCEEDINGS AND RECONSIDERATION REQUIREMENTS.—The amendments made by subsection (a) shall apply with respect to initial determinations made on or after October 1, 2003 under the following provisions:

"(A) Section 1869(c)(3)(A), (B), (C), and (D) of the Social Security Act (as added by section 2002 of the Patient Protection and Affordable Care Act (42 U.S.C. 1395h)).

"(B) Section 1869(c)(3)(C) of the Social Security Act (as added by section 521(c) of BIPA (114 Stat. 2763A–543)) is amended by striking "12" and inserting "4".

"(B) Subsection (c)(3)(C)(ii) of such section.

"(C) Section 1869(c)(3)(C)(iv) of such section to the extent that it applies to expedited reconsiderations under subsection (c)(3)(C)(iii) of such section.

"(3) TRANSITIONAL USE OF PEER REVIEW ORGANIZATIONS TO CONDUCT EXPEDITED RECONSIDERATIONS UNTIL QICS ARE OPERATIONAL.—Expeditied reconsiderations of initial determinations under section 1869(c)(3)(C)(iii) of the Social Security Act shall be made by peer review organizations until qualified independent contractors are available for such expedited reconsiderations.

(2) CONFORMING AMENDMENT.—Section 521(b) of BIPA (114 Stat. 2763A–543) and section 1869(c)(3)(C)(ii)(I) of the Social Security Act (42 U.S.C. 1395ff(c)(3)(C)(ii)(I)), as added by section 521 of BIPA, are repealed.

(3) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, 114 Stat. 2763A–534.

(g) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by subsection (d)(2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).
SEC. 516. HEARING RIGHTS RELATED TO DECISIONS BY THE SECRETARY TO DENY OR NOT RENEW A MEDICARE ENROLLMENT AGREEMENT; CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.

(a) Hearing Rights.—(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

``'
(3) Termination of Enrollment.—Nothing in this section shall apply to termination of enrollment on or after such date.
''

(b) Consultation Before Changing Provider Enrollment Forms.—Section 1871 (42 U.S.C. 1395hh), as amended by sections 501, 502, and 503, is amended by adding at the end the following new subsection:

``'
(4) Provider local coverage determination request defined.—In this subsection, the term 'provider local coverage determination request' means a request, filed with the Secretary, at such time and in such form and manner as the Secretary may specify, that the Secretary, pursuant to paragraph (4)(A), require a fiscal intermediary, carrier, or program safeguard contractor to revise a local coverage determination under this section with respect to an item or service.
''

SEC. 517. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) In General.—Section 1870 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

``'
(4) Effective date.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.
''

(b) Coordinator of Provider Coverage Determinations.—The Secretary may enter into contracts with any entity that is eligible to enter into a contract with respect to the performance of a particular function to perform the function on behalf of the Secretary, pursuant to paragraph (4)(A), of section 1874 of the Social Security Act, as added by subsection (c) of this section.

(c) Request for Local Coverage Determinations.—The amendment made by subsection (a) shall apply with respect to provider local coverage determination requests as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c) of this section.

(d) Request for Local Coverage Determinations by Providers.—Section 1869(d)(2)(B) is amended by adding at the end the following new paragraph:

``'
(5) Request for Local Coverage Determinations by Providers.—The Secretary shall require a fiscal intermediary, carrier, or program safeguard contractor identified in the provider local coverage determination request, to make or revise a local coverage determination with respect to the item or service that is the subject of the request not later than the date that is 210 days after the date on which the Secretary receives such request.
''

(e) Authorization of Appropriations.—There are authorized to be appropriated such sums as may be necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) Effective Dates.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendment made by subsection (a), (b), or (c) shall apply to—

(A) any request of any local coverage determination made on or after January 1, 2004;

(B) any request to make such a determination made on or after such date;

(C) any local coverage determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATIONS.—The Secretary may enter into contracts with any eligible entity to serve as a program safeguard contractor, and no further proceedings in relation to such request shall be conducted.''

(e) Authorization of Appropriations.—There are authorized to be appropriated such sums as may be necessary to carry out the amendments made by subsections (a), (b), and (c).

SEC. 518. PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.

(a) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—Section 1869(h)(5) (42 U.S.C. 1395ff(h)(5)) is amended to read as follows:

``'
(c) Request for Local Coverage Determinations by Providers.—Section 1869(d)(2)(B), as amended by section 151(d)(2)(B), is amended by adding at the end the following new paragraph:

``'
(5) Request for Local Coverage Determinations by Providers.—The Secretary shall require a fiscal intermediary, carrier, or program safeguard contractor identified in the provider local coverage determination request, to make or revise a local coverage determination with respect to the item or service that is the subject of the request not later than the date that is 210 days after the date on which the Secretary receives such request.
''

(b) Clarification of Local Coverage Determination Definition.—Section 1869(h)(2)(B) (42 U.S.C. 1395ff(h)(2)(B)) is amended, in paragraph (1), by inserting after subparagraph (A) the following new subparagraph (B):

``'
(B) a provider of services, physician, practitioner, or other supplier to appeal any determination of the Secretary with respect to an item or service.
''

(c) Authorization of Appropriations.—There are authorized to be appropriated such sums as may be necessary to carry out the amendments made by subsections (a), (b), and (c).

(d) Effective Dates.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendment made by subsection (a), (b), or (c) shall apply to—

(A) any review of any local coverage determination made on or after January 1, 2004;

(B) any request to make such a determination made on or after such date;

(C) any local coverage determination made on or after such date.

SEC. 5.1 CONTESTING THE CONTRACTORS.—The Secretary may enter into contracts with any eligible entity to serve as a program safeguard contractor, and no further proceedings in relation to such request shall be conducted.''

(e) Authorization of Appropriations.—There are authorized to be appropriated such sums as may be necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) Effective Dates.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendment made by subsection (a) shall apply to—

(A) any request of any local coverage determination made on or after January 1, 2004;

(B) any request to make such a determination made on or after such date;

(C) any local coverage determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATIONS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c) of this Act.

Subtitle C—Contracting Reform

SEC. 521. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) Consolidation and Flexibility in Medicare Administration.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

``'
CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

SEC. 1874A. (a) AUTHORITY.

(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a program safeguard contractor, and no further proceedings in relation to such request shall be conducted.''

(b) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

(c) the entity has sufficient assets to financially support the performance of such functions;

(d) the entity meets such other requirements as the Secretary may impose.

SEC. 522. CONCURRENT FLEXIBILITY IN ADMINISTRATION OF MEDICARE AND MEDICAID.

(a) Authorization of Appropriations.—There are authorized to be appropriated such sums as may be necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) Effective Dates.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendment made by subsection (a) shall apply to—

(A) any review of any local coverage determination made on or after January 1, 2004;

(B) any request to make such a determination made on or after such date;

(C) any local coverage determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATIONS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c) of this Act.

Subtitle C—Contracting Reform

SEC. 521. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) Consolidation and Flexibility in Medicare Administration.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

``'
CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

SEC. 1874A. (a) AUTHORITY.

(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a program safeguard contractor, and no further proceedings in relation to such request shall be conducted.''

(b) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

(c) the entity has sufficient assets to financially support the performance of such functions;

(d) the entity meets such other requirements as the Secretary may impose.

SEC. 522. CONCURRENT FLEXIBILITY IN ADMINISTRATION OF MEDICARE AND MEDICAID.

(a) Authorization of Appropriations.—There are authorized to be appropriated such sums as may be necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) Effective Dates.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendment made by subsection (a) shall apply to—

(A) any review of any local coverage determination made on or after January 1, 2004;

(B) any request to make such a determination made on or after such date;

(C) any local coverage determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATIONS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c) of this Act.

Subtitle C—Contracting Reform

SEC. 521. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) Consolidation and Flexibility in Medicare Administration.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

``'
CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

SEC. 1874A. (a) AUTHORITY.

(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a program safeguard contractor, and no further proceedings in relation to such request shall be conducted.''

(b) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

(c) the entity has sufficient assets to financially support the performance of such functions;

(d) the entity meets such other requirements as the Secretary may impose.
“(3) Medicare Administrative Contractor Defined.—For purposes of this title and title XI.

“(A) IN GENERAL.—The term ‘medicare administrative contractor’ means an agency, organization, or other person with a contract under this section.

“(B) Appropriate Medicare Administrative Contractor.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific Medicare, health plan, or provider of services, physicians, practitioners, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the appropriate Medicare administrative contractor is the Medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services, physician, practitioner, facility, or supplier or class of provider of services, physician, practitioner, facility, or supplier.

“(4) Functions Described.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and beneficiary services functions.

“(A) Determination of Payment Amounts.—Determining (subject to the provisions of section 1878 and to such written procedures as the Secretary shall provide for the appropriate Medicare administrative contractor) the amount of the payments required pursuant to this title to be made to providers of services, physicians, practitioners, facilities, suppliers, or individuals.

“(B) Making Payments.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

“(C) Beneficiary Education and Assistance.—Serving as a center for, and communicating or furnishing to the Secretary, and serving as a channel of communication from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

“(D) Provider Consultative Services.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services, physicians, practitioners, facilities, or suppliers.

“(E) Communication with Providers.—Serving as a center for, and communicating or furnishing to providers of services, physicians, practitioners, facilities, and suppliers, any information or instructions furnished to the medicare administrative contractor by the Secretary, and serving as a channel of communication from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

“(F) Provider Education and Technical Assistance.—Performing the functions described in subsections (e) and (1), relating to education, training, and technical assistance to providers of services, physicians, practitioners, facilities, and suppliers.

“(G) Additional Functions.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1881, as are necessary to carry out the purposes of this title.

“(5) Relationship to MIP Contracts.—

“(A) Nonduplication of Activities.—In entering into contracts under this section, the Secretary shall act so that actions of Medicare administrative contractors do not duplicate activities carried out under contracts entered into under the Medicare Integrity Program under section 1881, as necessary to carry out the purposes of the activity described in section 1881(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1833(a)(15)).

“(B) Construction.—An entity shall not be treated as entering into a contract merely by reason of having entered into a contract with the Secretary under section 1881.

“(6) Application of Federal Acquisition Regulation.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts entered into under this section.

“(b) Contracting Requirements.—

“(1) Use of Competitive Procedures.—The Secretary may provide for competitive procedures when entering into contracts with Medicare administrative contractors under this section.

“(A) Renewal of Contracts.—The Secretary may renew a contract with a Medicare administrative contractor under this section from term to term without regard to section 109(a) of title 41, or any other provision of law requiring competition, if the Medicare administrative contractor is performing functions applicable with respect to the contract, contractor, except that the Secretary shall provide for the application of provisions of Federal law as provided in laws with general applicability to Federal acquisition and procurement or the Federal Acquisition Regulation, or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with Medicare administrative contractors under this section.

“(B) Renewal of Contracts.—No disbursement officer shall be used for evaluating contractor performance under a contract; and

“(B)Disallowing Officers.—No disbursement officer, in the absence of the reckless disregard of the disbursement officer’s obligations or the intent by that officer to defraud the United States, shall be liable with respect to any payment made by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such authorization of the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

“(5) Limitation on Liability of Medicare Administrative Contractors and Certain Officers.—

“(A) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS.—No Medicare administrative contractor shall be liable to the United States in such amount as the Secretary may deem appropriate.

“(B) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of a contract or, entering into, a contract under this section, that the use or disclosure of any information covered by this title be provided to any person or entity.

“(C) Certification Requirements.—A contract, with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(D) Limitation on Liability of Medicare Administrative Contractors and Certain Officers.—

“(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(2) Certification Requirements.—The Secretary shall provide for the application of provisions of Federal law as provided in laws with general applicability to Federal acquisition and procurement or the Federal Acquisition Regulation, or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with Medicare administrative contractors under this section unless the contractor agrees—

“(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

“(B) Maintenance and Security Requirements.—The Secretary shall provide for the application of provisions of Federal law as provided in laws with general applicability to Federal acquisition and procurement or the Federal Acquisition Regulation, or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with Medicare administrative contractors under this section unless the contractor agrees—

“(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

“(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

“(3) Limitation on Liability of Medicare Administrative Contractors and Certain Officers.—

“(A) Limitation on Liability of Medicare Administrative Contractors.—No Medicare administrative contractor shall be liable to the United States in such amount as the Secretary may deem appropriate.

“(B) Disallowing Officers.—No disbursement officer, in the absence of the reckless disregard of the disbursement officer’s obligations or the intent by that officer to defraud the United States, shall be liable with respect to any payment made by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such authorization of the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

“(C) Certification Requirements.—A contract, with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(D) Limitation on Liability of Medicare Administrative Contractors and Certain Officers.—

“(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(2) Certification Requirements.—A contract, with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(3) Limitation on Liability of Medicare Administrative Contractors and Certain Officers.—

“(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(2) Certification Requirements.—A contract, with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(3) Limitation on Liability of Medicare Administrative Contractors and Certain Officers.—

“(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(2) Certification Requirements.—A contract, with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(3) Limitation on Liability of Medicare Administrative Contractors and Certain Officers.—

“(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(2) Certification Requirements.—A contract, with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(3) Limitation on Liability of Medicare Administrative Contractors and Certain Officers.—

“(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(2) Certification Requirements.—A contract, with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(3) Limitation on Liability of Medicare Administrative Contractors and Certain Officers.—

“(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(2) Certification Requirements.—A contract, with any Medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the Medicare administrative contractor for the making of payments by it under subsection (a)(3)(B).

“(3) Limitation on Liability of Medicare Administrative Contractors and Certain Officers.—
States for a payment by a certifying or disbarred officer unless, in connection with such a payment, the medicare administrative contractor acted with reckless disregard of its fiduciary duties under its medicare administrative contract or with intent to defraud the United States.

(4) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this section shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3733 of title 31, United States Code (commonly known as the ‘‘False Claims Act’’).

(5) INDENMIFICATION BY SECRETARY.—

(A) IN GENERAL.—Notwithstanding any other provision of law and subject to the succeeding provisions of this paragraph, in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from, or relating directly to, the claims administration process under this title, the Secretary may, to the extent specified in the contract with the contractor, indemnify the contractor (and such persons).

(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such actions arises directly from conduct that is determined by the Secretary to be criminal in nature, fraudulent, or grossly negligent.

(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

(D) WRITTEN APPROVAL FOR SETTLEMENT.—A contractor or other person described in subparagraph (A) may not propose to negotiate or compromise a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate a settlement. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement are conditioned upon the Secretary’s prior written approval of the final settlement.

(E) COMPLIANCE.—Nothing in this paragraph shall be construed—

(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

(ii) to permit the payment of costs not otherwise reasonable, reasonable, or allocable under the Federal Acquisition Regulations.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act (as added by paragraph (1) the Secretary shall consider the incorporation of performance standards described in sections 1816(b)(2)(A) of the type performance standards described in sections 1816(b)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1822(b)(2)(B) of such Act (relating to hearing of determinations and fair hearing requests), as such standards were in effect before the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395l) is amended as follows:

(1) The heading is amended to read as follows:

‘‘PROVISIONS RELATING TO THE ADMINISTRATION OF PART A’’.

(2) Subsection (a) is amended to read as follows:

‘‘The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.’’. (3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking ‘‘agreement under this section’’ and inserting ‘‘contract under section 1874A that provides for making payments under this part’’.

(5) Subsections (d) through (h) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking ‘‘An agreement with an agency or organization under this section’’ and inserting ‘‘A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part’’; and

(B) by striking ‘‘such agency or organization’’ and inserting ‘‘such medicare administrative contractor’’ each place it appears.

(7) Subsection (i) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

‘‘PROVISIONS RELATING TO THE ADMINISTRATION OF PART B’’.

(2) Subsection (a) is amended to read as follows:

‘‘The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.’’

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking ‘‘carriers’’ and inserting ‘‘medicare administrative contractors’’; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking ‘‘Each such contract shall provide that the carrier and inserting ‘‘The Secretary’’;

(ii) by striking ‘‘will’’ the first place it appears in each of subparagraphs (A), (B), (F), (H), and (L) and inserting ‘‘shall’’;

(iii) in clause (i), in the matter before clause (I), by striking ‘‘to the policyholders and subscribers of the carrier’’ and inserting ‘‘to the policyholders and subscribers of the medicare administrative contractor’’;

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking ‘‘if it makes determinations or payments with respect to physicians’ services’’; and

(II) by striking ‘‘carrier’’ and inserting ‘‘medicare administrative contractor’’;

(vi) by striking paragraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting ‘‘, the matter before clause (i), by striking ‘‘to the policyholders and subscribers of the carrier’’ and inserting ‘‘to the policyholders and subscribers of the medicare administrative contractor’’;

(viii) in the first sentence, after subparagraph (L), by striking ‘‘and shall contain’’ and all that follows through the period; and

(ix) in the seventh sentence, by inserting ‘‘medicare administrative contractor’’ after ‘‘carrier’’;

(D) by striking paragraph (5);

(E) in paragraph (6)(D), by striking ‘‘carrier’’ and inserting ‘‘medicare administrative contractor’’; and

(F) in paragraph (7), by striking ‘‘the carrier’’ and inserting ‘‘the Secretary’’ each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2), by striking ‘‘contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), and inserting ‘‘contract under section 1874A that provides for making payments under this part’’;

(C) in paragraph (3)(A), by striking ‘‘subsections (a)(1)(B) and inserting ‘‘section 1874A(a)(3)(B);’’

(D) in paragraph (4), by striking ‘‘carrier’’ and inserting ‘‘medicare administrative contractor’’;

(E) in paragraph (5), by striking ‘‘contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B) shall require the carrier’’ and inserting ‘‘contract under section 1874A that provides for making payments under this part shall require the medicare administrative contractor and ‘carrier responses’, respectively; and

(F) by striking paragraph (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking ‘‘carrier or carriers’’ and inserting ‘‘medicare administrative contractor or contractors’’.

(7) Subsection (h) is amended—

(A) in paragraph (1)—

(i) by striking ‘‘Each carrier having an agreement with the Secretary under subsection (a)’’ and inserting ‘‘The Secretary’’; and

(ii) by striking ‘‘Each such carrier’’ and inserting ‘‘The Secretary’’;

(B) in paragraph (3)(A)—

(i) by striking ‘‘a carrier having an agreement with the Secretary under subsection (a)’’ and inserting ‘‘medicare administrative contract having a contract under section 1874A that provides for making payments under this part’’; and

(ii) by striking ‘‘such carrier’’ and inserting ‘‘such contractor’’;

(C) in paragraph (3)(B)—

(i) by striking ‘‘a carrier’’ and inserting ‘‘a medicare administrative contractor’’ each place it appears; and

(ii) by striking ‘‘the carrier’’ and inserting ‘‘the contractor’’ each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(III), by striking ‘‘carriers’’ and inserting ‘‘medicare administrative contractors’’ each place it appears.

(8) Subsection (i) is amended—

(A) in paragraph (A)(I), by striking ‘‘carrier or carriers’’ and inserting ‘‘medicare administrative contractor’’; and

(B) in paragraph (2), by striking ‘‘carrier’’ and inserting ‘‘medicare administrative contractors’’.

(9) Subsection (p)(3)(A) is amended by striking ‘‘carrier’’ and inserting ‘‘medicare administrative contractor’’.

(10) Subsection (q)(1)(A) is amended by striking ‘‘carrier’’.

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this title, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(e) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for

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functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

(2) General transition rules.

(A) Coordination to enter into new agreements and contracts and waiver of provider nomination provisions during transition.—Prior to the date specified in paragraph (B), the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 during the time period without regard to any of the provider nomination provisions provided such agreement includes—

(B) Appropriate transition.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) Addendum—Not later than 6 months after the date of enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and administrative contractors.

(4) Applicable provisions under current contracts and agreements and under transition contracts.—The provisions contained in the exception (d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A shall be deemed to include agreements and contracts entered into pursuant to paragraph (2)(A).

(C) By adding at the end the following new subsection:

(D) Reporting on implementation.—

(1) Proposal for implementation.—At least 1 year before the date specified in subsection (d)(1), the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes a plan for an appropriate transition. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation, which shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) Status of implementation.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contractors and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary's oversight and management of medicare contractors to adapt to full competition.

Subtitle D—Education and Outreach Improvements

SEC. 531. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) Coordination of education funding.—In general.—Title XVIII is amended by inserting after section 1888 the following new section:

"PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—

"SEC. 1888. (a) Coordination of Education Funding.—The Secretary shall coordinate the educational activities provided through medicare contractors to adapt to paragraph (2)(A), the amount appropriated under subparagraph (A) for a fiscal year (beginning with the fiscal year 2004) is $25,000,000.

"(b) Incentives to improve contractor performance.—Section 1874A, as added by section 521(a)(1), is amended by adding at the end the following new subsection:

"(c) Improved provider education and training.—

(1) Increased funding for enhanced education and training through medicare integrity program.—Section 1874A(c)(4) (42 U.S.C. 1395i(k)(4)) is amended—

(A) in subparagraph (A), by striking "the amount appropriated" and inserting "the amount appropriated and";

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

"(CA) enhanced provider education and training—

"(i) in general.—In addition to the amount appropriated under subparagraph (B), the amount appropriated under subparagraph (A) for a fiscal year (beginning with the fiscal year 2004) is $25,000,000.

(ii) use.—The funds made available under this subparagraph shall be used only to increase the level of education and training of the educational activities or other information gathering covered under section 1893 of the social security act (42 u.s.c. 1395w,a-3) in the medicare contractors to adapt to paragraph (2)(A)."
in the scope of the contractor’s contract authority, in response to a written inquiry with respect to the furnishing of items or services or the submission of claims for benefits for such items or services;

‘(B) the Secretary determines that—

(i) the provider of services, physician, practitioner, or supplier shall not be subject to any penalty or interest under this title (or the provisions of title XI insofar as they relate to this title) relating to the provision of such items or service or such claim if the provider of services, physician, practitioner, or supplier reasonably relied on such guidance.

(C) the guidance was in error;

(iii) the provider of services, physician, practitioner, or supplier shall not be subject to any penalty or interest under this title (or the provisions of title XI insofar as they relate to this title) relating to the provision of such items or service or such claim if the provider of services, physician, practitioner, or supplier reasonably relied on such guidance.

in paragraphs (2) and (3), respectively; and

(iii) by adding at the end the following new subsection:

‘(5) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term ‘medicare contractor’ has the meaning given such term in subsection (e)(3).

SEC. 534. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1866 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end the following: ‘‘MEDICARE PROVIDER OMBUDSMAN;’’;

(2) by inserting ‘‘PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)’’ after ‘‘(a)’’;

(3) in paragraph (1), as so redesignated by subsection (b), by inserting ‘‘in this section’’; and

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

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

SEC. 535. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall evaluate the demonstration program, as defined in section 1874A(d)(1) or otherwise acting within this title.

(b) STAFF.—The Secretary shall provide appropriate staff to assist in performing the duties described in subsection (b).

(c) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII is amended by inserting after section 1806 the following section:

‘‘SEC. 1807. (a) IN GENERAL.—By not later than 1 year after the date of the enactment of the Medicare Education, Regulatory Reform, and Contracting Improvement Act of 2003, the Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman (including support staff) who shall have expertise and experience in the fields of health care and advocacy.

SEC. 536. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall evaluate the demonstration program, as defined in section 1874A(d)(1) or otherwise acting within this title.
employed by the Department of Health and Human Services provide advice and assistance to Medicare beneficiaries at the location of existing local offices of the Social Security Administration.

(b) Locations.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 states or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by Medicare beneficiaries.

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 1 out-stationing Medicare specialist in each rural area on a scheduled basis.

(c) Duration.—The demonstration program shall be conducted over a 4-year period.

(d) Evaluation and Report.—

(1) Evaluation.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing Medicare specialists at local social security offices.

(2) Report.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing Medicare specialists at local Social Security offices.

Subtitle E—Review, Recovery, and Enforcement Reform

SEC. 541. PREPAYMENT REVIEW.

(a) In General.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1) and 532(a), is amended by adding at the end the following new subsection:

"(g) Conduct of Prepayment Review.—"(1) Random Prepayment Review—A Medicare administrative contractor shall conduct random prepayment review in accordance with a standard random prepayment audit established by the Secretary.

"(2) Limitations on Initiation of Non-random Prepayment Review—A Medicare administrative contractor may not make an initial determination of non-random prepayment review of a provider of services, physician, practitioner, or supplier based on the initial identification by that provider of services, physician, practitioner, or supplier of an overpayment (at the election of the provider, physician, practitioner, or supplier) of such overpayment over a period of at least 1 year, but not longer than 3 years.

(3) Application of Standard Protocols for Random Prepayment Review.—Section 1874A(g)(1) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify.

(b) Recovery of Overpayments.—

(1) Use of Repayment Plan.—

(A) Definition.—If the repayment, within the period otherwise permitted by a provider of services, physician, practitioner, or other supplier, of an overpayment under this title meets the standards under subparagraph (B), the provider, physician, practitioner, or supplier requests the Secretary to enter into a repayment plan under this section; and

(B) Payment Audits.—Any payment audits conducted under this title, the contractor shall provide the provider of services, physician, practitioner, or supplier under this title, the contractor shall—

(i) give the provider of services, physician, practitioner, or supplier the amount of the proposed recovery as a proportion of the total recovery under this subparagraph; and

(ii) provide for consideration of the financial hardship imposed on a provider of services, physician, practitioner, or supplier in considering such a repayment plan.

(2) Limitations on Initiation of Non-random Prepayment Review.—If the Secretary determines that the provider of services, physician, practitioner, or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

(c) Rejection of No Fault Provisions.—Nothing in this section shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

(d) Limitation on Reconsideration.—(A) No Recoupment Until Reconsideration Exercised.—In the case of a provider of services, physician, practitioner, or supplier that amount that is determined to have received an overpayment under this title and that seeks a reconsideration of such determination by a qualified independent contractor under section 1899(c), the Secretary may not take any action (or authorize any other person, including any Medicare contractor, as defined in subsection (c)) for such overpayment until the date the reconsideration is rendered. If the provisions of section 1899(b)(1) (providing for such a determination by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall treated as a reference to the determination of the fiscal intermediary or carrier involved.

(B) Payment of Interest.—(1) RETURN OF RECOPUED AMOUNT WITH INTEREST IN CASE OF REVERSAL.—Insofar as such determination on appeal against the provider of services, physician, practitioner, or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment.

(2) Rate of Interest.—The rate of interest under this subparagraph shall be the rate of interest otherwise applicable under this title in the assessment of financial penalties.

(C) Medicare Contractor Defined.—For purposes of this subsection, the term "Medicare contractor" has the meaning given such term in section 1889(a).

(D) Payment Audits.—Any payment audits conducted under this title, the contractor shall provide to the provider of services, physician, practitioner, or supplier written notice (which may be provided in electronic form) of the intent to conduct such an audit.

(E) Explanation of Findings for All Audits.—Subject to subparagraph (C), if a Medicare contractor audits a provider of services, physician, practitioner, or supplier under this title, the contractor shall—

(i) give the provider of services, physician, practitioner, or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services, physician, practitioner, or supplier under this title, the contractor shall—

(ii) inform the provider of services, physician, practitioner, or supplier of the appeal process and plaintiff of the appeal process and plaintiff of an appropriate corrective action plan; and

(iii) inform the provider of services, physician, practitioner, or supplier of the appeal process and plaintiff of the appeal process for the audit of the audit in a manner that is understandable to the provider of services, physician, practitioner, or supplier under this title, the contractor shall—

(iii) provide the provider of services, physician, practitioner, or supplier with written notice of the intent to conduct such an audit.
(iii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or other findings of law enforcement-related audits.

(4) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services, physicians, practitioners, and suppliers, a process under which the Secretary provides for notice to one or more of providers of services, physicians, practitioners, and suppliers served by a Medicare contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services, physicians, practitioners, or suppliers under the program that is subject to such determination.

(b) Effective date.—Section 1886(c) of the Social Security Act, as added by subsection (a), shall apply to appeals initiated after the date that is 1 year after the date of the enactment of this Act.

SEC. 551. PROVISIONS RELATING TO THE REMEDIAL AND CORRECTIVE ACTIONS IMPLEMENTED UNDER MEDICARE+CARE PROJECTS.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to appeals initiated after the date that is 1 year after the date of the enactment of this Act.

SEC. 552. INFORMATION TO MEDICARE-CERTIFIED SKILLED NURSING FACILITIES ABOUT SKILLED NURSING FACILITY AND HOSPITAL BENEFITS.

(a) Availability of data.—The Secretary shall publicly provide information that enables hospital discharge planners, Medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the Medicare program.

(b) Inclusion of information in certain hospital discharge plans.

(1) In general.—Section 1861(m)(2)(D) (42 U.S.C. 1395x(e)(2)(D)) is amended—

(A) by striking ''hospice services'' and inserting in its place ''end-stage renal disease services''

(b) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 553. EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES CONSIDERATION.

The Secretary shall ensure, before making changes in documentation guidelines for, or clinical examples of, or codes to report evaluation and management physician services under title XVIII of the Social Security Act, that the process used in developing such guidelines, examples, or codes was widely consultative among physicians, reflects a broad consensus among specialties, and would allow verification of reported and furnished services.

SEC. 554. IMPROVEMENT IN OVERSIGHT OF HOSPITAL DISCHARGE PLANS AND COVERAGE.

(a) Council for technology and innovation.—Section 188k (42 U.S.C. 1395dd) is amended by adding at the end the following new subsection:

"(2) Limitation on reporting at the end of the following new subsection:

"(c) Council for technology and innovation.

(1) Establishment.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as the "CMS").

(2) Composition.—The Council shall be composed of senior CMS staff and clinicians for the purpose of developing and overseeing the implementation of an annual improvement plan for the oversight of hospital discharge plans.

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"(c) Council for technology and innovation.

(1) Establishment.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as the "CMS").

(2) Composition.—The Council shall be composed of senior CMS staff and clinicians for the purpose of developing and overseeing the implementation of an annual improvement plan for the oversight of hospital discharge plans.
and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

(3) DUTIES.—The Council shall coordinate the development, coding, and payment processes under this title with respect to new technologies, and shall coordinate the development of national clinical data standards for use by suppliers of medical devices and health information technology.

(d) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee to serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall have the experience, knowledge, and skills necessary to manage a multi-billion dollar program that has significant programmatic and financial implications.

(e) LISTS.—In making determinations under this section, the Secretary shall develop a list of tests that are not ordinarily covered by Medicare.

(f) REPORT.—Not later than 10 years after the date of enactment of this Act, the Secretary shall submit to Congress a report describing the implementation of this section.

SEC. 555. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) IN GENERAL.—The Secretary shall not request a hospital (including a critical access hospital) to report questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to Medicare secondary payer provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) REFERENCE LABORATORY SERVICES DESCRIBED.—Reference laboratory services described in this subsection are clinical laboratory tests or procedures of a disease or condition or a determination of the existence of an analyte by an outside laboratory.

(c) REPORT.—Not later than 2 years after the date of enactment of this Act, the Secretary shall submit to Congress a report describing the implementation of this section.
In selecting members described in paragraph (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients respectively.

(g) General Responsibilities.—The Advisory Group shall:

(1) review, recommend, and provide advice and recommendations to the Secretary with respect to such regulations and their application to hospitals and physicians;

(2) solicit comments and recommendations from hospitals, physicians, and other public regarding the implementation of such regulations;

(3) study and make recommendations on the application of such regulations to hospitals, physicians, and the public.

(d) Administrative Matters.—

(1) Chairperson.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

(2) Meetings.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and as often as necessary.

(f) Waiver of Administrative Limitation.—The Secretary shall establish the Advisory Group notwithstanding any limitation on the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 558. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) In General.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

"(e) In extraordinary, exigent, or other nonroutine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program’s service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (1) of section 1861(dd)(5). The provision of paragraph (2)(A)(i)(II) shall apply with respect to the services provided under such arrangements."

(b) Hospice Program May Provide Services Described in Paragraph (1) Other Than Directly by the Program If the Services Are Highly Specialized Services Provided by or Under the Supervision of a Registered Professional Nurse and Are Provided Nonroutinely and So Infrequently That the Provision of Such Services Directly Would Be Impracticable and Unreasonably Expensive."

(b) Conforming Payment Provision.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following:

"(f) The amount paid to a hospice program under this subsection with respect to the services under section 1812(a)(5) for which payment may be made under part A shall be the amount determined under a fee schedule established by the Secretary."

(c) Conforming Amendment.—Section 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended by inserting before the comma at the end the following: "and services described in paragraph (3),".

(d) Effective Date.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2004.

SEC. 560. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

SEC. 561. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) Technical Amendments Relating to Adverse Determination Under Bipartisan Agenda Act of 2003.—Subsection (b) (42 U.S.C. 1314)

(b) BIPA-Related Technical Amendments and Corrections.—

(a) In General.—Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395b(b)(6)(A)(ii)) is amended to read as follows: "(ii) where the service was provided under a contract under an arrangement between such physician or other person and a qualified entity (as defined by the Secretary) or other person, to the entity or person so indemnified."

(b) Effective Date.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.
joint and several liability for overpayment by such physician or other person and such entity or other person, and (II) meets such other program integrity and other safeguard requirements that the Secretary may determine to be appropriate.''.

(b) CONFORMING AMENDMENTS.—

(1) The second sentence of section 1822(b)(9) (42 U.S.C. 1395l(t)(2)) is amended by striking ''except to an employer or facility as described in clause (A)'', and inserting ''except to an employer, facility, or other person as described in paragraph (2)''

(2) Section 1819(b)(6) (42 U.S.C. 1395l(b)(6)) is amended by adding at the end the following:

(3) COORDINATION WITH EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan, or a Medicare Advantage organization offering a Medicare Advantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), shall enter into an agreement with each existing State pharmaceutical assistance program to coordinate the coverage provided under the plan with the assistance provided under the existing State pharmaceutical assistance program.

(B) ELECTION.—Under the process established under section 1860D-3(a), an eligible beneficiary who resides in a State with an existing State pharmaceutical assistance program and who is eligible to enroll in such program shall elect to enroll in a Medicare Prescription Drug plan or Medicare Advantage plan through the existing State pharmaceutical assistance program.

(C) EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAMS DEEMED TO BE INSURED.—In this paragraph, the term 'existing State pharmaceutical assistance program' means a program that has been established pursuant to a waiver under section 1115 or otherwise before January 1, 2004.

SA 1129. Mr. DASCHLE (for Mr. KERRY) submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and for other purposes; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

PHARMACEUTICAL ASSISTANCE PROGRAMS.—

(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan, or a Medicare Advantage organization offering a Medicare Advantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), shall enter into an agreement with each existing State pharmaceutical assistance program to coordinate the coverage provided under the plan with the assistance provided under the existing State pharmaceutical assistance program.

(B) ELECTION.—Under the process established under section 1860D-3(a), an eligible beneficiary who resides in a State with an existing State pharmaceutical assistance program and who is eligible to enroll in such program shall elect to enroll in a Medicare Prescription Drug plan or Medicare Advantage plan through the existing State pharmaceutical assistance program.

(C) EXISTING STATE PHARMACEUTICAL ASSISTANCE PROGRAMS DEEMED TO BE INSURED.—In this paragraph, the term 'existing State pharmaceutical assistance program' means a program that has been established pursuant to a waiver under section 1115 or otherwise before January 1, 2004.
provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table, as follows:

At the appropriate place in title II, insert the following:

SEC. 1. STUDY ON TRENDS IN EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.

(a) STUDY.—The Comptroller General of the United States, in consultation with employers, health benefit experts, academia, human resource professionals, State and local government officials, and employers, shall conduct a study to determine the effect of the amendments made by this Act on the provision of employment-based retiree health coverage (as such term is defined in section 1860D-20(e)(4)(B) of the Social Security Act). Such study shall examine the following:

(1) Trends in employment-based retiree health coverage, as such trends relate to retirees who are eligible for coverage under the Medicare program under title XVIII of the Social Security Act (as such term is defined in section 1809F(b)(3) of the Social Security Act).

(2) The extent to which health care coverage, including coverage under Medicare+Choice, MedicareAdvantage, and fee-for-service drug plans under the medicare program, are available to retirees who are eligible for coverage under the medicare program.

(3) The extent to which geographic location plays a role in the structure and availability of retiree health benefit coverage.

(4) Whether incentives built into this Act (and the amendments made by this Act) are sufficient to induce employers to maintain employment-based retiree health coverage, and whether other voluntary incentives exist to encourage employers to maintain such coverage.

(5) Whether obstacles exist to employers providing employment-based retiree health coverage, including administrative burden, the cost of prescription drugs, and the increasing overall health care costs.

(b) Information.—In conducting the study under subsection (a), the Comptroller General shall determine the effect of the amendments made by this Act on the provision of employment-based retiree health coverage using information available for the period—

(1) beginning on the date of enactment of this Act and ending on January 1, 2005; and

(2) beginning on January 1, 2006 and ending on January 1, 2007.

(c) Report.—Not later than July 1, 2007, the Comptroller General shall submit to the appropriate committees of Congress a report based on the study conducted under subsection (a).

SA 1131. Mr. KYL submitted an amendment intended to be proposed by him to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; which was ordered to lie on the table; as follows:

At the end of subtitle B of title IV, add the following:

SEC. 1. USE OF DATA COLLECTED BY ORGANIZATIONS AND ENTITIES IN DETERMINATION OF THE EFFECT OF MODIFICATIONS TO THE MEDICARE ADVANTAGE AND MEDICARE ADVANTAGE PLAN PROVISIONS.

(a) In general.—The Secretary shall reexamine the data required under section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–350) so that, in determining the payment component under subsection 184(h)(2)(A)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(A)(ii)) for purposes of determining relative values for payment for physicians’ services under the fee schedule under section 1848 of such Act (42 U.S.C. 1395w–4), the Secretary recognizes all costs of clinical staff employed by local government or governmental entities, including professional and paraprofessional staff employed by such entities, that are incurred by the local government or governmental entity so enrolled. The provisions of subsection (b) shall be substituted for $3,700 in subparagraph (B)(i)(I) of such section.

(b) Reporting.—By not later than January 15, 2005, the Secretary shall report to the appropriate committees of Congress with respect to the study conducted under subsection (a) with respect to the following:

(1) Medicare+Choice, MedicareAdvantage, and Medicare drug plans, including premium subsidies.

(2) Determination of the cost of prescription drugs, and the incentives to employers that did not provide prescription drug coverage acts as an incentive to employers that did not provide prescription drug coverage.

(c) Authorization.—There are authorized to be appropriated such sums as may be necessary to carry out this section.

SA 1132. Mr. SANTORUM proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program and for other purposes; as follows:

On page 343, between lines 15 and 16, insert the following:

“(1) Zero Premium Stop-Loss Protection and Access to Negotiated Prices for Eligible Beneficiaries Enrolled in MedicareAdvantage Plans.—

(1) In general.—Notwithstanding any provision of this Act or part B, a MedicareAdvantage plan shall be treated as meeting the requirements of this section if, in lieu of the qualified prescription drug coverage required, the plan makes available such coverage with the following modifications:

(A) No premium.—Notwithstanding subsection (d) or sections 1860D-13(e)(2) and 1860D–17, the amount of the MedicareAdvantage monthly beneficiary obligation for the qualified prescription drug coverage shall be zero.

(B) Beneficiary receives access to negotiated prices and stop-loss protection.

The Secretary shall establish procedures for imposing a monthly beneficiary obligation for enrollment under such plan. The amount of such obligation shall be an amount that the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under such a plan but was not so enrolled. The provisions of subsection (b) of such section shall apply to the penalty under paragraph (a) of such section if the penalty is similar to the manner such provisions apply to the penalty under part D.

(3) Procedures.—The Administrator shall establish procedures to carry out this section. Under such procedures, the Administrator may waive or modify any of the preceding provisions of this part or part D to the extent necessary to carry out this section.

(4) No effect on Medicare drug plans.—This subsection shall have no effect on eligible beneficiaries enrolled in a Medicare Prescription Drug Plan or under a contract under section 1860D–13(e)(1)."

SA 1133. Mr. GRASSLEY (for himself and Mr. BAUCUS) proposed an amendment to the bill S. 1, to amend title XVIII of the Social Security Act to provide for a voluntary prescription drug benefit under the Medicare program and to strengthen and improve the Medicare program, and for other purposes; as follows:

On page 8, line 12, insert “(including syringes and necessary insulin syringes associated with the administration of insulin, as defined by the Administrator)” before the semicolon.

On page 46, line 9, after the end period insert: “Such requirement shall not apply to
enrollees of a Medicare Prescription Drug plan who are enrolled in the plan pursuant to a contractual agreement between the plan and an employer or other group health plan that provides employment-based retiree health coverage (as defined in section 1860D–20(d)(4)(B)) if the premium amount is the same for all such enrollees under such agreement.

On page 51, line 19, insert "but with respect to the percentage of such costs that the individual is responsible for under that section", after "1860D–19".

On page 56, strike lines 3 through 19, and insert the following:

"(B) INNOCULATED PROVISIONS.—Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated under a Medicare Prescription Drug plan with respect to covered drugs under the plan relative to such drugs, on behalf of eligible beneficiaries, shall (notwithstanding any other provision of law) not be taken into account for the purposes of section 1927(c)(1)(C).

On page 74, strike lines 14 through 16, and insert the following:

"(D) the average aggregate projected cost of covered drugs under the plan relative to other Medicare Prescription Drug plans and Medicare Advantage plans; or

(E) other factors determined appropriate by the Administrator.

Beginning on page 88, strike lines 9 through page 89, line 10, and insert the following:

"(ii) the aggregate amount of payments made by the entity to pharmacies and other entities with respect to such coverage for such enrollees; and

"(iii) the aggregate amount of discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made to the entity with respect to such coverage for such enrollees.

"(2) CERTAIN EXPENSES NOT INCLUDED.—The amount under paragraph (1)(A) may not include—

"(i) administrative expenses incurred in providing the coverage described in subparagraph (A)(i); or

"(ii) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6a(2).

On page 128, between lines 12 and 13, insert the following:

"(B) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—

"(A) IN GENERAL.—The term ‘qualified State pharmaceutical assistance program’ means a State pharmaceutical assistance program, with respect to a qualifying covered individual who is covered under the program, the following requirements are met:

"(i) ASSURANCE.—The State offering the program shall, annually or at such other time as the Administrator may require, provide the Administrator an attestation, in accordance with the procedures established under section 1860D–19, that the actuarial value of prescription drug coverage under the plan is at least equal to the actuarial value of standard prescription drug coverage.

"(ii) AUDITS.—The sponsor of the plan, or an administrator of the plan designated by the sponsor, shall maintain (and afford the Administrator access to) such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made under this part to the extent required by the requirements in paragraph (i).

On page 92, strike lines 20 through page 93, line 25, and insert the following:

"(3) ESTABLISHMENT OF ALLOWABLE COSTS.—For each year, the Administrator shall establish the allowable costs for each Medicare Prescription Drug plan for the year. The allowable costs for a plan for a year shall be equal to the amount described in paragraph (1)(A)(i) for the plan for the year.

On page 126, strike lines 11 and 12, and insert the following:

"(i) is eligible for medicare cost-sharing described in section 1905(p)(3)(A)(i) under the State plan under title XIX (or under a waiver of such plan), on the basis of being described in section 1902(a)(10)(E)(iii), as determined under such plan (or under a waiver of such plan); and

"(ii) is eligible for medicare cost-sharing described in section 1905(p)(3)(A)(ii) under the State plan under title XIX (or under a waiver of such plan), on the basis of being described in section 1902(a)(10)(E)(iii), as determined under such plan (or under a waiver of such plan); and

On page 116, strike lines 11 and 12, and insert the following:

"(A) An eligible entity offering a Medicare Prescription Drug plan under this part.

"(B) A Medicare Advantage organization offering a Medicare Advantage plan under part C (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage).

"(C) The sponsor of a qualified retiree prescription drug plan.

"(D) A State offering a qualified State pharmaceutical assistance program.

Beginning on page 127, strike line 18, and insert the following:

"(B) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—

"(A) IN GENERAL.—The term ‘qualified State pharmaceutical assistance program’ means a State pharmaceutical assistance program, with respect to a qualifying covered individual who is covered under the program.

Beginning on page 127, strike line 18, and insert the following:

"(B) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—

"(A) IN GENERAL.—The term ‘qualified State pharmaceutical assistance program’ means a program—
Section 1860D–22. (a) Direct Subsidy. —

(i) that is in operation as of the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003;

(ii) that is sponsored and financed by a State and provides for the payment to a State offering a qualified State pharmaceutical assistance program (as defined in section 1860D–2(e)(6)) for each applicable low-income individual enrolled in the program for each month for which such individual is so enrolled.

(2) Amount of Payment. —

(A) In General. —The amount of the payment under paragraph (1) shall be the amount the Administrator estimates would be applicable to the applicable low-income individual under section 1860D–19 with respect to the applicable low-income individual if such individual was enrolled in this part and under a Medicare Part D plan or a Medicare Advantage plan.

(B) Maximum Payments. —In no case may the amount of the payment determined under subparagraph (A) with respect to an applicable low-income individual exceed, as estimated by the Administrator, the average amounts made in a year under section 1860D–19 for each applicable low-income individual enrolled under this part with income that is the same as the income of the applicable low-income individual.

(3) Applicable Low-Income Individual. —

For purposes of this subsection, the term ‘applicable low-income individual’ means an individual who is both —

(A) a qualifying covered individual (described in subparagraph (D) of section 1860D–19(e)); and

(B) a qualified Medicare beneficiary, a specified Medigap policy beneficiary, or a subsidy-eligible individual, as such terms are defined in section 1860D–19(a)(4).

(c) Payment Methods. —

(1) In General. —Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which intergovernmental amounts under this section are made during a year based on the Administrator’s best estimate of the amounts payable after obtaining all of the information.

(2) Source of Payments. —Payments under this section shall be made from the Prescription Drug Rebate Program as a whole.

(d) Construction. —Nothing in this section or section 1860D–20 shall affect the provisions of section 1860D–20(b).

147: On page 147, between lines 19 and 20, insert: "Secretary" and all that follows through "and all that follows through the following:"

(A) the determination of the eligibility of individuals residing in the State for medical assistance for payment of the cost of Medicare cost-sharing under the Medicaid program pursuant to sections 1902(a)(10)(E) and 1933, the transitional prescription drug assistance card program under section 1807A, or premium and cost-sharing subsidies under section 1860D–19, and

(B) the transitional prescription drug assistance card program under section 1807A, or premium and cost-sharing subsidies under section 1860D–19, and

(2) striking "$30,000,000" and inserting "$37,500,000."
"(i) a prescription shall be written and not transmitted electronically if the patient makes such a request; and
(ii) no additional charges may be imposed on the patient for making such a request.

On page 199, strike lines 10 through 14, and insert the following:

"(A) IN GENERAL.—Individuals or entities that submit electronic prescriptions electronically shall comply with the standards adopted or modified under this part.

On page 200, between lines 16 and 17, insert the following:

"(e) No Requirement to Transmit or Receive Prescriptions Electronically.—Nothing in this section shall require an individual or entity to transmit or receive prescriptions electronically.

On page 254, line 25, insert "(other than deemed agreements or agreements under section (j)(6))" before "with a sufficient number".

On page 255, line 7, before the period, insert the following: "except that, if a plan entirely meets such requirement with respect to a category of health care professional or provider on the basis of subparagraph (B), it may provide a higher beneficiary copayment in the case of health care professionals and providers of that category who do not have contracts or agreements (other than deemed agreements or agreements under section (j)(6)) to provide covered services under the terms of the plan.".

On page 379, strike lines 9 through 13, and insert the following:

"(A) In General.—The term 'specialized Medicare+Choice plans for special needs beneficiaries' means a Medicare+Choice plan that—
(1) exclusively serves special needs beneficiaries (as defined in subparagraph (B)), or
(2) to the extent provided in regulations prescribed by the Secretary, disproportionately serves special needs beneficiaries, frail elderly Medicare beneficiaries, or both.

Beginning on page 411, strike line 5 through page 414, line 9, and insert the following:

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) In General.—Section 1886(d)(3)(A)(iv) (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended by striking "(iv) For discharges" and inserting "(iv)(I) Subject to subparagraph (ii), for discharges and (ii) by adding at the end the following new

(b) Application to Subsection (d) Puerto Rico Hospitals.—Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—
(1) in subparagraph (A)—
(2) by adding the at the end following new

(c) Conforming Amendments.—

(1) Computing DRG-Specific Rates.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(2) by adding the at the end following the following new

(3) In the matter preceding clause (i), by inserting "for fiscal years before fiscal year 2004," before "for hospitals"; and

(4) by adding the following new

(5) For discharges occurring in a fiscal year (beginning with fiscal year 2004), the Secretary shall compute a standardized amount for hospitals located in any area in the United States and within each region equal to the standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area, increased by the applicable percentage increase under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year 2003, for hospitals located in all areas, to the product of—

(6) (i) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year 2003; and

"(ii) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.

(d) Technical Conforming Sunset.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(1) in the matter preceding subparagraph (A), by inserting "for fiscal years before fiscal year 1997," before "a regional adjusted DRG prospective payment rate"; and

(2) in subparagraph (D), in the matter preceding clause (i), by inserting "for fiscal years before fiscal year 1997," before "a regional DRG prospective payment rate for each region.

On page 430, strike lines 18 through 21, and insert the following:

(b) Permitting Nurse Practitioners, Physician Assistants, and Clinical Nurse Specialist to Review Hospice Plans of Care.—Section 1814(a)(7)(B) is amended by inserting "clinical nurse practitioner or clinical nurse specialist who is not an employee of the hospice program, and whom the individual identifies as the health care provider having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive Medicare hospice care" after "and is periodically reviewed by the individual's attending physician."
(c) Effective Date.—The amendments made by this section shall apply to hospice care furnished on or after October 1, 2004.

On page 486, line 9, strike “(iii)” and insert “(ii)”.

On page 488, after line 25, add the following:

(c) Limitation of Expenditures in Years Prior to 2014.—(1) In General.—The Secretary shall ensure that the total amount of expenditures under title XVIII of the Social Security Act (including amounts expended by reason of this section) in a year prior to 2014 does not exceed the sum of—

(A) the total amount of expenditures under such title XVIII that would have made if this section had not been enacted; and

(B) the applicable amount.

(b) Applicable Amount.—For purposes of paragraph (1), the term “applicable amount” means—

(A) for 2005, $322,000,000;

(B) for 2006, $341,000,000;

(C) for 2007, $366,000,000;

(D) for 2008, $383,000,000;

(E) for 2009, $400,000,000;

(F) for 2010, $420,000,000;

(G) for 2011, $440,000,000;

(H) for 2012, $488,000,000; and

(I) for 2013, $500,000,000.

(c) Steps to Ensure Funding Limitation Not Violated.—If the Secretary determines that the application of this section will result in the funding limitation described in paragraph (1) being exceeded for any year, the Secretary shall take appropriate steps to stay within such funding limitation, including through limiting the number of clinical trials deemed under section (a) and only covering a portion of the routine costs described in such subsection.

On page 516, after line 22, add the following:

Sec. 446. Authorization of Reimbursement for All Medicare Part B Services Furnished by Certain In-Dian Hospitals and Clinics.

(a) In General.—Section 1880(e) (42 U.S.C. 1395s(e)) is amended—

(1) in paragraph (1)(A), by striking “for services described in paragraph (2)” and inserting “for all items and services for which payment may be made under such part”;

(2) by striking paragraph (2); and

(3) by redesignating paragraph (3) as paragraph (2).

(b) Effective Date.—The amendments made by this section shall apply to items and services furnished on or after October 1, 2004.

Sec. 447. Coverage of Cardiovascular Screening Tests.

(a) Coverage.—Section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking “and” at the end;

(2) in subparagraph (V), by inserting “and” at the end; and

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

“Cardiovascular Screening Tests

(www(x)): The term ‘cardiovascular screening tests’ means the following diagnostic tests for the early detection of cardiovascular disease:

(A) Tests for the determination of cholesterol levels.

(B) Tests for the determination of lipid levels of the blood.

(C) Such other tests for cardiovascular disease as the Secretary may approve.”
the Treasury, Postal Service and General Government Appropriations Act, 1995. Fees collected under this section shall be available for use by the Internal Revenue Service under authority provided in advance in an appropriations Act.

SEC. 450A. INCREASING TYPES OF ORIGINATING TES FOR FELICITATING THE PROVISION OF TELE-HEALTH SERVICES ACROSS STATE LINES.

(a) INCREASING TYPES OF ORIGINATING SITES.—Section 183(h)(4)(C)(ii) (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subparagraph:

"(VIII) A board-and-care home (as defined by the Secretary)."

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 448. MEDICARE COVERAGE OF SELF-INJECTED BIOLOGICALS.

(a) COVERAGES.—

(1) IN GENERAL.—Section 1861(s)(2) (42 U.S.C. 1395b(s)(2)) is amended—

(A) in subparagraph (U), by striking "and" at the end; and

(B) in subparagraph (V), by inserting "and" at the end; and

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

"(W)(i) a self-injected biological (which is approved by the Food and Drug Administration that is prescribed as a complete replacement for a drug or biological (including the same biological for which payment is made under this title when it is furnished in conjunction with the service) that is otherwise described in subparagraph (A) or (B) and that is furnished during 2004 or 2005; and

(ii) a self-injected drug that is used to treat multiple sclerosis";

(b) CONFORMING AMENDMENT.—Subparagraphs (A) and (B) of section 1861(s)(2) of the Social Security Act (42 U.S.C. 1395b(s)(2)) are each amended by inserting "except for any drug or biological described in subparagraph (W)," after "which;"

(c) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to drugs and biologicals furnished on or after January 1, 2004 and before January 1, 2006.

SEC. 449. EXEMPTION FROM MEDICARE SECONDARY PAYER RULES FOR INDIVIDUALS WITH END-STAGE RENAL DISEASE.

Section 1862(b)(1)(C) (42 U.S.C. 1395y(b)(1)(C)) is amended—

(1) in the last sentence, by inserting "and, before January 1, 2004" after "prior to such date"; and

(2) by adding at the end the following new sentence: "Effective for items and services furnished on or after January 1, 2004 and before June 1, 2002, clauses (i) and (ii) shall be applied by substituting 36-month for 12-month each place it appears in the first sentence.

SEC. 450. REOPENING THE INTERNAL REVENUE SERVICE TO DEPOSIT INSTALLMENT AGREEMENT AND OTHER FEES IN THE TREASURY AS MISCELLANEOUS RECEIPTS.

Notwithstanding any other provision of law, the Secretary of the Treasury is required to deposit in the Treasury as miscellaneous receipts any fee receipts, including fees from installment agreements and restructured installment agreements, collected under the authority provided by Section 3 of the Administrative Provisions of the Internal Revenue Service of Public Law 103-329, the Treasury, Postal Service and General Government Appropriations Act, 1995. Fees collected under this section shall be available for use by the Internal Revenue Service under authority provided in advance in an appropriations Act.

SEC. 450A. INCREASING TYPES OF ORIGINATING TES FOR FELICITATING THE PROVISION OF TELE-HEALTH SERVICES ACROSS STATE LINES.

(a) INCREASING TYPES OF ORIGINATING SITES.—Section 183(h)(4)(C)(ii) (42 U.S.C. 1395m(m)(4)(C)(ii)) is amended by adding at the end the following new subparagraph:

"(VII) An assisted-living facility (as defined by the Secretary)."

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2005.

SEC. 450B. DEMONSTRATION PROJECT FOR COVERAGE OF SURGICAL FIRST ASSISTANT SERVICES.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part D of title XVIII of the Social Security Act under which payment is made for surgical first assistant services furnished by a certified registered nurse first assistant to a Medicare beneficiary.

(b) DEFINITIONS.—In this section:

(1) SURGICAL FIRST ASSISTANT SERVICES.—The term "surgical first assistant services" means services consisting of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

(2) CERTIFIED REGISTERED NURSE FIRST ASSISTANT.—The term "certified registered nurse first assistant" means an individual who—

(A) is a registered nurse and is licensed to practice nursing in the State in which the surgery first assisting services are performed;

(B) has completed a minimum of 2,000 hours of first assisting a physician with surgery and related preoperative, intraoperative, and postoperative care; and

(C) is certified as a registered nurse first assistant by an organization recognized by the Secretary.

(c) PAYMENT RATES.—Payment under the demonstration project for surgical first assisting services furnished by a certified registered nurse first assistant shall be made at the rate of 80 percent of the lesser of the actual charge for the services or 85 percent of the amount determined under the fee schedule established under section 1840(b) of the Social Security Act (42 U.S.C. 1395w–4(b)) for the same services if furnished by a physician.

(d) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in 2 States selected by the Secretary.

(e) DURATION.—The Secretary shall conduct the demonstration project for the 3-year period beginning on the date that is 90 days after the date of the enactment of this Act.

(f) REPORT.—Not later than January 1, 2007, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient outcomes under the project, as well as an analysis of the cost effectiveness of the project.

(g) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide the demonstration project funds under the Medicare Supplementary Insurance Trust Fund established under section 1811 of the Social Security Act (42 U.S.C. 1395w) of such funds as are necessary for the Secretary to carry out the project under this section.

(2) BUDGET NEUTRALITY.—In conducting the project under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the project under this section was not implemented.

(3) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act to the extent that the Secretary determines is necessary to conduct demonstration projects.

SEC. 450C. EQUITABLE TREATMENT FOR CHILDREN'S HOSPITALS AND CHILDREN'S HOSPITALS.

(a) IN GENERAL.—Section 1833(i)(7)(D)(ii) (42 U.S.C. 1395l(i)(7)(D)(ii)) is amended to read as follows:

"(ii) PERMANENT TREATMENT FOR CANCER HOSPITALS AND CHILDREN'S HOSPITALS.—

"(I) IN GENERAL.—Subject to clause (II), in the case of a hospital described in clause (II), or (v) of section 1886(b)(1)(B), for covered OPD services for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.

"(II) SPECIAL RULE FOR CERTAIN CHILDREN'S HOSPITALS.—In the case of a hospital described in section 1886(d)(1)(B)(iii) that is located in a State for which the PPS amount is less than the greater of the pre-BBA amount or the reasonable operating and capital costs without reductions of the hospital in proportion to the percentage of payment under this subsection shall be increased by the amount of such difference."
SEC. 450D. TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.

Section 1416(b) (42 U.S.C. 1395w-4(b)) is amended—

(1) in paragraph (1), in the matter preceding subparagraph (A), by striking “paragraph (2)” and inserting “paragraphs (2) and (4)”;

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

“(4) TREATMENT OF PHYSICIANS' SERVICES FURNISHED IN ALASKA.—

“(A) IN GENERAL.—With respect to physicians’ services furnished in Alaska on or after January 1, 2004, and before January 1, 2006, for such services shall be determined as follows:

“(i) Subject to clause (ii), the payment amount for a service furnished in a year shall be an amount equal to—

“(I) in the case of services furnished in calendar year 2001, 90 percent of the VA Alaska fee schedule amount for the service for fiscal year 2001; and

“(II) in the case of services furnished in calendar year 2005, the amount determined under subclause (I) for 2004, increased by the annual update determined under subsection (d) for the year involved.

“(ii) In the case of a service for which there is no fee schedule amount for fiscal year 2001, the payment amount shall be an amount equal to—

“(I) the amount of payment for the service that would otherwise apply under this section; plus

“(II) an amount equal to the applicable percent (as described in subparagraph (C)) of the amount described in subclause (I).

“(B) VA ALASKA FEE SCHEDULE AMOUNT.—

For purposes of this paragraph, the term ‘VA Alaska fee schedule amount’ means the amount that was paid by the Department of Veterans Affairs in Alaska in fiscal year 2001 for non-Department of Veterans Affairs physicians associated with either outpatient or inpatient care provided to individuals eligible for hospital care or medical services under chapter 17 of title 38, United States Code, at a non-Department facility (as that term is defined in section 1701(4) of such title 38).

“(C) APPLICABLE PERCENT.—For purposes of this paragraph, the applicable percent means the weighted average percentage (based on claims under this section) by which the fiscal year 2001 VA Alaska fee schedule amount exceeds the mean for physicians’ services rendered in the United States (or an equivalent foreign area in which the services are furnished) for the year in which the project is conducted under paragraph (1).

“(B) LIMITATION.—The total amount of the payments that may be made under this section shall not exceed $2,500,000 for each fiscal year in which the project is conducted under paragraph (1).

“(c) COVERAGE AS MEDICARE PART B SERVICES.—

(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, medical nutrition therapy services furnished under the project shall be considered to be services furnished under part B of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) PAYMENT.—For such services shall be made at a rate of 80 percent of the actual charge for the services or 85 percent of the fee schedule amount provided under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for the same services if such services were furnished by a physician.

“(d) APPLICATION OF LIMITS OF BILLING.—The provisions of section 1822(b)(2) of the Social Security Act (42 U.S.C. 1395b–2) shall apply to a group weight loss management professional furnishing services under the project in the same manner as they apply to a practitioner described in subparagraph (C) of such section furnishing services under title XVIII of such Act.

“(e) REPORTS.—The Secretary shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the project and a final report on the project not later than the date that is 6 months after the date on which the project concludes. The final report shall include an evaluation of the impact of the use of group weight loss management services as part of medical nutrition therapy on Medicare beneficiaries and on the Medicare program, including any impact on reducing costs under the program and improving the health of beneficiaries.

“(A) DEFINITIONS.—For purposes of this section—

“(1) The term ‘obesity’ means that an individual has a Body Mass Index (BMI) of 30 and above.

“(2) GROUP WEIGHT LOSS MANAGEMENT SERVICES.—The term ‘group weight loss management services’ means comprehensive serv-

ices furnished by a group weight loss professional who has been diagnosed and referred by a physician as having impaired glucose tolerance and who are obese that consist of—

“(A) a community-based treatment based on the needs of individuals as determined by a group weight loss management professional; or

“(B) a specific program or method that has demonstrated its efficacy to produce and maintain weight loss through results published in peer-reviewed scientific journals using recognized research methods and statistical analysis that provides—

“(i) assessment of current body weight and recording of weight status at each meeting session;

“(ii) provision of a healthy eating plan;

“(iii) provision of an activity plan; and

“(iv) provision of a behavior modification plan; and

“(v) a weekly group support meeting.

“(3) GROUP WEIGHT LOSS MANAGEMENT PROFESSIONAL.—The term ‘group weight loss management professional’ means an individual who has completed training to provide a program or method that has completed clinical trials and published evidence of efficacy through publications in peer-reviewed scientific journals who—

“(A)(i) holds a baccalaureate or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) in nutrition social work, psychology with experience in behavioral modification methods to reduce obesity; or

“(ii) has completed a curriculum of training for a specific behavioral based weight management program established under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) and recommended in the NIH Clinical Guidelines on Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, chapters 1, 2, 3, 4, and pursuant to guidelines by the Secretary; and

“(B) is licensed or certified as a group weight loss management professional by the State in which the services are performed; or

“(C) is certified by an organization that meets such criteria as the Secretary establishes.

“(4) IN GENERAL.—Subject to subparagraph (A), the Secretary shall provide for the demonstration program described in paragraphs (2) and (3) of section 455A of the Public Health Service Act (42 U.S.C. 300gg–24), recommended in the NIH Clinical Guidelines on Identification, Evaluation, and Treatment of Overweight and Obesity in Adults, and parts 1, 2, 3, 4, and pursuant to guidelines by the Secretary; and

“(5) IN GENERAL.—(A) The Secretary shall submit to the Committee on Ways and Means and the Committee on Commerce of the House of Representatives and the Committee on Finance of the Senate a report on the project in the same manner as they report on the project in the same manner as they reported to Congress in the last legislative session.

“(B) The Secretary shall provide for the demonstration program under subsection (a) for a limited period of time.
(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395f(b)(2)) is amended—
(A) in subparagraph (A)(ii), by striking "promptly as determined in accordance with paragraph (2)";
(B) in subparagraph (B)—
(i) by redesigning clauses (i) through (iii) as clauses (ii) through (iv), respectively; and
(ii) by redesigning clauses (iv) to (Z) as so redesignated, the following new clause:
"(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this subsection with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly as determined in accordance with regulations. Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.",(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).
(b) CLARIFYING AMENDMENTS TO CONDITIONAL PAYMENT PROVISIONS.—Section 1862(b)(2) (42 U.S.C. 1395f(b)(2)) is further amended—
(1) in subparagraph (A), in the matter following clause (i), by inserting the following sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by failure to obtain insurance, or otherwise) in whole or in part.";
(2) in subparagraph (B)(i), as redesignated by subsection (a)(2)(B)—
(A) by striking the first sentence and inserting—"A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or has had a responsibility to make payment with respect to such item or service. A primary plan’s responsibility for such payment may be demonstrated by a judgment, a payment condition upon the recipient’s compromise, waiver, settlement (whether or not there was a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means.",(B) in the final sentence, by striking "on the date notice of, or information related to, a primary plan’s responsibility for such payment or other information is received" and inserting "on the date notice of, or information related to, a primary plan’s responsibility for such payment or other information is received"; and
(3) in subparagraph (B)(ii), as redesignated by subsection (a)(2)(B), by striking the first sentence and inserting the following: "In order to recover payment made under this title for an item or service, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, or otherwise) to maintain payment with respect to such item or service (whether or not there was a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan’s insured, or by other means.",(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395f(b)) is amended—
(1) by redesigning paragraph (2) by moving the indentation of clauses (i) through (v) 2 ems to the left; and
(2) in paragraph (3)(A), by striking "such" before "paragraphs":
SEC. 457. MEDICARE PANCREATIC ISLET CELL TRANSPLANTATION DEMONSTRATION GUIDANCE.
(a) ESTABLISHMENT.—In order to test the appropriateness of pancreatic islet cell transplantation, 120 days after the date of the enactment of this Act, the Secretary shall establish a demonstration project which the Secretary, for purposes of payments under section 1842 of title XVIII of the Social Security Act for pancreatic islet cell transplantation and related items and services in the case of medicare beneficiaries who have type 1 (juvenile) diabetes and have end stage renal disease.
(b) DURATION OF PROJECT.—The authority of the Secretary to conduct the demonstration project under this section shall terminate on the date that is 5 years after the date of the establishment of the project.
(c) EVALUATION.—The Secretary shall conduct an evaluation of the outcomes of the demonstration project. Not later than 180 days after the date of the termination of the demonstration project under subsection (b), the Secretary shall submit to Congress a report on the project, including recommendations to paragraph 543, sentence at the end: "An entity that engages in a business, trade, or profession shall be deemed to have a self-insured plan if it carries its own risk (whether by failure to obtain insurance, or otherwise) in whole or in part.",(a) IN GENERAL.—Section 1895 of the Social Security Act (42 U.S.C. 1395ff(b)) is amended by adding at the end the following:
"(1) INCREASE IN MEDICARE PAYMENT FOR CERTAIN HOME HEALTH SERVICES.—
(a) IN GENERAL.—Section 1895 of the Social Security Act (42 U.S.C. 1395ff(b)) is amended by adding at the end the following:
"(f) INCREASE IN PAYMENT FOR SERVICES FURNISHED IN A RURAL AREA.—
"(1) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1861(s)(2)(D)) on or after October 1, 2004, and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under this section for such services by 10 percent.
"(2) WAIVER OF BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under this section applicable to home health services furnished during any period to offset the increase in payments resulting from the application of paragraph (1).
(b) PAYMENT ADJUSTMENT.—Section 1895(b)(3)(A) of the Social Security Act (42 U.S.C. 1395ff(b)(3)(A)) is amended by adding at the end the following:
"(a) AMENDMENT.—Section 1869(b)(3)(A) of the Social Security Act (42 U.S.C. 1395ff(b)(3)(A)) is amended—
(1) by redesigning paragraph (3)(A) by moving the indentation of clauses (i) through (iv) 2 ems to the left; and
(2) in paragraph (4)(A), by striking "such" before "paragraphs":
SEC. 519. ELIMINATION OF REQUIREMENT TO USE SOCIAL SECURITY ADMINISTRATION ADMINISTRATIVE LAW JUDGES.
The first sentence of section 1869(f)(2)(A)(i) is amended—
SEC. 520. ELIMINATION OF REQUIREMENT FOR DE NOVO DEPARTMENTAL APPEALS BOARD.
Section 1869(d)(2) (42 U.S.C. 1395ff(d)(2)) is amended to read as follows:
(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out section 1874A(f) of the Social Security Act, as added by subsection (a).
On page 625, between lines 19 and 20, insert the following:

Subtitle F—Other Improvements

SEC. 551. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT CERTIFIED NURSING FACILITY AND HOSPITAL BENEFITS.

(a) In general.—The Secretary shall provide that in medicare beneficiary notices provided under section 1806(a)(1) of the Social Security Act, 42 U.S.C. 1395b–7(a), with respect to the post-hospital extended care services and inpatient hospital services under title XVIII of Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for medicare beneficiary and spell of illness involved.

(b) Effective date.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of enactment of this Act.

SEC. 552. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) Availability of data.—The Secretary shall ensure that information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) Inclusion of information in certain hospital discharge plans.—

(1) In general.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended—

(A) by striking “hospice services” and inserting “hospice care and post-hospital extended care services”; and

(B) by inserting, before the period at the end the following: “and, in the case of individual who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides.”

(2) Effective date.—The amendments made by paragraph (1) shall take effect on the date that is 60 days after the date of enactment of this Act.

SEC. 553. EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES CONSIDERED TO BE MANDATORY.

The Secretary shall ensure, before making changes in documentation guidelines for, or clinical examples of, or codes to report evaluation and management services under title XVIII of Social Security Act, that the process used in developing such guidelines, examples, or codes was widely consulted among physicians, reflects a broad consensus among specialties, and would allow verification of reported and furnished services.

SEC. 554. COUNCIL FOR TECHNOLOGY AND INNOVATION.

Section 1868 (42 U.S.C. 1395e), as amended by section 339(a), is amended by adding at the end the following new subsection:

“(c) Council for Technology and Innovation.—

“(1) Establishment.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as ‘CMS’).

“(2) Composition.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed under paragraph (4)).

“(3) Duties.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

“(4) Executive Coordinator for Technology and Innovation.—The Secretary shall appoint a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. The Executive Coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as the single public point of contact for groups and entities regarding the coding, coverage, and payment processes under this title.”

SEC. 555. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) In general.—Section 1861 (42 U.S.C. 1395f–1) is amended by adding after subsection (g) the following new subsection:

“(h)(1) Subject to paragraph (2), a group health plan may require a claims determination for such benefit if a participant or enrollee makes a claim for benefits under the group health plan.

“(2) A group health plan may not require a claims determination for such benefit if the participant or enrollee makes a claim for benefits under the group health plan.

(2) Effective date.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of enactment of this Act.

SEC. 556. 100 PERCENT FMAP FOR MEDICAL ASSISTANCE PROVIDED TO A NATIVE HAWAIIAN (AS DEFINED UNDER THE MEDICAID PROGRAM) OR A NATIVE HAWAIIAN QUALIFIED HEALTH CENTER OR A NATIVE HAWAIIAN HEALTH CARE SYSTEM UNDER THE MEDICAID PROGRAM.

(a) General.—Section 1866(b)(2) of the Social Security Act (42 U.S.C. 1396b(b)(2)) is amended, in the third sentence thereof, with respect to medical assistance provided to a Native Hawaiian (as defined in section 12 of the Native Hawaiian Health Care Improvement Act) or a Federally-qualified health center or a Native Hawaiian health care system (as so defined) whether directly, by referral, or under contract or other arrangement with a Federally-qualified health center or a Native Hawaiian health care system and another health care provider” before the period.

Effective date.—The amendment made by this section applies on or after the date of enactment of this Act.

SEC. 617. EXTENSION OF MORTARIUM.


(1) by striking “until December 31, 2002”, and

(2) by striking “Kent Community Hospital Complex in Michigan or.”

(b) Effective date.—
(1) PERMANENT EXTENSION.—The amendment made by subsection (a)(1) shall take effect as if included in the amendment made by section 4758 of the Balanced Budget Act of 1997.

(2) MODIFICATION.—The amendment made by subsection (a)(2) shall take effect on the date of enactment of this Act.

SEC. 618. COMPTROLLER GENERAL OF UNITED STATES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of price controls imposed on pharmaceuticals in France, Germany, Italy, Japan, the United Kingdom, and Canada to review the impact such regulations have on consumers, including American consumers, and on innovation in medicine. The study shall include the following:

(1) The pharmaceutical price control structure in each country for a wide range of pharmaceuticals, compared with average pharmaceutical prices paid by Americans covered by private sector health insurance.

(2) The proportion of the cost for innovation borne by American consumers, compared with consumers in the other 6 countries.

(3) A review of how closely the observed prices in local markets correspond to the prices that efficiently distribute common costs of production (“Ramsey prices”).

(4) A review of any peer-reviewed literature that relates variation in health consequences to patients in the listed countries that result from the absence or delayed introduction of medicines, including the cost of not having access to medicines, in terms of lower life expectancy and lower quality of health.

(5) The impact on American consumers, in terms of reduced research into new or improved medicines (including the cost of delaying the introduction of a significant advance in certain major diseases), if similar price controls were adopted in the United States.

(6) The existing standards under international conventions, including the World Trade Organization and the North American Free Trade Agreement, regarding regulated pharmaceutical prices, including any restrictions on anti-competitive laws that might apply to price regulations and how economic harm can be mitigated.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit a report on the study conducted under subsection (a).

SEC. 619. SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION.

(a) IN GENERAL.—Title XI (42 U.S.C. 1320 et seq.) is amended by adding at the end the following new part:

‘‘PART D.—SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION’’

‘‘SAFETY NET ORGANIZATIONS AND PATIENT ADVISORY COMMISSION’’

‘‘SEC. 181. (a) ESTABLISHMENT.—There is hereby established the ‘‘Safety Net Organizations and Patient Advisory Commission’’ (in this section referred to as the ‘‘Commission’’).

‘‘(b) REVIEW OF HEALTH CARE SAFETY NET PROGRAMS.—The Comptroller General of the United States shall conduct an ongoing review of the health care safety net programs (as described in paragraph (3)(C)) by—

‘‘(A) monitoring each health care safety net program to document and analyze the effects of changes to these programs on the core health care safety net;

‘‘(B) evaluating the impact of the Emergency Medical Treatment and Labor Act, the Health Insurance Portability and Accountability Act of 1996, the Balanced Budget Act of 1997, the Medicare, Medicaid, and SCHIP Benefits Protection and Improvement Act of 2000, Prescription Drug and Medicare Improvement Act of 2003, and other forces on the core health care safety net to continue their roles in the core health care safety net system to care for uninsured individuals, Medicaid beneficiaries, and other vulnerable populations;

‘‘(C) monitoring existing data sets to assess the status of the core health care safety net and health outcomes for vulnerable populations;

‘‘(D) wherever possible, linking and integrating existing data systems to identify impending failures of core health care safety net systems and providers;

‘‘(E) establishing an early-warning system to identify impending failures of core health care safety net systems and providers; and

‘‘(F) monitoring and providing oversight for the transition of individuals receiving supplemental security income benefits, medical assistance under title XIX, or child health assistance under title XXI who enroll with a managed care entity (as defined in section 1923(a)(1)(B)), including the review of—

‘‘(i) the degree to which these plans have the capacity (including case management and management information system infrastructure) to offer appropriately managed care services to such an individual;

‘‘(ii) the degree to which these plans may be overburdened by adverse selection; and

‘‘(iii) the degree to which emergency care programs are used by enrollees of these plans; and

‘‘(G) identifying and disseminating the best practices for more effective application of the lessons that have been learned.

‘‘(2) REPORTS.—

‘‘(A) ANNUAL REPORTS.—Not later than June 1 of each year (beginning with 2005), the Commission shall, based on the review conducted under paragraph (1), submit to the appropriate committees of Congress a report on—

‘‘(i) the health care needs of the uninsured; and

‘‘(ii) the financial and infrastructure stability of the Nation’s core health care safety net.

‘‘(B) AGENDA AND ADDITIONAL REVIEWS.—

‘‘(I) AGENDA.—The Chair of the Commission shall consult periodically with the Chairpersons and Ranking Minority Members of the appropriate committees of Congress regarding the Commission’s agenda and progress toward achieving the agenda.

‘‘(ii) ADDITIONAL REVIEWS.—The Commission shall conduct additional reviews and submit additional reports to the appropriate committees of Congress on topics relating to the health care safety net programs under the following circumstances:

‘‘(I) If requested by the Chairpersons or Ranking Minority Members of such committees.

‘‘(II) If the Commission deems such additional reviews and reports necessary to complete the study.

‘‘(C) AVAILABILITY OF REPORTS.—The Commission shall transmit to the Comptroller General and the Secretary a copy of each report submitted under this subsection and shall make such reports available to the public.

‘‘(3) DEFINITIONS.—In this section:

‘‘(A) APPROPRIATE COMMITTEES OF CONGRESS.—The term ‘appropriate committees of Congress’ means the Committees on Ways and Means and Energy and Commerce of the House of Representatives and the Committees on Finance and Education, Labor, and Pensions of the Senate.

‘‘(B) CORE HEALTH CARE SAFETY NET.—The term ‘core health care safety net’ means any health care program that the Commission determines to be appropriate.

‘‘(i) by legal mandate or explicitly adopted mission, offers access to health care services to patients, regardless of the ability of the patient to pay for such services;

‘‘(ii) has a case mix that is substantially comprised of patients who are uninsured, covered under the medicaid program, covered under any other public health care program, or are otherwise vulnerable populations.

‘‘Such term includes disproportionate share hospitals, Federally qualified health centers, other Federal, State, and locally supported clinics, rural health clinics, local health departments, and providers covered under the Emergency Medical Treatment and Labor Act.

‘‘(C) HEALTH CARE SAFETY NET PROGRAMS.—The term ‘health care safety net programs’ includes the following:

‘‘(i) Medicaid.—The medicaid program under title XIX.

‘‘(ii) SCHIP.—The State children’s health insurance program under title XXI.

‘‘(iii) MEDICAID.—The medicaid program under section 1902(a)(10)(B).

‘‘(iv) FQHC PROGRAMS.—Each federally funded program under which a health center (as defined in section 330(c) of the Public Health Service Act), a Federally qualified health center (as defined in section 1861(aa)(4)), or a Federally-qualified health center (as defined in section 1905(l)(2)(B)) receives funds.

‘‘(v) HHC PROGRAMS.—Each federally funded program under which a rural health clinic (as defined in section 1861(aa)(4) or 1905(l)(1)) receives funds.

‘‘(vi) DSH PAYMENT PROGRAMS.—Each federally funded program under which a rural health center (as defined in section 1861(aa)(4) or 1905(l)(1)) receives funds.

‘‘(vii) EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT.—All care provided under section 1867 for the uninsured, underinsured, beneficiaries under title XIX, and other vulnerable individuals.

‘‘(viii) OTHER HEALTH CARE SAFETY NET PROGRAMS.—The Commission determines to be appropriate.

‘‘(D) VULNERABLE POPULATIONS.—The term ‘vulnerable populations’ includes uninsured and underinsured individuals, low-income individuals, farm workers, homeless individuals, individuals with disabilities, individuals with HIV or AIDS, and such other individuals as the Commission may designate.

‘‘(E) MEMBERSHIP.—
“(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 13 members appointed by the Comptroller General of the United States (in this section referred to as the ‘‘Comptroller General’’), to serve for 3 years, with the appropriate committees of Congress.

“(2) QUALIFICATIONS.—

“(A) IN GENERAL.—The membership of the Commission shall include individuals with national recognition for their expertise in health finance and economics, health care safety net organizations and program management, actuarial science, health facility management, health plans and integrated delivery systems, management of health facilities, allopathic and osteopathic medicine (including emergency medicine), and other providers of health services, and other related fields. The person whom the Comptroller General designates another member for the remainder of that member’s term.

“(6) MEETINGS.—The Commission shall meet at the call of the Chair or upon the written request of a majority of its members.

“(4) COMPENSATION.—

“(5) CHAIR; VICE CHAIR.—The Comptroller General shall establish a system for the selection of the Chair and Vice Chair for the term of appointment, except that in the case of vacancy of the Chair or Vice Chair, the Comptroller General may designate another member for the remainder of that member’s term.

“(6) EFFECTIVE DATE.—The Comptroller General of the United States shall appoint the initial members of the Safety Net Organizations and Patient Advisory Commission established under subsection (a) not later than June 1, 2004.

SEC. 620. ESTABLISHMENT OF PROGRAM TO PREVENT ABUSE OF NURSING FACILITY RESIDENTS.

“(A) IN GENERAL.—

“(1) SCREENING OF SKILLED NURSING FACILITY AND NURSING FACILITY PROVISIONAL EMPLOYEES.—

“(B) PROHIBITION ON HIRING OF ABUSIVE WORKERS.—

“(C) MAJORITY NONPROVIDERS.—Individuals who are directly involved in the provision, or management of the delivery, of items and services covered under the health care safety net programs of Federal agencies; and

“(D) ETHICAL DISCLOSURE.—The Comptroller General shall establish a system for public disclosure by members of the Commission of financial and other potential conflicts of interest relating to such members.

“(3) TERMS.—

“(A) IN GENERAL.—The terms of members of the Commission shall be for 3 years except that of the members first appointed, the Comptroller General shall designate—

“(i) four to serve a term of 1 year;

“(ii) four to serve a term of 2 years; and

“(iii) two to serve a term of 3 years.

“(B) VACANCIES.—

“(i) IN GENERAL.—A vacancy in the Commission shall be filled in the same manner in which the vacancy occurred.

“(ii) APPOINTMENT.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member’s predecessor was appointed shall be appointed only for the remainder of that term.

“(iii) TERMS.—A member may serve after the expiration of that member’s term until a successor has taken office.

“(4) COMPENSATION.—

“(A) MEMBERS.—While serving on the business of the Commission (including travel time) (other than pay of members of the Commission), all personnel of the Commission shall be treated as if they were employees of the United States Senate.

“(B) TREATMENT.—For purposes of pay (other than pay of members of the Commission) and employment benefits, rights, and privileges, all personnel of the Commission shall be treated as if they were employees of the United States Senate.

“(5) IN GENERAL.—The Comptroller General shall designate a member of the Commission, at the time of appointment of the member as Chair and a member as Vice Chair for that term of appointment, except that in the case of vacancy of the Chair or Vice Chair, the Comptroller General may designate another member for the remainder of that member’s term.

“(6) MEETINGS.—The Commission shall meet at the call of the Chair or upon the written request of a majority of its members.

“(7) DIRECTOR AND STAFF; EXPERTS AND CONSULTANTS.—Subject to such review as the Comptroller General determines necessary to ensure the efficient administration of the Commission, the Commission may—

“(i) employ and fix the compensation of an Executive Director (subject to the approval of the Comptroller General) and such other personnel as may be necessary to carry out the duties of the Commission under this section; and

“(ii) enter into contracts or make other arrangements, as may be necessary for the conduct of the work of the Commission (without regard to section 3709 of the Revised Statutes (5 U.S.C.));

“(8) SCREENING OF SKILLED NURSING FACILITY WORKERS.—

“(A) BACKGROUND CHECKS OF PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), after a skilled nursing facility selects an individual for a provisional or as a skilled nursing facility worker, the facility, prior to employing such worker in a status other than a provisional status to the extent permitted under subparagraph (B)(ii), shall—

“(i) give such worker written notice that the facility is required to perform background checks with respect to provisional employees;

“(ii) require, as a condition of employment, that such worker—

“(B) SCREENING OF SKILLED NURSING FACILITY WORKERS.—

“(1) SCREENING OF SKILLED NURSING FACILITY AND NURSING FACILITY PROVISIONAL EMPLOYEES.—

“(2) DATA COLLECTION.—In order to carry out the duties of the Commission under this section, the Commission shall—

“(A) use existing information, both published and unpublished, where possible, collected by the Secretary, the staff of the Commission or under other arrangements made in accordance with this section;

“(B) carry out, or award grants or contracts for, original research and experimentation, where existing information is inadequate; and

“(C) adopt procedures allowing any interested party to submit information for the Commission’s use in making reports and recommendations.

“(3) ACCESS OF GOV TO INFORMATION.—The Comptroller General shall have unrestricted access to all deliberations, records, and nonproprietary data that pertains to the work of the Commission, immediately upon request. The exchange of providing such information shall be borne by the General Accounting Office.

“(4) PERIODIC AUDIT.—The Commission shall be subject to an audit by the Comptroller General.

“(5) APPLICATION OF FACA.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Commission.

“(1) AUTHORIZATION OF APPOINTMENTS.—

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“(1) AUTHORIZATION OF APPOINTMENTS.—

“(1) APPLICATION OF FACA.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) does not apply to the Comptroller General.
The term ‘conviction for a relevant crime’ shall be fined in accordance with title 18, an act of resident neglect or abuse or misappropriation of resident property; or such other types of acts as the Secretary may specify in regulations.

(iv) SKILLED NURSING FACILITY WORKER.—The term ‘skilled nursing facility worker’ means any individual (other than a volunteer) that has access to a patient of a skilled nursing facility under an employment or provision of services with respect to such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing services permitted by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers and (B) MEDICAID PROGRAM.—Section 1919(b) (42 U.S.C. 1396n(b)) is amended by adding at the end the following new paragraph:

(8) SCREENING OF NURSING FACILITY WORKERS.—

(A) BACKGROUND CHECKS ON PROVISIONAL EMPLOYEES.—Subject to subparagraph (B)(ii), the Secretary shall require a background check under subparagraph (B)(ii), reasonably relies upon information about such individual provided by the State pursuant to subsection (e)(6) or section 1128E shall be liable in any action brought by such individual based on the employment determination resulting from the information.

(iii) CRIMINAL PUNISHMENT.—Whoever knowingly violates the provisions of clause (i) shall be fined not more than $5,000, United States Code, imprisoned for not more than 2 years, or both.

(iv) KNOWING RETENTION OF WORKER.—A nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed $2,000, and $10,000 for the second and each subsequent violation within any 5-year period, $5,000.

(v) PERIODIC CANCER OF WORKER.—In addition to any civil penalty under clause (i), a skilled nursing facility worker who

(I) knowingly continues to employ a skilled nursing facility worker in violation of subparagraph (A) or (B); or

(II) knowingly fails to report a skilled nursing facility worker under subparagraph (C),

shall be subject to a civil penalty in an amount not to exceed $5,000 for the first such violation, and $10,000 for the second and each subsequent violation within any 5-year period.

(vi) DEFINITIONS.—In this paragraph:

(I) CONVICTION FOR A RELEVANT CRIME.—The term ‘conviction for a relevant crime’ means any Federal or State criminal conviction for—

(I) any offense described in paragraphs (1) through (4) of section 1129A(a),

(II) any other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, and other interested parties.

(ii) DISQUALIFYING INFORMATION.—The term ‘disqualifying information’ means information for a relevant crime or a finding of patient or resident abuse. The term ‘disqualifying information’ means any substantiated finding of patient or resident abuse or neglect or a misappropriation of patient or resident property.

(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ‘finding of patient or resident abuse’ means any substantiated finding of patient or resident abuse.

(iv) SKILLED NURSING FACILITY WORKER.—The term ‘skilled nursing facility worker’ means any individual (other than a volunteer) that has access to a patient of a skilled nursing facility under an employment or provision of services with respect to such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing services permitted by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers.

(v) USE OF INFORMATION.—

(I) IN GENERAL.—In the case of a small rural skilled nursing facility (as defined by the Secretary), the Secretary shall provide, by regulation after consultation with providers of nursing facility services and entities representing long-term care employees, for an appropriate level of supervision with respect to any provisional employees employed by the facility in accordance with the provisions of subparagraph (B)(ii). Such regulation should encourage the provision of direct supervision of such employees whenever practicable with respect to such a facility and if such supervision would not impose an unreasonable cost or other burden on the facility.

(ii) REPORTING REQUIREMENTS.—A skilled nursing facility shall report to the State any instance in which the facility determines that a skilled nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property in the course of employment by the facility.

(iii) USE OF INFORMATION.—

(I) IN GENERAL.—A nursing facility that obtains information about a skilled nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

(ii) IMMUNITY FROM LIABILITY.—A skilled nursing facility in which the facility determines that a skilled nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property shall have an absolute immunity from liability for any civil or criminal action brought by any individual based on the employment determination resulting from the information.

(iii) CRIMINAL PUNISHMENT.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

(iv) CIVIL PUNISHMENT.—

(I) IN GENERAL.—A nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed $2,000 and $10,000 for the second and each subsequent violation within any 5-year period, $5,000.

(II) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a nursing facility that

(I) knowingly continues to employ a skilled nursing facility worker in violation of paragraph (A) or (B); or

(II) knowingly fails to report a skilled nursing facility worker under paragraph (C),

shall be subject to a civil penalty in an amount not to exceed $5,000 for the first such violation, and $10,000 for the second and each subsequent violation within any 5-year period.

(III) DEFINITIONS.—In this paragraph:

(I) CONVICTION FOR A RELEVANT CRIME.—The term ‘conviction for a relevant crime’ means any Federal or State criminal conviction for—

(I) any offense described in paragraphs (1) through (4) of section 1129A(a),

(II) any other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, and other interested parties.

(ii) DISQUALIFYING INFORMATION.—The term ‘disqualifying information’ means information for a relevant crime or a finding of patient or resident abuse.

(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term ‘finding of patient or resident abuse’ means any substantiated finding of patient or resident abuse.

(iv) SKILLED NURSING FACILITY WORKER.—The term ‘skilled nursing facility worker’ means any individual (other than a volunteer) that has access to a patient of a skilled nursing facility under an employment or provision of services with respect to such facility. Such term includes individuals who are licensed or certified by the State to provide such services, and nonlicensed individuals providing services permitted by the Secretary, including nurse assistants, nurse aides, home health aides, and personal care workers.

(v) USE OF INFORMATION.—

(I) IN GENERAL.—A nursing facility that obtains information about a skilled nursing facility worker pursuant to clauses (iii) and (iv) of subparagraph (A) may use such information only for the purpose of determining the suitability of the worker for employment.

(ii) IMMUNITY FROM LIABILITY.—A skilled nursing facility in which the facility determines that a skilled nursing facility worker has committed an act of resident neglect or abuse or misappropriation of resident property shall have an absolute immunity from liability for any civil or criminal action brought by any individual based on the employment determination resulting from the information.

(iii) CRIMINAL PUNISHMENT.—Whoever knowingly violates the provisions of clause (i) shall be fined in accordance with title 18, United States Code, imprisoned for not more than 2 years, or both.

(IV) CIVIL PUNISHMENT.—

(I) IN GENERAL.—A nursing facility that violates the provisions of this paragraph shall be subject to a civil penalty in an amount not to exceed $2,000, and $10,000 for the second and each subsequent violation within any 5-year period, $5,000.

(II) KNOWING RETENTION OF WORKER.—In addition to any civil penalty under clause (i), a nursing facility that

(I) knowingly continues to employ a skilled nursing facility worker in violation of paragraph (A) or (B); or

(II) knowingly fails to report a skilled nursing facility worker under paragraph (C),

shall be subject to a civil penalty in an amount not to exceed $5,000 for the first such violation, and $10,000 for the second and each subsequent violation within any 5-year period.

(F) DEFINITIONS.—In this paragraph:

(I) CONVICTION FOR A RELEVANT CRIME.—The term ‘conviction for a relevant crime’ means any Federal or State criminal conviction for—

(I) any offense described in paragraphs (1) through (4) of section 1129A(a),

(II) any other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with representatives of long-term care providers, representatives of long-term care employees, and other interested parties.
subsection violation within any 5-year period.

"(F) DEFINITIONS.—In this paragraph:

"(i) Conviction for a relevant crime.—The term 'conviction for a relevant crime' means any Federal or State criminal conviction for—

"(I) any offense described in paragraphs (1) through (4) of section 1128(a); and

"(II) such other types of offenses as the Secretary may specify in regulations, taking into account the severity and relevance of such offenses, and after consultation with the representatives of long-term care providers, representatives of long-term care employees, consumer advocates, and appropriate Federal and State officials.

"(ii) DISQUALIFYING INFORMATION.—The term 'disqualifying information' means information about a conviction for a relevant crime or a finding of patient or resident abuse.

"(iii) FINDING OF PATIENT OR RESIDENT ABUSE.—The term 'finding of patient or resident abuse' means any substantiated finding by a State agency under subsection (q)(1)(C) or a Federal agency that a nursing facility worker has committed—

"(I) any act of patient or resident abuse or neglect or a misappropriation of patient or resident property; or

"(II) such other types of acts as the Secretary may specify in regulations.

"(iv) NURSING FACILITY WORKER.—The term 'nursing facility worker' means any individual who is defined by the Secretary, including nurse assistants, nurse aids, home health aides, and personal care workers and attendants.''.

"(F) DEFINITIONS.—In this paragraph:

"(1) BACKGROUND CHECKS.—(A) IN GENERAL.—Upon receipt of a request by a skilled nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), the Attorney General shall provide a search and exchange of records described in subparagraph (B).

"(B) SEARCH AND EXCHANGE OF RECORDS BY ATTORNEY GENERAL.—Upon receipt of a request pursuant to subparagraph (A), the Attorney General shall direct a search of the criminal history records of the Federal Bureau of Investigation for any criminal history records corresponding to the fingerprints and other positive identification information submitted. The Attorney General shall provide any corresponding information resulting from the search to the Secretary.

"(C) STATE REPORTING OF INFORMATION CONCERNING CRIMINAL BACKGROUND CHECKS ON SKILLED NURSING FACILITY EMPLOYEES.—Upon receipt of the information provided by the Attorney General pursuant to subparagraph (B), the State shall—

"(i) review the information to determine whether the individual has any conviction for or a relevant crime (as defined in subsection (b)(8)(F)(iii));

"(ii) immediately report to the skilled nursing facility in writing the results of such review;

"(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E;

"(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—(1) AUTHORITY TO CHARGE FEES.—

"(I) ATTORNEY GENERAL.—The Attorney General may charge a fee to any State requesting a search and exchange of records pursuant to subsection (b)(8) for conducting the search and providing the records. The amount of such fee shall not exceed the lesser of the actual cost of such activities or $50. Such fees shall be available to the Attorney General, or, in the Attorney General's discretion, to the Federal Bureau of Investigation until expended.

"(II) In general.—The Attorney General may charge a fee to any skilled nursing facility a fee for initiating the criminal background check under this paragraph and subsection (b)(8), including fees charged by the Secretary and, for performing the review and report required by subparagraph (C). The amount of such fee shall not exceed the actual cost of such activities.

"(II) Prohibition on charging.—An entity may not impose on a provisional employee or an employee any charges relating to the performance of a background check under this paragraph.

"(E) REGULATIONS.—(A) IN GENERAL.—In addition to the Secretary's authority to promulgate regulations under this title, the Attorney General, in consultation with the Secretary, may promulgate such regulations as are necessary to carry out the Attorney General's responsibilities under this paragraph and subsection (b)(9), including regulations regarding the confidentiality, use, retention, destruction, and dissemination of information, audits and recordkeeping, and the imposition of fees.

"(D) APPEAL PROCEDURES.—The Attorney General, in consultation with the Secretary, shall promulgate such regulations as are necessary to establish procedures by which a provisional employee or an employee may appeal or dispute the accuracy of the information obtained in a background check conducted under this paragraph. Appeals shall be limited to instances in which a provisional employee or an employee is incorrectly identified as the subject of the background check, or when information about the provisional employee or employee has been updated to reflect changes in the provisional employee's or employee's criminal record.

"(E) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON NURSING FACILITY EMPLOYEES.—(A) IN GENERAL.—Upon receipt of a request by a nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State shall—

"(i) review the information to determine whether the individual has any conviction for or a relevant crime (as defined in subsection (b)(8)(F)(iii));

"(ii) immediately report to the skilled nursing facility in writing the results of such review;

"(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E;

"(F) REPORT.—Not later than 2 years after the date of enactment of this paragraph, the Attorney General shall submit a report to Congress on—

"(1) the number of requests for searches and exchanges of records made under this section;

"(ii) the disposition of such requests; and

"(iii) the cost of responding to such requests.

"(2) MEDICAID.—Section 1915(e) (42 U.S.C. 1396r(e)) is amended by adding at the end the following:

"(8) FEDERAL AND STATE REQUIREMENTS CONCERNING CRIMINAL BACKGROUND CHECKS ON NURSING FACILITY EMPLOYEES.—(A) IN GENERAL.—Upon receipt of a request by a nursing facility pursuant to subsection (b)(8) that is accompanied by the information described in subclauses (II) through (IV) of subsection (b)(8)(A)(ii), a State shall—

"(i) review the information to determine whether the individual has any conviction for or a relevant crime (as defined in subsection (b)(8)(F)(iii));

"(ii) immediately report to the skilled nursing facility in writing the results of such review;

"(iii) in the case of an individual with a conviction for a relevant crime, report the existence of such conviction of such individual to the database established under section 1128E;
existence of such conviction of such individual to the database established under section 1128E.

(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS

(i) AUTHORITY TO CHARGE FEES.—

(ii) AUDITS AND RECORDKEEPING.—The Attorney General may charge a fee to any State requested to conduct monitoring and oversight activities to ensure the safety of a Medicare beneficiary.

(iii) REQUIREMENTS.—The regulations required under paragraph (i) shall provide the following:

(A) Supervision of a provisional employee shall consist of ongoing, good faith, verifiable efforts by the supervisor of the provisional employee to conduct monitoring and oversight activities to ensure the safety of a Medicare beneficiary.

(B) For purposes of subparagraph (A), monitoring and oversight activities may include (but are not limited to) the following:

(1) Follow-up telephone calls to the Medicare beneficiary;

(2) Unannounced visits to the Medicare beneficiary’s home while the provisional employee is serving the Medicare beneficiary;

(3) To the extent practicable, limiting the provisional employee’s duties to serving only those Medicare beneficiaries in a home or setting where another family member or relative is a resident of the home or setting where the Medicare beneficiary is present.

(C) In promulgating such regulations, the Secretary shall take into account the staffing and geographic issues faced by small rural entities (as defined by the Secretary) that provide home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services to an individual entitled to benefits under part A or enrolled under part B, including an individual provided with a MedicareChoice Plus plan by MedicareChoice organization under part C (in this section referred to as a Medicare beneficiary).

(E) REGULATIONS.—

(i) IN GENERAL.—With respect to an entity that provides home health services, such entity shall be considered to have satisfied the requirements of section 1919(b)(8)(B)(ii) if the entity meets such requirements for supervision of provisional employees of the entity as the Secretary shall, by regulation, specify in accordance with paragraph (2).

(ii) REQUIREMENTS.—The regulations required under paragraph (i) shall provide the following:

(A) Supervision of a provisional employee shall consist of ongoing, good faith, verifiable efforts by the supervisor of the provisional employee to conduct monitoring and oversight activities to ensure the safety of a Medicare beneficiary.

(B) For purposes of subparagraph (A), monitoring and oversight activities may include (but are not limited to) the following:

(1) Follow-up telephone calls to the Medicare beneficiary;

(2) Unannounced visits to the Medicare beneficiary’s home while the provisional employee is serving the Medicare beneficiary;

(3) To the extent practicable, limiting the provisional employee’s duties to serving only those Medicare beneficiaries in a home or setting where another family member or relative is a resident of the home or setting where the Medicare beneficiary is present.

(C) In promulgating such regulations, the Secretary shall take into account the staffing and geographic issues faced by small rural entities (as defined by the Secretary) that provide home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services. Such regulations should encourage the provision of monitoring and oversight activities to ensure the safety of a Medicare beneficiary.

(D) FEES FOR PERFORMANCE OF CRIMINAL BACKGROUND CHECKS.—

(i) IN GENERAL.—With respect to an entity that provides home health services, such entity shall be considered to have satisfied the requirements of section 1919(b)(8)(B)(ii) if the entity meets such requirements for supervision of provisional employees of the entity as the Secretary shall, by regulation, specify in accordance with paragraph (2).

(ii) REQUIREMENTS.—The regulations required under paragraph (i) shall provide the following:

(A) Supervision of a provisional employee shall consist of ongoing, good faith, verifiable efforts by the supervisor of the provisional employee to conduct monitoring and oversight activities to ensure the safety of a Medicare beneficiary.

(B) For purposes of subparagraph (A), monitoring and oversight activities may include (but are not limited to) the following:

(1) Follow-up telephone calls to the Medicare beneficiary;

(2) Unannounced visits to the Medicare beneficiary’s home while the provisional employee is serving the Medicare beneficiary;

(3) To the extent practicable, limiting the provisional employee’s duties to serving only those Medicare beneficiaries in a home or setting where another family member or relative is a resident of the home or setting where the Medicare beneficiary is present.

(C) In promulgating such regulations, the Secretary shall take into account the staffing and geographic issues faced by small rural entities (as defined by the Secretary) that provide home health services, hospice care (including routine home care and other services included in hospice care under this title), or long-term care services. Such regulations should encourage the provision of monitoring and oversight activities to ensure the safety of a Medicare beneficiary.

The State shall provide, through the agency responsible for surveys and certification of skilled nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of patient property; and (III) in subparagraph (C), by striking “a nurse aide” and inserting “an individual” and (ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following:

“The State shall provide, through the agency responsible for surveys and certification of skilled nursing facilities under this subsection, for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of patient property; and

(II) in the fourth sentence of subparagraph (C), by inserting “(i) by inserting ‘or described in paragraph (e)(2)A(iii)’ after ‘used by the facility’; and

(III) in subparagraph (D)—

(aa) by striking “NURSE AIDE REGISTRY” and inserting “EMPLOYER REGISTRY”; and

(bb) by striking “(e)(2)A(iii)” and inserting “individual”.

(B) MEDICAID.—Section 1919 (42 U.S.C. 1396b) is amended—

(i) in subsection (c)(2)—

(I) in the paragraph heading, by striking “NURSE AIDE REGISTRY” and inserting “EMPLOYER REGISTRY”;

(II) in subparagraph (A)—

(aa) by striking “By not later than January 1, 1989, the” and inserting “The”;

(bb) by striking “a registry of all individuals” and inserting “a registry of (i) all individuals”;

(cc) by striking “(i) by inserting” and inserting “(i) by inserting”;

and (ii) in subsection (g)(1)—

(I) by striking the first sentence of subparagraph (C) and inserting the following:

“The State shall provide, through the agency responsible for surveys and certification of nursing facilities under this subsection,
for a process for the receipt and timely review and investigation of allegations of neglect and abuse and misappropriation of resident property by a nurse aide or a nursing facility with respect to a resident of a nursing facility, by another individual used by the facility in providing services to such a resident, or by an individual described in subsection (e)(2)(A)(iiii) after "used by the facility"; and

(II) in the fourth sentence of subparagraph (C), by inserting "or described in subsection (e)(2)(A)(iiii)" after "used by the facility"; and

(III) in subparagraph (D)—

(aa) in the subparagraph heading, by striking "nurse aide" and

(bb) in clause (i), in the matter preceding subclause (I), by striking "a nurse aide" and inserting "an individual"; and

(cc) in clause (ii), by striking "nurse aide" and inserting "individual".

(d) Reimbursement of Costs for Background Checks.—The Secretary of Health and Human Services shall reimburse nursing facilities, skilled nursing facilities, and other entities for costs incurred by the facilities and entities in order to comply with the requirements imposed under sections 1919(b)(8) and 1919(b)(8) of such Act (42 U.S.C. 1385b–3(b), 1386b(b)(8)), as added by this section.

(e) Inclusion of Abusive Acts Within a Long-Term Care Facility or Provider in the National Healthcare Fraud and Abuse Data Collection Program.—(1) In general.—Section 1128E(g)(1)(A) (42 U.S.C. 1320a–7e(g)(1)(A)) is amended—

(A) by redesignating clause (v) as clause (vi); and

(B) by inserting after clause (iv), the following:

"(vii) a finding of abuse or neglect of a patient or a resident of a long-term care facility, or misappropriation of such a patient's or resident's property."

(2) Coverage of Long-Term Care Facility or Provider Employers.—Section 1128E(g)(2) (42 U.S.C. 1320a–7e(g)(2)) is amended by inserting "and, and includes any individual of a long-term care facility or provider (other than any volunteer) that has access to a patient or resident of such a facility under an employment or other contract, or both, with the facility or employer, or is a provider of services at the facility or through the provider, including individuals who are licensed or certified by the Secretary to provide services at the facility or through the provider, and nonlicensed individuals who provide services at the facility or through the provider, including nurse assistants, aides, home health aides, individuals who provide personal care workers and attendants) before the period.

(3) Reporting by Long-Term Care Facilities or Providers.—

(A) in general.—Section 1128E(b)(1) (42 U.S.C. 1320a–7e(b)(1)) is amended by striking "long-term care facility or provider" and inserting "long-term care facility or provider employers".

(B) Correction of information.—Section 1128E(c)(2) (42 U.S.C. 1320a–7e(c)(2)) is amended by striking "and health plan" and inserting "health plan, and long-term care facility or provider".

(4) Access to reported information.—Section 1128E(d)(1) (42 U.S.C. 1320a–7e(d)(1)) is amended by striking "long-term care facility or provider employers" and inserting "health plan, and long-term care facilities or providers".

(5) Mandatory check of database by long-term care facilities or providers.—Section 1128E(d) (42 U.S.C. 1320a–7e(d)) is amended by adding at the end the following:

"(3) MANDATORY CHECK OF DATABASE BY PROVIDER.—The term 'long-term care facility or provider' means a skilled nursing facility (as defined in section 1819(a)), a nursing facility (as defined in section 1919(a)), a home health agency, a provider of hospice care (as defined in section 1861(d)(1)), a long-term care hospital (as defined in section 1886(d)(1)(C)), an intermediate care facility for the mentally retarded (as defined in section 1905(d)), or any other facility or entity that provides, or is a provider of, long-term care services, health services, or hospice care (including routine home care and other services included in hospice care under title XVIII), and receives payment for such services under the medicare program (under title XVIII) or the medicaid program under title XIX."

(6) Authorization of appropriations.—There is authorized to be appropriated to carry out the amendments made by this section, $10,200,000 for fiscal year 2004.

(7) Prevention and training demonstration project.—(1) Establishment.—The Secretary of Health and Human Services shall establish a demonstration program to provide grants to develop information on best practices in patient abuse prevention training (including behavior training and interventions) for managers and staff of hospital and health care facilities.

(2) Eligibility.—To be eligible to receive a grant under paragraph (1), an entity shall be—

(A) a public or private nonprofit entity, including a state agency that provides technology, training, and other services related to improving health care in rural areas; and

(B) a public or private nonprofit entity, including a state agency that provides technology, training, and other services related to improving health care in rural areas.

SEC. 621. Office of Rural Health Policy Improvements.

Section 711(b) (42 U.S.C. 912(b)) is amended—

(1) in paragraph (3), by striking "and" after the comma at the end;

(2) in paragraph (4), by inserting "and" after the comma at the end; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) administer grants, cooperative agreements, and contracts to provide technical assistance and other activities as necessary to support activities related to improving health care in rural areas."

AUTHORITY FOR COMMITTEES TO MEET

Committee on Agriculture, Nutrition, and Forestry

Mr. McConnell. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to conduct a hearing during the session of the Senate on Thursday, June 26, 2003. The purpose of this hearing will be to receive H.R. 1904, the Healthy Forests Restoration Act of 2003.

The PRESIDING OFFICER. Without objection, it is so ordered.

Committee on Banking, Housing, and Urban Affairs

Mr. McConnell. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on June 26, 2003, at 10:00 a.m. to conduct a hearing on "Affiliate Sharing Practices and Their Relationship with the Fair Credit Reporting Act."

The PRESIDING OFFICER. Without objection, it is so ordered.

Committee on Commerce, Science, and Transportation

Mr. McConnell. Mr. President, I ask unanimous consent that the Committee on Commerce, Science, and Transportation be authorized to meet on June 26, 2003, at 9:30 a.m. on pending committee business.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. McConnell. Mr. President, I ask unanimous consent that the Committee on Finance be authorized to meet during the session on Thursday,
June 26, 2003

II. Nominations: William H. Pryor, Jr., to be United States Circuit Judge for the Eleventh Circuit; Diane M. Stuart to be Director, Violence Against Women Office, United States Department of Justice; and Thomas M. Kane to be United States District Judge for the Western District of Pennsylvania.

III. Bills: S.J. Res. 1, a joint resolution proposing an amendment to the constitution of the United States to protect the innocence of crime victims [Kyl, Chambliss, Cornyn, Craig, DeWine, Feinstein, Graham, Grassley]; S. 1280, a bill to amend the Protect Act to clarify the liability of the National Center for Missing and Exploited Children [Hatch, Biden]; S. 174, a resolution designating Thursday, November 20, 2003, as “Feed America Thursday” [Hatch]; and S. 175, a resolution designating the month of October 2003, as “Family History Month” [Hatch].

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the nominations of Josette Sheeran Shimer, to Deputy United States Trade Representative, Executive Office of the President and James J. Jochum, to be Assistant Secretary, Department of Commerce, be reported.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Thursday, June 26, 2003, at 2 p.m. to hold a hearing on The Department of State’s Office of Children’s Issues—Responding to International Parental Abduction.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Thursday, June 26, 2003, at 9:30 a.m., to hold a Business Meeting.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON THE JUDICIARY

Mr. MCCONNELL. Mr. President, I ask unanimous consent that the Committee on the Judiciary Subcommittee on Terrorism, Technology, and Homeland Security be authorized to meet to conduct a hearing on “Terrorism: Growing Wahhabi Influence in the United States” on Thursday, June 26, 2003 at 2 p.m., in Dirksen 226.

Panel 1: David Aufhauser, General Counsel, U.S. Treasury Department, Washington, DC; and Larry A. Merford, Assistant Director, Counterterrorism Division, Federal Bureau of Investigation, Washington, DC.

Panel 2: Dr. Alex Alexiev, Distinguished Fellow, Center for Security Policy, Washington, DC; and Stephen Schwartz, Senior Fellow, Foundation for Defense of Democracies, Washington, DC.

The PRESIDING OFFICER. Without objection, it is so ordered.

UNANIMOUS CONSENT REQUEST—EXECUTIVE CALENDAR

Mr. FRIST. Mr. President, I ask unanimous consent that the Senate immediately proceed to executive session to consider the following nominations on today’s Executive Calendar: Calendar Nos. 48 and 49, the nominations of Daniel Pearson and Charlotte A. Lane, to be members of the U.S. International Trade Commission, which have been pending on the Executive Calendar since March 5. I further ask unanimous consent that the nominations be confirmed, the motions to reconsider be laid upon the table, the President be immediately notified of the Senate’s action, and the Senate then return to legislative session.

The PRESIDING OFFICER. Is there objection?

Mr. FRIST. Mr. President, on behalf of my colleagues on the other side of the aisle, I object to my own request.

The PRESIDING OFFICER. Objection is heard.
depository institutions to provide for check truncation, in order to improve the check processing system;

(b) authorizes the Board to regulate all aspects of the check truncation system, including the receipt, payment, collection, and clearing of checks, and related functions of the payment system pertaining to checks; and

(c) determines, as a condition of such authority by the Board to supersede any State law, including the Uniform Commercial Code, as in effect in any State; and

(2) check truncation is no less desirable in 2003 for both financial service customers and the financial services industry, to reduce costs, improve efficiency in check collections, and expedite for Federal Reserve Account holders than it was in 1987, when Congress first directed the Board to consider establishing such a process.

(b) PURPOSES.—The purposes of this Act are—

(1) to facilitate check truncation by authorizing substitute checks;

(2) to foster innovation in the check collection system without mandating receipt of checks in electronic form; and

(3) to improve the overall efficiency of the Nation’s payments system.

SEC. 3. DEFINITIONS. In this Act, the following definitions shall apply:

(A) ACCOUNT.—The term “account” means a deposit account at a bank.

(B) BANK.—The term “bank”—

(1) means any person located in a State engaged in the business of banking, including any depository institution; and

(2) includes—

(i) any Federal reserve bank;

(ii) any Federal home loan bank; and

(iii) to the extent that it acts as a payor—

(I) the Treasury of the United States;

(II) the United States Postal Service;

(III) a State government; and

(IV) a unit of general local government.

(C) COLLECTING BANK.—The term “collecting bank” means any bank handling a check for collection except the paying bank.

(D) DEPOSITORY BANK.—The term “depository bank” means—

(i) the first bank to which a check is transferred, even if such bank is also the paying bank of the check; or

(ii) a bank to which a check is transferred for deposit in an account at such bank, even if the check is physically received and endorsed first by another bank.

(E) DEPOSITORY INSTITUTION.—The term “depository institution” has the same meaning as in section 19(b)(1)(A) of the Federal Reserve Act (12 U.S.C. 461(b)(1)(A)).

(F) PAYING BANK.—The term “paying bank” means—

(i) the bank by which a check is payable, unless the check is payable at or through another bank and is sent to the other bank for payment or collection; or

(ii) the bank at or through which a check is payable, except to which the check is sent for payment or collection.

(G) RECEIVING BANK.—The term “receiving bank” means—

(i) the bank by which a check is payable to order

(ii) the bank at or through which a check is payable to order or

(iii) the bank by which a check is payable to a third party.

(H) RETURNING BANK.—The term “returning bank” means a bank (other than the paying or depositary bank) handling a returned check or notice in lieu of return.

(I) TREATMENT AS COLLECTING BANK.—No provision of this Act shall be construed as affecting the treatment of a returning bank as collecting bank for purposes of section 4-202(b) of the Uniform Commercial Code.

(J) BOARD.—The term “Board” means the Board of Governors of the Federal Reserve System.

(K) BUSINESS DAY.—The term “business day” has the same meaning as in section 602(2) of the Expedited Funds Availability Act (12 U.S.C. 4001(2)).

(L) CHECK.—The term “check”—

(1) has the same meaning as in 602(2) of the Expedited Funds Availability Act (12 U.S.C. 4001(2)).

(2) means a draft, payable on demand and drawn on or payable through or at an office of a bank, whether or not negotiable, that is handled for forward collection or return, including a substitute check and a travelers check; and

(3) does not include a noncash item or an item payable in a medium other than United States dollars.

(M) CONSUMER.—The term “consumer” means an individual who—

(A) with respect to a check handled for forward collection, draws the check on a consumer account; or

(B) with respect to a check handled for return, deposits the check into, or cashes the check against, a consumer account.

(N) CONSUMER ACCOUNT.—The term “consumer account” has the same meaning as in section 602(10) of the Expedited Funds Availability Act (12 U.S.C. 4001(10)).

(O) CUSTOMER.—The term “customer” means a person having an account with a bank.

(P) FORWARD COLLECTION.—The term “forward collection” means the transfer by a bank of a check to a collecting bank for settlement or the paying bank for payment.

(Q) INDENNIFYING BANK.—The term “indennifying bank” means a bank that is providing an indemnity under section 6 with respect to a substitute check.

(R) MICR LINE.—The term “MICR line” or “magnetic ink character recognition line” means the magnetic ink characters printed on the bank routing number, account number, check number, check amount, and other information, that are printed near the bottom of a check in magnetic ink and in accord with generally applicable industry standards.

(S) NONCASH ITEM.—The term “noncash item” has the same meaning as in section 602(14) of the Expedited Funds Availability Act (12 U.S.C. 4001(14)).

(T) PERSON.—The term “person” means a natural person, corporation, unincorporated company, partnership, government unit or instrumentality, trust, or any other entity or organization.

(U) RECONVERTING BANK.—The term “reconverting bank” means—

(A) the bank that creates a substitute check; or

(B) if a substitute check is created by a person other than a bank, the first bank that transfers or presents such substitute check.

(V) SUBSTITUTE CHECK.—The term “substitute check” means a paper reproduction of the original check that—

(A) contains an image of the front and back of the original check;

(B) bears a MICR line containing all the information appearing on the MICR line of the original check, except as provided under generally applicable industry standards for substitute checks to facilitate the processing of substitute checks;

(C) conforms, in paper stock, dimension, and otherwise, with generally applicable industry standards for substitute checks; and

(D) is suitable for automated processing in the same manner as the original check.

(W) STATE.—The term “State” has the same meaning as in section 6(a) of the Federal Deposit Insurance Act (12 U.S.C. 1813(a)).

(X) TRUTH IN Lending.—The term “Truth in Lending” means to remove an original paper check from the check collection or return process and send to a recipient, in lieu of such original paper check, a substitute check or another paper or electronic form of the original check, except as provided under generally applicable industry standards for substitute checks or original checks such that it will be asked to make a payment based on a check it has already paid.

Y TECHNOLOGY.—The term “technology” means any person having an account with a bank.

(Z) UNITED STATES.—The term “United States” means a unit of general local government that is a unit of general local government or an electronic image of the original check, except as provided under generally applicable industry standards for substitute checks or original checks such that it will be asked to make a payment based on a check it has already paid.

(A) UNIFORM COMMERCIAL CODE.—The term “Uniform Commercial Code” means the Uniform Commercial Code in effect in any State or States, as adopted, except as provided under generally applicable industry standards for substitute checks or original checks such that it will be asked to make a payment based on a check it has already paid.

(B) UNIT OF GENERAL LOCAL GOVERNMENT.—The term “unit of general local government” has the same meaning as in section 602(24) of the Expedited Funds Availability Act (12 U.S.C. 4001(24)).

(C) OTHER TERMS.—Unless the context requires otherwise, terms used in this Act that are not defined in this section shall have the same meanings as in the Uniform Commercial Code.

SEC. 4. GENERAL PROVISIONS GOVERNING SUBSTITUTE CHECKS.

(A) NO AGREEMENT REQUIRED.—A person may deposit, present, or send for collection or return a substitute check without an agreement with the recipient, to the extent that the bank has made the warranties described in section 5 with respect to the substitute check.

(B) LEGAL EQUIVALENCE.—A substitute check shall be the legal equivalent of an original check for all purposes, including any provision of any Federal or State law, and for all persons, if the substitute check—

(1) accurately represents all of the information on the front and back of the original check as of the time at which the original check was finished;

(2) bears the legend: “This is a legal copy of your check. You can use it the same way you would use the original check.”

(C) ENDORSEMENTS.—A reconverting bank shall ensure that the substitute check for which the bank is the reconverting bank bears all endorsements applied by parties that previously handled the check (whether in electronic form or in the form of the original paper check or a substitute check) for forward collection or return.

(D) IDENTIFICATION OF RECONVERTING BANK.—A reconverting bank shall identify itself as a reconverting bank on any substitute check for which the bank is a reconverting bank, so as to preserve any previous reconverting bank identifications, in conformance with generally applicable industry standards.

(E) APPLICABLE LAW.—A substitute check that is the legal equivalent of the original check under subsection (b) shall be subject to any provision of law applicable to the protection of consumers, of part 229 of title 12, Code of Federal Regulations (or any successor thereto), the Uniform Commercial Code, and any other applicable Federal or State law that would apply if the substitute check were the original check, to the extent that such provision of law is not inconsistent with this Act.

SEC. 5. SUBSTITUTE CHECK WARRANTIES.

A bank that transfers, presents, or returns a substitute check and receives consideration for the check warrants to the transferee, any subsequent collecting or returning bank, the depositary bank, the depositor, and any endorser (regardless of whether the warrantee receives the substitute check or another paper or electronic form of the substitute or original check) that

(1) the substitute check meets all the requirements for legal equivalence under section 4(b); and

(2) no depositary bank, dragee, drawer, or endorser will receive presentment or return of the substitute check, the original check, or a copy of a paper or electronic form of the substitute or original check such that

(a) the substitute check meets all the requirements for legal equivalence under subsection (b); and

(b) to any depositary bank, the drawer, the payee, the depositor, and any endorser, up to the amounts described in subsections (b) and (c), as applicable, to the extent of any loss incurred by any warrantee of a check that is due and payable at the time of receipt of a substitute check instead of the original check.
(b) Indemnity Amount.—

(1) Amount in Event of Breach of Warranty.—The amount of the indemnity under subsection (a) shall be the amount of any loss (including costs and reasonable attorney fees and other expenses of representation) proximately caused by a breach of a warranty established under section 5.

(2) Amount in Event of Breach of Warranty.—In the absence of a breach of a warranty established under section 5, the amount of the indemnity under subsection (a) shall be the sum of—

(A) the amount of any loss, up to the amount of the substitute check; and

(B) interest and expenses (including costs and reasonable attorney fees and other expenses of representation).

c) Comparative Negligence.—

(1) General.—If a loss under subsection (a) results in whole or in part from the negligence or failure to act in good faith on the part of an indemnitee, the indemnification of that party under this section shall be reduced in proportion to the amount of negligence or bad faith attributable to that party.

(2) Rule of Construction.—Nothing in this section reduces the rights of a consumer or any other party to the Uniform Commercial Code or other applicable provision of Federal or State law.

d) Effect of Producing Original Check or Substitute Check.—

(1) In General.—If the indemnifying bank produces the original check or a copy of the original check (including an image of a substitute check) that accurately represents all of the information on the front and back of the original check (as of the time at which the original check was truncated), or is otherwise sufficient to determine whether or not a claim is valid, the indemnifying bank shall—

(A) be liable under this section only for losses covered by the indemnity that are incurred up to the production of the original check or copy provided to the indemnitee party; and

(B) have a right to the return of any funds it has paid under the indemnity in excess of those losses.

(2) Coordination of Indemnity with Implied Warranty.—The production of the original check, substitute check, or copy under paragraph (1) that accurately represents all of the information on the front and back of the original check (as of the time at which the original check was truncated), or is otherwise sufficient to determine whether or not a claim is valid, imposes a duty on the indemnifying bank to—

(A) determine the validity of any claim described in subparagraph (C).

(b) Procedures for Claims.—

(1) In General.—To make a claim for an expedited recredit under subsection (a) with respect to a substitute check, the consumer shall provide to the bank that holds the account of such consumer—

(A) a description of the claim, including an explanation of—

(i) why the substitute check was not properly charged to the subject consumer account; or

(ii) the warranty claim with respect to such check;

(B) a statement that the consumer suffered a loss and an estimate of the amount of the loss; and

(C) the reason why production of the original check or a better copy of the original check is necessary to determine the validity of the charge to the subject consumer account or the warranty claim; and

(D) sufficient information to identify the substitute check and to investigate the claim.

(2) Claim in Writing.—

(A) In General.—The bank holding the consumer account that is the subject of a claim by the consumer under subsection (a) may, in the discretion of the bank, require the consumer to submit the information required under paragraph (1) in writing.

(B) Means of Submission.—A bank that requires a submission of information under subparagraph (A) may permit the consumer to make the substitution of information during the business day following the 40-day period beginning on the date on which the consumer submits the claim, the balance in the consumer account was negative or would have become negative if checks or other charges to the account had been paid; or

(ii) the remaining amount of the substitute check that was charged against the consumer account, if any, together with interest if the account is an interest-bearing account, not later than the 45th calendar day following the business day on which the bank determines that the claim of the consumer is valid.

(B) Procedure for Claims.—If the bank has not made the recredited funds available for withdrawal by the consumer by the business day on which the bank determines that the claim of the consumer is valid, the bank shall recredit the consumer account under subsection (c).

(C) Availability of Recredit.—

(1) Next Business Day Availability.—Except as provided in paragraph (a), the bank that provides a recredit to a consumer account under subsection (a) shall make the recredited funds available for withdrawal by the consumer by the next business day after the business day on which the bank recredits the consumer account under subsection (c).

(2) Safeguard Exceptions.—A bank may delay a recredit to a consumer account under subsection (b) if the bank determines that the claim of the consumer is valid, or the 45th calendar day following the business day on which the bank receives the claim of the consumer is valid.

(D) New Accounts.—The claim is made during the 30-day period beginning on the business day on which the consumer account was established.

(B) Repeated Overdrafts.—Without regard to the charge that is the subject of the claim for which the recredit was made—

(i) on 2 or more business days during the 6-month period ending on the date on which the consumer submits the claim, the balance in the consumer account was negative or would have become negative in the amount of $5,000 or more if checks or other charges to the account had been paid; or

(ii) on 2 or more business days during such 6-month period, the balance in the consumer account was negative or would have become negative in the amount of $5,000 or more if checks or other charges to the account had been paid.

(C) Prevention of Fraud Losses.—The bank does not have a reasonable cause to believe that the claim is fraudulent, based on facts (other than the fact that the check in question or the consumer is of a particular class) that would cause a well-grounded belief in the reasonable person that the claim is fraudulent.

(3) Overdraft Fees.—No bank that, in accordance with paragraph (2), delays the availability of a recredit under subsection (c) to any consumer account may impose any overdraft fees with respect to drafts drawn by the consumer on such recredited amount before the end of the 5-day period beginning on the date on which notice of the delay in the availability of such amount is sent by the bank to the consumer.

(e) Reversal of Recredit.—A bank may reverse a recredit to a consumer account if the bank—

(1) determines that a substitute check for which the bank recredited a consumer account under subsection (c) was in fact properly charged to the consumer account; and

(2) notifies the consumer in accordance with subsection (f)(3).

(f) Notice to Consumer.—

(1) Notice if Consumer Claim Not Valid.—If a bank determines that a substitute check subject to the claim of a consumer under this section was in fact properly charged to the consumer account, the bank shall send the consumer notice of the determination following the business day on which the bank makes the determination.
(A) the original check or a copy of the original check (including an image or a substitute check) that—

(i) accurately represents all of the information on the front and back of the original check as of the time at which the original check was truncated; or

(ii) is otherwise sufficient to determine whether or not the consumer is obligated to accept the substitute check, and

(B) an explanation of the basis for the determination by the bank that the substitute check was properly charged, including a statement that the bank may request copies of any information or documents on which the bank relied in making the determination.

(2) NOTICE OF REVERSAL OF RECREDIT.—If a bank recredits a consumer account under subsection (c), the bank shall send to the consumer, not later than the business day following the business day on which the bank makes the recredit, a notice of—

(A) the amount of the recredit; and

(B) the date on which the recredited funds will be available for withdrawal.

(3) NOTICE OF REVERSAL OF RECREDIT.—In addition to the notice required under paragraph (1), if a bank reverses a recredited amount under subsection (e), the bank shall send to the consumer, not later than the business day following the business day on which the bank reverses the recredit, a notice of—

(A) the amount of the reversal; and

(B) the date on which the recredit was reversed.

(4) MODE OF DELIVERY.—A notice described in this subsection shall be delivered by United States mail (or other means of delivery, which the consumer has agreed to receive account information).

(g) OTHER CLAIMS NOT AFFECTED.—Providing a recredit in accordance with this section shall not absolve the bank from liability for a claim made under any other provision of law, such as a claim brought under the Uniform Commercial Code, or from liability for additional damages under section 6 or 10.

(h) SCOPE OF APPLICATION.—This section shall only apply to customers who are consumers.

SEC. 8. EXPEDITED RECREDIT PROCEDURES FOR BANKS.

(a) RECREDIT CLAIMS.—

(1) IN GENERAL.—A bank may make a claim against an indemnifying bank for expedited recredit for which that bank is indemnified, if—

(A) the indemnifying bank has indemnified the claimant bank for expedited recredit from a consumer under section 7 with respect to a substitute check, the claimant bank has not made any indemnifying claim, the indemnifying bank is not absolved from liability for any claim, and the consumer has agreed to receive account information.

(B) a statement to the claimant bank, the original check (including an image or a substitute check) that—

(i) accurately represents all of the information on the front and back of the original check as of the time at which the original check was truncated; or

(ii) is otherwise sufficient to determine that the claim of the bank is not valid;

(C) the amount of the loss suffered by the other person under the Uniform Commercial Code or other applicable provision of Federal or State law.

(2) 120-DAY PERIOD.—Any claim under paragraph (1) may be submitted by the claimant bank to the indemnifying bank in accordance with section 7(e), if the claimant bank receives a claim from a consumer under section 7(a) from a consumer that the indemnifying bank receives a claim from a consumer under section 7(d) from an indemnifying bank to which an indemnifying bank receives a claim from a consumer under section 7(c).

(i) the amount of the loss suffered by the other person.

(ii) an indemnifying bank shall provide to each consumer that is a customer of the bank, in accordance with section 7(d), a brief notice about substitute checks that describes the substitute check and the circumstances under which the substitute check is legal equivalent of an original check for all purposes, including any provision of any Federal or State law, and for all persons, if the substitute check is the identity of the consumer or which a bank recredits

A timely claim by a consumer under section 7 for expedited recredit constitutes timely notice of a claim to the indemnifying or warranting bank.

SEC. 12. CONSUMER AWARENESS.

(a) IN GENERAL.—During the 3-year period beginning on the effective date of this Act, each bank shall provide each customer that is a customer of the bank, in accordance with subsection (b), a brief notice about substitute checks that describes the substitute check and the circumstances under which the substitute check is the legal equivalent of an original check for all purposes, including any provision of any Federal or State law, and for all persons, if the substitute check is the identity of the consumer or which a bank recredits...
as of the time at which the original check was truncated; and

(B) bears the legend: "This is a legal copy of your check. You can use it in the same way you would a check."; and

(2) the consumer receives substitute checks along with periodic account statements; and

(b) DISTRIBUTION.—

(1) IN GENERAL.—The notice required by subsection (a) shall be provided to each consumer that is a customer of the bank as of the effective date of this Act, and that receives original checks or substitute checks along with periodic account statements, not later than together with the first regularly scheduled communication with the customer after the effective date of this Act;

(b) at the time at which a customer relationship is initiated, if such relationship is initiated on or after the effective date of this Act and such customer will receive original checks or substitute checks along with periodic account statements; and

(c) to each customer of the bank that requests a copy of a check and receives a substitute check; and

(2) MODE OF DELIVERY.—A bank may provide the notices required by this subsection by United States mail, or by any other means through which the consumer has agreed to receive account information.

(c) MODEL LANGUAGE.—

(1) IN GENERAL.—Not later than 9 months after the date of enactment of this Act, the Board shall publish model forms and clauses that a depository institution may use to describe each of the elements required by subsection (a).

(2) MODE OF DELIVERY.—A bank shall provide notice in a model form or clause that accurately describes the policies and practices of the bank. A bank may use any information in the model form or clause that is not required by this Act, or rearrange the format of such form.

(3) USE OF MODEL LANGUAGE NOT REQUIRED.—This section shall not be construed as requiring any bank to use a model form or clause that the Board prepares under this subsection.

SEC. 13. EFFECT ON OTHER LAW.

This Act shall supersede any provision of Federal or State law, including the Uniform Commercial Code, that is inconsistent with this Act, but only to the extent of the inconsistency.

SEC. 14. REGULATIONS.

The Board may prescribe such regulations as it deems necessary to implement, prevent circumvention of, or facilitate compliance with the provisions of this Act.

SEC. 15. STUDY AND REPORT ON FUNDS AVAILABILITY.

(a) STUDY.—In order to evaluate the implementation and the impact of this Act, the Board shall conduct a study of—

(1) the percentage of total checks cleared in which the paper check is not returned to the paying bank;

(2) the extent to which financial institutions make funds available to consumers for local and nonlocal checks prior to the expiration of maximum hold periods;

(3) the length of time within which depositary banks learn of the nonsupport of local and nonlocal checks prior to the expiration of maximum hold periods;

(4) the increase or decrease in check-related losses over the study period; and

(5) the appropriateness of the time periods and amounts described in sections 601 and 604 of the Expedited Funds Availability Act, as in effect on the date of enactment of this Act.

(b) REPORT TO CONGRESS.—Not later than 30 months after the date of enactment of this Act, the Board shall submit a report to Congress concerning the results of the study conducted under this section, together with any recommendations for legislative action.

SEC. 16. EVALUATION AND REPORT BY THE COMPTROLLER GENERAL.

(a) STUDY.—Not later than 5 years after the date of enactment of this Act, the Comptroller General of the United States shall evaluate the implementation and administration of this Act, including—

(1) an estimate of the gains in economic efficiency made possible from check truncation;

(2) an evaluation of the benefits accruing to consumers and financial institutions from reduced transportation costs, longer hours for accepting deposits for credit within 1 business day, the impact of fraud losses, and an estimate of consumer retention of the total benefits derived from this Act; and

(3) an assessment of consumer acceptance of the check truncation process resulting from this Act, as well as any new costs incurred by consumers who had their original checks returned with their regular monthly statements prior to the date of enactment of this Act.

(b) REPORT TO CONGRESS.—Not later than 5 years after the date of enactment of this Act, the Comptroller General shall submit a report to Congress concerning the findings and conclusions of the Comptroller General in connection with the evaluation conducted pursuant to subsection (a), together with such recommendations for legislative and administrative action as the Comptroller General may determine to be appropriate.

SEC. 17. VARIATION BY AGREEMENT.

(a) SECTION 8.—Any provision of section 8 may be varied by agreement of the banks involved.

(b) NO OTHER PROVISIONS MAY BE VARIED.—Except as provided in subsection (a), no provision of this Act may be varied by agreement of any person or persons.

SEC. 18. EFFECTIVE DATE.

Except as otherwise specifically provided in this Act, this Act shall become effective 12 months after the date of enactment of this Act.

COMMENDING AUGUST HIEBERT

EXPRESSING SENSE OF THE SENATE REGARDING THE CENTENARY OF THE RHODES SCHOLARSHIPS IN THE UNITED STATES

HONORING MAYNARD HOLBROOK JACKSON, JR.

COMMENDING GENERAL ERIC SHINSEKI

Mr. FRIST. Mr. President, I ask unanimous consent that the resolutions be agreed to, en bloc; that the preamble be agreed to, en bloc; that the motions to reconsider be laid upon the table; and that any statements relating to these resolutions be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The resolution (S. Res. 186) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. Res. 186

Whereas Augie Hiebert came to Alaska in 1939 and built the first successful commercial radio station;

Whereas he picked up the first report of the raid on Pearl Harbor from his radio station in Fairbanks, Alaska giving military leaders the first recorded record of the attack that began World War II;

Whereas in 1953, Augie Hiebert founded Alaska's first television station;

Whereas Augie Hiebert established Alaska's first FM radio station and was named president of the Alaska Broadcasting system, overseeing the affiliation of nine stations that serve all major Alaska communities;

Whereas Augie Hiebert helped establish Alaska's first satellite earth station activated in 1970;

Whereas Augie Hiebert led in the development of the territory and State of Alaska, working for a half century to pioneer modern radio and television on behalf of the broadcast industry;

Whereas Augie Hiebert has been a pillar of the Alaska community as president of the Anchorage Chamber of Commerce and the Association of the U.S. Army in Alaska, and as director of the Alaska Educational Broadcasting Committee, the CBE Television Network Affiliates Association, the Civil Air Patrol, and the Pioneers of Alaska; Now, therefore be it

Resolved, That it is the sense of the Senate that Augie Hiebert is commended for his service to the communications industry in Alaska and the world and for bringing the best that broadcasting has to offer to the people of Alaska.

The resolution (S. Res. 187) was agreed to.

The preamble was agreed to.

The resolution, with its preamble, reads as follows:

S. Res. 187

Whereas the Rhodes Scholarships, the oldest international fellowships, were initiated after the death of Cecil Rhodes in 1902, and now bring outstanding students from the United States, Australia, Bangladesh, Bermuda, Canada, the Commonwealth Caribbean, Germany, Hong Kong, India, Jamaica, Kenya, Malaysia, New Zealand, Pakistan, Singapore, South Africa, Uganda, Zambia, and Zimbabwe to the University of Oxford; Whereas the first American Rhodes Scholars were elected in 1904, and since that time
The resolution (S. Res. 190) was agreed to. The preamble was agreed to.

The resolution, with its preamble, reads as follows:

The resolution (S. Res. 190) was agreed to. The preamble was agreed to.

The resolution, with its preamble, reads as follows:

SEC. 2. TRANSMITTAL OF RESOLUTION.

The Senate directs the Secretary of the Senate to transmit an enrolled copy of this resolution to General Eric Shinseki.

MEASURE READ THE FIRST TIME—S. 11

Mr. FRIST. Mr. President, I understand that S. 11 is at the desk, and I ask for its first reading.

The PRESIDING OFFICER. The measure is read the first time.

The legislative clerk read as follows: A bill (S. 11) to protect patients’ access to quality and affordable health care by reducing the effects of excessive liability costs.

Mr. FRIST. I now ask for its second reading and object to further proceedings on this matter.

The PRESIDING OFFICER. Objection is heard. The bill will remain at the desk.

UNANIMOUS CONSENT AGREEMENT—ADJOURNMENT RESOLUTION

Mr. FRIST. Mr. President, I ask unanimous consent that when the Senate receives the adjournment resolution, it be agreed to and the motion to reconsider be laid upon the table, provided the text is identical to the resolution that is at the desk.

The PRESIDING OFFICER. Without objection, it is so ordered.
ORDERS FOR FRIDAY, JUNE 27, 2003

Mr. FRIST. Mr. President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 10:15 a.m., Friday, June 27. I further ask that following the prayer and the pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time for the two leaders be reserved for their use later in the day and the Senate then begin a period for morning business with Members permitted to speak for up to 10 minutes each.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. FRIST. Tomorrow, the Senate will be in a period for morning business. Members will be able to pay tribute to our departed friend and colleague Strom Thurmond. We will give Members an opportunity to submit statements for the RECORD so they can be compiled for a printed tribute to Senator Thurmond. There will be no rolcall votes tomorrow.

Again, I thank my colleagues for their hard work over the past several weeks. We will have more to say about recent accomplishments of the Senate tomorrow and the events which culminated in tonight’s passage—or this morning’s passage—of the historic prescription drug benefits bill.

ADJOURNMENT UNTIL 10:15 A.M. TOMORROW

Mr. FRIST. If there is no further business to come before the Senate, I ask unanimous consent that the Senate stand in adjournment as a mark of further respect for the late Senator Strom Thurmond.

There being no objection, the Senate, at 1:15 a.m., adjourned until Friday, June 27, 2003, at 10:15 a.m.

NOMINATIONS

Executive nominations received by the Senate June 26, 2003:

DEPARTMENT OF ENERGY

RICK A. DEARBORN, OF OKLAHOMA, TO BE AN ASSISTANT SECRETARY OF ENERGY, CONGRESSIONAL AND INTERGOVERNMENTAL AFFAIRS, VICE DAN R. BROUILLETTE, RESIGNED.

OFFICE OF SPECIAL COUNSEL

SCOTT J. BLOCH, OF KANSAS, TO BE SPECIAL COUNSEL, OFFICE OF SPECIAL COUNSEL, FOR THE TERM OF FIVE YEARS, VICE ELAINE D. KAPLAN, RESIGNED.

DEPARTMENT OF HOMELAND SECURITY

PENROSE C. ALBRIGHT, OF VIRGINIA, TO BE AN ASSISTANT SECRETARY OF HOMELAND SECURITY. (NEW POSITION)

DEPARTMENT OF JUSTICE

RENE ACOSTA, OF VIRGINIA, TO BE AN ASSISTANT ATTORNEY GENERAL, VICE RALPH P. BOYD, JR.

IN THE ARMY

THE FOLLOWING NAMED OFFICER TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be colonel

REGINA M. CURTIS, 0000

NANCY M. PRICKETT, 0000

STEPHEN J. DEMSKI, 0000

JOSEPH F. MARANTO, 0000

THE FOLLOWING NAMED OFFICERS TO THE GRADE INDICATED IN THE RESERVE OF THE ARMY UNDER TITLE 10, U.S.C., SECTION 12203:

To be major

ANDREW S. KANTNER, 0000

DANIEL A. TANABE, 0000

CONFIRMATION

Executive nomination confirmed by the Senate June 26, 2003:

EXECUTIVE OFFICE OF THE PRESIDENT

JOSHUA B. BOLTEN, OF THE DISTRICT OF COLUMBIA, TO BE DIRECTOR OF THE OFFICE OF MANAGEMENT AND BUDGET.

THE ABOVE NOMINATION WAS APPROVED SUBJECT TO THE NOMINEE’S COMMITMENT TO RESPOND TO REQUESTS TO APPEAR AND TESTIFY BEFORE ANY DULY CONSTITUTED COMMITTEE OF THE SENATE.
HIGHLIGHTS

Senate passed S. 1—Prescription Drug and Medicare Improvement Act.
House Committee ordered reported the Defense and Legislative appropriations for fiscal year 2004.
House Committees ordered reported 11 sundry measures.
House passed H.R. 1, Medicare Prescription Drug, Modernization, Health Savings and Affordability Act.

Senate

Chamber Action

Routine Proceedings, pages S8605–S8817

Measures Introduced: Thirty-one bills and six resolutions were introduced as follows: S. 11, S. 1338–1367, S. Res. 187–190, and S. Con. Res. 56–57.

Measures Reported:

S. 1025, to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, with amendments. (S. Rept. No. 108–80)


S. Res. 62, calling upon the Organization of American States (OAS) Inter-American Commission on Human Rights, the United Nations High Commissioner for Human Rights, the European Union, and human rights activists throughout the world to take certain actions in regard to the human rights situation in Cuba.

S. Res. 138, to amend rule XXII of the Standing Rules of the Senate relating to the consideration of nominations requiring the advice and consent of the Senate.

S. Res. 149, expressing the sense of the Senate that the international response to the current need for food in the Horn of Africa remains inadequate, and with an amended preamble.

S. Res. 174, designating Thursday, November 20, 2003, as “Feed America Thursday”.

S. Res. 175, designating the month of October 2003, as “Family History Month”.

S. Res. 178, to prohibit Members of the Senate and other persons from removing art and historic objects from the Senate wing of the Capitol and Senate office buildings for personal use.

S. 148, to provide for the Secretary of Homeland Security to be included in the line of Presidential succession.

Measures Passed:

State Children's Health Insurance Program Amend Act: Senate passed S. 312, to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children’s Health Insurance Program, after agreeing to the following amendment proposed thereto:

Grassley Amendment No. 1113, to make a technical correction.
**Prescription Drug and Medicare Improvement Act:** By yeas to nays (Vote No. 262), Senate passed S. 1, to amend title XVIII of the Social Security Act to make improvements in the Medicare program, to provide prescription drug coverage under the Medicare program, after agreeing to the committee amendment in the nature of a substitute, and after taking action on the following amendments proposed thereto: Pages S8605–33, S8635–78, S8679–85, S8686–S8701

Adopted:

Baucus (for Cantwell) Modified Amendment No. 942, to prohibit an eligible entity offering a Medicare Prescription Drug plan, a Medicare Advantage Organization offering a Medicare Advantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements. Pages S8606, S8612–17

By 97 yeas to 1 nay (Vote No. 249), McConnell Amendment No. 1097, to protect seniors who are diagnosed with cancer from high prescription drug costs.

By 69 yeas to 29 nays (Vote No. 251), Bingaman/Domenici Modified Amendment No. 1065, to update, beginning in 2009, the asset or resource test used for purposes of determining the eligibility of low-income beneficiaries for premium and cost-sharing subsidies. Pages S8606, S8622–23

Nelson (FL) Amendment No. 936, to provide for an extension of the demonstration for ESRD managed care. Page S8606

Nelson (FL) Amendment No. 938, to provide for a study and report on the propagation of concierge care. Page S8606

Thomas/Lincoln Modified Amendment No. 988, to provide for the coverage of marriage and family therapist services and mental health counselor services under part B of the Medicare program. Page S8606

Baucus (for Snowe) Amendment No. 1027, to express the sense of the Senate regarding the implementation of the Prescription Drug and Medicare Improvement Act of 2003. Page S8633

Baucus (for Murkowski/Stevens) Amendment No. 1041, to require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project. Pages S8633, S8687

Subsequently, the adoption of Amendment No. 1041 (listed above) was vitiated. Page S8633

By a unanimous vote of 98 yeas (Vote No. 252), McConnell Amendment No. 1102, to protect seniors who are diagnosed with Alzheimer’s disease from high prescription drug costs. Pages S8624, S8635–36

Subsequently, the amendment was modified. Page S8635

By 71 yeas to 26 nays (Vote No. 255), Grassley/Baucus Modified Amendment No. 1092, to evaluate alternative payment and delivery systems. Pages S8606, S8610–12, S8618–21, S8637–38

Grassley (for Bond) Amendment No. 1014, to include pharmacy services in the study relating to outpatient pharmacy therapy reimbursements. Page S8614

Baucus (for Dodd) Amendment No. 1015, to provide for a study on making prescription pharmaceutical information accessible for blind and visually-impaired individuals. Page S8647

Grassley (for Hatch) Amendment No. 1059, to direct the Secretary of Health and Human Services to conduct a review and report on current standards of practice for pharmacy services provided to patients in nursing facilities. Page S8647

Grassley (for Hatch/Wyden) Amendment No. 1106, to establish a Citizens Health Care Working Group to facilitate public debate about how to improve the health care system for Americans and to provide for hearings by Congress on the recommendations that are derived from this debate. Page S8647

Grassley (for Murkowski) Amendment No. 1086, to ensure that pharmacies operated by the Indian Health Service and Indian health programs are included in the network of pharmacies established by entities and organizations under part D. Page S8647

Baucus (for Mikulski) Modified Amendment No. 1033, to extend certain municipal health service demonstration projects. Page S8644

Baucus (for Lincoln) Modified Amendment No. 1067, to provide coverage for kidney disease education services under the Medicare program. Pages S8644–47

Lincoln Amendment No. 959, to establish a demonstration project for direct access to physical therapy services under the Medicare program. Page S8606

Lincoln Amendment No. 935, to clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs. Page S8606

Reid (for Jeffords) Amendment No. 1038, to improve the critical access hospital program. Page S8606

Reid (for Johnson/Cochran) Amendment No. 1095, to provide for a 1-year medication therapy management assessment program. Pages S8617–18

Grassley (for Murkowski/Stevens) Amendment No. 1096, to require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project. Page S8681

Grassley (for Brownback/Nelson (NE)) Amendment No. 1122, to provide for improvements in access to services in rural hospitals and critical access hospitals. Page S8681
Grassley (for Coleman) Amendment No. 1074, to amend title XVIII of the Social Security Act to make improvements in the national coverage determination process to respond to changes in technology.

Grassley (for Collins) Amendment No. 1023, to provide for the establishment of a demonstration project to clarify the definition of homebound.

Grassley (for Kyl) Amendment No. 1114, to require the GAO to study the impact of price controls on pharmaceuticals.

Grassley (for Kyl) Amendment No. 1115, to express the sense of the Senate concerning Medicare payments to physicians and other health professionals.

Grassley (for Chambliss) Amendment No. 1045, to provide for a demonstration project for the exclusion of brachytherapy devices from the prospective payment system for outpatient hospital services.

Grassley (for Craig) Amendment No. 1058, to restore the Federal Hospital Insurance Trust Fund to the financial position it would have been in if a clerical bookkeeping error had not occurred.

Grassley (for Baucus) Amendment No. 1117, to establish the Safety Net Organizations and Patient Advisory Commission.

Grassley (for Bayh) Amendment No. 1044, to adjust the urban health provider payment.

Grassley (for Shelby) Amendment No. 1056, to prevent the Secretary of Health and Human Services from modifying the treatment of certain long-term care hospitals as subsection (d) hospitals.

Grassley (for Murray) Modified Amendment No. 961, to make improvements in the Medicare-Advantage benchmark determinations.

Grassley (for Bond/Roberts) Amendment No. 1013, to ensure that patients are receiving safe and accurate dosages of compounded drugs.

Grassley (for Kyl) Amendment No. 1121, to express the sense of the Senate concerning the structure of Medicare reform and the prescription drug benefit to ensure Medicare’s long-term solvency and high quality of care.

Grassley (for Collins) Modified No. 989, to increase Medicare payments for home health services furnished in a rural area.

Grassley (for Dole/Edwards) Amendment No. 1126, to provide for the treatment of certain entities for purposes of payments under the Medicare program.

Grassley (for Reed) Amendment No. 996, to modify the GAO study of geographic differences in payments for physicians’ services relating to the work geographic practice cost index.

Grassley (for Specter) Amendment No. 1118, to express the sense of the Senate regarding the establishment of a nationwide permanent lifestyle modification program for Medicare beneficiaries.

Grassley (for Specter) Amendment No. 1085, to express the sense of the Senate regarding payment reductions under the Medicare physician fee schedule.

Allard/Feingold Amendment No. 1017, to provide for temporary suspension of OASIS requirement for collection of data on non-Medicare and non-Medicaid patients.

Baucus (for Harkin) Amendment No. 968, to restore reimbursement for total body orthotic management for nonambulatory, severely disabled nursing home residents.

Graham (SC) Modified Amendment No. 948, to provide for the establishment of a National Bipartisan Commission on Medicare Reform.

Dayton Modified Amendment No. 960, to require a streamlining of the Medicare regulations.

Baucus (for Feingold) Amendment No. 1054, to establish an Office of the Medicare Beneficiary Advocate.

Enzi Amendment No. 1030, to encourage the availability of Medicare-Advantage benefits in medically underserved areas.

Grassley Amendment No. 1133, to provide for a managers’ amendment.

Rejected:

Harkin Modified Amendment No. 991, to establish a demonstration project under the Medicare program to encourage the provision of community-based services to individuals with disabilities. (By 50 yeas to 48 nays (Vote No. 247), Senate tabled the amendment.)

By 39 yeas to 59 nays (Vote No. 248), Edwards/Harkin Amendment No. 1052, to strengthen protections for consumers against misleading direct-to-consumer drug advertising.

Reid (for Boxer) Amendment No. 1036, to eliminate the coverage gap for individuals with cancer. (By 55 yeas to 44 nays (Vote No. 250), Senate tabled the amendment.)

Durbin Amendment No. 1108, to provide additional assistance for certain eligible beneficiaries under part D. (By 57 yeas to 41 nays (Vote No. 253), Senate tabled the amendment.)

By 39 yeas to 59 nays (Vote No. 254), Dorgan/Pryor Amendment No. 1103 (to Amendment No. 1092), to reduce aggregate beneficiary obligations by $2,400,000,000 per year beginning in 2009.
By 33 yeas to 65 nays (Vote No. 256), Sessions Amendment No. 1011, to express the sense of the Senate that the Committee on Finance should hold hearings regarding permitting States to provide health benefits to legal immigrants under Medicaid and SCHIP as part of the authorization of the temporary assistance for needy families program.

By 47 yeas to 51 nays (Vote No. 257), Rockefeller Modified Amendment No. 975, to make all Medicare beneficiaries eligible for Medicare prescription drug coverage.

By 43 yeas to 55 nays (Vote No. 258), Bingaman Amendment No. 1066, to permit the establishment of 2 new Medigap plans for Medicare beneficiaries enrolled for prescription drug coverage under part D.

By 42 yeas to 54 nays (Vote No. 259), Baucus (for Levin) Amendment No. 1111, to ensure that current retirees who have prescription drug coverage who will lose their prescription drug coverage as a result of the enactment of this legislation have the option of drug coverage under the Medicare fallback.

By 21 yeas to 75 nays (Vote No. 260), Hagel/Ensign Modified Amendment No. 1026, to provide Medicare beneficiaries with a drug discount card that ensures access to affordable prescription drugs.

Baucus (for Feinstein) Modified Amendment No. 1060, to provide for an income-related increase in the part B premium for individuals with income in excess of $75,000 and married couples with income in excess of $150,000. (By 38 yeas to 59 nays (Vote No. 261), Senate earlier failed to table the amendment.)

Withdrawn:
Kyl Amendment No. 1093 (to Amendment No. 1092), in the nature of a substitute.

Grassley (for Craig) Amendment No. 1087, to permit the offering of consumer-driven health plans under Medicare Advantage.

Santorum Amendment No. 1132, to allow eligible beneficiaries in Medicare Advantage plans to elect zero premium, stop-loss drug coverage protection.

Kerry Amendment No. 958, to increase the availability of discounted prescription drugs.

Lincoln Modified Amendment No. 934, to ensure coverage for syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin.

Baucus (for Jeffords) Amendment No. 964, to include coverage for tobacco cessation products.


Akaka Amendment No. 980, to expand assistance with coverage for legal immigrants under the Medicaid program and SCHIP to include citizens of the Freely Associated States.

Akaka Amendment No. 979, to ensure that current prescription drug benefits to Medicare-eligible enrollees in the Federal Employees Health Benefits Program will not be diminished.

Bingaman Amendment No. 973, to amend title XVIII of the Social Security Act to provide for the authorization for reimbursement for all Medicare part B services furnished by certain Indian hospitals and clinics.

Baucus (for Lautenberg) Amendment No. 986, to make prescription drug coverage available beginning on July 1, 2004.

Murray Amendment No. 990, to make improvements in the Medicare Advantage benchmark determinations.

Dayton Amendment No. 977, to require that benefits be made available under part D on January 1, 2004.

Baucus (for Dorgan) Amendment No. 993, to amend title XVIII of the Social Security Act to provide for coverage of cardiovascular screening tests under the Medicare program.

Smith/Bingaman Amendment No. 962, to provide reimbursement for Federally qualified health centers participating in Medicare managed care.

Hutchison Amendment No. 1004, to amend title XVIII of the Social Security Act to freeze the indirect medical education adjustment percentage under the Medicare program at 6.5 percent.

Conrad Amendment No. 1019, to provide for coverage of self-injected biologicals under part B of the Medicare program until Medicare Prescription Drug plans are available.

Conrad Amendment No. 1020, to permanently and fully equalize the standardized payment rate beginning in fiscal year 2004.

Conrad Amendment No. 1021, to address Medicare payment inequities.

Clinton Amendment No. 999, to provide for the development of quality indicators for the priority areas of the Institute of Medicine, for the standardization of quality indicators for Federal agencies, and for the establishment of a demonstration program for the reporting of health care quality data at the community level.
Clinton Amendment No. 953, to provide training to long-term care ombudsman.  Pages S8606, S8687
Clinton Amendment No. 954, to require the Secretary of Health and Human Services to develop literacy standards for informational materials, particularly drug information.  Pages S8606, S8687
Reid (for Corzine) Modified Amendment No. 1037, to provide conforming changes regarding federally qualified health centers.  Pages S8606, S8632
Reid (for Inouye) Amendment No. 1059, to amend title XIX of the Social Security Act to provide 100 percent reimbursement for medical assistance provided to a Native Hawaiian through a Federally-qualified health center or a Native Hawaiian health care system.  Page S8606
Enzi/Lincoln Amendment No. 1051, to ensure convenient access to pharmacies and prohibit the tying of contracts.  Pages S8606, S8687
Hagel/Ensign Amendment No. 1012, to provide Medicare beneficiaries with an additional choice of Medicare Prescription Drug plans under part D that consists of a drug discount card and protection against high out-of-pocket drug costs.  Pages S8606, S8687
Baucus (for Akaka) Amendment No. 1061, to provide for treatment of Hawaii as a low-DSH State for purposes of determining a Medicaid DSH allotment for the State for fiscal years 2004 and 2005.  Pages S8606, S8687
Stabenow/Levin Amendment No. 1075, to permanently extend a moratorium on the treatment of a certain facility as an institution for mental diseases.  Pages S8606, S8687
Stabenow/Levin Amendment No. 1076, to provide for the treatment of payments to certain comprehensive cancer centers.  Pages S8606, S8687
Stabenow/Levin Amendment No. 1077, to provide for the redistribution of unused resident positions.  Pages S8606, S8687
Enzi/Lincoln Amendment No. 1024, to amend title XVIII of the Social Security Act to repeal the Medicare outpatient rehabilitation therapy caps.  Pages S8606, S8687
Smith/Feingold Amendment No. 1073, to allow the Secretary to include in the definition of 'specialized Medicare+Choice plans for special needs beneficiaries' plans that disproportionately serve such special needs beneficiaries or frail, elderly Medicare beneficiaries.  Pages S8606, S8687
Baucus (for Mikulski) Amendment No. 1088, to provide equitable treatment for children's hospitals.  Pages S8606, S8687
Baucus (for Mikulski) Amendment No. 1089, to provide equitable treatment for certain children's hospitals.  Pages S8606, S8687
Baucus (for Mikulski) Amendment No. 1090, to permit direct payment under the Medicare program for clinical social worker services provided to residents of skilled nursing facilities.  Pages S8606, S8687
Baucus (for Mikulski) Amendment No. 1091, to extend certain municipal health service demonstration projects.  Pages S8606, S8687
Baucus (for Levin) Amendment No. 1110, to ensure that beneficiaries initially covered by a private insurer under this act who are subsequently covered by a Medicare fallback plan have the option of retaining a Medicare fallback plan.  Pages S8632, S8687
Baucus (for Murkowski/Stevens) Amendment No. 1041, to require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project.  Page S8687

A unanimous-consent agreement was reached providing that following passage of S. 1 (listed above), the bill be held at the desk, and when the Senate receives H.R. 1, House companion measure, all after the enacting clause be stricken and the text of S. 1 be inserted in lieu thereof; Senate insisted on its amendment, request a conference with the House thereon, and the Chair be authorized to appoint conference on the part of the Senate; providing further, passage of S. 1 be vitiated and the bill be returned to the Senate Calendar.  Page S8811

Check Truncation Act: Senate passed H.R. 1474, to facilitate check truncation by authorizing substitute checks, to foster innovation in the check collection system without mandating receipt of checks in electronic form, and to improve the overall efficiency of the Nation's payments system, after striking all after the enacting clause and inserting the text of S. 1334, Senate companion measure.  Pages S8811–15

Subsequently, S. 1334 was returned to the Senate Calendar.

Commending August Hiebert: Senate agreed to S. Res. 186, commending August Hiebert for his service to the Alaska Communications Industry.  Pages S8815–16
Rhodes Scholarships: Senate agreed to S. Res. 187, expressing the sense of the Senate regarding the centenary of the Rhodes Scholarships in the United States and the establishment of the Mandela Rhodes Foundation.  Pages S8815–16
Honoring Maynard Holbrook Jackson, Jr.: Senate agreed to S. Res. 188, honoring Maynard Holbrook Jackson, Jr., former Mayor of the City of Atlanta, and extending the condolences of the Senate on his death.  Pages S8815–16
Commending General Eric Shinseki: Senate agreed to S. Res. 190, commending General Eric
Shinseki of the United States Army for his outstanding service and commitment to excellence.

Adjournment Resolution—Agreement: A unanimous-consent agreement was reached providing that when the Senate receives an adjournment resolution from the House, it be agreed to, providing that the text is identical to the resolution being held at the desk.

Nominations Confirmed: Senate confirmed the following nominations:
- Joshua B. Bolten, of the District of Columbia, to be Director of the Office of Management and Budget.

Nominations Received: Senate received the following nominations:
- Rick A. Dearborn, of Oklahoma, to be an Assistant Secretary of Energy (Congressional and Intergovernmental Affairs).
- Scott J. Bloch, of Kansas, to be Special Counsel, Office of Special Counsel, for the term of five years.
- Penrose C. Albright, of Virginia, to be an Assistant Secretary of Homeland Security. (New Position)
- Rene Acosta, of Virginia, to be an Assistant Attorney General

Messages From the House:

Measures Referred:

Measures Placed on Calendar:

Measures Read First Time:

Executive Communications:

Executive Reports of Committees:

Additional Cosponsors:

Statements on Introduced Bills/Resolutions:

Additional Statements:

Amendments Submitted:

Authority for Committees To Meet:

Record Votes: Sixteen record votes were taken today. (Total—262)

Adjournment: Senate met at 9:15 a.m., and adjourned at 1:15 a.m. on Friday, June 27, 2003, until 10:15 a.m., on the same day. (For Senate's program, see the remarks of the Majority Leader in today's Record on page S8817.)
sharing practices in relation to the Fair Credit Reporting Act, focusing on privacy protections, security risks and threats to the credit reporting system, retail credit card programs, and merchandise returns, after receiving testimony from Vermont Assistant Attorney General Julie Brill, Montpelier; Joel R. Reidenberg, Fordham University School of Law, and Martin Wong, Citigroup, Inc., both of New York, New York; Ronald A. Prill, Target Financial Services, Minneapolis, Minnesota, on behalf of the National Retail Federation; Edmund Mierzwinski, U.S. Public Interest Research Group, Washington, D.C.; Terry Baloun, Wells Fargo Bank, Sioux Falls, South Dakota; and Angela Maynard, Keycorp, Cleveland, Ohio.

BUSINESS MEETING

Committee on Commerce, Science, and Transportation: Committee ordered favorably reported the following business items:

S. 1264, to reauthorize the Federal Communications Commission, with amendments;

H.R. 1320, to amend the National Telecommunications and Information Administration Organization Act to facilitate the reallocation of spectrum from governmental to commercial users, with an amendment;

An original bill to authorize funds for highway safety programs, motor carrier safety programs, hazardous materials transportation safety programs, and boating safety programs;

S. 1262, to authorize appropriations for fiscal years 2004, 2005, and 2006 for certain maritime programs of the Department of Transportation, with amendments; and

S. 1218, to provide for Presidential support and coordination of interagency ocean science programs and development and coordination of a comprehensive and integrated United States research and monitoring program, with an amendment in the nature of a substitute.

NOMINATIONS:

Committee on Finance: Committee concluded hearings to examine the nominations of Josette Sheeran Shiner, of Virginia, to be a Deputy United States Trade Representative, with the rank of Ambassador, and James J. Jochum, of Virginia, to be an Assistant Secretary of Commerce, after each nominee testified and answered questions in their own behalf.

BUSINESS MEETING

Committee on Foreign Relations: Committee ordered favorably reported the following business items:

S. Res. 90, expressing the sense of the Senate that the Senate strongly supports the nonproliferation programs of the United States, with an amendment;

S. Res. 62, calling upon the Organization of American States (OAS) Inter-American Commission on Human Rights, the United Nations High Commissioner for Human Rights, the European Union, and human rights activists throughout the world to take certain actions in regard to the human rights situation in Cuba;

S. Res. 149, expressing the sense of the Senate that the international response to the current need for food in the Horn of Africa remains inadequate, with an amendment; and

The nominations of Robert W. Fitts, of New Hampshire, to be Ambassador to Papua New Guinea, and to serve concurrently and without additional compensation as Ambassador to the Solomon Islands and Ambassador to the Republic of Vanuatu, Marsha E. Barnes, of Maryland, to be Ambassador to the Republic of Suriname, John E. Herbst, of Virginia, to be Ambassador to Ukraine, Tracey Ann Jacobson, of the District of Columbia, to be Ambassador to Turkmenistan, George A. Krol, of New Jersey, to be Ambassador to the Republic of Belarus, John F. Maisto, of Pennsylvania, to be Permanent Representative of the United States of America to the Organization of American States, with the rank of Ambassador, Greta N. Morris, of California, to be Ambassador to the Republic of the Marshall Islands, Roger Francisco Noriega, of Kansas, to be an Assistant Secretary of State (Western Hemisphere Affairs), William B. Wood, of New York, to be Ambassador to the Republic of Colombia, and certain Foreign Service Officer promotion lists.

INTERNATIONAL PARENTAL ABDUCTION

Committee on Foreign Relations: Committee concluded hearings to examine the Department of State’s Office of Children’s Issues, focusing on responding to international parental abduction, after receiving testimony from Senator Lincoln; and Maura Harty, Assistant Secretary of State, Bureau of Consular Affairs.

NOMINATIONS:

Committee on Governmental Affairs: Committee ordered favorably reported the nominations of Judith Nan Maculupo, to be an Associate Judge of the Superior Court of the District of Columbia; Fern Flanagan Saddler, to be an Associate Judge of the Superior Court of the District of Columbia; and Joshua B. Bolten, of the District of Columbia, to be Director of the Office of Management and Budget.

BUSINESS MEETING

Committee on Indian Affairs: Committee ordered favorably reported the following business items:

S. 281, to amend the Transportation Equity Act for the 21st Century to make certain amendments with respect to Indian tribes, to provide for training
and technical assistance to Native Americans who are interested in commercial vehicle driving careers, with an amendment in the nature of a substitute; and

The nominations of Lisa Genevieve Nason, of Alaska, Georgianna E. Ignace, of Wisconsin, John Richard Grimes, of Massachusetts, each to be a Member of the Board of Trustees of the Institute of American Indian and Alaska Native Culture and Arts Development, and Charles W. Grim, of Oklahoma, to be Director of the Indian Health Service, Department of Health and Human Services.

BUSINESS MEETING

Committee on the Judiciary: Committee ordered favorably reported the following business items:

S. Res. 174, designating Thursday, November 20, 2003, as “Feed America Thursday”;
S. Res. 175, designating the month of October 2003, as “Family History Month”; and

The nominations of Diane M. Stuart, of Utah, to be Director of the Violence Against Women Office, Department of Justice; and Thomas M. Hardiman, to be United States District Judge for the Western District of Pennsylvania.

Also, committee resumed markup of S. 1125, to create a fair and efficient system to resolve claims of victims for bodily injury caused by asbestos exposure, but did not complete action thereon, and recessed subject to call.

GROWING WAHHABI INFLUENCE

Committee on the Judiciary: Subcommittee on Terrorism, Technology, and Homeland Security concluded hearings to examine the ideological structure of Wahhabism, an extreme and violent form of Islam, and its potential for political and social influence in the United States, after receiving testimony from David Aufhauser, General Counsel, Department of the Treasury; Larry A. Mefford, Assistant Director, Counterterrorism Division, Federal Bureau of Investigation, Department of Justice; and Alex Alexiev, Center for Security Policy, and Stephen Schwartz, Foundation for Defense of Democracies, both of Washington, D.C.

House of Representatives

Chamber Action


Additional Cosponsors: Pages H6261–64

Reports Filed: Reports were filed today as follows:

H.R. 438, to increase the amount of student loans that may be forgiven for teachers in mathematics, science, and special education, amended (H. Rept. 108–182);
H.R. 2211, to reauthorize title II of the Higher Education Act of 1965, amended (H. Rept. 108–183);
H.R. 2210, to reauthorize the Head Start Act to improve the school readiness of disadvantaged children, amended (H. Rept. 108–184); and
H.R. 74, to direct the Secretary of Agriculture to convey certain land in the lake Tahoe Basin Management Unit, Nevada, to the Secretary of the Interior, in trust for the Washoe Indian Tribe of Nevada and California (H. Rept. 108–185).

Guest Chaplain: The prayer was offered by the guest Chaplain, Rabbi Milton Balkany, Dean, Bais Yaakov of Brooklyn, New York.

Journal: Agreed to the Speaker’s approval of the Journal of June 25 by yea-and-nay vote of 357 yeas to 68 nays, Roll No. 327.


Agreed To:
Hastings of Florida amendment No. 4 printed in H. Rept. 108–176, debated on June 25, that directs the Director of Central Intelligence to establish a pilot project to improve recruitment of ethnic and cultural minorities and women with diverse skills and language abilities (agreed to by recorded vote of 418 ayes with none voting "no", Roll No. 318; pages H6256–57

Rejected:
Kucinich amendment No. 5 printed in H. Rept. 108–176, debated on June 25, that sought to direct the Inspector General of the Central Intelligence
Agency to conduct an audit of all communications between the CIA and the Office of the Vice President that relate to weapons of mass destruction obtained or developed by Iraq (rejected by recorded vote of 76 ayes to 347 noes, Roll No. 319); and

Lee amendment No. 6 printed in H. Rept. 108–176, debated on June 25, that sought to require a GAO study on intelligence sharing by the Department of Defense and intelligence community with United Nations inspectors searching for weapons of mass destruction (rejected by recorded vote of 185 ayes to 239, Roll No. 320).

H. Res. 295, the rule that provided for consideration of the bill was agreed to on June 25.

Recess: The House recessed at 11:48 a.m. and reconvened at 12:53 p.m.

Motions to Suspend the Rules on Wednesdays During the Remainder of the One Hundred Eighth Congress: The House agreed to H. Res. 297, providing for motions to suspend the rules by recorded vote of 226 ayes to 203 noes, Roll No. 323.

Late Report: The Committee on Appropriations received permission to have until midnight to file a privileged report making appropriations for the Legislative Branch for the fiscal year ending September 30, 2004.


Rejected the Obey motion to recommit the bill to the Committee on Appropriations. Earlier, a point of order was sustained against another Obey motion that sought to recommit the bill to the Committee on Appropriations with instructions to report it back forthwith with an amendment that increases funding for various programs including fitness facilities, family housing, and barracks.

Point of order was sustained against the Obey amendment that sought to reinstate funding for various programs including fitness facilities, family housing, and barracks.

Earlier, the House agreed to H. Res. 298, the rule that provided for consideration of the bill by voice vote. Agreed to order the previous question by yeas and-nay vote of 220 yeas to 200 nays, Roll No. 324.

Suspension—Support for Freedom in Hong Kong: The House agreed to suspend the rules and agree to H. Res. 277, expressing support for freedom in Hong Kong (agreed to by 2/3 yeas-and-nay vote of 426 yeas to 1 nay, Roll No. 326). The motion was debated on June 25.

Order of Business—DoD Appropriations: Agreed that it be in order on Tuesday, July 8, for the Speaker, as though pursuant to clause 2(b) of rule 18, to declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of a bill reported pursuant to section 6 of H. Res. 299, making appropriations for the Department of Defense for the fiscal year ending September 30, 2004, which shall proceed according to the following order: the first reading shall be dispensed with; all points of order against consideration of the bill are waived; general debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Appropriations; after general debate the bill shall be considered for amendment under the five-minute rule; points of order against provisions in the bill for failure to comply with clause 2 of rule XXI are waived; during consideration of the bill for amendment, the Chairman of the Committee of the Whole may accord priority in recognition on the basis of whether the member offering an amendment has caused it to be printed in the portion of the Congressional Record designated for that purpose in clause 8 of rule XVIII. Amendments so printed shall be considered as read. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

State Children's Health Insurance Program (SCHIP) Allocations: The House passed H.R. 531, to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program (SCHIP) by unanimous consent.

Medicare Prescription Drug, Modernization, Health Savings and Affordability Act: The House passed H.R. 1, to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program and to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed
to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements by 216 ayes to 215 noes with 1 voting "present," Roll No. 332.

Pages H6007–H6105, H6107–H6256

Pursuant to Section 3 of the rule in the engrossment of H.R. 1, the Clerk shall add the text of H.R. 2596, as passed by the House as a new matter at the end of H.R. 1, conform the title of H.R. 1 to reflect the addition of the text of H.R. 2596 to the engrossment, and then lay H.R. 2596 on the table.

Page H6256

Rejected the Thompson of California motion to recommit the bill jointly to the Committee on Ways and Means and the Committee on Energy and Commerce with instructions to report the same back to the House promptly with amendments in the nature of a substitute that establish the Prescription Drug and Medicare Improvement Act. By recorded vote of 208 ayes to 223 noes, Roll No. 331.

Pages H6181–H6255

Rejected the Rangel amendment in the nature of a substitute numbered 1 printed in H. Rept. 108–181 that sought to provide prescription drug coverage for all Medicare beneficiaries, enhance Medicare+Choice plans, includes payments for oncology providers and related cancer drug therapy programs; improve rural health delivery; and implement various provisions dealing with Medicare Parts A and B, Medicaid, regulatory reduction and the reimportation of prescription drugs by recorded vote of 176 ayes to 255 noes with 1 voting "present", Roll No. 330.

Page H6181

H. Res. 299, the rule that providing for consideration of both H.R. 1, Medicare Prescription Drug and Modernization Act, and H.R. 2596, Health Savings and Affordability Act was agreed to by recorded vote of 221 ayes to 203 noes, Roll No. 322. Earlier agreed to order the previous question by yea-and-nay vote of 226 yeas to 203 nays, Roll No. 321.

Pages H5972–73

Health Savings and Affordability Act: The House passed H.R. 2596, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements by yea-and-nay vote of 237 yeas to 191 nays, Roll No. 328.

Pages H5952–73, H5992–H6006

Section 3 of H. Res. 299, the rule providing for consideration of the bill, provides that in the engrossment of H.R. 1, the clerk shall add the text of H.R. 2596, as passed by the House as a new matter at the end of H.R. 1, and then lay H.R. 2596 on the table.

Pages H6256

Independence Day District Work Period: The House agreed to H. Con. Res. 231, providing for a conditional adjournment of the House of Representatives and a conditional recess or adjournment of the Senate.

Page H6257

Senate Concurrence in Adjournment Resolution: Agreed that when the House adjourns today, it adjourn to meet at 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its concurrence in H. Con. Res. 231, in which case the House shall stand adjourned pursuant to that concurrent resolution.

Page H6257

Calendar Wednesday: Agreed to dispense with the Calendar Wednesday business of Wednesday, July 9.

Page H6257

Speaker Pro Tempore: Read a letter from the Speaker wherein he appointed Representative Tom Davis of Virginia to act as Speaker pro tempore to sign enrolled bills and joint resolutions through Monday, July 7.

Page H6257

Senate Messages: Messages received from the Senate today appear on pages H5941, and H5992.

Referrals: S. 163 was referred to the Committees on Education and the Workforce and Resources, S. 498 was referred to the Committee on Financial Services, S. 867 was referred to the Committee on Government Reform, and S. 1207 and S. 312 were held at the desk.

Page H6258

Call of the House: On the Call of the House, 421 members reported their presence, Roll No. 329.

Page H6178


Adjournment: The House met at 10 a.m. and at 2:47 a.m. on Friday, June 27, pursuant to the provisions of H. Con. Res. 231, the House stands adjourned until 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its adoption of H. Con. Res. 231, in which case the House shall stand adjourned pursuant to that concurrent resolution until 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its concurrence in H. Con. Res. 231, in which case the House shall stand adjourned pursuant to that concurrent resolution.
Committee Meetings

MANDATORY COUNTRY OF ORIGIN LABELING LAW REVIEW

Committee on Agriculture: Held a hearing to review the mandatory country of origin labeling law. Testimony was heard from the following officials of the USDA: Charles Lambert, Deputy Under Secretary, Marketing and Regulatory Programs; Nancy Bryson, General Counsel; and Keith Collins, Chief Economist; and public witnesses.

DEFENSE AND LEGISLATIVE APPROPRIATIONS

Committee on Appropriations: Ordered reported the following appropriations for fiscal year 2004: Defense and Legislative.

FOREIGN RELATIONS AUTHORIZATION ACT


FINANCIAL MAINSTREAM—BROADEN ACCESS

Committee on Financial Services: Subcommittee on Financial Institutions and Consumer Credit held a hearing entitled "Serving the Underserved: Initiatives to Broaden Access to the Financial Mainstream." Testimony was heard from Wayne Abernathy, Assistant Secretary, Financial Institutions, Department of the Treasury; Dennis Dollar, Chairman, National Credit Union Administration; and public witnesses.

COMPETITIVE SOURCING FOR 21ST CENTURY

Committee on Government Reform: Held a hearing titled "New Century, New Process: A Preview of Competitive Sourcing for the 21st Century." Testimony was heard from David M. Walker, Comptroller, GAO; Angela Styles, Director, Office of Federal Procurement Policy, OMB; Philip Grone, Principal Assistant Deputy Under Secretary, Installations and Environment, Department of Defense; Scott J. Cameron, Deputy Assistant Secretary, Performance and Management, Department of the Interior; and public witnesses.

ASIA AND THE PACIFIC—U.S. SECURITY POLICY

Committee on International Relations: Subcommittee on East Asia and the Pacific held a hearing on U.S. Security Policy in Asia and the Pacific: Restructuring America’s Forward Deployment. Testimony was heard from the following officials of the Department of Defense: Peter Rodman, Assistant Secretary, International Security Affairs; and Adm. Thomas B. Fargo, USN, Commander, U.S. Pacific Command; and Christopher LaFleur, Special Envoy, Northeast Asia Security Consultations, Bureau of East Asian and Pacific Affairs, Department of State.

AMERICAN SERVICEMEMBERS’ PROTECTION ACT AMENDMENTS

Committee on International Relations: Subcommittee on Europe approved for full Committee action H.R. 2550, to amend the American Servicemembers’ Protection Act of 2002 to provide clarification with respect to the eligibility of certain countries for United States military assistance.

HOMETOWN HEROES SURVIVORS BENEFITS

Committee on the Judiciary: Subcommittee on Crime, Terrorism, and Homeland Security held a hearing on H.R. 919, Hometown Heroes Survivors Benefits. Testimony was heard from Michael E. Williams, Jr., Fire Rescue Training Specialist, Office of the State Fire Marshall, Department of Insurance, State of North Carolina; and public witnesses.

OVERSIGHT—CONSULAR IDENTIFICATION CARDS

Committee on the Judiciary: Subcommittee on Immigration, Border Security, and Claims held an oversight hearing on “The Federal Government’s Response to the Issuance and Acceptance in the U.S. of Consular Identification Cards.” Testimony was heard from Roberta S. Jacobson, Acting Deputy Assistant Secretary, Bureau of Western Hemisphere Affairs, Department of State; Steven McCraw, Assistant Director, Office of Intelligence, FBI, Department of Justice; C. Stewart Verdery, Assistant Secretary, Policy and Planning, Border and Transportation Security Directorate, Department of Homeland Security; and a public witness.

MISCELLANEOUS MEASURES

Committee on Resources: Subcommittee on Fisheries Conservation, Wildlife and Oceans held a hearing on the following bills: H.R. 1204, to amend the National Wildlife Refuge System Administration Act of 1966 to establish requirements for the award of concessions in the National Wildlife Refuge System, to provide for maintenance and repair of properties located in the System by concessionaires authorized to use such properties; and H.R. 2408, National Wildlife Refuge Volunteer Act of 2003. Testimony was heard from Marshall P. Jones, Jr. Deputy Director, U.S. Fish and Wildlife Service, Department of the Interior; and public witnesses.
NASA FLEXIBILITY ACT

Committee on Science: Subcommittee on Space and Aeronautics approved for full Committee action, as amended, H.R. 1085, NASA Flexibility Act of 2003.

COMPUTER RESERVATION SYSTEMS REGULATIONS AND SMALL BUSINESS—TRAVEL INDUSTRY

Committee on Small Business: Subcommittee on Regulatory Reform and Oversight held a hearing entitled: “CRS Regulations and Small Business in the Travel Industry.” Testimony was heard from Tom Sullivan, Chief Counsel, Office of Advocacy, SBA; and public witnesses.

NATIONAL RAIL INFRASTRUCTURE FINANCING PROPOSALS

Committee on Transportation and Infrastructure: Subcommittee on Railroads held an oversight hearing on National Rail Infrastructure Financing Proposals. Testimony was heard from the following officials of the Department of Transportation: Allan Rutter, Administrator, Federal Railroad Administration; and Roger Nober, Chairman, Surface Transportation Board; Joseph Boardman, Commissioner, Department of Transportation, State of New York; and public witnesses.

VETERAN'S LEGISLATION

Committee on Veterans' Affairs: Ordered reported the following measures: H.R. 1516, as amended, National Cemetery Expansion Act of 2003; H.R. 2297, as amended, Veterans Benefits Act of 2003; H.R. 116, as amended, Veterans' New Fitzsimons Health Care Facilities Act of 2003; H.R. 1720, as amended, Veterans Health Care Facilities Capital Improvement Act; H.R. 2357, as amended, to amend title 38, United States Code, to establish standards of access to care for veterans seeking health care from the Department of Veterans Affairs; H.R. 2433, as amended, Health Care for Veterans of Project 112/Project SHAD Act of 2003; H.R. 2595, to restore the operation of the Native American Veteran Housing Loan Program during fiscal year 2003 to the scope of that program as in effect on September 30, 2002; and H. Con. Res. 159, declaring Emporia, Kansas, to be the founding city of the Veterans Day holiday and recognizing the contributions of Alvin J. King and Representative Ed Rees to the enactment into law of the observance of Veterans Day.

PROJECT BIOSHIELD ACT


NEW PUBLIC LAWS

(For last listing of Public Laws, see DAILY DIGEST, p. D713 )


COMMITTEE MEETINGS FOR FRIDAY, JUNE 27, 2003

Senate

No meetings/hearings scheduled.

House

No committee meetings are scheduled.
Next Meeting of the SENATE
10:15 a.m., Friday, June 27

Senate Chamber

Program for Friday: Senate will be in a period of morning business.

Next Meeting of the HOUSE OF REPRESENTATIVES
2 p.m., Monday, July 7

House Chamber

Program for Monday: To be announced.