declares the House in recess subject to the call of the Chair.

Accordingly (at 11 o'clock and 48 minutes a.m.), the House stood in recess subject to the call of the Chair.

□ 1253

AFTER RECESS

The recess having expired, the House was called to order by the Speaker pro tempore (Mr. LATOURETTE) at 12 o'clock and 53 minutes p.m.

PROVIDING FOR CONSIDERATION OF H.R. 1, MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003, AND H.R. 2596, HEALTH SAVINGS AND AFFORDABILITY ACT OF 2003

Ms. PRYCE of Ohio. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 299 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 299

Resloved, That upon the adoption of this resolution it shall be in order without intervention of any point of order to consider in the House the bill (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 for other purposes. The bill shall be considered as a read for amendment. The previous question shall be considered as ordered on the bill and on any amendment thereto to final passage without intervening motion except: (1) three hours of debate on the bill equally divided among and controlled by the chairmen and ranking minority members of the Committee on Energy and Commerce and the Committee on Ways and Means; (2) the amendment printed in the report of the Committee on Rules accompanying this resolution, if offered by Representative Rangel of New York or his designee, which shall be in order without intervention of any point of order, shall be considered as read, and shall be considered as read, and shall be separately debatable for one hour equally divided and controlled by the proponent and an opponent; and (3) one motion to recommit with or without instructions.

SEC. 2. Upon the adoption of this resolution it shall be in order on the legislative day of June 26 or June 27, 2003, without intervention of any point of order to consider in the House the bill (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, and for other purposes. The bill shall be considered as read for amendment. The previous question shall be considered as ordered on the bill to final passage without intervening motion except: (1) one hour of debate on the bill equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means; and (2) one motion to recommit.

SEC. 3. (a) In the engrossment of H.R. 1, the Clerk shall await the disposition of H.R. 2596 under section 2.

(b) If H.R. 2596 is passed by the House, the Clerk shall—

(1) add the text of H.R. 2596 as new matter at the end of H.R. 1;

(2) conform the title of H.R. 1 to reflect the addition of the text of H.R. 2596 to the engrossment;

(3) assign appropriate designations to provisions within the engrossment; and

(4) conform provisions for short titles within the engrossment.

(c) Upon the addition of the text of H.R. 2596 to the engrossment of H.R. 1, H.R. 2596 shall be laid on the table.

SEC. 4. During consideration of H.R. 1 and H.R. 2596 pursuant to this resolution, notwithstanding the operation of the previous question, the Chair may postpone further consideration of either bill to a time designated by the Speaker.

SEC. 5. Upon the adoption of this resolution it shall be in order, any rule of the House to the contrary notwithstanding, to consider concurrent resolutions providing for adjournment of the House and Senate during the month of July.

SEC. 6. The Committee on Appropriations may have until midnight on Thursday, July 3, 2003, to file a report to accompany a bill making appropriations for the Department of defense for the fiscal year ending September 30, 2004, and for other purposes.

The SPEAKER pro tempore. The gentlewoman from Ohio is recognized for 1 hour.

Ms. PRYCE of Ohio. Mr. Speaker, for purposes of debate only, I yield the customary 30 minutes to the gentlewoman from New York (Ms. SLAUGHTER), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purposes of debate only.

Mr. Speaker, House Resolution 299 is a multi-part rule providing for the consideration of H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003, and H.R. 2596, the Health Savings and Affordability Act of 2003.

This rule provides for consideration of H.R. 1 under a modified closed rule, an appropriate rule for such a delicate, complex, and historic piece of legislation. The rule provides for 3 hours of general debate equally divided between the chairmen and ranking minority members of the Committee on Energy and Commerce and the Committee on Ways and Means. The rule waives all points of order against consideration of H.R. 1.

After general debate it will be in order to consider an amendment printed in the report accompanying this resolution, if offered, by the gentleman from New York (Mr. RANGEL) or his designee and debatable for 1 hour. All points of order are waived against the amendment. Finally, the rule permits the minority to offer a motion to recommit to H.R. 1 with or without instructions.

Section 2 of this rule provides for the consideration of H.R. 2596, the Health Savings and Affordability Act of 2003, either today, the legislative day of June 26, or tomorrow, June 27, under a closed rule. The rule provides 1 hour of general debate in the House equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means. All points of order against the consideration of H.R. 2596 are waived. Finally, the rule provides for one motion to recommit with or without instructions.

□ 1300

I would like to take a moment to clarify for my colleagues that upon passage of both pieces of legislation, the text of H.R. 2596 shall be added as a new matter at the end of H.R. 1. In simple terms, these two bills will become one. However, this bill does not preclude either bill from moving forward independently.

Finally, the remaining sections of this rule provide for some housekeeping provisions and provisions which will allow this body to move forward in the appropriations process.

Mr. Speaker, today is a historic day. For years now, seniors across this country have consistently voiced to Congress the same major concerns: the skyrocketing costs of prescription drugs. Their concerns are not perceived; they are very, very real. Each year, a typical senior pays approximately $1,300 on prescription drugs, filling about 22 prescriptions on average. Today, the House will consider a plan to give all seniors a prescription drug benefit through Medicare.

In passing this bill, as I believe we will do before this day is over, we will renew America's promise to our seniors, reduce the cost of prescription drugs, and revolutionize medicine in the 21st century.

I would like to thank the gentleman from California (Chairman THOMAS) and the gentleman from Louisiana (Chairman TAUZIN) for their exemplary cooperation, their remarkable leadership, and inspiring vision they have provided on this complex, yet very much-needed legislation. I would like to take a moment just to give special thanks to them for working so closely with me on a couple of provisions that will greatly benefit cancer patients and hospitals across the country. Included in this legislation is immediate Medicare coverage for oral anticancer drugs through a demonstration project that will offer extraordinary support to seniors who are fighting cancer. It will enable them to afford the newest life-saving medicines in the comfort of their own homes, rather than be hooked up to chemotherapies by infusions in a hospital or clinical setting.

I also commend the chairmen's interest and support in assisting hospitals who serve a disproportionate number of uninsured and indigent populations. Hospitals across this country, including many of our Nation's children's hospitals, will be better able to serve their patients with over $3 billion in additional funding. Finally, rural hospitals are finally getting their fair share: $27.2 billion.

Since 1965, Medicare has provided a guarantee of health care coverage for more than 40 million seniors. Today, our seniors are counting on the stability, longevity, and integrity of this program for their secure retirement. But if we do not act and pass this bill before us today, the future of Medicare will be certain: certain bankruptcy. Our inaction will have sealed the fate

for one of our Nation's most trusted programs.

So today, we will do two long-overdue things. First, we will modernize Medicare to save it for future seniors; and, second, we will provide the much-needed prescription drug coverage.

The prescription drug package the House is considering here today will provide the same universal guaranteed Medicare health services as those that currently exist. If you are 65 or older, you qualify for Medicare, and you qualify for this benefit. It is that simple. And we provide significant and immediate savings for seniors on their medicines. Specifically, this plan provides Medicare beneficiaries with a prescription drug discount card offering over 25 percent in savings, catastrophic protections, giving seniors 100 percent coverage for out-of-control drug costs beyond $3,500 year, and full assistance for our neediest citizens.

Equally important, this rule makes in order a provision establishing health savings accounts, a revolutionary tool, so that every American, not just seniors, can set aside savings now for their medical expenses, tax-free. With over 40 million uninsured, this is so important, and the plan provides for a catch-up provision so that seniors can take advantage and set aside more money more quickly.

Mr. Speaker, this is a remedy for what ails America's uninsured. Our plan is designed for those people who might be shut out of work-based coverage and offers all Americans, regardless of their income or age, access to health coverage with no bureaucracy or costly mandates.

Finally, this package includes chronic care management for all Medicare beneficiaries.

Mr. Speaker, one-third of Medicare beneficiaries have one or more chronic illnesses. This provision will help better manage diseases, reduce health care costs, and enhance health and quality of life.

So here we are at a major crossroad. Seniors continue to tell us that adding a prescription drug benefit to Medicare is not some pie-in-the-sky policy that they would merely prefer become law. No. The majority of seniors are telling us that they cannot go another year without help, without any assistance, without any help with their drug costs, and without access to higher-quality health care.

Therefore, some questions need to be asked for those who will come forward in the next few hours and oppose this package. Ask them: How is this package not an improvement for our seniors who have no coverage and are struggling to pay for their medications? And ask them: How is the huge prescription drug savings that will result from this plan not useful to seniors? Ask them: How is bringing Medicare into the 21st century and saving it for future generations not wise for our children, our grandchildren, and our great grandchildren?

Now, some of my colleagues will no doubt put forth $1 trillion, pie-in-the-sky plans. These packages would bust any budget, Republican, Democrat, or otherwise. As a matter of fact, the Democrat substitute actually is larger than the sum of two budgets. The Democrat Spratt budget had $528 billion for Medicare, and the Democrat Blue Dog budget had $400 billion dedicated to Medicare. That is a total of $920 billion. But the Democrat substitute that they are offering today is over $1 trillion, more than the combination of those two Democrat budgets. Mr. Speaker, that is unacceptable.

Mr. Speaker, the lack of prescription drug coverage under Medicare is exactly what age discrimination looks like in 2003. Seniors are the last group of people who are forced to pay retail costs for their medications and, Mr. Speaker, that should be enough of a violation of civil rights to get even the ACLU involved.

I said just a moment ago that today is a historic day, and it is. Today we apply a little common sense by recognizing that health care is simply not what it was 30 years ago, and that Medicare is not what it was 30 years ago. It must change to keep up. Today, we will take the first steps in creating the next generation of quality health care, a new era where prescription drugs make regular doctor visits less frequent, where cutting-edge treatments make hospital stays nearly obsolete in the future, and where life-saving medications reduce formerly deadly diseases to mere manageable symptoms within longer and healthier lives.

Today I urge my colleagues to be bold, to be courageous, to show leadership, and to take America's health care system into a new frontier, a place where it has needed to go for far too long now. Time is precious and so are our seniors. I urge this Congress to pass the underlying rule and approve H.R. 1, the Medicare Improvement and Prescription Drug Act of 2003.

Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I thank the gentlewoman from Ohio for yielding me the customary 30 minutes, and I yield myself such time as I may consume.

(Ms. SLAUGHTER asked and was given permission to revise and extend her remarks.)

Ms. SLAUGHTER. Mr. Speaker, this is a very sad day for most of us. A program that has served America well and has given peace of mind and good health care to seniors for over 40 years is under threat today; and actually, what we know is going to be before us is the death of Medicare.

One of the saddest parts about this bill today is that the Democrats have no role in it. To all of my colleagues who showed up last night at the Committee on Rules, or this morning, actually, at the Committee on Rules with amendments that they thought that they could use to strengthen the bill, I apologize to you that there is no possibility in the world that you could do it. I hope that you did not hate yourself this morning for all the sleep that you lost for nothing.

Mr. Speaker, this rule is an affront to the democratic process. The underlying bill will harm every single one of the 40 million Americans served by Medicare. At 1 a.m. this morning, with absolutely no meaningful opportunity to review the almost 700-page prescription drug legislation, the Committee on Rules met to consider the resolution now before us. By now I should be used to it, but we cannot tolerate these continual attacks on democracy. When you refuse to allow half this House to speak and to give their amendments, you are cutting out half of the population of the United States from any participation in the legislation that goes on here. It defies reason and it defies common sense that political expediency and newspaper headlines could force this monumental legislation, probably the most monumental that any of us will do in our tenure in the Congress of the United States, to force it through the Chamber with little more than cursory consideration.

The other body, on the other hand, has spent over 2 weeks debating similar legislation. In stark contrast, we meet when nobody is around, up in the attic, as someone said today, and are permitted only 3 hours to discuss the largest overhaul of Medicare in its history. The people we represent would be disgusted if they understood how this issue is being handled.

We are not naming a post office here. We are considering, as I said, the most important change to Medicare since its creation. This decision will affect so many people. It is no simple undertaking, and it certainly deserves more debate than allowed by this rule.

To add even more confusion to the messy process, the Committee on Rules incorporated the so-called Health Savings Account bill into the rule for the Medicare overhaul legislation, so what we are doing here are two rules. So-called health savings accounts would create a new tax advantage, personal savings accounts, used to pay the out-of-pocket medical expenses. At first glance, perhaps it sounds innocuous. But when you look at the fine print, you see that it basically amounts to a $72 billion tax cut over the next 10 years while the Federal deficit continues to grow out of control. Even worse, it is a tax break with a destructive purpose: to threaten the traditional employer-based health care by actually encouraging companies to reduce their employees' health coverage.

Mr. Speaker, perhaps the most egregious problem with the legislation before us is it does nothing to address the skyrocketing prices of prescription drugs. Oh, sure, they will tell us that we can import drugs from Canada, but the fact of the matter is that an amendment inserted into the Senate

bill by one of our Senators says that it cannot be done unless it is certified by the Secretary of HHS, who has stated already that he will not do it. Therefore, any debate today about being able to import drugs is absolutely a farce.

The consumer price index on which Social Security cost-of-living adjustments are based rose 98 percent, and the prescription drug costs that are crippling older Americans rose even higher. Seniors on Medicare are expected to spend $1.8 trillion on prescription drugs over the next decade.

Today's Washington Post tells a story of Marie Urban of Cleveland. After her housing and Medicare payment, she has $459 a month for utilities, food, car insurance, taxes, and medication. She told The Post that some months she has 87 cents left over. This is wrong. She deserves better. A few years ago, as a temporary Band-Aid, I organized a bus load of seniors to travel to Canada to purchase medications at fractions of the prices charged in the American market. We had dozens more people interested than we could accommodate, but those who went saved anywhere from $100 to $650 on a 3-month supply of medication.

We are fortunate to live in an age when science provides the medications that cure illness and improve the quality of life and extend life. But the promise of the wonder drug is meaningless if you cannot afford to buy it. The skyrocketing price of prescription drugs is the number one concern of American seniors and, indeed, most Americans. H.R. 1 does nothing to freeze or reduce the exorbitant cost of prescription drugs. In fact, again, the idea of going to Canada and handing it out with one hand and taking it away with the other is something that the drug companies will be very happy about, because they have fought in every possible venue to keep the reimportation of drugs.

At the same time, we hoped that we might do what the Veterans Administration has done with great success. By negotiating for the people that they represent with the drug companies, they have been able to save many of their veterans a great deal of money. Seniors fear this bill is a rush to privatize Medicare. We saw the flop of Medicare+Choice when many, many private insurance companies pulled out completely on senior citizens, leaving many of them in parts of the United States completely uncovered. Indeed, they have told us again, they do not want to cover a prescription drug program. One hundred percent of the people they cover will buy medicine. This is not what they consider a good business proposition.

Forty years ago, Congress created the Medicare program because private industry would not offer health insurance to older people. Companies saw the older people as a threat to their profits. We should have learned this lesson in the 1960s, because nothing has changed; and now we are today taking away what is probably the most important issue to senior citizens, will they be able to get health care.

□ 1315

Don Young, who is the President of the Health Insurance Association of Americans, quoted here often, has said, ''We caution Congress against relying on drug only insurance as a mechanism to deliver a benefit.''

Ira Loss, an analyst with Washington Analysis, said, ''The private sector that is supposed to be excited about this isn't. It creates a new benefit program built around insurance products that do not exist and are likely to never exist.''

Mr. Speaker, this proposal would replace Medicare's guaranteed coverage with what is essentially a voucher program to purchase private insurance, assuming that there is an insurer willing to sell it to you. But those who want the traditional fee-for-service Medicare will be forced to pay higher premiums. We have no idea, for example, what Part B would cost because it is not in the bill, which is intended to force the beneficiaries out of traditional Medicare and into private insurance.

Mr. Speaker, senior citizens do not want this legislation. We have all received call after call and letter after letter beseeching us to oppose this plan. They did not contact me because they need prescription drug coverage. They called and wrote me because they know this bill will not provide them with the help they desperately need.

According to the Consumers Union, the average Medicare user spends $2,318 for prescription medicine. Under this plan, the out-of-pocket drugs would rise to $2,954 for the average senior on Medicare. So this program is a placebo, not a cure, legislation crafted to provide political cover for the majority, not provide prescription drug coverage for seniors. Some may argue that this is something better than nothing, but it is only a start and, frankly, what we have in Medicare has not been that bad. But as many of our constituents say, a bad bill is worse than no bill.

Mr. Speaker, this bill that will raise premiums and reduce their choices and dismantle Medicare is a very bad bill. I urge my colleagues to oppose the rule.

Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. WOOLSEY).

(Ms. WOOLSEY asked and was given permission to revise and extend her remarks.)

Ms. WOOLSEY. Mr. Speaker, this sham Republican bill fails to provide women with the real prescription drug coverage they need and they deserve.

Here we are, again, discussing ways to help seniors afford the prescription drugs that they need. And once again, the majority insists on a sham proposal that gives seniors nothing more than a false sense of security.

My female colleagues and I would like to remind everyone that as we debate proposals to add a prescription drug benefit to Medicare, the decisions we make will overwhelmingly impact our mothers, grandmothers, sisters, and aunts. Women are living longer than ever, and longer than men—this is good news. However, the poverty that many women experience during their final years is certainly not good news.

There are several reasons women's ''golden years'' are not so golden. While most women have worked their entire lives, a good portion of this work was not in the paid workforce. You don't earn a pension for time spent caring for children or elderly parents.

When many of our mothers and grandmothers were in the workforce, they were denied equal pay for equal work. Some worked only part time, trying to balance the responsibilities of their jobs and their families. As a result, they've made less over their lifetimes—and now their monthly Social Security benefit is smaller. These women deserve financial stability, and still, the Republican prescription drug proposal denies them the security that comes with knowing that can afford to pay for their medical care.

No one needs a drug benefit more than elderly women. But instead of a real prescription drug benefit, all they are getting from the majority are empty promises, a ''donut hole'' coverage gap, and increased premiums for the services they already enjoy. Our mothers and grandmothers deserve better. We can and we must do better. Oppose this sham Republican plan, and support the Democratic alternative.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. LINDA T. SÁNCHEZ.)

(Ms. LINDA T. SÁNCHEZ of California asked and was given permission to revise and extend her remarks.)

Ms. LINDA T. SÁNCHEZ of California. Mr. Speaker, this sham Republican prescription bill provides elderly women with nothing more than a false sense of security.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. SOLIS).

(Ms. SOLIS asked and was given permission to revise and extend her remarks.)

Ms. SOLIS. Mr. Speaker, this bill is a sham. It does not provide adequate prescription drug benefit.

Este projecto de ley no ayudara a los ancionos. No ayudara ni a nuestras madres ni a nuestras abuelitas.

(English translation of the above statement is as follows:)

It will not help our mothers, nor our grandmothers.

Mr. Speaker, I rise to call attention to the American women who will be disproportionately impacted by Medicare reform. The reality we must confront is that women simply live longer than men—about 19 years into retirement, while men can expect to live 15 years. So although this means we have longer to cherish our mothers and grandmothers, it also means that women are more susceptible to multiple and chronic illness, and require more long-term care needs.

It is no surprise then that women comprise the majority of Medicare. In fact, we constitute 58 percent of the Medicare population at 65, and 71 percent at the age of 85. Yet even more crucial is the fact that four out of five of America's elderly women are widowed and almost half live out their days alone. Compound

this misfortune with the reality that these widowed women are four times more likely, and a single or divorced woman are five times more likely, to live in poverty after retirement than a married man.

America's elderly women, many of whom live alone and in poverty, have higher out-of-pocket health care costs and are now being denied access to a secure and responsible Medicare prescription drug plan under the Republican Plan. Almost 8 out of 10 women on Medicare use prescription drugs regularly, though most pay for these medications out-of-pocket. Now we are telling these women, who already spend 20 percent more on prescription drugs than their male counterparts, that they must navigate the privatized ropes, and we can only hope, not guarantee, that they will have affordable coverage and monthly premiums. Even middle-class women who have made wise financial planning decisions will quickly find that high drug costs may undermine any retirement security they have worked hard to establish.

My district, which is predominately Latino, will be one of the hardest hit by this new legislation. Latina women make up the largest minority percentage (58 percent) on Medicare with incomes less than $10,000. These minority women historically rely on public, rather than private, health insurance. Now, we are stripping their only health coverage security and implementing a new, privatized and completely unmapable plan!

Have we not learned our lessons from Medicare+Choice that private plans do not participate in many regions, that their premiums and benefits vary greatly by geographic are, that participation by Medicare HMO's has been unstable, and that private plans are not less costly than traditional Medicare?

By 2025, Latinos are expected to comprise 18 percent of the elderly population and they are continually encountering strategically placed barriers that hinder their equal right to quality health care.

Let's not forget all the mothers, grandmothers, and sisters now and in the future for whom Medicare represents a lifeline to a healthy retirement. Who wants to tell the millions of hard working women who take care of their families that once again, because of irresponsible and unbalanced tax cuts, their health care and prescription drug needs will be sacrificed?

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. HARMAN).

(Ms. HARMAN asked and was given permission to revise and extend her remarks.)

Ms. HARMAN. Mr. Speaker, I rise in opposition to the bill to end Medicare as we know it, which will hurt our sisters, mothers, and grandmothers.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Wisconsin (Ms. BALDWIN).

(Ms. BALDWIN asked and was given permission to revise and extend her remarks.)

Ms. BALDWIN. Mr. Speaker, I rise in opposition to this bill which fails to provide women with the affordable and reliable Medicare prescription drug coverage that they desperately need and deserve.

Mr. Speaker, I urge my colleagues to vote against this sham of a bill. It seeks to privatize Medicare and does not provide a real, guaranteed, affordable drug benefit that our seniors desperately need.

When I am home in Wisconsin, one of the issues I hear most about, in the grocery store, on the street, at the airport baggage claim, or in meetings from Monroe to Baraboo, is that seniors cannot afford to pay their prescription drug coverage. Seniors send me receipts for their drug bills and ask me how they are supposed to afford their rising drug costs on a fixed budget.

The Republican drug bill on the floor today is not going to provide seniors with the relief they deserve. Instead of providing a real, affordable prescription drug benefit, this bill seeks to privatize the Medicare program. It is my belief that privatization of Medicare is unwarranted. Medicare has been a vital component of our Nation's health care system since its creation in 1965. In fact, Medicare was originally created because private insurance plans were simply not providing health insurance to seniors and people with disabilities. For nearly 40 years, Medicare has done the job that private insurers would not—or could not—do.

Why then, would we rely on private insurers to provide a Medicare prescription drug benefit to our Nation's seniors? This bill relies on private insurers to provide a prescription drug benefit. Seniors would have to join HMOs and private insurance plans to get the benefit. The prices and benefits under this private coverage would vary from region to region, so that a senior in Wisconsin would have to pay a different premium than a senior in Florida. These geographic disparities are simply unacceptable.

There are no assurances in this bill that prescription drugs would be affordable. In fact, this bill takes no steps to stop or slow the skyrocketing cost of prescription drugs. Instead, this bill provides partial coverage of drug spending until $2,000 and then leaves seniors high and dry. There is a huge gap in coverage where seniors may pay 100 percent out of pocket and continue paying premiums, until they reach a high out-of-pocket cap. Half of all seniors will fall into this gaping hole. I believe seniors deserve affordable drug coverage, and we should not help some seniors cover their drug costs while leaving others out in the cold.

Lastly, the Republican drug plan does not offer the same benefit to everyone on Medicare. This plan calls for ''means-testing'' for Medicare benefits, meaning seniors with higher incomes would have to pay more money out-of-pocket before they reach the catastrophic limit. This provision would fundamentally change the Medicare program. Since its inception in 1965, the central promise of Medicare was that it would provide a consistent benefit for everyone, and means-testing would violate this promise.

I support the Democratic proposal that will be offered as an amendment today. This proposal would add a new Part D in Medicare to provide voluntary prescription drug coverage for all Medicare beneficiaries. This proposal would provide the same benefits, premiums, and cost sharing for all beneficiaries no matter where they live. It would guarantee fair drug prices by giving the Secretary of the Department of Health and Human Services the authority to use the collective bargaining clout of all 40 million Medicare beneficiaries to negotiate drug prices. The savings would then be passed on to seniors. In addition, the Democratic proposal makes drugs more affordable by allowing the safe reimportation of drugs from Canada and makes lower cost generic drugs available more quickly. Unlike the Republican bill, there are no gaps in coverage in the Democratic proposal. Coverage is provided for any drug a senior's doctor provides. Seniors would be able to choose where to fill their prescriptions and would not have to join an HMO or private insurance plan to get drug coverage. This is the proposal seniors have been asking for, not one full of complexities and gaps in coverage like the Republican plan we will vote on shortly.

Today we are voting on a bill that is a sham. It is a sad mockery of what seniors in our country deserve. Instead of providing a comprehensive Medicare prescription drug benefit for America's seniors, the Republicans have decided to make sure this bill suits the big drug companies and leads down the road of privatizing Medicare. This is just plain wrong for the retirees of the greatest generation, who worked hard, lived through the depression, won a war, and raised their families.

Seniors need a comprehensive prescription drug benefit that is affordable and dependable for all—with no gaps or gimmicks in coverage. The Republican proposal fails on all these counts, and I urge my colleagues to vote against it.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Mrs. CAPPS).

(Mrs. CAPPS asked and was given permission to revise and extend her remarks.)

Mrs. CAPPS. Mr. Speaker, I oppose this Republican prescription bill because it provides elderly women with nothing more than a false sense of security.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. WATSON).

(Ms. WATSON asked and was given permission to revise and extend her remarks.)

Ms. WATSON. Mr. Speaker, I rise in opposition to this sham Republican Medicare bill. That is why I wear my black arm band because it is the death of Medicare and it does not provide the adequate prescription drug coverage our mothers, grandmothers, sisters, and nieces deserve.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Mrs. DAVIS).

(Mrs. DAVIS of California asked and was given permission to revise and extend her remarks.)

Mrs. DAVIS of California. Mr. Speaker, I oppose this unacceptable bill that is particularly harmful to senior women.

Mr. Speaker, I rise to talk about older women and their need for a real prescription drug benefit. The legislation we have before us represents a hollow substitute for a bona fide Medicare prescription drug benefit. Some will claim that the Republican Medicare reform

legislation provides a prescription drug benefit and declare success. Well, Mr. Speaker, we aren't fooling anyone.

We aren't fooling Donna Koski, from San Diego, who cannot afford her medication. She wrote to tell me, ''HMOs are no longer helping us with the cost [of drugs]. I worked and paid taxes all my life, raised five kids in California and now have five grandkids. I can't afford rent or so many things that I once took for granted would be there when I retired. What is to become of senior citizens [like me]?'' We aren't fooling Sidney and Edith Horwitz, from La Jolla, who told me. ''Figure out a way to give us drug benefits without joining a HMO. Deregulation and outsourcing to private companies has been a travesty to consumers.''

Mr. Speaker, my constituents want an affordable prescription drug benefit that will be there when they need it. They do not want to privatize Medicare. However, the bill we will discuss dismantles Medicare and does nothing to lower prescription drug prices. This proposal eliminates the security of traditional Medicare by requiring it to compete with private plans in 2010. It would transform Medicare from a defined benefit to a defined contribution program and ultimately eliminate Medicare as we know it. Because, private Medicare plans tend to aggressively recruit younger and healthier seniors, open competition will mean rising out-of-pocket costs for the vast majority who would choose the stable benefits and premiums of traditional Medicare. The result of open competition will be the transformation of today's universal, national risk pool into a multitude of regional pools segmented by age, income, residence and health status. To many, this transformation sounds more like a scheme than meaningful reform.

Our seniors need more stability and certainty than this—especially older women who are counting on Congress to provide a real solution to the rising cost of prescription drugs. Women, literally, are the face of Medicare. They constitute 58 percent of the Medicare population at 65. They constitute 71 percent of the Medicare population at 85. Women have a greater rate of health problems since they live longer. They have lower incomes, which make access to affordable prescription drugs more difficult. More than 1 in 3 women on Medicare (nearly 7 million) lack prescription drug coverage.

The Republication Medicare reform plan will only perpetuate these health care disparities. Where is the benefit for our seniors who are living on a fixed income and cannot afford to pay out-of-pocket during the coverage gap? Where is the benefit for the women who, because they were stay-at-home mothers and did not earn a pension, cannot afford the prescription drugs they desperately need?

For my constituents, the Republican proposal is not good enough. I cannot support this legislation when I know we can do better. We are doing more than providing prescription drugs, we are legislating the future of Medicare.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Georgia (Ms. MAJETTE).

(Ms. MAJETTE asked and was given permission to revise and extend her remarks.)

Ms. MAJETTE. Mr. Speaker, I oppose this sham Republican Medicare bill because it does not provide the adequate prescription drug coverage that our mothers and grandmothers absolutely deserve.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from New York (Mrs. MALONEY).

(Mrs. MALONEY asked and was given permission to revise and extend her remarks.)

Mrs. MALONEY. Mr. Speaker, I oppose this Republican Medicare bill, and I urge every woman, man, every American to read the fine print. There are gaping holes. There are problems. I will put this into the RECORD and I am totally opposed to this bill.

Mr. Speaker, the health of America's older women is at serious risk. Whatever Medicare Prescription Drug bill we pass will have an enormous impact on older women, both now and in the future, and women are concerned.

More than half of Medicare recipients age 65 are women; by age 85, 71 percent are women. And most older women live on fixed incomes. Older women tend to have more chronic health conditions than men, and eight of ten women on Medicare use prescription drugs regularly.

In the face of these facts, the ''bait and switch'' tactics of the Republican Medicare Prescription Drug bill are simply outrageous. Seniors think we're giving them help with high cost drugs. They think we're offering them supplemental insurance—guaranteed, cheaper and permanent—to ease their burden of skyrocketing drug costs on fixed incomes. But the Republican bill is a cruel trick. Seniors who are sickest and taking expensive medications—mostly women on fixed incomes—get a little bit of help with the first 2000 bucks of drug expenses. But then they get the ''donut hole''—a big fat zero until they pay a $3000 ransom to get more help with their drug bills.

The fiscal irresponsibility of the Republican bill is stunning and illogical. Instead of putting the purchasing power of America's seniors to work as a huge bargaining chip to lower prescription drug costs, the Republicans prohibit the Secretary of HHS from negotiating for lower drug prices on behalf of seniors. The Democrats believe prescription drugs should be affordable for seniors—but our amendments to have the Secretary negotiate on seniors' behalf were defeated.

The height of hypocrisy in the Republican bill is the fact that it actually discourages employers from continuing to offer drug coverage for retired seniors who have already paid health insurance premiums throughout their working lives. The Congressional Budget Office estimates that a third of employers will drop retiree drug benefit coverage if the Republic bill becomes law.

Frankly, the Republican Medicare Prescription Drug bill is cruel. This is not compassionate conservatism. It is blatant bias against elderly, against women, and against the poor. It is the first step in doing away with Medicare as an entitlement and it is the first step toward dividing our elderly into the needy and those who can afford to ''buy out''. The purpose of Medicare was to help the elderly with needed care as they age, and to do it with dignity and not on the basis of ability to pay.

Prescription drug coverage would save money in the long term because drug therapies can be substituted for more costly treatments like hospitalization and surgery. But what seniors—men and women—need and want is help that they can understand and can rely on, not the ''bait and switch'' of the Republican plan.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Connecticut (Ms. DELAURO).

(Ms. DeLAURO asked and was given permission to revise and extend her remarks.)

Ms. DELAURO. Mr. Speaker, the Republican Medicare bill fails to provide Americans with real prescription drug coverage, that which they need and that which they deserve.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Illinois (Ms. SCHAKOWSKY).

(Ms. SCHAKOWSKY asked and was given permission to revise and extend her remarks.)

Ms. SCHAKOWSKY. Mr. Speaker, I rise against the Republican bill that kills Medicare and fails to provide affordable prescription coverage to the elderly and people with disabilities.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. LEE).

(Ms. LEE asked and was given permission to revise and extend her remarks.)

Ms. LEE. Mr. Speaker, this bogus Republican prescription drug bill will effectively dismantle and kill Medicare and leave millions of seniors, especially our women, our mothers, our grandmothers behind.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Minnesota (Ms. MCCOLLUM).

(Ms. McCOLLUM asked and was given permission to revise and extend her remarks.)

Ms. MCCOLLUM. Mr. Speaker, this Medicare bill fails to provide women with real prescription drug coverage they need and deserve.

Ms. SLAUGHTER. Mr. Speaker, I reserve the balance of my time.

Ms. PRYCE of Ohio. Mr. Speaker, I yield 3 minutes to the gentleman from Kentucky (Mr. FLETCHER) for some substantive remarks. Dr. Fletcher is a member of the Committee on Energy and Commerce and also a member of the medical profession, and we look forward to what he has to add to this debate.

Mr. FLETCHER. Mr. Speaker, let me thank the gentlewoman from Ohio (Ms. PRYCE) for her leadership in chairing our majority conference as well as her leadership on this issue and this rule.

Mr. Speaker, I find it interesting to see and observe the number of people that have stood in line here to talk about this bill, even though CBO estimates that 93 percent of our seniors will take advantage of this bill. That means many of the sisters, mothers and family members that these Members have just spoken about will take

advantage of this legislation. As a matter of fact, I would imagine if we asked these Members how many of them take advantage of the Federal Health Benefit Plan, that probably the majority of them, if not all of them, choose to participate in that.

Now, we offer something here in this prescription drug bill that gives them a similar choice, and yet for some reason they seem to deride what we are doing.

This is the single most pressing health care issue facing our country: providing prescription drugs for our seniors. This bill does several things. One, it is a voluntary program. Two, it provides something that is affordable, not only affordable for seniors but affordable for taxpayers, and it is something that far exceeds anything that has been looked at or has had a reasonable opportunity of being passed that this Congress has ever put forth. It is flexible. It provides choice and security. It provides a modernization of Medicare that will address the concerns of prevention and chronic disease management which are so needed in this country.

It also prevents a catastrophic illness from bankrupting a family. Often a catastrophic illness can bankrupt a family, and we know of families that have saved money their entire life and then one illness in the family has bankrupted them. This bill absolutely prevents that from happening due to the cost of prescription drugs.

We also find that it helps a number of low income seniors, particularly women, and I am shocked that these Members would not stand up and support this bill, because women are particularly affected. Many women live on fixed incomes of Social Security and are having to choose between food and medicine. I saw them as a physician. I saw them as patients of mine. In Kentucky nearly 35 percent of Medicare beneficiaries will qualify for low income assistance under this bill.

Mr. Speaker, not only that but in Kentucky, Medicare recipients are spending 67 percent of their total prescription drug costs out-of-pocket, which is the highest in the Nation.

Additionally, with this bill, they were talking about Democrats not having input, but we had 30 hours of debate in the Committee on Energy and Commerce. As a matter of fact, a Democratic colleague of mine, the gentleman from Texas (Mr. GREEN) and I put forward an amendment for diabetes screening. We passed that. It is part of this bill.

So I think this is a tremendously important piece of legislation. Every senior will have reduced costs in the prescription drug expenses that they pay because the Federal Government will negotiate a lower price for these drugs. What we see here is an opportunity. We will negotiate a lower price for the prescription drugs.

Mr. Speaker, I would hope Members would support this rule and that Members would support this prescription drug bill.

Ms. SLAUGHTER. Mr. Speaker, we have so little time to try to make any points here.

Mr. Speaker, I yield 2 minutes to the gentleman from Massachusetts (Mr. MCGOVERN), a member of Committee on Rules.

Mr. MCGOVERN. Mr. Speaker, this is a sad day for this House and, more importantly, it is a sad day for America's senior citizens.

This bill is a complex and controversial $400 billion Medicare privatization plan that will affect the lives of 40 million senior citizens. For 38 years Medicare has been there for our parents and our grandparents, helping them live longer, more healthy lives. It is a sacred promise with the elderly of this country and this House is about to radically and fundamentally break that promise.

If that were not bad enough, the Republican leadership blocks out all amendments and all but one substitute to this bill. For example, this bill mandates for the first time a co-payment for senior citizens who receive Medicare home health care. I have been fighting for years to protect home health care from cuts, so I had an amendment before the Committee on Rules around 4:30 this morning to eliminate that co-pay because I think it is unfair and I think we should help seniors who use home health care, not charge them more money. But like every single other amendment, Democrat or Republican, my amendment was not made in order.

The other body has spent the last 2 weeks, Mr. Speaker, debating, discussing and amending their prescription drug bill. They seem to recognize that this is a big deal. So how much time do we give our seniors in this House? Not 2 weeks, not even 2 days. Three hours. What a terrible disservice to the people I represent, the people we all represent.

This bill ends Medicare as we know it and turns it into a convoluted, complicated voucher program of HMOs and PPOs and shifting coverage. It is a bill that leaves a huge gap in coverage, penalizing people for getting sick. It is a bill that moves us towards privatizing Medicare and leaves our seniors at the mercy of the insurance industry and the big drug companies. It is a bill that only a CEO could love. Senior citizens deserve a drug benefit within Medicare. They should not be left at the mercy of the HMO accountants who are more concerned with the bottom line and profit margins than with adequate health care.

Our substitute works like the rest of Medicare. It tackles the high cost of drugs and it guarantees our seniors meaningful, consistent prescription drug coverage. That is what our seniors deserve. I urge my colleagues to vote no on the rule and yes on the Democratic substitute.

Ms. PRYCE of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from New Hampshire (Mr. BRADLEY).

Mr. BRADLEY of New Hampshire. Mr. Speaker, I rise today in support of H.R. 1 and the rule that accompanies this important legislation, for today we will begin to finally provide for a prescription drug benefit under Medicare for America's senior citizens.

H.R. 1 will ease the financial burden placed on America's seniors, improve access to the medications they need, and introduce market measures that will curb future cost increases.

According to a recent study, the House plan, our plan, would reduce the average overall cost of prescription drugs by 25 percent through aggregating the purchasing power of seniors. In addition to these overall savings, the plan provides significant and immediate savings for seniors through provisions, including a prescription drug discount card which would provide a 10 to 15 percent savings; significant front-end coverage with a cost sharing agreement that has seniors paying 20 percent on the first $2,000 of drug costs after they pay a deductible and a monthly membership fee. Beyond that it involves catastrophic protection providing 100 percent coverage for out of control drug costs beyond $3,500. And, lastly, and perhaps most importantly, assistance for low income seniors, enabling those Medicare beneficiaries that have income of 135 percent of the poverty line to receive full coverage on their prescription drugs.

Mr. Speaker, the advancement of medical research and technology has led to the development of new drugs that can dramatically reduce the need for surgery, for hospitalization and for nursing home care.

□ 1330

It is high time that we provide America's senior citizens with improved access to these drugs at prices they can afford. I urge my colleagues to support the rule and to support the legislation.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. BROWN).

Mr. BROWN of Ohio. Mr. Speaker, I thank my friend from New York for yielding me the time.

Mr. Speaker, we should reject this rule because H.R. 1 offers the wrong vision for Medicare. H.R. 1 asks every Member a fundamental question, what do you want Medicare to be? If you want Medicare coverage that is guaranteed, dependable, universal and fair, you will vote against H.R. 1. If you want Medicare to cover every senior everywhere, you will vote against H.R. 1. If you want Medicare to offer the same coverage to seniors on Park Avenue as seniors in Appalachian, Ohio, you will vote against H.R. 1.

But Mr. Speaker, if you want Medicare to offer unreliable, selective, discriminatory coverage, you will support H.R. 1. If you want Medicare to offer seniors in Appalachian, Ohio, less coverage than seniors on Park Avenue or no coverage at all, you will vote for H.R. 1. If you want Medicare to offer

rural seniors coverage, but at three or four times the price, then you will vote for H.R. 1. If you want a plan written by the drug companies and by the insurance companies because of their huge contributions to the Republican Party, if you want that, then you will vote for H.R. 1; and if you want a bill that will force people who now have prescription drug coverage, a bill that will force seniors who now have prescription drug coverage to drop that coverage, then you will vote for H.R. 1.

The gentleman from New York (Mr. RANGEL) and the gentleman from Michigan (Mr. DINGELL) will offer a substitute amendment with a different version of Medicare. The Rangel-Dingell substitute strengthens Medicare by adding a prescription drug benefit, no unaffordable cost sharing, no gaps in coverage. The Rangel-Dingell substitute would maintain Medicare's guaranteed coverage, remaining faithful to the trust Medicare has earned from America's seniors.

The Rangel-Dingell substitute harnesses seniors' purchasing power to demand better prices from the drug industry. My friend from Kentucky had it all wrong when he said the Republican plan does that. The Republican plan, because it was written by the drug companies, does nothing to bring prices down.

Vote ''no'' on the rule. Vote ''no'' on H.R. 1. Vote ''yes'' on the Rangel-Dingell substitute.

Ms. PRYCE of Ohio. Mr. Speaker, I am pleased to yield such time as he may consume to the gentleman from California (Mr. ISSA), my distinguished colleague.

(Mr. ISSA asked and was given permission to revise and extend his remarks.)

Mr. ISSA. Mr. Speaker, I support this bipartisan, Republican-led, legendary, historic event that we are participating in here today.

Mr. Speaker, I rise today to comment Chairman THOMAS, Chairman TAUZIN, and the House Republican leadership for their work on H.R. 1.

This landmark legislation will provide America's seniors with a lifetime prescription drug benefit through Medicare. This new benefit will mean permanent prescription drug access, lower drug costs and a limit on catastrophic drug expenses for all beneficiaries.

I am especially pleased to see that this bill enacts meaningful Medicare reforms that specifically affect California and my constituents in the 49th Congressional District.

H.R. 1 includes language that allows the Secretary of Health and Human Services to designate plans that serve special needs beneficiaries as Specialized Medicare Advantage plans. This provision enhances the development of more effective approaches to chronic illness care by providing an opportunity for additional frail elderly demonstrations to move into mainstream Medicare. One example of this type of demonstration is the SCAN program, which currently serves over 50,000 Southern Californians—including 10,000 who live inside the 49th Congressional District.

I also want to thank leadership for their work to ensure stable funding in the Medicaid disproportionate share hospital (DSH) program. H.R. 1 provides all states with a one time 20% increase in their DSH allotments. This 20% increase means an additional $184 million in Fiscal Year 2004 for California's safety net hospitals. This additional funding will help ensure that services to the most vulnerable populations remain available.

I believe that we must bring Medicare into the 21st century and that no American should be denied needed prescription drugs because he or she cannot afford them. I recognize that the lack of a prescription drug benefit for our seniors signifies the fact that Medicare has fallen behind the times. H.R. 1 is the best prescription drug benefit plan for America and I urge my colleagues to support its passage.

Ms. PRYCE of Ohio. Mr. Speaker, I am pleased to yield such time as he may consume to the gentleman from California (Mr. DREIER), my distinguished colleague, the chairman of the Committee on Rules, who led us through our hearing on this last night to the historic conclusion today on the floor.

(Mr. DREIER asked and was given permission to revise and extend his remarks.)

Mr. DREIER. Mr. Speaker, the first revision I would like to make to my very good friend and the role that I play was leading us through this morning as we did, in fact, as has been pointed out, beginning late at night. We began late at night because we were all working together to fashion a bill which I am convinced that at the end of the day will enjoy bipartisan support in this House of Representatives.

It has been the gentleman from Illinois (Mr. HASTERT), the Speaker, who, as the author of this legislation, has been in the lead on not only the issue of bringing about measures to strengthen and protect and improve Medicare but also to put into place a very important expansion of medical savings accounts, which I joined him in championing for many, many years.

This is a historic day, as many as have said; and my colleague, the gentlewoman from Ohio (Ms. PRYCE), has been working diligently over the last several days and weeks and months to get us here.

I mentioned the gentleman from Illinois (Speaker HASTERT). There are lots of other people, the gentleman from California (Mr. THOMAS), the chairman of the Committee on Ways and Means; the gentleman from Louisiana (Mr. TAUZIN), the chairman of the Committee on Energy and Commerce; but I would like to talk about the Representatives who did at 12:50 this morning appear before the Committee on Rules.

The gentleman from Oregon (Mr. WALDEN) represented the Committee on Energy and Commerce and did a wonderful job; but no one has been more intimately involved in dealing with health care issues than the gentlewoman from Connecticut (Mrs. JOHNSON), and I was very impressed with the fact that she was able, in her presentation before the Committee on Rules, over a 90-minute period, to deal with virtually every question that came forward; and, Mr. Speaker, it was so apparent that her grasp of this issue, coupled with her commitment to ensure that our senior citizens finally have the opportunity for the first time under the structure put in place for Medicare have access to affordable prescription drugs; and, Mr. Speaker, it was very interesting to note that while there was bipartisan praise for the gentlewoman from Connecticut (Mrs. JOHNSON) as this hearing began at 12:50 this morning, the final panel that came before us at probably about 4:30 or so, I cannot remember exactly what time it was, maybe 4:15 this morning, had a Democrat on the final panel praising the gentlewoman from Connecticut (Mrs. JOHNSON), not necessarily agreeing with everything that she said, but praising her for the fine work that she has involved herself in on this issue.

I believe that as we look at what it is that we are trying to do here there are so many very important and positive developments that have taken place. I know my friend from Ohio has just mentioned the very important issue of the disproportionate share of hospitals that provide assistance under Medicaid. Increasing the level of funding for those hospitals that are shouldering that responsibility has been one of the challenges that the Los Angeles area, which I am honored to represent, has faced; and we, I believe, are going to be able to help deal with that.

At the same time, I have to say that in looking at some of the things that have been said that were critical of this rule and of the measure, first on the rule, Mr. Speaker, we have put into place what I believe is a very fair rule. In the 107th Congress we all know that we dealt with this issue, and there was no substitute made in order. So in this Congress we have done that, but in bringing the health savings accounts, which are a very important item, designed to provide incentives for people to make choices and plan for their long-term health care needs by bringing this measure in with our very important Medicare package, what we have done is we have provided the minority with three opportunities, the substitute and two opportunities to offer motions to recommit, and there was no substitute offered on the other and I suspect we would have made that. We conceivably could have had four opportunities for the minority, if they had submitted those to us, that would have been made in order; and we, as the majority, have basically one opportunity and that is our bill.

I acknowledge that as members of the majority we have been able under Speaker HASTERT's leadership to put this package together; but anyone who claims that we are not giving an opportunity to the minority for their proposals to be considered is really wrong, and we have provided the proposal which was submitted to us by the ranking minority member of the Committee

on Ways and Means and ranking minority member on the Committee on Energy and Commerce. So I believe we are going to, as this debate proceeds, find that there are Democrats who will want to join with us; and I congratulate them for understanding the fact that this is going to be the first opportunity to truly provide access to affordable prescription drugs to our senior citizens.

I will tell my colleagues, Mr. Speaker, in voting ''no'' on this package, at the end of the day we will see Members saying no to our attempt to put into place a program that will meet that very important need. So I just want to say that I know there a lot of staff people who have been involved in this, and I particularly want to express my appreciation to the members of the Committee on Rules, very ably led staff on our side by my friend Billy Pitts, and we on this committee had members on both the Democratic and the Republican side who did meet from 12:50 this morning until our filing of the rule by the gentlewoman from Ohio (Ms. PRYCE) and I at 6:20 this morning.

And the reason we did it is that this is such an important issue. The reason we did it is that we want to make sure that we get this done for the American people, and I am convinced that our chance to come together has been made possible by all those who were involved in this, and I thank my friend for yielding me the time.

Ms. SLAUGHTER. Mr. Speaker, I am pleased to yield such time as she may consume to the gentlewoman from California (Ms. PELOSI), the minority leader.

(Ms. PELOSI asked and was given permission to revise and extend her remarks.)

Ms. PELOSI. Mr. Speaker, I thank the gentlewoman for yielding me the time. I think this is a sham Republican Medicare bill which fails to provide women with a real prescription drug benefit which they need and they deserve.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from New York (Ms. VELÁZQUEZ).

(Ms. VELÁZQUEZ asked and was given permission to revise and extend her remarks.)

Ms. VELÁZQUEZ. Mr. Speaker, I think the sham Republican Medicare bill fails to provide women with the real prescription drug coverage that they need and deserve.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Ms. WATERS).

(Ms. WATERS asked and was given permission to revise and extend her remarks.)

Ms. WATERS. Mr. Speaker, I think this is a sham Republican prescription bill because elderly women are dying from preventable diseases. This is nothing more than a false sense of security.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Mrs. NAPOLITANO).

(Mrs. NAPOLITANO asked and was given permission to revise and extend her remarks.)

Mrs. NAPOLITANO. Mr. Speaker, I think this is an unfinished Republican Medicare bill because it does not provide the simple, adequate prescription drug coverage for all our mothers, our sisters, and our grandmothers.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Mrs. CAPPS).

(Mrs. CAPPS asked and was given permission to revise and extend her remarks.)

Mrs. CAPPS. Mr. Speaker, I thank my colleague for yielding me the time.

Mr. Speaker, I rise in opposition to this rule and to the Medicare bill. The rule is unfair. The bill is unacceptable. It provides spotty coverage that will not help seniors with their expensive medications, and it reneges on a promise we have made to America's seniors and those with disabilities by ending Medicare as we have known it.

I want to speak about a provision in the bill that still cuts, even with yesterday's revisions, hundreds of millions of dollars for cancer care. A cut like this will be devastating to seniors with cancer.

If this bill is passed, cancer centers will close, especially satellite centers that are located close to where seniors live. Those that remain open will admit fewer patients and lay off oncology nurses.

Medicare beneficiaries do pay too much for their oncology medications. We all agree that we must fix this, but Medicare also pays way too little for essential oncology services. The overpayments for oncology drugs has been used to pay for treatments oncologists provide to cancer patients. So we must fix both parts of this problem.

The bill fixes overpayment of drugs, but still cuts some $300 million from cancer care to do it. The quality of cancer care will suffer.

The gentleman from Georgia (Mr. NORWOOD) and I submitted amendments last night to fix both parts of this problem and protect the quality of cancer care for all Americans, but these amendments were not made in order; and now seniors will not only not get sufficient prescription drug coverage but those with cancer, seniors with cancer, will see their treatments jeopardized, thwarted, cut off. What will seniors with cancer do?

I urge my colleagues to vote against the rule and against this bill.

Ms. PRYCE of Ohio. Mr. Speaker, I yield myself such time as I may consume.

In response to the gentlewoman from California (Mrs. CAPPS), who we both share an abiding concern about cancer patients and their treatment, I would just like to set the record straight in that the bill on the floor today increases oncology practice expenses by $190 million. That is 83 percent over their current payment, and it is 50 percent higher than any other specialty. It also includes an average sales price plus 12 percent for 2 years. Now, that is $240 to $250 million on top of a $190 million increase in practice expenses.

In addition to that, we have provided for oral cancer therapies, the new, upcoming way to treat cancer, so that chemotherapies are not the only treatment that seniors can get. They can stay home and take a pill in their own surroundings rather than go be hooked up to some infusion device.

These are wonderful steps forward for the cancer community.

Mrs. CAPPS. Mr. Speaker, will the gentlewoman yield?

Ms. PRYCE of Ohio. I yield to the gentlewoman from California.

Mrs. CAPPS. Mr. Speaker, I thank my colleague for yielding, and we do share a very strong interest in this issue, and we both also know that oncology services involve more than the oncologist, and, yes, this bill does raise from the terrible low cut that was originally in it some 12 percent; but it still leaves a huge vacuum for the services that are provided by oncology nurses, the whole panoply of outpatient and clinic setting services that patients who are receiving chemotherapy, which is such a devastating treatment to go through, need in order to maintain.

It is really a life-and-death situation for people who receive a diagnosis of cancer and then find out that they have to go to the doctor and get their medication, and then they have to find some way to have the services delivered because Medicare will not cover this wide comprehensive care in a cancer center, and that is what we need to have a full debate upon.

Ms. PRYCE of Ohio. Reclaiming my time, I disagree with the gentlewoman's analysis of how it works. There is a provision that will allow physicians to stockpile, if they prefer.

□ 1345

But on to another issue, Mr. Speaker. There were statements made earlier that there were no cost savings in this bill, by a former speaker. There are cost savings. There is group purchasing and insurance benefits, a 25 to 30 percent savings. There is a discount card, 15 to 20 percent savings. There is a Medicare best price, $18 billion in savings. Average wholesale price reform, $15 billion in savings. There is Hatch-Waxman reforms and reimportation reforms, all generating savings. And that is how we are able to expand and generate better treatment for seniors through the upcoming years.

Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentleman from Rhode Island (Mr. LANGEVIN).

Mr. LANGEVIN. Mr. Speaker, I rise in opposition to the proposed rule providing for consideration of the Medicare Prescription Drug and Modernization Act.

This rule restricts the House to 3 hours of debate on the largest ever overhaul of a program that has been critical to the health of our Nation's seniors for 38 years. Furthermore, the rule blocked dozens of amendments, including one of my own, which could have resulted in tremendous savings for seniors by opening the door for the Health and Human Services Department to use the bulk purchasing power of America's 40 million Medicare beneficiaries to negotiate lower medication prices for them.

As a result, Members are denied the opportunity to address many disturbing provisions in this bill. To mention just a few, the failure to address the rapidly rising cost of prescription drugs that will soon render this benefit meaningless; the tremendous gaps in coverage that will result in less help for those who need it most; and the provisions that fundamentally alter the structure and entitlement of Medicare by requiring the program to compete with private plans beginning in 2010.

Mr. Speaker, the list of Members' concerns with this bill goes on and on and on. The other Chamber has been debating this bill for 2 weeks, meanwhile the United States House of Representatives will have a mere 3 hours of debate on this bill that we are presented with. This is an affront to democracy.

Ms. PRYCE of Ohio. Mr. Speaker, I continue to reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from Oregon (Mr. DEFAZIO).

Mr. DEFAZIO. Mr. Speaker, I thank the gentlewoman for yielding me this time.

We have heard a lot about the new benefits and protections that will be afforded by this bill. Unfortunately, most of the benefits and protections will not go to seniors in need, they will go to the pharmaceutical and the insurance industry. This bill will do a good job of protecting the monopoly profits and price gouging by the pharmaceutical industry.

Perhaps the gentleman from Kentucky has not read or at least he doesn't understand the bill. Section 1801 prohibits the Federal Government, Medicare, from negotiating lower prices from the pharmaceutical industry, a provision inserted at the behest of the pharmaceutical industry to protect their profits. The VA negotiates very successfully, and that would lower the cost of drugs much more than the puny benefits in this bill at a cost of $400 billion. But, no, that is prohibited in this legislation.

The bill does not allow the reimportation of U.S. manufactured drugs from Canada because that would provide a greater benefit than the puny benefits in this bill. Here are three drugs: Tamoxifen. If we could just reimport, if Americans could just buy the drug by mail from Canada, they would save 90 percent. But a couple with a $4,500 a year drug bill will get a 22 percent benefit under this legislation. For Vioxx, for arthritis, 52 percent if you could just buy it in Canada and bring it back into this country. Under this bill, a 22 percent reduction for seniors who pay $4,500 a year for drugs. And then Xalatan, for glaucoma, a little closer, 33 percent from Canada, 22 percent under this bill.

So without any cost, without spending $400 billion and without spending a penny, but impinging on the profits of the pharmaceutical industry, we could provide much better benefits by negotiating or allowing reimportation.

But it does not stop there. It also benefits the insurance industry. It is going to drive seniors from Medicare into private insurance, provide subsidies to private insurance to provide unspecified benefits at a cost to be determined in the future when those benefits might become available in the year 2006, and they can be withdrawn at any time by those industries.

This is not the security our seniors deserve and it is outrageous that this should be offered without any amendments being allowed to this party.

Ms. PRYCE of Ohio. Mr. Speaker, I continue to reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentlewoman from Connecticut (Ms. DELAURO).

Ms. DELAURO. Mr. Speaker, this House has sometimes risen to the occasion on matters of great national importance; the first Gulf War, September 11, when we came together to bind the Nation's wounds and provide for the national security of the Nation. Unfortunately, this legislation does not rise to the occasion. It does not deliver an adequate prescription drug benefit or hold down the cost of drugs. What it does do is open the door to the privatization of Medicare. It turns it over to the HMOs, to the private insurance market which has dropped over half of the Medicare enrollees in my State of Connecticut over the last 4 years. And seniors have not forgotten.

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

Throughout my time in Congress, the single most common concern I have heard from seniors at the local stop-and-shops where I meet with them every weekend is how expensive their prescription drug bills are. Seniors know that they are being taken advantage of. They know they can get drugs cheaper in Canada and overseas. And when seniors find out that we are doing nothing to hold down the excessive profiteering of the pharmaceutical companies, when they find out that their coverage essentially stops during midsummer while they still have to pay the premiums, they are going to feel betrayed. And they are being betrayed.

If we allow this bill to become law, we would be saying that guaranteed health care for our seniors is no longer the obligation or the responsibility of this government. I did not come to the Congress to preside over the dismantling of Medicare. Our social contract with our seniors must be honored, and I urge my colleagues to support a plan that does that and not this Republican sham. Oppose the rule and oppose the bill.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from Tennessee (Mr. COOPER).

(Mr. COOPER asked and was given permission to revise and extend his remarks.)

Mr. COOPER. Mr. Speaker, I thank the gentlewoman for yielding me this time.

Mr. Speaker, this should be a great day for this country. We should be on the verge of passing a real Medicare prescription drug benefit for our seniors. But, unfortunately, we are not. The Republican majority is rushing through a sham bill in this House in barely 24 hours. They would not let anybody see a copy of this bill until 11:50 p.m. last night. The Committee on Rules' deliberations began at 12:50 a.m. last night and lasted, as has been mentioned, until 4 a.m.

What are they afraid of? What are they hiding? And why would they not allow amendments like the Dooley amendment to be offered on this floor? It is my understanding in the other body that Senators HAGEL, ENSIGN, and CLINTON will be offering the Dooley approach as a substitute to that legislation. The other body has deliberated on this matter for some 2 weeks in the full light of day so that all senior citizens around this country, all families around this country, could pay attention to the details of this legislation and judge for themselves whether it is good medicine for the American people or not.

But not only is the Republican majority hiding the real substance of this bill, they have failed to learn the lessons of past efforts of this House to reform the health care system. Number one, health care legislation that works must not be partisan. This bill is almost an entirely Republican-only bill. That dooms it to failure from the start. Second, real health care reform must not be overly complex. This is one of the most complex bills that seniors could ever imagine facing. The red tape is incredible. And, third, this bill should not be overly burdensome to seniors, but it is. Watch out when your seniors back home realize they have to pay $35 a month for a very questionable benefit.

There is a donut hole in coverage, and that is almost too complex to explain in the 2 minutes I am allowed here, but this bill is so inferior to the Dooley bill, which solves these problems in a simple, clear and fair fashion. Under the Dooley bill, there is a zero monthly premium.

Mr. Speaker, I urge a ''no'' vote on the previous question.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentleman from Illinois (Mr. EMANUEL).

(Mr. EMANUEL asked and was given permission to revise and extend his remarks.)

Mr. EMANUEL. Mr. Speaker, like the preceding speaker before me from Tennessee, my good friend, the Dooley-Tauscher bill, I think, addresses the right priorities, the right common values we have. It does not try to end Medicare as we know it. It keeps Medicare, that has done so well over 40 years, intact. And unlike the other bills, it lives within the $400 billion frame. It is true to the principles that have held Medicare true. It relies on part B of Medicare to deliver the benefit. It does not try to privatize that benefit. It is a low-income benefit for our seniors. But, most importantly, it is universal in its benefit. Everybody would get it. There would be a minimum of a 25 to 30 percent discount on drugs.

One of the biggest debates here is not only a benefit under Medicare of prescription drugs, but it is making the drugs that our elderly need every day when they go to the drugstore or their local pharmacy, making those medications affordable. The benefit accounts for all drug spending. That is the core principle here. It is a universal benefit.

So this is the right type of approach. The other day the Washington Post endorsed it. And, today, in the other body, a bipartisan group of Senators will be introducing it. I think it expresses our common values and our common principles of what is true to our vision of what Medicare should be, not what it should not be.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. DAVIS).

Mr. DAVIS of Florida. Mr. Speaker, one of the things that we can all agree upon here today is that there ought to be an open and honest debate in our country and with our seniors as to exactly how to accomplish writing a prescription drug benefit. There are Democrats here who recognize that we have to live within the budget constraints that have been forced upon us, and we are ready to take the first step, even though it would not be the final step we would take. We are ready to work with Republicans.

This bill that is being forced on the House of Representatives today with a minimum amount of debate is a sham. There are many ways to illustrate the point. Probably the best is the private insurance companies who are being asked to provide this drug benefit are saying, once again, we do not want to do it. We do not want your money. There are not many people here in Washington who tell the government we do not want your money. These private insurance companies do not want to write this drug benefit. This bill is a sham.

The bill sets no details on premium, no details on the scope of the coverage. What are seniors getting under this bill? They do not know because we honestly do not know. The Dooley bill deserves a debate here today. It represents a compromise between what the Senate and the House is trying to do here and what the Democrats are proposing in the substitute. We deserve to have a debate on the Dooley bill.

Mr. Speaker, the rule should be defeated, the motion should be defeated, and we should debate the Dooley bill.

Ms. PRYCE of Ohio. Mr. Speaker, I reserve the balance of my time.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as he may consume to the gentleman from Massachusetts (Mr. TIERNEY).

(Mr. TIERNEY asked and was given permission to revise and extend his remarks.)

Mr. TIERNEY. Mr. Speaker, I rise in opposition to this bill, which is not modernization of Medicare. It ends it, it does not mend it. And there is no choice here for doctors, only for insurance companies. It is going to put a lot of seniors who have good retirement plans back into the Medicare system without the care and the prescription drugs they need.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LATOURETTE). The Chair has an announcement. As indicated by previous occupants of the Chair on June 27, 2002, and on March 24, 1995, although a unanimous consent request to insert remarks in debate may comprise a simple declarative statement of the Member's attitude toward the pending measure, it is improper for a Member to embellish such a request with other oratory, and it can become an imposition on the time of the Member who has yielded for that purpose.

Ms. SLAUGHTER. Mr. Speaker, we will pay attention to that.

Mr. Speaker, I yield such time as she may consume to the gentlewoman from Indiana (Ms. CARSON).

(Ms. CARSON of Indiana asked and was given permission to revise and extend her remarks.)

Ms. CARSON of Indiana. Mr. Speaker, I will be brief, and I appreciate the opportunity to speak about how the Medicare bill fails to provide women with the real prescription drug coverage that they need, especially to senior women of this Nation.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentleman from Wisconsin (Mr. KIND).

(Mr. KIND asked and was given permission to revise and extend his remarks.)

□ 1400

Mr. KIND. Mr. Speaker, I rise in opposition to the rule, and encourage my colleagues to vote ''no'' on the previous question so we can have a real and honest debate today, and make in order the Dooley substitute.

I, along with others in the New Democratic Coalition, have worked long and hard to offer a viable alternative to the base bill. The bill before us, unfortunately, will jeopardize the very sanctity of the Medicare program. The Dooley bill, on the other hand, is simple, progressive and affordable. It helps those seniors who needs the most assistance, the low-income and those with high drug costs. It offers zero premium payments; it is Medicare as seniors know it. The benefits are integrated into Medicare part B, and every beneficiary gets a guaranteed benefit for no additional premium.

Unlike the House and Senate Republican bills, this bill has no gap in coverage, and it is fiscally responsible. It fits within the budget resolution that was passed earlier this year.

Later today, it is my understanding that Senators HAGEL and CLINTON and ENSIGN will be offering the same exact Dooley substitute on the Senate floor. We should be allowed to debate the same measure today. I urge a ''no'' vote on the previous question.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. THOMPSON).

(Mr. THOMPSON of California asked and was given permission to revise and extend his remarks.)

Mr. THOMPSON of California. Mr. Speaker, I rise today against this rule. Members should have an opportunity to vote on an enhanced version of the bipartisan Senate bill. That is the Blue Dog prescription drug benefit bill. Unfortunately for seniors across this country, our friends across the aisle have disallowed a debate on this better bill. It is better because it has a guaranteed fall-back, which means if seniors cannot get a PPO, they will have Medicare. It is better because there are no premium supports, which means seniors are not going to be penalize for staying in Medicare; and it is better because it does not privatize Medicare. Medicare is an important program that has saved the lives of many seniors, and an inclusion of a prescription drug benefit deserves an open debate.

Mr. Speaker, I urge opposition to this rule so the Blue Dog proposal can be debated and seniors can have the best coverage that we can afford at this time.

Mr. Speaker, today I rise in opposition to the rule of the Republican Medicare Prescription Drug Bill, H.R. 1. It serves only one purpose—ensuring that the voices of several in the Democratic Party are never heard on this critical issue.

I stand here on behalf of the Blue Dog Coalition—a group which engaged in this debate by crafting a moderate, affordable prescription drug alternative that would have appealed to Members on both sides of the aisle. But this

body will never consider the Blue Dog substitute, because the Rules Committee denied us the opportunity to debate our proposal and have a vote on the House floor.

As you know, the Blue Dogs are a group of fiscally conservative Democrats, who are committed—as a coalition—to the passage of a prescription drug benefit that fits within our $400 billion budget window. On Tuesday evening, the Coalition formally endorsed legislation based upon the bipartisan Senate Medicare bill (S. 1).

The Senate has come together to develop a strong bipartisan benefit. It is not perfect. But, in recent years, the perfect has become the enemy of the good and, unfortunately, the perfect is out of our price range. The Senate offers America's seniors a good benefit. It carries a monthly premium of $35. A deductible of $275. A 50 percent cost-share through the first $4500 of drug spending. And, it offers a catastrophic benefit that kicks in after beneficiaries have spent $3700 out of pocket. Further, it corrects a variety of inadequacies in our Medicare reimbursement system for rural providers. And, it does all of this without putting Medicare on the path to privatization. But, with a score of $389 billion, there was some room for improvements. And, that is just what the Blue Dog Coalition has done.

We have strengthened the rural provider package by accelerating the start dates to 2004. And, we have improved the adjustments made to the wage index labor share—dropping the labor share to 62 percent.

We have built upon the Senate's critically important fall-back provisions. The fall-back means that seniors—such as those living in rural areas without two or more plans providing service—will always have access to a drug benefit. We have provided an additional layer of stability for those seniors, by requiring the fall-back plans to contract for two years as opposed to one.

We have included the Senate Generic drug amendment, which has been scored by CBO as a cost-saver because it streamlines and clarifies the process by which generic medications can be brought to market. This will increase the amount of affordable medications available to all of our seniors.

We have incorporated disclosure requirements, to ensure that our plans are fully demonstrating how savings are passed on to our beneficiaries.

We allow the Secretary to negotiate on behalf of all Medicare beneficiaries for the best prices possible.

We permit the re-importation of medications from Canada, provided that the Secretary certifies that such action would not jeopardize the health and safety of the American public.

We allow Medicare to operate as the primary payor for all dually eligible beneficiaries, lifting some of the financial burden off of the shoulders of our states.

We allow a portion of employer contributions to be counted towards the beneficiary out of pocket limits, encouraging our employers to continue sponsoring retiree health plans.

And we are able to make these improvements within the confines of the $400 billion budget allocation.

Unfortunately, the Congressional Budget Office was not able to complete a score on our legislation prior to the convening of the Rules Committee. However, the majority of the changes we have made to the already-scored Senate bill were based upon Senate amendments that have either been introduced and passed or are pending introduction. As such, they have all been scored by CBO for their sponsoring offices. The availability of that information has allowed the Blue Dogs to say with certainty that this legislation fits within the $400 billion budget window.

But, Members with questions about the Blue Dog substitute will never have the opportunity to pose them because the rule has prevented all debate on this alternative. Medicare is a complex program and the debate on the addition of a new prescription drug benefit cannot be a simple one. Voices should be heard, debate should be had, and all options should be fully explored before one course of action is decided upon. Unfortunately—to the detriment of this body and America's seniors—that is not happening.

I urge my colleagues to oppose this rule, and in doing so allow the House of Representatives to give this critical issue the open and deliberate debate that it fully deserves.

Ms. PRYCE of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. GINGREY), another physician in our conference.

Mr. GINGREY. Mr. Speaker, I thank the gentlewoman from Ohio (Ms. PRYCE) for giving me an opportunity to speak on this issue. I rise in favor of the rule and in favor of this bill.

I have delivered probably 5,000 or more babies over a 30-year medical career; but I will be prouder today of this delivery that we are giving to our seniors, that we have promised them for the last 2 years. Finally today that delivery will occur. This will be the best delivery that I have ever given because what we are talking about is not just a prescription drug benefit; we are also talking about modernizing Medicare so that it will not be going bankrupt by the year 2030.

With a prescription drug benefit, we will have an opportunity for our seniors to avoid prolonged hospital stays and prolonged nursing home stays, difficult expensive surgery. Let them take those medications early in the disease process so that high blood pressure does not result in a stroke or heart attack or so the diabetes they are suffering with does not end up in them being a dialysis patient.

This is a good bill. This is a bill that our leadership is finally going to give to our seniors; and I tell Members this is the day to do it, and this is the finest delivery we can offer to our seniors.

Ms. SLAUGHTER. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I am sure the gentleman from Georgia (Mr. GINGREY) is pleased that the Democrats tried to make the gentleman's amendment in order last night.

Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Mrs. TAUSCHER).

Mrs. TAUSCHER. Mr. Speaker, I rise today to strongly urge my colleagues to vote against the rule and to defeat the previous question. This will allow us to debate a much more realistic and fiscally responsible Medicare bill.

It is clear that the status quo is not working to make prescription drugs affordable for seniors. It is also clear that our country's economic situation does not give Congress a lot of options for solving this growing problem. Under the Dooley-Tauscher plan, seniors do not have to pay a premium, and the generous low-income benefit far exceeds the one offered by the majority. For seniors whose income is 150 percent of the Federal poverty level, roughly equal to $13,400, they will only have a 10 percent cost share.

Furthermore, any prescription drug plan needs to be part of Medicare, which seniors like and trust. Our plan is managed by Medicare. The benefit is integrated into Medicare part B, and every beneficiary gets a guaranteed benefit at no additional cost. By leveraging the buying power of all seniors, our plan allows every single person on Medicare to benefit from immediate drug savings regardless of how many prescriptions they are filling a month.

Finally, Mr. Speaker, our seniors need to be protected from catastrophic drug costs. Seniors who have high drug costs will be able to access the full benefit sooner because our plan focuses on the total cost of the drug, not discounted price paid out of pocket. Our plan has an extra safety net for those who really need it, people with total drug costs of $4,000 a year.

Under our bill, companies that currently provide prescription drug coverage to their retirees will have the incentive to continue doing so because the Federal Government will assume the risk of drug coverage once beneficiaries reach their deductible.

We need to be smart and realistic about how we can provide every American senior with prescription drug coverage. Given the current economic situation, our plan is the one that provides this coverage and is fiscally achievable. I urge my colleagues to defeat the previous question and support the Dooley-Tauscher substitute.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from the Virgin Islands (Mrs. CHRISTENSEN).

(Mrs. CHRISTENSEN asked and was given permission to revise and extend her remarks.)

Mrs. CHRISTENSEN. Mr. Speaker, I rise in opposition to the sham Republican Medicare bill which fails to provide women with the real prescription drug coverage that they need and deserve, and undermines the entire program.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. DOOLEY).

Mr. DOOLEY of California. Mr. Speaker, I rise to ask that the previous question be defeated so we can offer a real prescription drug benefit to seniors. It is unfortunate that the bill being offered by our Republican colleagues is one that seniors are going to find is so complex that it is going to result in taxpayers displacing a lot of

private sector contributions which are already providing prescription drug benefits.

Why in the world would we design a drug benefit program where we are actually going to be trading taxpayer dollars for dollars that are already being spent by corporations for their retirees?

There is a better alternative, and that is the bill we would like to offer, that is, we take the $400 billion that President Bush has talked about, roll it into Medicare part B, and use a drug card much like President Bush has talked about which ensures that every senior will have access to negotiated prices which ensures that they have 10 to 20 percent savings. We do this without an increase in premiums. We also target seniors facing catastrophic health care costs by ensuring that after they have purchased drugs that cost $4,000, that the Federal Government will be there to pick up the vast majority of their drug costs from that point on.

We also recognize that there are a lot of seniors in this country that cannot afford the $4,000, so we provide a low-income benefit that provides significant assistance to all those seniors who have incomes less than 200 percent of poverty. This would ensure that 50 percent of the seniors on Medicare today would have a subsidized low-income benefit that would help provide them access to much-needed prescription drugs.

It is time for this Congress to come together and say, if seniors have a limited amount of resources, let us target those resources of those seniors that are in greatest need. Those are the seniors with very high drug costs and those seniors with the least ability to pay, and the system should be simple.

The Republican plan that we are going to be considering on the floor today provides seniors the benefit if they are low-income, but not if they have $6,000 in assets or a car that is too valuable. We need a plan that seniors can understand, that they do not need to be an accountant to figure out; and that is what our alternative would provide.

Ms. PRYCE of Ohio. Mr. Speaker, I yield 2 minutes to the gentleman from Kentucky (Mr. WHITFIELD), a member of the Committee on Energy and Commerce.

Mr. WHITFIELD. Mr. Speaker, today represents the culmination of 4 to 5 years of Congress' efforts to provide a prescription drug benefit for senior citizens on Medicare. Two years ago, the House of Representatives passed a prescription drug benefit for senior citizens. Last year we did the same. The Senate did not do it the year before, nor did they do it last year; but this year both the House and the Senate will pass a prescription drug benefit.

This is a meaningful plan. It is going to provide basically free medicines for any senior citizen on Medicare who is at 135 percent of the poverty level and below. The only thing they will be expected to pay is a small $2 copay for generic drugs and a small $5 copay for name-brand drugs.

I have heard a lot of comments today about private insurance companies are going to be involved in administering this plan. I think it is important to recognize that today's Medicare plan uses private insurance companies to handle all of the reimbursement charges for Medicare. So we are not doing anything dramatically different in this bill than what is being done today.

I would also say the fact that this bill would provide catastrophic coverage for seniors is going to be a tremendous benefit. It will give them the peace of mind to know that no matter how high their drug costs may be, at some point the Federal Government will pay for all of it, the taxpayers will pay for all of it. I would also say that this bill provides an important rural health benefit package that is going to benefit all of rural America. It also provides additional monies, important monies that are needed for disproportionate share hospitals. It will benefit every children's hospital in America today. All those hospitals that provide care for people on Medicaid will receive additional funds. I think this is an important bill, and I urge Members to vote for the previous question and to adopt this new prescription drug benefit for Medicare beneficiaries.

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

Today, the House votes on the biggest change in Medicare in its 40-year history, a change that will affect 40 million Americans; but the Republican leaders have rigged the rules to prevent the House from voting on serious alternatives offered by Republicans and Democrats alike.

Mr. Speaker, I will call for a ''no'' vote on the previous question in the hope that the House gets the chance to consider an additional alternative that the Republican leaders fear. If the previous question is defeated, I will offer an amendment to the rule that will make in order the Dooley prescription drug alternative substitute. It makes all senior citizens enrolled in Medicare part B eligible for prescription drug assistance without increasing their premiums. Unlike the Republican bill, it has no sickness penalty or doughnut hole that seniors can fall through. Unlike the Republican bill, it does not encourage companies to drop seniors' existing drug plans.

Let me make it clear that a ''no'' vote on the previous question will not stop the consideration of H.R. 1. It will simply allow the House to vote on the Dooley substitute. However, a ''yes'' vote on the previous question will prevent the House from voting. I urge a ''no'' vote.

Mr. Speaker, I ask unanimous consent that the text of the amendment be printed in the RECORD immediately prior to the vote on the previous question.

The SPEAKER pro tempore (Mr. LATOURETTE). Is there objection to the request of the gentlewoman from New York?

There was no objection.

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

Ms. PRYCE of Ohio. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, passing this plan is the right thing to do. It makes the kind of commonsense changes to the health care system in this country that the American public needs. Adding this Medicare benefit will renew our promise to our seniors. It will reduce the cost of prescription drugs, and it will revolutionize medicine for the 21st century. Seniors deserve this assistance now. They deserved it yesterday. They deserved it last week; and actually, they deserved it last year. It is time for this body to act. I urge my colleagues to support this fair rule and pass the needed reform today.

□ 1415

The material previously referred to by Ms. SLAUGHTER is as follows:

PREVIOUS QUESTION FOR H. RES. 299—RULE ON H.R. 1 AND H.R. 2596 MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT AND HEALTH SAVINGS AND AFFORDABILITY ACT

In the first section of the resolution strike ''and (3)'' and insert the following:

''(3) the further amendment in the nature of a substitute specified in section 7 of this resolution if offered by Representative Doley of California or a designee, which shall be in order without intervention of any point of order, shall be considered as read, and shall be separately debatable for 60 minutes equally divided and controlled by the proponent and an opponent; and (4)''

At the end of the resolution add the following new section:

''Sec. 7. The further amendment in the nature of a substitute referred to in the first section of this resolution is as follows:''

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Rx Now 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) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE RX NOW

Sec. 100. Purpose.

Subtitle A—Part B Drug Benefit with High Deductible and No Premium

Sec. 101. Inclusion of high-deductible outpatient prescription drug benefit under part B.

Sec. 102. Provision of benefits through medicare approved prescription drug plans.

Subtitle B—Benefits for Low-income Beneficiaries

Sec. 111. Benefits for low-income beneficiaries.

Sec. 112. Improving enrollment process under medicaid.

TITLE II—RURAL HEALTH CARE IMPROVEMENTS

Sec. 201. Fairness in the medicare disproportionate share hospital (DSH) adjustment for rural hospitals.
Sec. 202. Immediate establishment of uniform standardized amount in rural and small urban areas.
Sec. 203. Establishment of essential rural hospital classification.
Sec. 204. More frequent update in weights used in hospital market basket.
Sec. 205. Improvements to critical access hospital program.
Sec. 206. Redistribution of unused resident positions.
Sec. 207. Two-year extension of hold harmless provisions for small rural hospitals and sole community hospitals under prospective payment system for hospital outpatient department services.
Sec. 208. Exclusion of certain rural health clinic and Federally qualified health center services from the prospective payment system for skilled nursing facilities.
Sec. 209. Recognition of attending nurse practitioners as attending physicians to serve hospice patients.
Sec. 210. Improvement in payments to retain emergency capacity for ambulance services in rural areas.
Sec. 211. Three-year increase for home health services furnished in a rural area.
Sec. 212. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
Sec. 213. GAO study of geographic differences in payments for physicians' services.
Sec. 214. Treatment of missing cost reporting periods for sole community hospitals.
Sec. 215. Extension of telemedicine demonstration project.
Sec. 216. Adjustment to the medicare inpatient hospital PPS wage index to revise the labor-related share of such index.
Sec. 217. Establishment of floor on geographic adjustments of payments for physicians' services.

TITLE I—MEDICARE RX NOW

SEC. 100. PURPOSE.

The purpose of this title is to provide for outpatient prescription drug benefits to medicare beneficiaries in the following manner:

(1) Medicare beneficiaries enrolled under medicare part B qualify for outpatient prescription drug benefits after an annual deductible (initially set at $4,000) has been met. This benefit is available without any additional premium.

(2) There are fixed dollar copayments for this coverage, with the average of such copayments equal to 20 percent of the benefits and the amount of the copayments varying depending upon whether the drugs are generic, preferred brand-name, or non-preferred brand-name drugs.

(3) The benefits are provided through medicare-approved prescription drug plans. These plans may be current plans, such as Medicare+Choice plans, employer-based retiree coverage, medigap plans, State assistance programs, medicaid, drug discount card plans, and other qualified plans (as determined by the Secretary). All of these plans must offer, in addition to the high-deductible coverage, discounts for prescription drugs both while the annual deductible is being satisfied and after it is satisfied.

(4) To assure access to medicare-approved prescription drug plans for all medicare beneficiaries, the Secretary will solicit bids for prescription drug discount plans that will be available in all geographic regions to all medicare beneficiaries.

(5) All pharmacies that comply with electronic claims processing standards may provide drugs under the program.

(6) This title also provides for the availability of additional benefits in the form of a waiver of the annual deductible and reduced copayments, thereby providing immediate entitlement to prescription drug benefits, for medicare beneficiaries who have incomes under 200 percent of the poverty line and who are not eligible for medicaid prescription drug benefits.

Subtitle A—Part B Drug Benefit with High Deductible and No Premium

SEC. 101. INCLUSION OF HIGH-DEDUCTIBLE OUTPATIENT PRESCRIPTION DRUG BENEFIT UNDER PART B.

(a) COVERAGE.—Section 1832(a) (42 U.S.C. 1395k(a)) is amended—

(1) by striking ''and'' at the end of paragraph (1);

(2) by striking the period at the end of paragraph (2) and inserting ''; and''; and

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

''(3) entitlement to have access to a prescription drug plan that provides discounts on purchases for outpatient prescription drugs and, effective beginning with 2006, for payment made on his behalf (subject to the provisions of this part) for high-deductible outpatient prescription drug coverage under section 1845.''.

(b) DESCRIPTION OF HIGH-DEDUCTIBLE PRESCRIPTION DRUG BENEFIT.—Title XVIII is amended by inserting after section 1844 the following new section:

''OUTPATIENT PRESCRIPTION DRUG COVERAGE

''SEC. 1845. (a) HIGH-DEDUCTIBLE OUTPATIENT PRESCRIPTION DRUG COVERAGE DEFINED.—

''(1) IN GENERAL.—For purposes of this part, the term 'high-deductible outpatient prescription drug coverage' means payment of—

''(A) expenses for covered outpatient prescription drugs incurred in a year after the individual has incurred expenses for such drugs in the year of an amount equal to the annual deductible specified in paragraph (2); reduced by

''(B) cost-sharing described in paragraph (3).

For periods before 2006, such coverage shall consist of access to discounts for prescription drugs under a medicare-approved prescription drug plan.

''(2) ANNUAL DEDUCTIBLE.—

''(A) IN GENERAL.—The annual deductible under this paragraph—

''(i) for 2006 is equal to $4,000; and

''(ii) for a subsequent year is equal to the amount specified in subparagraph (B) for that year, except that, if the amount specified in such subparagraph is not a multiple of $10, it shall be rounded to the nearest multiple of $10.

''(B) INFLATIONARY ADJUSTMENT.—The amount specified in this subparagraph—

''(i) for 2006, is $4,000; or

''(ii) the amount specified in this subparagraph for a subsequent year is the amount specified in this subparagraph for the previous year increased by the annual percentage increase in average per capita aggregate expenditures for covered outpatient prescription drugs in the United States for medicare beneficiaries, as determined by the Secretary for the 12-month period ending in July of the previous year.

''(3) COST-SHARING.—

''(A) THREE-TIERED COPAYMENT STRUCTURE.—Subject to the succeeding provisions of this paragraph , in the case of a covered outpatient drug that is dispensed in a year to an eligible individual, the individual shall be responsible for a copayment for the drug in an amount equal to the following (or, if less, the price for the drug negotiated pursuant to subsection (c)(5)):

''(i) GENERIC DRUGS.—In the case of a generic covered outpatient drug, the base copayment amount specified in accordance with subparagraph (B) for each prescription (as defined by the Secretary) of such drug.

''(ii) PREFERRED BRAND NAME DRUGS.—In the case of a preferred brand name covered outpatient drug, 4 times the copayment amount applied under clause (i) for each prescription (as so defined) of such drug.

''(iii) NONPREFERRED BRAND NAME DRUG.—In the case of a nonpreferred brand name covered outpatient drug, 150 percent of the copayment amount applied under clause (ii) for each prescription (as so defined) of such drug.

''(B) ESTABLISHMENT OF BASE COPAYMENT AMOUNT CONSISTENT WITH 80:20 BENEFIT RATIO.—For each year beginning with 2006 the Secretary shall establish a base copayment amount in a manner consistent with the principle (subject to reasonable rounding rules) that the ratio of the aggregate amount of benefits provided under this section to the aggregate copayments under this paragraph for each year should be approximately equal to 80 to 20.

''(C) DISCOUNTS ALLOWED FOR NETWORK PHARMACIES.—A medicare-approved prescription drug plan may reduce copayments for its designees below the level otherwise provided under this paragraph, but in no case shall such a reduction result in an increase in payments made by the Secretary under this section to a plan.

''(D) TREATMENT OF MEDICALLY NECESSARY NONPREFERRED DRUGS.—A nonpreferred brand name drug shall be treated as a preferred brand name drug under this paragraph if such nonpreferred drug is determined (pursuant to procedures established under subsection (c)(6)) to be medically necessary.

''(E) REQUIREMENT FOR DESIGNATION OF PREFERRED BRAND NAME DRUGS.—Within each category of therapeutic-equivalent covered outpatient prescription drugs (as defined by the Secretary, in consultation with the Medicare Payment Advisory Commission, each medicare-approved prescription drug plan shall provide for the designation of at least one preferred brand name covered outpatient drug.

''(4) PAYMENT OF BENEFITS BEYOND DEDUCTIBLE.—

''(A) IN GENERAL.—There shall be paid from the Federal Supplementary Medical Insurance Trust Fund, in the case of each individual who is covered under the insurance program established by this part and incurs expenses for covered outpatient prescription drugs with respect to which benefits are payable under this section, amounts equal to the amounts provided under paragraph (1).

''(B) COUNTING OF INCURRED EXPENSES.—Expenses with respect to covered outpatient prescription drugs under this section shall—

''(i) be treated as incurred regardless of whether they are reimbursed by a third-party payor;

''(ii) not be treated as incurred unless the expenses were incurred during a period in which the individual was covered under this part; and

''(iii) not be treated as incurred unless information concerning the transaction giving rise to such expenses has been electronically

transmitted by the pharmacy or other entity dispensing the covered outpatient prescription drugs to the medicare-approved prescription drug plan consistent with electronic claims standards established under subsection (c)(3).''.

SEC. 102. PROVISION OF BENEFITS THROUGH MEDICARE APPROVED PRESCRIPTION DRUG PLANS.

(a) IN GENERAL.—Section 1845 of the Social Security Act, as inserted by section 101(a), is further amended by adding at the end the following:

''(b) PROVISION OF BENEFITS THROUGH A MEDICARE APPROVED PRESCRIPTION DRUG PLAN.—

''(1) IN GENERAL.—In the case of an individual entitled to benefits for high-deductible outpatient prescription drug coverage under this section, the individual shall obtain such benefits through a medicare-approved prescription drug plan that is designated under this subsection.

''(2) DESIGNATION PROCESS.—The Secretary shall provide for a process for designation of medicare-approved prescription drug plans consistent with the following:

''(A) FREQUENCY OF DESIGNATIONS.—The Secretary shall permit individuals, on an annual basis and at such other times during a year as the Secretary may specify, to change the plan designated.

''(B) DISSEMINATION OF INFORMATION.—The Secretary shall provide for the dissemination of information on designation of plans under this subsection. Such dissemination may be coordinated with the dissemination of information on Medicare+Choice plan selection under part C.

''(C) DEFAULT ASSIGNMENT.—In the case of an individual who is enrolled under this part who has not otherwise designated a medicare-approved prescription drug plan, the Secretary shall assign the individual to an appropriate prescription drug discount card plan serving the area in which the individual resides.

''(D) DEEMED DESIGNATION.—The Secretary may deem an individual who is enrolled in a medicare-approved prescription drug plan described in subparagraph (A) through (E) of subsection (c)(2) as having designated such plan, but shall permit the individual to designate a prescription drug discount card plan instead. The Secretary shall establish rules in cases where an individual is enrolled in more than one such plan.

''(3) DESIGNEE DEFINED.—In this section, the term 'designee' means such an individual who makes such a designation and, with respect to a plan, an individual who has designated that plan under this subsection.

''(c) MEDICARE-APPROVED PRESCRIPTION DRUG PLANS.—

''(1) IN GENERAL.—For purposes of this part, the term 'medicare-approved prescription drug plan' means a health plan or program described in paragraph (2) that—

''(A) beginning with 2006, provides at least high-deductible outpatient prescription drug coverage to designees of that plan or program;

''(B) meets the applicable requirements of paragraph (3) and succeeding paragraphs of this subsection with respect to such designees;

''(C) has entered into an agreement with the Secretary to provide and exchange electronically such information as the Secretary may require for the administration of the program of benefits under this section; and

''(D) meets such additional requirements as the Secretary may specify, including requiring the provision of appropriate periodic audits.

''(2) TYPES OF PLANS AND PROGRAMS THAT MAY QUALIFY.—The types of plans and programs that may qualify as a medicare-approved prescription drug plan are the following:

''(A) A Medicare+Choice plan.

''(B) A group health plan, including a retirement health benefits plan, that provides prescription drug coverage.

''(C) A State plan under title XIX.

''(D) A health benefits plan under the Federal employees' health benefits program under chapter 89 of title 5, United States Code.

''(E) A medicare supplemental policy.

''(F) State pharmaceutical assistance program.

''(G) A prescription drug discount card plan (described in subsection (d)).

''(H) Any other prescription drug plan that is determined to meet such requirements as the Secretary establishes.

''(3) ADMINISTRATION THROUGH CARD-BASED ELECTRONIC MECHANISM.—

''(A) USE OF MEDICARE PRESCRIPTION DRUG CARD.—Claims for benefits under this section under a medicare-approved prescription drug plan may only be made electronically through the use of an electronic prescription card system (in this paragraph referred to as the 'system').

''(B) STANDARDS FOR ELECTRONIC PRESCRIPTION CARD SYSTEM.—The Secretary shall establish standards for the system, including the following:

''(i) CARDS.—Standards for claims cards to be used by designees under the system.

''(ii) COORDINATION OF ELECTRONIC INFORMATION.—Standards for the real-time transmittal among pharmacies, medicare-approved prescription drug plans, and the Secretary (including an appropriate data clearinghouse operated by or under contract with the Secretary) of information on expenses incurred for covered outpatient prescription drugs by designees.

''(iii) CONFIDENTIALITY.—Standards that assure the confidentiality of individually identifiable information of designees and that are consistent with the regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(iv) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—Prescriptions must be written and transmitted electronically (other than by facsimile), except in emergency cases and other exceptional circumstances recognized by the Secretary.

''(v) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL.—The program provides for the electronic transmittal to the prescribing health care professional of information that includes—

''(I) information (to the extent available and feasible) on the drug or drugs being prescribed for that patient and other information relating to the medical history or condition of the patient that may be relevant to the appropriate prescription for that patient;

''(II) cost-effective alternatives (if any) for the use of the drug prescribed; and

''(III) information on the drugs included in the applicable formulary.

To the extent feasible, such program shall permit the prescribing health care professional to provide (and be provided) related information on an interactive, real-time basis.

''(C) STANDARDS.—

''(i) DEVELOPMENT.—The Secretary shall provide for the development of uniform standards relating to the electronic prescription drug program described in subparagraph (B). Such standards shall be compatible with standards established under part C of title XI.

''(ii) ADVISORY TASK FORCE.—In developing such standards the Secretary shall establish a task force that includes representatives of physicians, hospitals, pharmacies, beneficiaries, pharmacy benefit managers, individuals with expertise in information technology, and pharmacy benefit experts of the Departments of Veterans Affairs and Defense and other appropriate Federal agencies to provide recommendations to the Administrator on such standards, including recommendations relating to the following:

''(I) The range of available computerized prescribing software and hardware and their costs to develop and implement.

''(II) The extent to which such standards and systems reduce medication errors and can be readily implemented by physicians, pharmacies, and hospitals.

''(III) Efforts to develop uniform standards and a common software platform for the secure electronic communication of medication history, eligibility, benefit, and prescription information.

''(IV) Efforts to develop and promote universal connectivity and interoperability for the secure electronic exchange of such information.

''(V) The cost of implementing such systems in the range of hospital and physician office settings and pharmacies, including hardware, software, and training costs.

''(VI) Implementation issues as they relate to part C of title XI, and current Federal and State prescribing laws and regulations and their impact on implementation of computerized prescribing.

''(iii) DEADLINES.—

''(I) The Secretary shall constitute the task force under clause (ii) by not later than April 1, 2004.

''(II) Such task force shall submit recommendations to the Secretary by not later than January 1, 2005.

''(III) The Secretary shall provide for the development and promulgation, by not later than January 1, 2006, of national standards relating to the electronic prescription drug program described in clause (ii). Such standards shall be issued by a standards organization accredited by the American National Standards Institute (ANSI) and shall be compatible with standards established under part C of title XI.

''(4) ACCEPTANCE OF CLAIMS THROUGH ALL QUALIFYING PHARMACIES.—A medicare-approved prescription drug plan shall—

''(A) permit the participation of any pharmacy that meets terms and conditions that the plan has established;

''(B) provide for acceptance and process of claims for designees from any pharmacy that meets standards the Secretary has established under paragraph (3) to carry out real-time transmittal of claims to such plans and that provides for disclosure, in the case of dispensing of a brand name drug to a designee, of information on the availability of generic equivalents at reduced cost to the designee; and

''(C) permit enrollees to receive benefits (which may include a 90-day supply of drugs or biologicals) through a community pharmacy, rather than through mail order, with any differential in cost paid by such enrollees.

''(5) REQUIREMENT TO NEGOTIATE DISCOUNTS AND GENERIC EQUIVALENTS.—A medicare-approved prescription drug plan shall provide designees of the plan with the following:

''(A) NEGOTIATED PRICES.—Access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits or only partial benefits may be payable with respect to such drugs because of the application of the deductible under subsection (a)(2) or copayment under subsection (a)(3) or because the drugs are procured before January 1, 2006.

''(B) GENERIC EQUIVALENTS.—Information on the availability of generic equivalents at reduced cost to such designees.

''(6) TREATMENT OF NONPREFERRED BRAND NAME DRUGS.—

''(A) PROCEDURES REGARDING THE DETERMINATION OF DRUGS THAT ARE MEDICALLY NECESSARY.—

''(i) IN GENERAL.—A medicare-approved prescription drug plan shall have in place procedures on a case-by-case basis to treat a nonpreferred brand name drug as a preferred brand name drug for purposes of subsection (a) if the nonpreferred brand name drug is determined—

''(I) to be not as effective for the designee in preventing or slowing the deterioration of, or improving or maintaining, the health of the individual; or

''(II) to have a significant adverse effect on the individual.

''(ii) REQUIREMENT.—The procedures under clause (i) shall require that determinations under such clause are based on professional medical judgment, the medical condition of the enrollee, and other medical evidence.

''(B) PROCEDURES REGARDING APPEAL RIGHTS WITH RESPECT TO DENIALS OF CARE.—Such a plan shall have in place procedures to ensure a timely internal review (and timely independent external review) for resolution of denials of coverage in accordance with the medical exigencies of the case in accordance with requirements established by the Secretary that are comparable to such requirements for Medicare+Choice organizations under part C and to ensure notice to designees regarding such procedures. A designee shall have the further right to an appeal of such a denial of coverage in the same manner as is provided under section 1852(g)(5) in the case of a failure to receive health services under a Medicare+Choice plan.

''(7) PROMPT PAYMENT OF PHARMACIES FOR COVERED BENEFITS.—Medicare-approved prescription drug plans shall provide for payment to qualifying pharmacies of benefits under subsection (a)(4) promptly in accordance with rules no less generous than the rules applicable under section 1842(c)(2)(B).

''(8) EDUCATION.—Medicare-approved prescription drug plans shall apply methods to identify and educate providers, pharmacists, and designees regarding—

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

''(B) instances or patterns of substandard care;

''(C) potential adverse reactions to covered outpatient prescription drugs;

''(D) inappropriate use of antibiotics;

''(E) appropriate use of generic products; and

''(F) the importance of using covered outpatient prescription drugs in accordance with the instruction of prescribing providers.

''(9) NOT AT FINANCIAL RISK.—The entity offering a medicare-approved prescription drug plan shall not be at financial risk for the provision of high-deductible prescription drug coverage under the plan to designees, but there shall be performance incentives (based on risk corridors negotiated between the entity and the Secretary and subject to audit) in relation to the administration of the contract and the entity's ability to reduce costs through appropriate incentive mechanisms.

''(10) PROVISION OF DATA.—The entity offering such a plan shall provide the Secretary with such information as is required to make payments to the entity under this section.

''(d) PRESCRIPTION DRUG DISCOUNT CARD PLANS.—

''(1) SOLICITATION OF BIDS.—The Secretary shall solicit bids from entities to offer prescription drug discount card plans to individuals enrolled under this part either nationwide or in large geographic areas. The Secretary shall award bids in a manner so that such plans are offered in all areas of the United States. The Secretary may not award a contract based on such a bid to an entity with respect to a plan unless the entity and plan meet the applicable requirements to be a medicare-approved prescription drug plan under this section.

''(2) LIMITATION ON BENEFITS.—The entity offering a prescription drug discount card plan shall not offer (or charge for) benefits to designees of the plan in addition to high-deductible prescription drug coverage, access to negotiated prices, and other benefits required under this section and, in the case of subsidy eligible individuals, benefits under subsection (h).

''(e) PAYMENT OF PLANS.—

''(1) IN GENERAL.—The Secretary shall provide, in the contract entered into between the Secretary and entities that offer medicare-approved prescription drug plans, for payment to the plans for high-deductible prescription drug coverage offered through the plan, including expanded coverage for low-income individuals under subsection (g) and taking into account performance incentives described in paragraph (2). In addition, in the case of prescription drug discount card plans, the Secretary shall provide for payment of administrative costs in carrying out the contract (taking into account the performance incentives described in paragraph (2)), based on rates negotiated between the Secretary and the entity in the solicitation process under subsection (d).

''(2) INCENTIVES FOR COST AND UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT.—The Secretary shall include in the contract such financial or other performance incentives for cost and utilization management and quality improvement as the Secretary may deem appropriate.

''(f) COVERED OUTPATIENT PRESCRIPTION DRUGS DEFINED.—

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

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

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

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

''(2) EXCLUSIONS.—

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

''(B) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient prescription drug under this section shall not be so considered if payment for such drug is available under part A or under this part (other than under this section).''.

(b) NO EFFECT ON PART B PREMIUM.—

(1) IN GENERAL.—Section 1839(a) (42 U.S.C. 1395r(a)) is amended by adding at the end the following new paragraph:

''(5) Notwithstanding the previous provisions of this subsection, in computing actuarial rates there shall not be taken into account benefits and administrative costs that are attributable to the prescription drug coverage provided under section 1845.''.

(2) SPECIAL ENROLLMENT PERIOD; WAIVER OF LATE ENROLLMENT PENALTY.—

(A) Section 1837 (42 U.S.C. 1395p) is amended by adding at the end the following new subsection:

''(k) There shall also be a general enrollment period during the period beginning on July 1, 2005, and ending on November 30, 2005.''.

(B) Section 1838(a) (42 U.S.C. 1395q(a)) is amended—

(i) by striking ''or'' at the end of paragraph (2);

(ii) by striking the period at the end of paragraph (3) and inserting '', or''; and

(iii) by adding at the end the following new paragraph:

''(4) in the case of an individual who enrolls pursuant to subsection (k) of section 1837, January 1, 2006.''.

(C) Section 1839(b) (42 U.S.C. 1395r(b)) is amended by inserting ''or a general enrollment period under section 1837(k)'' after ''not pursuant to a special enrollment period under section 1837(i)(4)''.

(3) GOVERNMENT CONTRIBUTION.—Section 1844(a)(1) (42 U.S.C. 1395w(a)(1)) is amended—

(A) by striking ''plus'' at the end of subparagraph (A);

(B) by striking ''; plus'' at the end of subparagraph (B) and inserting '', plus''; and

(C) by adding at the end the following new subparagraph:

''(C) a Government contribution equal to the aggregate amounts expended from the Trust Fund for benefits and administrative expenses attributable to the prescription drug coverage provided under section 1845; plus''.

(c) MEDICARE AS PRIMARY PAYOR.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended by adding at the end the following new paragraph:

''(7) EXCEPTION FOR OUTPATIENT PRESCRIPTION DRUG BENEFIT.—The previous provisions of this subsection shall not apply to benefits provided under section 1845.''.

Subtitle B—Benefits for Low-income Beneficiaries

SEC. 111. BENEFITS FOR LOW-INCOME BENEFICIARIES.

(a) IN GENERAL.—

(1) FIRST DOLLAR COVERAGE.—Section 1845, as inserted by section 101(b), is amended by adding at the end the following new subsection:

''(g) FIRST DOLLAR COVERAGE FOR CERTAIN LOW-INCOME INDIVIDUALS.—

''(1) IN GENERAL.—In the case of a subsidy eligible individual (as defined in paragraph (2)), this section shall be applied as if the annual deductible were equal to zero but, with respect to costs incurred before the amount of the annual deductible otherwise applicable, the following copayment amounts shall apply:

''(A) 10 PERCENT COPAYMENT FOR INDIVIDUALS WITH INCOMES UP TO 150 PERCENT OF POVERTY.—For subsidy eligible individuals with income that does not exceed 150 percent of the poverty line, the copayment amounts shall be the copayments amounts specified in subsection (a)(3), which reflects an average benefit percentage of 90 percent.

''(B) 50 PERCENT COPAYMENT FOR INDIVIDUALS WITH INCOMES ABOVE 150 PERCENT OF POVERTY.—For subsidy eligible individuals with income that exceeds 150 percent of the poverty line, the copayment amounts shall be

the copayments amounts specified in subsection (a)(3) increased by 150 percent, which reflects an average benefit percentage of 50 percent, but in no case shall such copayment amount exceed the price negotiated for the drug involved.

''(2) DETERMINATION OF ELIGIBILITY.—

''(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, subject to subparagraph (D), the term 'subsidy eligible individual' means an individual who—

''(i) is enrolled under this part;

''(ii) has income below 150 percent (or such higher percent, not to exceed 200 percent, as a State may specify under subparagraph (B)) of the Federal poverty line; and

''(iii) is not eligible for medical assistance with respect to prescription drugs under title XIX.

For purposes of this section, an individual shall not be treated as eligible for medical assistance with respect to prescription drugs under title XIX (including under a waiver under section 1115) only if, with respect to such assistance, the individual is charged a copayment greater than a nominal amount (as described in section 1916(a)(3)) and there is no monthly or similar dollar limit established for the amount of such assistance over any period of time.

''(B) COVERAGE OF INDIVIDUALS WITH INCOME UP TO 200 PERCENT OF POVERTY AT STATE OPTION.—One of the 50 States or the District of Columbia may, at its option and subject to section 1935(c), specify a percent of income, that exceeds 150 percent but does not exceed 200 percent, that will apply for purposes of this subsection to individuals residing in the State.

''(C) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy eligible individual shall be determined under the State medicaid plan for the State under section 1935(a) or by the Social Security Administration. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this subparagraph.

''(D) INCOME DETERMINATIONS.—For purposes of applying this subsection—

''(i) income shall be determined in the manner no less restrictive than the manner described in section 1905(p)(1)(B); and

''(ii) the term 'Federal poverty line' means the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(E) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual but may be eligible for financial assistance with prescription drug expenses under section 1935(f).

''(3) ADMINISTRATION OF SUBSIDY PROGRAM.—The Secretary shall provide a process whereby, in the case of an individual who is determined to be a subsidy eligible individual and who is enrolled in a medicare-approved prescription drug plan—

''(A) the Secretary provides for a notification of the entity offering the plan that the individual is eligible for a subsidy under paragraph (1);

''(B) such entity adjusts the benefits for prescription drug coverage accordingly and submits to the Secretary information on the amount of such benefits provided; and

''(C) the Secretary periodically and on a timely basis reimburses the entity for the amount of such benefits (including reasonable related administrative costs) that are provided only because of the application of this subsection.

''(4) RELATION TO MEDICAID PROGRAM.—

''(A) IN GENERAL.—For provisions providing for eligibility determinations, and additional financing, under the medicaid program, see section 1935.

''(B) COORDINATION.—The Secretary shall develop and implement a plan for the coordination of prescription drug benefits under this part with the benefits provided under the medicaid program under title XIX, with particular attention to insuring coordination of payments and prevention of fraud and abuse. In developing and implementing such plan, the Secretary shall involve the States, the data processing industry, pharmacists, and pharmaceutical manufacturers, and other experts and representatives of low-income medicare beneficiaries.''.

(2) REDUCTION IN CATASTROPHIC COPAYMENTS FOR LOW INCOME INDIVIDUALS.—Section 1845(a), as inserted by section 101(b), is amended—

(A) in paragraph (3)(A), by inserting ''and paragraph (5)'' after ''Subject to the succeeding provisions of this paragraph''; and

(B) by adding at the end the following new paragraph:

''(5) REDUCTION IN COPAYMENTS FOR LOW-INCOME INDIVIDUALS TO 10 PERCENT.—In the case of a subsidy eligible individual with income that does not exceed 150 percent of the poverty line (as defined for purposes of subsection (g)), the copayment otherwise applicable under paragraph (3) shall be ½ of the copayment amount otherwise applicable.''.

(b) MEDICAID AMENDMENTS.—

(1) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—

(A) REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(i) by striking ''and'' at the end of paragraph (64);

(ii) by striking the period at the end of paragraph (65) and inserting ''; and''; and

(iii) by inserting after paragraph (65) the following new paragraph:

''(66) provide for making eligibility determinations under sections 1845(a)(5), 1845(g), and 1935(a).''.

(2) NEW SECTION.—Title XIX of such Act is further amended—

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

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

''SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

''SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDY.—

''(1) IN GENERAL.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall—

''(A) make determinations of eligibility for subsidies under (and in accordance with) sections 1845(g) and 1845(a)(5);

''(B) inform the Secretary of such determinations in cases in which such eligibility is established; and

''(C) otherwise provide the Secretary with such information as may be required to carry out section 1845.

''(2) STATE OPTION FOR COVERAGE OF ADDITIONAL LOW-INCOME INDIVIDUALS.—A State may elect under paragraph (2)(B) of section 1845(g) to cover additional low-income medicare beneficiaries under the prescription drug subsidy program provided under such subsection, subject to contribution under subsection (c).

''(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

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

''(A) For expenditures attributable to costs incurred during 2006, the otherwise applicable Federal matching rate shall be increased by 10 percent of the percentage otherwise payable (but for this subsection) by the State.

''(B)(i) For expenditures attributable to costs incurred during 2007 and each subsequent year through 2013, the otherwise applicable Federal matching rate shall be increased by the applicable percent (as defined in clause (ii)) of the percentage otherwise payable (but for this subsection) by the State.

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

''(I) 2007 is 20 percent; or

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

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

''(2) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate administrative expenditures described in paragraph (1) that may otherwise be made for similar eligibility determinations.

''(c) STATE CONTRIBUTION AT SCHIP MATCHING RATE TOWARDS ADDITIONAL LOW-INCOME SUBSIDIES FOR OPTIONAL SUBSIDY ELIGIBLE INDIVIDUALS COVERED UNDER STATE OPTION.—In the case of a State that specifies a percent of income under section 1845(g)(2)(B) for a quarter, the amount of payment made to the State under section 1903(a)(1) for the quarter shall be reduced by the product of—

''(1) 100 percent less the enhanced FMAP described in section 2105(b) for that State and quarter; and

''(2) the additional amount of payment made under section 1845 because of the application of such specification.''.

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C. 1396b(a)(1)) is amended by inserting before the semicolon the following: '', reduced by the amount computed under section 1935(d)(1) for the State and the quarter''.

(2) AMOUNT DESCRIBED.—Section 1935, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

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

''(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2006) the amount computed under this subsection is equal to the sum of the product described in paragraph (3) plus the product of the following:

''(A) MEDICARE BENEFITS FOR MEDICAID ELIGIBLES.—The total amount of payments made in the quarter because of the operation of section 1845 that are attributable to individuals who are residents of the State and are eligible for medical assistance with respect to prescription drugs under this title. For purposes of this subparagraph, an individual shall not be treated as eligible for medical assistance with respect to prescription drugs under title XIX (including under a

waiver under section 1115) only if, with respect to such assistance, the individual is charged a copayment greater than a nominal amount (as described in section 1916(a)(3)) and there is no monthly or similar dollar limit established for the amount of such assistance over any period of time.

''(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

''(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

''(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the 'phase-out proportion' for a calendar quarter in—

''(A) 2006 is 90 percent;

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

''(C) a year after 2013 is 0 percent.

''(3) PRODUCT.—The product described in this paragraph for a State for a calendar quarter is the State matching rate described in paragraph (1)(B) for that State and quarter multiplied by the additional expenditures made under section 1845 as a result of the following:

''(A) REDUCTIONS IN CATASTROPHIC COPAYMENTS.—The application of subsection (a)(5) thereof.

''(B) FIRST DOLLAR COVERAGE.—The application under subsection (g) of reduced copayments amounts insofar as such amounts are less than 25 percent of the amount of the price otherwise negotiated for the drug involved.

(3) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—Section 1935, as so inserted and amended, is further amended by adding at the end the following new subsection:

''(e) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to benefits under part B of title XVIII and is eligible for medical assistance with respect to prescribed drugs under this title, medical assistance shall continue to be provided under this title for prescribed drugs to the extent payment is not made under such part B, without regard to section 1902(n)(2).''.

(4) CLARIFYING AMENDMENTS.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended—

(A) in subparagraph (B), by inserting '', but not including any copayments under section 1845'' after ''section 1813''; and

(B) in subparagraph (C), by inserting '', but not including any deductible under section 1845'' after ''section 1833(b)''..

(d) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—Section 1935 of such Act, as so inserted and amended, is further amended—

(A) in subsection (a) in the matter preceding paragraph (1), by inserting ''subject to subsection (f)'' after ''section 1903(a)'';

(B) in subsection (c)(1), by inserting ''subject to subsection (f)'' after ''1903(a)(1)''; and

(C) by adding at the end the following new subsection:

''(f) TREATMENT OF TERRITORIES.—

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

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

''(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries under section 1845(g)), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in paragraph (3).

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

''(A) provides medical assistance under section 1845(g) with respect to the provision of covered outpatient drugs to low-income medicare beneficiaries whose income does not exceed an income level specified under the plan; and

''(B) assures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

''(3) INCREASED AMOUNT.—

''(A) IN GENERAL.—The amount specified in this paragraph for a State for a year is equal to the product of—

''(i) the aggregate amount specified in subparagraph (B); and

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

''(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

''(i) 2006, is equal to $25,000,000; or

''(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1845(a)(2)(B) for the year involved.

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

(2) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting ''and section 1935(f)(1)(B)'' after ''Subject to subsection (g)''.

(e) MEDICAID REDUCTION OF COPAYMENTS FOR QMBS.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended by adding at the end the following new subparagraph:

''(E) The difference between the copayment amounts established under sections 1845(g)(1)(A) and 1845(a)(5) for covered outpatient drugs and the nominal copayment amounts that would apply to such drugs if covered under this title, pursuant to section 1916(a).''.

(f) RENEGOTIATION OF PHARMACY PLUS WAIVERS.—In the case of States which as of the date of the enactment of this Act have entered into demonstration projects (popularly known as pharmacy plus waivers) under section 1115 of the Social Security Act under which the State is provided flexibility to offer medical assistance for prescription drug coverage in return for limitations on payments for certain optional populations, the Secretary of Health and Human Services shall renegotiate such projects in order to account for the additional prescription drug benefits made available under the amendments made by this title.

SEC. 112. IMPROVING ENROLLMENT PROCESS UNDER MEDICAID.

(a) AUTOMATIC REENROLLMENT WITHOUT NEED TO REAPPLY.—

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

(A) by redesignating paragraph (6) as paragraph (9); and

(B) by inserting after paragraph (5), the following new paragraph:

''(6) In the case of an individual who has been determined to qualify as a qualified medicare beneficiary or to be eligible for benefits under section 1902(a)(10)(E)(iii), the individual shall be deemed to continue to be so qualified or eligible without the need for any annual or periodic application unless and until the individual notifies the State that the individual's eligibility conditions have changed so that the individual is no longer so qualified or eligible.''.

(2) CONFORMING AMENDMENT.—Section 1902(e)(8) (42 U.S.C. 1396a(e)(8)) is amended by striking the second sentence.

(b) USE OF SIMPLIFIED APPLICATION PROCESS.—Such section 1905(p) is further amended by adding at the end the following new paragraph:

''(7) A State shall permit individuals to apply to qualify as a qualified medicare beneficiary or for benefits under section 1902(a)(10)(E)(iii) through the use of the simplified application form developed under section 1905(p)(5)(A) and shall permit such an application to be made over the telephone, the Internet, or by mail, without the need for an interview in person by the applicant or a representative of the applicant.''.

(c) ROLE OF SOCIAL SECURITY OFFICES.—

(1) ENROLLMENT AND PROVISION OF INFORMATION AT SOCIAL SECURITY OFFICES.—Such section is further amended by adding at the end the following new paragraph:

''(8) The Commissioner of Social Security shall provide, through local offices of the Social Security Administration—

''(A) for the enrollment under State plans under this title for appropriate medicare cost-sharing benefits for individuals who qualify as a qualified medicare beneficiary or for benefits under section 1902(a)(10)(E)(iii); and

''(B) for providing oral and written notice of the availability of such benefits.''.

(2) CLARIFYING AMENDMENT.—Section 1902(a)(5) (42 U.S.C. 1396a(a)(5)) is amended by inserting ''as provided in section 1905(p)(10)'' before ''except''.

(d) OUTSTATIONING OF STATE ELIGIBILITY WORKERS AT SSA FIELD OFFICES.—Section 1902(a)(55) (42 U.S.C. 1396a(a)(55)) is amended—

(1) by striking ''subsection (a)(10)(A)(i)(IV), (a)(10)(A)(i)(VI), (a)(10)(A)(i)(VII), or (a)(10)(A)(ii)(IX)'' and inserting ''paragraph (10)(A)(i)(IV), (10)(A)(i)(VI), (10)(A)(i)(VII), (10)(A)(ii)(IX), or (10)(E)''; and

(2) in subparagraph (A), by inserting ''and in the case of applications of individuals for medical assistance under paragraph (10)(E), at locations that include field offices of the Social Security Administration''.

TITLE II—RURAL HEALTH CARE IMPROVEMENTS

SEC. 201. FAIRNESS IN THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT FOR RURAL HOSPITALS.

(a) EQUALIZING DSH PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1886(d)(5)(F)(vii) (42 U.S.C. 1395ww(d)(5)(F)(vii)) is amended by inserting '', and, after October 1, 2003, for any other hospital described in clause (iv),'' after ''clause (iv)(I)'' 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, 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 (xiii)'';

(ii) in subclause (III)—

(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)'';

(iii) in subclause (IV)—

(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 (xi)'';

(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 (xi)''; and

(v) in subclause (VI)—

(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)'';

(B) in clause (viii), by striking ''The formula'' and inserting ''For discharges occurring before October 1, 2003, the formula''; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking ''For purposes'' and inserting ''With respect to discharges occurring before October 1, 2003, for purposes''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2003.

SEC. 202. 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—

(1) in clause (iv), by inserting ''and ending on or before September 30, 2003,'' after ''October 1, 1995,''; and

(2) by redesignating clauses (v) and (vi) as clauses (vii) and (viii), respectively, and inserting after clause (iv) the following new clauses:

''(v) 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) 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 '', each of'';

(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 (II), 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 (II), by striking the period at the end and inserting ''; and''; 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 applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

''(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 inserting '', for fiscal years before fiscal year 1997,'' before ''a regional adjusted DRG prospective payment rate''; and

(B) 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,''.

SEC. 203. ESTABLISHMENT OF ESSENTIAL RURAL HOSPITAL CLASSIFICATION.

(a) CLASSIFICATION.—Section 1861(mm) (42 U.S.C. 1395x(mm)) is amended—

(1) in the heading by adding ''ESSENTIAL RURAL HOSPITALS'' at the end; and

(2) by adding at the end the following new paragraphs:

''(4)(A) The term 'essential rural hospital' means a subsection (d) hospital (as defined in section 1886(d)(1)(B)) that is located in a rural area (as defined for purposes of section 1886(d)), has more than 25 licensed acute care inpatient beds, has applied to the Secretary for classification as such a hospital, and with respect to which the Secretary has determined that the closure of the hospital would significantly diminish the ability of medicare beneficiaries to obtain essential health care services.

''(B) The determination under subparagraph (A) shall be based on the following criteria:

''(i) HIGH PROPORTION OF MEDICARE BENEFICIARIES RECEIVING CARE FROM HOSPITAL.—(I) A high percentage of such beneficiaries residing in the area of the hospital who are hospitalized (during the most recent year for which complete data are available) receive basic inpatient medical care at the hospital.

''(II) For a hospital with more than 200 licensed beds, a high percentage of such beneficiaries residing in such area who are hospitalized (during such recent year) receive specialized surgical inpatient care at the hospital.

''(III) Almost all physicians described in section 1861(r)(1) in such area have privileges at the hospital and provide their inpatient services primarily at the hospital.

''(ii) SIGNIFICANT ADVERSE IMPACT IN ABSENCE OF HOSPITAL.—If the hospital were to close—

''(I) there would be a significant amount of time needed for residents to reach emergency treatment, resulting in a potential significant harm to beneficiaries with critical illnesses or injuries;

''(II) there would be an inability in the community to stablize emergency cases for transfers to another acute care setting, resulting in a potential for significant harm to medicare beneficiaries; and

''(III) any other nearby hospital lacks the physical and clinical capacity to take over the hospital's typical admissions.

''(C) In making such determination, the Secretary may also consider the following:

''(i) Free-standing ambulatory surgery centers, office-based oncology care, and imaging center services are insufficient in the hospital's area to handle the outpatient care of the hospital.

''(ii) Beneficiaries in nearby areas would be adversely affected if the hospital were to close as the hospital provides specialized knowledge and services to a network of smaller hospitals and critical access hospitals.

''(iii) Medicare beneficiaries would have difficulty in accessing care if the hospital were to close as the hospital provides significant subsidies to support ambulatory care in local clinics, including mental health clinics and to support post acute care.

''(iv) The hospital has a committment to provide graduate medical education in a rural area.

''(C) QUALITY CARE.—The hospital inpatient score for quality of care is not less than the median hospital score for qualify 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.

A hospital classified as an essential rural hospital may not change such classification and a hospital so classified shall not be treated as a sole community hospital, medicare dependent hospital, or rural referral center for purposes of section 1886.''.

(b) PAYMENT BASED ON 102 PERCENT OF ALLOWED COSTS.—

(1) INPATIENT HOSPITAL SERVICES.—Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following:

''(11) In the case of a hospital classified as an essential rural hospital under section 1861(mm)(4) for a cost reporting period, the payment under this subsection for inpatient hospital services for discharges occurring during the period shall be based on 102 percent of the reasonable costs for such services. Nothing in this paragraph 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.''.

(2) HOSPITAL OUTPATIENT SERVICES.—Section 1833(t)(13) (42 U.S.C. 1395l(t)(13)) is amended by adding at the end the following new subparagraph:

''(B) SPECIAL RULE FOR ESSENTIAL RURAL HOSPITALS.—In the case of a hospital classified as an essential rural hospital under section 1861(mm)(4) for a cost reporting period, 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 this part or as waiving any requirement for billing for such services.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to cost reporting periods beginning on or after October 1, 2004.

SEC. 204. MORE FREQUENT UPDATE IN WEIGHTS USED IN HOSPITAL MARKET BASKET.

(a) MORE FREQUENT UPDATES IN WEIGHTS.—After revising the weights used in the hospital market basket under section 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 subsection (a), including an explanation of the reasons for, and options considered, in determining such frequency.

SEC. 205. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) INCREASE IN PAYMENT AMOUNTS.—

(1) IN GENERAL.—Sections 1814(l), 1834(g)(1), and 1883(a)(3) (42 U.S.C. 1395f(l); 1395m(g)(1); 42 U.S.C. 1395tt(a)(3)) are each amended by inserting ''equal to 102 percent of'' before ''the reasonable costs''.

(2) 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 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(A) in the heading—

(i) by inserting ''CERTAIN'' before ''EMERGENCY''; and

(ii) by striking ''PHYSICIANS'' and inserting ''PROVIDERS'';

(B) by striking ''emergency room physicians who are on-call (as defined by the Secretary)'' and inserting ''physicians, physician assistants, nurse practitioners, and clinical nurse specialists 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''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply with respect to costs incurred for services provided on or after January 1, 2004.

(c) MODIFICATION OF THE ISOLATION TEST FOR COST-BASED CAH AMBULANCE SERVICES.—

(1) IN GENERAL.—Section 1834(l)(8) (42 U.S.C. 1395m(l)), as added by section 205(a) of BIPA (114 Stat. 2763A–482), is amended by adding at the end the following: ''The limitation described in the matter following subparagraph (B) in the previous sentence shall not apply if the ambulance services are furnished by such a provider or supplier of ambulance services who is a first responder to emergencies (as determined by the Secretary).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to ambulances services furnished on or after the first cost reporting period that begins after the date of the enactment of this Act.

(d) REINSTATEMENT OF PERIODIC INTERIM PAYMENT (PIP).—

(1) IN GENERAL.—Section 1815(e)(2) (42 U.S.C. 1395g(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);

(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;''.

(2) DEVELOPMENT OF ALTERNATIVE METHODS OF PERIODIC INTERIM PAYMENTS.—With respect to periodic interim payments to critical access hospitals for inpatient critical access hospital services under section 1815(e)(2)(E) of the Social Security Act, as added by paragraph (1), the Secretary shall develop alternative methods for such payments that are based on expenditures of the hospital.

(3) REINSTATEMENT OF PIP.—The amendments made by paragraph (1) shall apply to payments made on or after January 1, 2004.

(e) CONDITION FOR APPLICATION OF SPECIAL PHYSICIAN PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1834(g)(2) (42 U.S.C. 1395m(g)(2)) is amended by adding after and below 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 must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians who have not assigned such billing rights.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall be effective as if included in the enactment of section 403(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–371).

(f) 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. 1395i–4(c)(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 subsection (f)) 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 on an annual, average basis, 96 hours per patient;''.

(2) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395i–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 with respect to designations made on or after October 1, 2004.

(g) ADDITIONAL 5-YEAR PERIOD OF FUNDING FOR GRANT PROGRAM.—

(1) IN GENERAL.—Section 1820(g) (42 U.S.C. 1395i–4(g)) is amended by adding at the end the following new paragraph:

''(4) FUNDING.—

''(A) IN GENERAL.—Subject to subparagraph (B), payment for grants made under this subsection during fiscal years 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. 1395i–4) is amended by striking subsection (j).

SEC. 206. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

(a) IN GENERAL.—Section 1886(h)(4) (42 U.S.C. 1395ww(h)(4)) is amended—

(1) in subparagraph (F)(i), by inserting ''subject to subparagraph (I),'' after ''October 1, 1997,'';

(2) in subparagraph (H)(i), by inserting ''subject to subparagraph (I),'' after ''subparagraphs (F) and (G),''; and

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

''(I) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

''(i) REDUCTION IN LIMIT BASED ON UNUSED POSITIONS.—

''(I) IN GENERAL.—If a hospital's resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (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 subclause (III) (or subclause (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 of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2002.

''(III) REFERENCE RESIDENT LEVEL.—Subject to subclause (IV), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during any of the reference periods.

''(IV) ADJUSTMENT PROCESS.—Upon the timely request of a hospital, the Secretary may adjust the reference resident level for a hospital to be the resident level for the hospital for the cost reporting period that includes July 1, 2003.

''(V) AFFILIATION.—With respect to hospitals which are members of the same affiliated group (as defined by the Secretary under subparagraph (H)(ii)), the provisions of this section shall be applied with respect to such an affiliated group by deeming the affiliated group to be a single hospital.

''(ii) 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 such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

''(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or 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 an increase under 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 the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

''(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 subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in 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 is deemed to be equal to the locality 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 (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

''(iii) RESIDENT LEVEL AND LIMIT DEFINED.—In this subparagraph:

''(I) RESIDENT LEVEL.—The term 'resident level' means, with respect to a hospital, the total number of full-time equivalent residents, before the application of weighting factors (as determined under this paragraph), in the fields of allopathic and osteopathic medicine for the hospital.

''(II) OTHERWISE APPLICABLE RESIDENT LIMIT.—The term 'otherwise applicable resident limit' means, with respect to a hospital, the limit otherwise applicable under subparagraphs (F)(i) and (H) on the resident level for the hospital determined without regard to this subparagraph.''.

(b) CONFORMING AMENDMENT TO IME.—Section 1886(d)(5)(B)(v) (42 U.S.C. 1395ww(d)(5)(B)(v)) is amended by adding at the end the following: ''The provisions of subparagraph (I) of subsection (h)(4) shall apply with respect to the first sentece of this clause in the same manner as it applies with

respect to subparagraph (F) of such subsection.''.

(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 limits under section 1886(h)(4)(I)(ii)(II) of the Social Security Act (as added by subsection (a)).

SEC. 207. TWO-YEAR EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS UNDER PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) HOLD HARMLESS PROVISIONS.—

(1) IN GENERAL.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(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)(5)(D)(iii)) located in a rural area'' after ''100 beds''; and

(C) by striking ''2004'' and inserting ''2006''.

(2) EFFECTIVE DATE.—The amendment made by subsection (a)(2) shall apply with respect to payment for OPD services furnished on and after January 1, 2004.

(b) STUDY; ADJUSTMENT.—

(1) STUDY.—The Secretary shall conduct a study to determine if, under the prospective payment system for hospital outpatient department services under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)), costs incurred by rural providers of services by ambulatory payment classification groups (APCs) exceed those costs incurred by urban providers of services.

(2) ADJUSTMENT.—Insofar as the Secretary determines under paragraph (1) that costs incurred by rural providers exceed those costs incurred by urban providers of services, the Secretary shall provide for an appropriate adjustment under such section 1833(t) to reflect those higher costs by January 1, 2005.

SEC. 208. EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES FROM THE PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES.

(a) IN GENERAL.—Section 1888(e)(2)(A) (42 U.S.C. 1395yy(e)(2)(A)) is amended—

(1) in clause (i)(II), by striking ''clauses (ii) and (iii)'' and inserting ''clauses (ii), (iii), and (iv)''; and

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

''(iv) EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Services described in this clause are—

''(I) rural health clinic services (as defined in paragraph (1) of section 1861(aa)); and

''(II) Federally 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.''.

(b) CERTAIN SERVICES FURNISHED BY AN ENTITY JOINTLY OWNED BY HOSPITALS AND CRITICAL ACCESS HOSPITALS.—For purposes of applying section 411.15(p)–(3)(iii) of title 42 of the Code of Federal Regulations, the Secretary shall treat an entity that is 100 percent owned as a joint venture by 2 Medicare-participating hospitals or critical access hospitals as a Medicare-participating hospital or a critical access hospital.

(c) TECHNICAL AMENDMENTS.—Sections 1842(b)(6)(E) and 1866(a)(1)(H)(ii) (42 U.S.C. 1395u(b)(6)(E); 1395cc(a)(1)(H)(ii)) are each amended by striking ''section 1888(e)(2)(A)(ii)'' and inserting ''clauses (ii), (iii), and (iv) of section 1888(e)(2)(A)''.

(d) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to services furnished on or after January 1, 2004.

SEC. 209. RECOGNITION OF ATTENDING NURSE PRACTITIONERS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.

(a) IN GENERAL.—Section 1861(dd)(3)(B) (42 U.S.C. 1395x(dd)(3)(B)) is amended by inserting ''or nurse practitioner (as defined in subsection (aa)(5))'' after ''the physician (as defined in subsection (r)(1))''.

(b) PROHIBITION ON NURSE PRACTITIONER CERTIFYING NEED FOR HOSPICE.—Section 1814(a)(7)(A)(i)(I) (42 U.S.C. 1395f(a)(7)(A)(i)(I)) is amended by inserting ''(which for purposes of this subparagraph does not include a nurse practitioner)'' after ''attending physician (as defined in section 1861(dd)(3)(B))''.

SEC. 210. IMPROVEMENT IN PAYMENTS TO RETAIN EMERGENCY CAPACITY FOR AMBULANCE SERVICES IN RURAL AREAS.

Section 1834(l) (42 U.S.C. 1395m(l)) is amended—

(1) by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A–486), as paragraph (9); and

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

''(10) ASSISTANCE FOR RURAL PROVIDERS FURNISHING SERVICES IN LOW MEDICARE POPULATION DENSITY AREAS.—

''(A) IN GENERAL.—In the case of ground ambulance services furnished on or after January 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, estimate the average increase in cost per trip for such services as compared with the cost per trip for the average ambulance service.

''(B) QUALIFIED RURAL AREA DEFINED.—For purposes of subparagraph (A), the term 'qualified rural area' is a rural area (as defined in section 1886(d)(2)(D)) with a population density of medicare beneficiaries residing in the area that is in the lowest three quartiles of all rural county populations.''.

SEC. 211. THREE-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))) during 2004, 2005, and 2006, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 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 subsection (a).

SEC. 212. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDERSERVED POPULATIONS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a–7(b)(3)), as amended by section 101(b)(2), is amended—

(1) in subparagraph (F), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (G), by striking the period at the end and inserting ''; and''; and

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

''(H) any remuneration between a public or nonprofit private health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, donations or loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.''.

(b) RULEMAKING FOR EXCEPTION FOR HEALTH CENTER ENTITY ARRANGEMENTS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish, on an expedited basis, standards relating to the exception described in section 1128B(b)(3)(H) 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 standards 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 results in savings of Federal grant funds or increased revenues to the health center entity.

(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.

(2) INTERIM FINAL EFFECT.—No 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). Such rule shall be effective and final immediately on an interim basis, subject to such change and revision, after public notice and opportunity (for a period of not more than 60 days) for public comment, as is consistent with this subsection.

SEC. 213. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services in different geographic areas. Such study shall include—

(1) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

(2) an evaluation of the measures used for such adjustment, including the frequency of revisions; and

(3) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component.

(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 subsection (a). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

SEC. 214. TREATMENT OF MISSING COST REPORTING PERIODS FOR SOLE COMMUNITY HOSPITALS.

(a) IN GENERAL.—Section 1886(b)(3)(I) (42 U.S.C. 1395ww(b)(3)(I)) is amended by adding at the end the following new clause:

''(iii) In no case shall a hospital be denied treatment as a sole community hospital or payment (on the basis of a target rate as such as a hospital) because data are unavailable for any cost reporting period due to changes in ownership, changes in fiscal intermediaries, or other extraordinary circumstances, so long as data for at least one applicable base cost reporting period is available.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost reporting periods beginning on or after January 1, 2004.

SEC. 215. EXTENSION OF TELEMEDICINE DEMONSTRATION PROJECT.

Section 4207 of Balanced Budget Act of 1997 (Public Law 105–33) is amended—

(1) in subsection (a)(4), by striking ''4-year'' and inserting ''8-year''; and

(2) in subsection (d)(3), by striking ''$30,000,000'' and inserting ''$60,000,000''.

SEC. 216. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX 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—

(1) by striking ''WAGE LEVELS.—The Secretary'' and inserting ''WAGE LEVELS.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary''; and

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

''(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2004.—

''(I) IN GENERAL.—Except as provided in subclause (II), for discharges occurring on or after October 1, 2003, the Secretary shall substitute the '62 percent' for the proportion described in the first sentence of clause (i).

''(II) HOLD HARMLESS FOR CERTAIN HOSPITALS.—If the application of subclause (I) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this 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 previous sentence for any period as if the amendments made by section 202(a) of the Medicare Rx Now Act of 2003 had not been enacted.''.

SEC. 217. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC ADJUSTMENTS OF PAYMENTS FOR PHYSICIANS' SERVICES.

Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)) is amended—

(1) in subparagraph (A), by striking ''subparagraphs (B) and (C)'' and inserting ''subparagraphs (B), (C), (E), and (F)''; and

(2) by adding at the end the following new subparagraphs:

''(E) FLOOR FOR WORK 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)(iii), the Secretary shall increase the work geographic 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 'applicable floor index' means—

''(I) 0.980 with respect to services furnished during 2004; and

''(II) 1.000 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, 2005, 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.''.

Ms. PRYCE of Ohio. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore (Mr. LATOURETTE). The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Ms. SLAUGHTER. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

Pursuant to clauses 8 and 9 of rule XX, this 15-minute vote on ordering the previous question will be followed by 5-minute votes on adopting the resolution, if ordered, and on adopting House Resolution 297 which was debated earlier today.

The vote was taken by electronic device, and there were—yeas 226, nays 203, not voting 6, as follows:

[Roll No. 321]

YEAS—226

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NAYS—203

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Emerson
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff

Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velazquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—6

Brown-Waite, Ginny
Cummings
Gephardt
Johnson (CT)
McInnis
Smith (WA)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in this vote.

□ 1436

Mr. SANDLIN and Mr. TURNER of Texas changed their vote from ''yea'' to ''nay.''

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. LATOURETTE). The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Ms. SLAUGHTER. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote, followed by a second 5-minute vote on the question of adoption of House Resolution 297 debated earlier today.

The vote was taken by electronic device, and there were—ayes 221, noes 203, not voting 11, as follows:

[Roll No. 322]

AYES—221

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Hall
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Young (AK)
Young (FL)

NOES—203

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Bartlett (MD)
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Flake
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hefley
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Ryan (OH)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Toomey
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velazquez
Visclosky
Waters
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—11

Carter
Gephardt
Gutknecht
Istook
Jones (NC)
Matsui
McInnis
Rush
Smith (WA)
Watson
Wolf

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 1444

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore. Pursuant to section 6 of House Resolution 299 and clause 1 of rule XXI, all points of order are reserved against provisions contained in the bill making appropriations for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes.

PROVIDING FOR CONSIDERATION OF MOTIONS TO SUSPEND THE RULES

The SPEAKER pro tempore. The pending business is the question of agreeing to the resolution, House Resolution 297.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. MCGOVERN. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 226, noes 203, not voting 5, as follows:

[Roll No. 323]

AYES—226

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Crane
Crenshaw
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest