Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Frelinghuysen
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Goode
Goodlatte
Goss
Graham
Granger
Graves
Green (WI)
Greenwood
Grucci
Gutknecht
Hansen
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hilleary
Hobson
Hoekstra
Horn
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
Kerns
King (NY)
Kingston
Kirk
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCrery
McHugh
McInnis
McKeon
Mica
Miller, Dan
Miller, Gary
Miller, Jeff
Moran (KS)
Morella
Myrick
Nethercutt
Ney
Northup
Norwood
Nussle
Osborne
Ose
Otter
Paul
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Reynolds
Riley
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schaffer
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Stump
Sullivan
Sununu
Sweeney
Tancredo
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Tiberi
Toomey
Upton
Vitter
Walden
Walsh
Wamp
Watkins (OK)
Watts (OK)
Weldon (FL)
Weller
Whitfield
Wicker
Wilson (NM)
Wolf
Wu
Young (AK)
Young (FL)

NOT VOTING—6

Engel
Oxley
Roukema
Traficant
Weldon (PA)
Wilson (SC)

□ 2034

Messrs. SOUDER, SHADEGG, BURR of North Carolina, and WU changed their vote from ''yea'' to ''nay.''

Mr. ROTHMAN and Mr. DELAHUNT changed their vote from ''nay'' to ''yea.''

So the motion to commit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the passage of the Senate bill.

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

RECORDED VOTE

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

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 215, noes 214, answered ''present'' 1, not voting 5, as follows:

[Roll No. 279]

AYES—215

Aderholt
Akin
Armey
Bachus
Baker
Ballenger
Barton
Bass
Bereuter
Biggert
Bilirakis
Blunt
Boehlert
Boehner
Bonilla
Bono
Boozman
Brady (TX)
Brown (SC)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Cannon
Cantor
Capito
Castle
Chabot
Chambliss
Coble
Collins
Combest
Cooksey
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal
DeLay
DeMint
Diaz-Balart
Doolittle
Dreier
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Frelinghuysen
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Goodlatte
Goss
Graham
Granger
Graves
Green (WI)
Greenwood
Grucci
Gutknecht
Hall (TX)
Hansen
Hart
Hastert
Hastings (WA)
Hayworth
Hefley
Herger
Hilleary
Hobson
Hoekstra
Horn
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Keller
Kelly
Kennedy (MN)
Kerns
King (NY)
Kingston
Kirk
Knollenberg
Kolbe
Kucinich
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCrery
McHugh
McInnis
McKeon
Mica
Miller, Dan
Miller, Gary
Miller, Jeff
Morella
Myrick
Nethercutt
Ney
Northup
Norwood
Nussle
Osborne
Ose
Otter
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Reynolds
Riley
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schaffer
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Smith (WA)
Souder
Stearns
Stump
Sullivan
Sununu
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Tiberi
Toomey
Upton
Vitter
Walden
Walsh
Watkins (OK)
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOES—214

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldacci
Baldwin
Barcia
Barr
Barrett
Becerra
Bentsen
Berkley
Berman
Berry
Bishop
Blagojevich
Blumenauer
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Capps
Capuano
Cardin
Carson (IN)
Carson (OK)
Clay
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Cramer
Crowley
Cummings
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley
Doyle
Duncan
Edwards
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank
Frost
Gephardt
Gonzalez
Goode
Gordon
Green (TX)
Gutierrez
Hall (OH)
Harman
Hastings (FL)
Hill
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind (WI)
Kleczka
LaFalce
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Luther
Lynch
Maloney (CT)
Maloney (NY)
Markey
Mascara
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Mink
Mollohan
Moore
Moran (KS)
Moran (VA)
Murtha
Nadler
Napolitano
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Peterson (MN)
Phelps
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Ross
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schakowsky
Schiff
Scott
Serrano
Sherman
Shows
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Thurman
Tierney
Towns
Turner
Udall (CO)
Udall (NM)
Velazquez
Visclosky
Wamp
Waters
Watson (CA)
Watt (NC)
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

ANSWERED ''PRESENT''—1

Bartlett

NOT VOTING—5

Engel
Hayes
Oxley
Roukema
Traficant

□ 2047

Mrs. TAUSCHER changed her vote from ''present'' to ''no.''

So the Senate bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Mr. HAYES. Mr. Speaker, on rollcall No. 279 I was detained on the floor by legislative business. Had I voted, I would have voted ''present.''

MEDICARE MODERNIZATION AND PRESCRIPTION DRUG ACT OF 2002

Mr. LINDER. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 465 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 465

Resolved, That upon the adoption of this resolution it shall be in order without intervention of any point of order (except those arising under section 302(f) of the Congressional Budget Act of 1974) to consider in the House the bill (H.R. 4954) 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 and reform payments and the

regulatory structure of the Medicare Program, and for other purposes. The bill shall be considered as read for amendment. In lieu of the amendment recommended by the Committee on Ways and Means, the amendment in the nature of a substitute printed in the report of the Committee on Rules accompanying this resolution shall be considered as adopted. All points of order against the bill, as amended, are waived. The previous question shall be considered as ordered on the bill, as amended, to final passage without intervening motion except: (1) two hours of debate on the bill, as amended, with one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means and one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Energy and Commerce; and (2) one motion to recommit with or without instructions.

The SPEAKER pro tempore (Mr. SIMPSON). The gentleman from Georgia (Mr. LINDER) is recognized for 1 hour.

Mr. LINDER. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentlewoman from New York (Mrs. SLAUGHTER), pending which I yield myself such time as I may consume.

Mr. Speaker, H. Res. 465 is a closed rule that provides 2 hours of debate in the House, with 1 hour equally divide and controlled by the chairman and ranking minority member of the Committee on Ways and Means and 1 hour equally divided and controlled by the chairman and ranking minority member of the Committee on Energy and Commerce.

H. Res. 465 waives all points of order against consideration of the bill, except those arising under section 302(f)of the Congressional Budget Act of 1974. H. Res. 465 provides that in lieu of the amendment recommended by the Committee on Ways and Means, the amendment in the nature of a substitute printed in the report of the Committee on Rules accompanying this resolution shall be considered as adopted.

The rule waives all points of order against the bill as amended and provides one motion to recommit, with or without instructions.

Mr. Speaker, I urge my colleagues to join me in approving this rule so that the full House can proceed to consider this important Medicare reform legislation. The underlying bill is critically important legislation that is designed to provide much-needed financial assistance to seniors to ease the burden of the rising costs of prescription drugs.

H.R. 4954 seeks to improve the Medicare program by introducing free market forces in order to bring down drug prices and medical costs overall by introducing competition to a program that currently has none.

In addition to unleashing market forces on prescription drug prices, the bill seeks to move the Medicare+Choice program into a more competitive structure, the durable medical equipment and off-the-shelf orthotics are subject to competitive bidding and, finally, Medicare contractors will bid competitively for business. All of these reform elements will help move Medicare in the right direction, and our seniors will surely reap the benefits of a more consumer-friendly and patient-sensitive Medicare.

The House voted on similar legislation in the 106th Congress but was unable to reach agreement with the other body and the Clinton White House in order to enact a law to help our seniors. Well, with our new administration under President Bush now in office, I believe the House of Representatives needs to seize the historic opportunity to move a Medicare prescription drug benefit proposal through the 107th Congress in order to give our President a chance to sign such important legislation into law.

I applaud the hard work and leadership of my friends and colleagues, the gentleman from California (Mr. THOMAS), the chairman of the Committee on Ways and Means, and the gentleman from Louisiana (Mr. TAUZIN), the chairman of the Committee on Energy and Commerce, and their respective ranking members in bringing this legislation to the House floor today.

I urge my colleagues on both sides of the aisle to support H. Res. 465, a rule that will allow the House to consider and pass legislation that will improve the lives of millions of seniors across the country by providing them affordable prescription drugs.

Mr. Speaker, I neglected to say earlier that all time yielded in the pursuit of passage of the rule is yielded for the purpose of debate only.

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

Ms. SLAUGHTER. Mr. Speaker, I thank the gentleman from Georgia 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, with the rule before us today, this body is being asked to hand over one of the most popular government programs in history to private insurance companies. Medicare is a critical program, a program that benefits a wide spectrum of our constituents and one that American families have come to depend on for their loved ones in need. But today, in a cynical nod to the pharmaceutical industry, the leadership has shut out any meaningful debate. No Democrat substitute will be allowed, no amendments to guarantee affordable prescription drugs for our seniors will be permitted, and anyone voicing dissent has been silenced.

□ 2100

Indeed, in the wee hours of this morning in the Committee on Rules, one of my colleagues made it clear that he wanted the free market to determine drug prices, and declared that Medicare was, attention, a Soviet-style program, echoing the sentiment made by his former leader, Newt Gingrich, that Medicare should be allowed ''to wither on the vine.''

Make no mistake: the contempt for Medicare runs deep within this leadership, as it does for other vital social programs. By calling Medicare Soviet-style, we can be certain that this is not a mandate to ensure the future of the program, but rather, the opposite.

Mr. LINDER. Mr. Speaker, will the gentlewoman yield? She is misquoting something I said, and I would like to respond to it.

The SPEAKER pro tempore (Mr. LATOURETTE). The gentleman has not been yielded to.

Mr. LINDER. Will the gentlewoman yield?

Ms. SLAUGHTER. No, I want to finish my statement.

Mr. LINDER. She referred directly.

The SPEAKER pro tempore. The time is controlled by the gentlewoman from New York.

Ms. SLAUGHTER. But rather the opposite, a call to leave seniors to the mercies of the private sector and the free market, rather than guarantee them livable, affordable health care.

My constituents and others around the Nation are reeling from public programs that have been turned over to the so-called free market. Utility rates, cable rates, you name it, the free market has ensured exorbitant prices with diminished service. Pensions and retirement security have taken a similar beating.

Moreover, the timing of this proposal could not be worse. The proposal places the program in the private sector at a time when private insurers have dropped Medicare+Choice beneficiaries by the thousands.

Private insurers will inevitably alter plans and move in and out of markets, leading to unpredictability for our seniors. A given drug might be covered one month, but not the next. Premiums could double from year to year without warning.

The rule before us is one of the most heavy-handed procedures to come out of the Committee on Rules, and given the last few weeks, that is saying something. Amendment after amendment was blocked from floor consideration.

My colleague, the gentlewoman from Florida (Mrs. THURMAN), and the gentleman from Maine (Mr. ALLEN) had a remarkably sensible idea of requiring that prescription drug plans negotiate with pharmaceuticals for lower prescription drug prices, a necessity before we put a Federal program on top of them. Canada does it, and France does it, Germany, Italy, Japan, Britain.

Virtually every developed country in the world has committed itself to negotiating lower drug prices for its citizens. Even the United States demonstrated remarkable success when negotiating Cipro prices during the anthrax attacks last fall.

But under this rule, this very sensible amendment will not be permitted.

This is even more remarkable when we consider that the underlying bill prohibits the Federal Government from pushing for lower prescription prices.

My colleagues, the gentleman from New Jersey (Mr. PALLONE) and the gentlewoman from California (Mrs. CAPPS), attempted to ensure that all seniors have the option of prescription drug coverage, especially in those geographic areas where insurance companies choose not to offer a plan. Under the current bill, there is no guarantee that seniors will have access to coverage at all if insurers should decide not to cover their area.

The amendment will never see the light of day, however, under this rule. Instead, we are left with a fundamentally flawed document that fails our constituents on every level. The proposed plan would be administered through either HMOs or drug-only insurance plans.

The fact that drug-only insurance plans do not exist in the private market does not deter proponents from their privatization agenda. In fact, they are so bent on privatizing the drug benefit that they are prepared to bribe private plans with a subsidy as large as 99.99 percent in order to get them to offer drug coverage to seniors, regardless of the quality of the service or extent of the benefit.

Mr. Speaker, a little more history may be in order. The Medicare program was originally created because the private sector did not offer affordable and reliable health insurance to the elderly and the disabled. Health care has certainly changed in the past 30 years, but what has not changed is the fact that the private market does not want to ensure people who are old, disabled, and likely to need care.

Mr. Speaker, the inadequacies in this bill continue, and I will highlight them briefly. The measure penalizes seniors who receive aid with prescription drug costs from charitable, church, or State programs by not counting the costs paid by those parties toward the individual's Medicare deductible.

Seniors may actually have to drop out of programs like New York's Elderly Prescription Insurance Coverage, the EPIC program, in an attempt to obtain their Medicare benefits.

The proposal has numerous gaps that leave seniors without coverage while requiring them to pay premiums. For example, earlier this month I received a letter from a 71-year-old constituent who must take medication to prevent a recurrence of a potentially dangerous, deadly fungal lung infection. The drug costs her nearly $1,000 a month. Under the majority plan, this woman would still pay well over $3,000 a year for this medication, and in addition, she would have to drop out of New York's program, which is currently helping her with these expenses.

The proposal includes copayments, premiums, and deductibles that will be unaffordable for many low- and middle-income seniors. The $35-per-month premium is a suggested amount and certainly not a guarantee. Insurers could choose to charge double or triple that amount if they chose to.

The bill is opposed by numerous respected organizations, including the National Council on Aging, AARP, Families U.S.A., and the National Committee to Preserve Social Security and Medicare.

Mr. Speaker, the majority has taken the proverbial sow's ear and is trying to convince America it is a silk purse. My constituents are not fooled, and I hope my colleagues will not be, either.

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, I express my opposition to this sham bill that is harmful to senior women.

Mr. Speaker, studies show that older women live an average of six years longer than men. Often widowed and living alone, the average woman age 65 and older struggles to survive on an annual income of $15,615.

During her lifetime she probably spent 17 years out of the workforce caring for children, and perhaps 18 years caring for elderly parents. Her retirement income is also smaller because she probably did not receive a pension, and was paid less than most men.

As a result, she receives lower Social Security benefits. She spends a larger percentage of her income on housing costs—leaving less money for necessary expenses like utilities, food, and health care. This is a particularly difficult problem because the average older woman spends 20 percent of her income each year on out-of-pocket health care costs.

Even though Medicare is not typically thought of as a woman's program, it's central to a woman's well-being. Because women live longer than their male counterparts, they also rely on Medicare and its benefits longer.

While Medicare provides women with critical access to health care, gaps in the program leave women vulnerable to unaffordable out-of-pocket-costs. According to the Kaiser Family Foundation, women account for nearly 7 in 10 Medicare beneficiaries with incomes below the poverty level.

Similarly, access to affordable prescription drugs is a woman's issue. Why? Because women make up a large portion of consumers purchasing prescription drugs.

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. In addition, because of age, women report more chronic conditions that require ongoing treatment, accompanied by a regimen of costly drugs.

As the costs of prescription drugs continue to rise these out-of-pocket expenses will continue to take a higher percentage of older women's limited monthly income. Where do we draw the line? When will we enact a drug benefit that will allow all seniors to live out their lives without being forced to choose between food or medicine?

It's time we start considering women's needs when we debate prescription drug proposals.

Sadly, the GOP's Medicare modernization plan will only perpetuate persistent health care disparities among women because it creates new gaps in coverage.

If the GOP plan prevails, seniors won't feel any more certain about their benefits—in fact, the GOP proposal allows plans to vary their benefits and premiums from one region to another; from one plan to another and, the GOP plan provides no guarantees. Their plan would privatize prescription drug plans like an HMO . . . not put the plan under Medicare. Our seniors need more stability and certainty than that—especially older women who are counting on Congress to provide a real solution to the high cost of prescription drugs.

Women are major stakeholders in the debate over Medicare's future and a prescription drug benefit. Policies that expand access to outpatient prescription drugs and long-term care would help fill coverage gaps that drive up out-of-pocket spending for women.

Conversely, policies that erode coverage or that shift costs to beneficiaries could affect women, especially those with low incomes.

Older women are one of the nation's most at-risk gropus, and a prescription drug benefit must meet their needs. Understanding the full implications of proposed reforms for aging women must be an essential component of efforts to preserve and protect medicare for generations to come.

Under the GOP plan, there will be no real winners—only struggling survivors, seniors who manage to make ends meet.

For my constituents and the older women in this country, merely getting by is not good enough, so instead, let's make everyone a winner by enacting a prescription drug benefit that guarantees seniors and women real assistance.

After a lifetime of taking care of their families, older women deserve better than what the Republican leadership is proposing. That's why I strongly urge my colleagues to stop further debate on this sham of a proposal and get serious about providing genuine relief to Medicare recipients.

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

(Mrs. JONES of Ohio asked and was given permission to revise and extend her remarks.)

Mrs. JONES of Ohio. Mr. Speaker, I express my opposition to this bill that is particularly harmful to senior women, like my mother.

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, I express my opposition to this sham bill that is particularly harmful to senior women. This is a shame.

Ms. SLAUGHTER. 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 express my opposition to this bill that does not allow senior women to be able to afford to live, particularly those senior women who suffer from cardiovascular disease.

Mr. Speaker, I rise in support of the American people. The same American people who have been paying too much for prescription drugs and have been waiting for years for Congress to pass a fair Medicare prescription drug benefit. This plan that the Republican leadership has brought to the floor is a sham.

Where is the benefit for our seniors who are living on a fixed income and cannot afford such a high co-payment? 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 that are needed for a better quality of life.

The costs of prescription drugs for seniors are rising at a rate greater than that of inflation.

Senior women must be accounted for and given a platform regarding prescription drug benefits because they make up almost 60% of the Medicare population. Without affordable benefits, women will be forced to pay extremely high costs for prescription drugs that they already struggle to afford.

We need a plan that makes prescription drugs more affordable for the people who cannot live without these products. What the Republicans are proposing is not help for seniors, but more heartache.

The ''plan'' the Republicans have drawn up would not be a benefit to anyone except the insurance companies.

Forcing Medicare recipients into private plans which cover less than half of the costs of prescription drugs is not a benefit?

A plan that forces Medicare recipients to pay for a gap in coverage of at least $1,800 a year is not a benefit!

A plan that does not guarantee the same coverage for the entire country, that seniors in Indiana could pay a higher premium than those in a different part of the country, is not a benefit!

There are over 844,835 people on Medicare in my state of Indiana. That is 14% of the population. 44% of these people are under 200% of the federal poverty level. I will not go home and tell them that I gave away their security to a private company trying to make money off of their health.

Prescription drug benefits are particularly crucial for women because they tend to live an average of 6 years longer than men and are more likely to suffer from prolonged chronic illness. Senior women have a longer period of time to incur out of pocket cost to pay for prescription drugs and deserve to be provided with considerable benefits.

Not only do women tend to live longer than men, but they are also at an unfair disadvantage where their income is concerned. The average annual income for women age 65 and older is $15,615, which is only half of the annual income of men. Recent surveys indicate that eight out of ten women on Medicare, approximately 17 million women, use prescription drugs regularly and most pay for these medications themselves. Senior women have a limited income and must receive affordable prescription drug benefits that they can rely on.

How dare the Republicans try to give to the seniors of this country a plan that is not equal to what they receive as Members of Congress! They have stated over and over that seniors deserve the same coverage as Members of Congress.

When the non-partisan Congressional Research Service did a comparison of the drug benefit under the Blue Cross-Blue Shield Standard option available to Federal Employees to the Democrat and Republican prescription drug plans, they found that the Republican plan would give about 40% of the coverage Members of Congress receive, but the Democratic plan would give comparable coverage.

In addition, when given the opportunity to rectify this gap in coverage, the Republicans on the Committee voted against giving this same coverage.

Whay type of thinking is this?

Give the minority a voice! Let there be a vote on the Democratic Medicare Prescription Drug benefit, a plan that actually helps seniors and does not hurt them!

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 express my opposition to this shameful bill that is particularly harmful to our senior women who live longer and have the largest consumption of purchases of drugs.

PARLIAMENTARY INQUIRY

Mr. LINDER. Parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore. The gentleman from Georgia will state his parliamentary inquiry.

Mr. LINDER. Mr. Speaker, at what point does this series of speeches become credited against their time?

The SPEAKER pro tempore. After their request for unanimous consent to revise and extend their remarks in opposition, the Chair will count against the minority's time any speeches that are given. To this point, the Chair has not heard any.

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

(Mrs. MINK of Hawaii asked and was given permission to revise and extend her remarks.)

Mrs. MINK of Hawaii. Mr. Speaker, I rise on behalf of my constituents to oppose the rule and the passage of this bill as a fatal step towards privatization of Social Security.

Mr. Speaker, I rise today to urge my colleagues to oppose the Republican's prescription drug benefit plan because it does not provide a meaningful prescription drug benefit.

There are 40 million elderly and disabled people enrolled in Medicare. They need Medicare to obtain basic health care coverage. Unfortunately, the program has a very limited prescription drug benefit. Since Congress created Medicare in 1965, it has struggled to find a way to create an adequate prescription drug benefit.

Prescription drug expenditures have grown at a double-digit rate almost every year since 1980. Congress needs to act now to help those currently in the system and the estimated 77 million Americans who will be in Medicare by 2030. These Americans expect to obtain affordable prescription drugs through Medicare. Congress cannot wait any longer. It must create a prescription drug benefit.

Even though creating a prescription drug benefit is one of the most important bills of this Congress, the Republican leadership has prohibited members of the House from offering amendments or even voting on the Democrat's substitute. Since the Republicans began their rule, they have imposed ''gag'' rules to prevent a full debate on may important issues. In a chamber dedicated to the principles of democracy and a free and open debate, it is unacceptable for the Republican leadership to prevent members from even considering other prescription drug plans or amending the Republican plan. The House should have an opportunity to amend the bill created by the Republican leadership because it is flawed. It is not a guaranteed Medicare benefit. It relies on HMOs and other private insurance companies, who may restrict benefits at any time.

The Republican's bill (H.R. 4954) does not create a defined prescription drug benefit under Medicare. It subsidizes private insurance companies, who will offer prescription drug coverage to Medicare beneficiaries. This plan leaves the elderly alone in a fight with private insurance companies to obtain the prescription drug coverage they need.

H.R. 4954 does not specifically define the type of benefit that insurance companies must provide. The insurance companies can create strict rules that limit access to certain expensive drugs that could hurt a company's bottom line. Doctors will prescribe medicine without any assurance that seniors will be able to obtain them through their private insurer.

Additionally, insurance companies can limit which pharmacies participate in their network. Seniors in rural areas may be forced to travel many miles to find a pharmacy that is ''acceptable'' to their private insurance provider.

By relying on private insurers, the elderly will not even know how much their monthly premium will cost. The Republicans think it will be $35 per month. It might be higher. It might be lower. Premiums could vary from county to county and year to year. The monthly premiums in the Republican's prescription drug benefit plan could rise beyond the resources of the disabled and the elderly. In Nevada, the only state where a similar plan is offered, premiums exceed $80 per month.

The Republican plan does not provide sufficient coverage. It covers less than a quarter of Medicare beneficiaries' estimated drug costs over the next 10 years, and the complicated coverage formula has a large hole. After providing partial coverage on the first $2,000 seniors spend on prescription drugs, the Republican plan does not provide any additional help until they pay $3,800. It does not cover expenses between $2,000 and $3,800. The elderly must find a way to pay for these expenses by themselves.

America needs a prescription drug plan that truly helps the elderly obtain the drugs they desperately need. We do not need a plan that exposes Medicare beneficiaries to the whims of private insurance companies who are more interested in profits than providing comprehensive benefits.

Under the Democratic proposal, which the Republicans refused to debate: the monthly

premium is locked in at $25, the annual deductible is only $100, Medicare pays 80% of seniors' drug costs up to $2,000, and there is a $2,000 out-of-pocket limit per beneficiary per year.

The Democratic proposal fully integrates prescription drug benefits into the Medicare program. It allows the elderly to rely on their governmental prescription drug benefit, rather than depending on the generosity of profit driven insurance companies.

This House has an opportunity to pass legislation to help disabled and elderly women obtain affordable prescription drugs. I urge my colleagues to support the Democratic plan to create a simple prescription drug plan that helps all seniors pay for the skyrocketing cost of prescription drugs. I urge my colleagues to vote against the Republican bill because it fails to do this.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. The Chair would advise the gentlewoman from New York that one came close to debate.

Ms. SLAUGHTER. Mr. Speaker, we will watch it.

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

(Ms. ROYBAL-ALLARD asked and was given permission to revise and extend her remarks.)

Ms. ROYBAL-ALLARD. Mr. Speaker, I rise to express my strong opposition to this irresponsible bill that is particularly harmful to women.

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

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

Mrs. THURMAN. Mr. Speaker, I express my opposition to this rule and to this sham bill that is particularly harmful to senior women.

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

(Mrs. MCCARTHY of New York asked and was given permission to revise and extend her remarks.)

Mrs. MCCARTHY of New York. Mr. Speaker, I express my opposition to this sham bill that is particularly harmful to senior women.

I have seen much in my lifetime, but nothing like the blatant disregard for America's seniors by House Republican Leadership. Prescription Drugs is a life and death issue affecting millions of seniors.

This body should not be forced to debate a bill severaly lacking in substance and without even the opportunity for a discussion on an alternative.

Unfortunately, there is no room for discussion.

There is no room for options.

There is no chance for an open, constructive and spirited debate on what America's seniors need most—a Prescription Drug Benefit under Medicare.

The bill before us today is nothing but a SHAM proposal, which does nothing to provide a real, guaranteed prescription drug benefit to our nation's seniors.

I was a nurse before I came to Congress. Let me tell you what this bill does not do for America's seniors.

This bill does not bring down the cost of prescription drugs.

This bill does not guarantee a prescription drug benefit for seniors; and This bill does not guarantee coverage for any drug prescribed by their doctor.

What the bill does do, however, is to provide benefits to insurance companies.

As a nurse, the worst aspect of this bill to me is that the higher your drug bills get, the less help you get with paying those bills.

Our seniors deserve a plan that is guaranteed and affordable. They should not have to worry about coverage gaps, or which pharmacy they can go to for their prescription drugs.

And they certainly shouldn't be limited to which drugs their doctor can prescribe.

We owe our seniors more than vague promises. We owe them a prescription drug benefit that will be there whenever they need it, and for whatever drug their doctor prescribes.

We owe it to the American people not to support this sham Prescription Drug Bill.

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

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

Mrs. TAUSCHER. Mr. Speaker, I express my opposition to this sham bill that is particularly harmful to senior women, my sisters, and my mother.

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

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

Ms. KILPATRICK. Mr. Speaker, I express my opposition to this sham Republican bill that is harmful to women all over America.

Mr. Speaker, I rise today to stress the importance of providing a meaningful prescription drug benefit for seniors in our nation. We have paid lip service for too long and now is the time for Members of Congress to deliver good on our word.

However, while we need to enact a prescription drug coverage under Medicare, we cannot afford to enact a benefit that is anything less than what seniors deserve—a meaningful benefit that is voluntary and universal and will provide seniors with affordable prescription drugs. The plan that Republicans plan to offer does not meet these important goals.

Most importantly, the proposed Republican plan does not provide seniors with the promise of guaranteed universal coverage. What does this mean? The Republican plan relies on private insurance plans or Medicare HMOs to offer prescription drug coverage to seniors and offers no concrete or strict guidelines for benefits. Simply put, Republicans have put the industry's interests above those of seniors. Seniors will be given no guarantee of meaningful drug coverage and will be at the mercy of the private industry. Seniors have worked too hard and contributed too much to this nation for us to give them anything but the best we can. And, Mr. Speaker, the Republican plan is definitely not the best we can do—it is far from it.

Democrats are committed to providing a universal, comprehensive drug benefit through Medicare for all seniors. We also are committed to addressing the high cost of prescription drugs that have skyrocketed out of control. It is time for Congress to deliver on our promise and provide seniors with a true prescription drug benefit. Anything less is unsatisfactory.

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, I express my opposition to this sham bill that is particularly harmful to senior women.

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

Ms. BROWN of Florida. Mr. Speaker, I ask unanimous consent to revise and extend my remarks, and I rise against this shameful GOP prescription drug so-called benefit that is very much against my grandmother and all of the grandmothers in this country.

Mr. CUNNINGHAM. Mr. Speaker, I object. I object to the last one.

The SPEAKER pro tempore. There was objection to the statement of the gentlewoman from Florida.

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

(Mrs. MEEK of Florida asked and was given permission to revise and extend her remarks.)

Mrs. MEEK of Florida. Mr. Speaker, this is a sham bill. I represent senior women very seriously.

Mr. Speaker, I rise in strong opposition to both the "sham" prescription drug bill that the Republican leadership has brought to the floor today, and to the unconscionable Rule that the Republican Leadership has proposed, a Rule that denies the Democrats an opportunity to offer a Substitute bill providing real prescription drug coverage through Medicare.

Mr. Speaker, no one in America should have to choose between buying medicine or food, between paying their utility bills or their drug store account, between taking their medicine or living in pain and discomfort. Yet this is the problem that many of our people face every day and we all know it. "Miracle drugs," no matter how innovative or effective, are worthless to those who cannot afford them. Yet today there are huge numbers of seniors who are unable to follow their doctor's orders because they cannot afford the medications their doctors prescribe.

The problem is obvious and so is the solution. Unfortunately, it involves the one thing

that our people want and that the Republican Leadership steadfastly refuses to provide: a real prescription drug benefit through Medicare.

The Republican Leadership knows that American people want a real prescription drug benefit through Medicare. The Republican Leadership's efforts to pass this bill are attempt to create an illusion for the voters this fall. They want to give their candidates a talking point with the voters so they can say that they support prescription drug coverage without actually having to provide it. This is a sham. Our seniors deserve much better.

Mr. Speaker, America's seniors, particularly older women, need comprehensive prescription drug coverage through Medicare and fair drug pricing. The Republican bill on the floor provides neither. The Republican bill is unworkable, unreliable and grossly inadequate.

Mr. Speaker, America's seniors do not want to be left to their own devices and sent on a wild goose chase shopping for private drug plans with no guaranteed benefits, plans that private health insurers do not even want to offer. They should not have to join an HMO that tells them where they are able to fill their prescriptions in order to get drug coverage. They deserve the reductions in drug prices that can only be obtained if we pass a real prescription drug bill that takes advantage of the purchasing power of Medicare's 40 million beneficiaries.

While I am outraged by the Republican Leadership's refusal to allow the Democrats an opportunity to offer a Substitute, I certainly understand the reason for it and so do the American people. The Republican Leadership will not allow the Democrats to offer a Substitute because they know their bill cannot withstand a ''side by side'' comparison with the Democratic Substitute.

The Democratic Substitute that the Republican Leadership will not allow to be debated and voted on has a yearly out of pocket limit on drug costs of $2000. Why would the Republican Leadership want to highlight the fact that under their bill, seniors will have to pay $100% of their drug costs between $2000 and $3700 when nearly one half of all seniors have drug costs over $2000 and would be subject to this gap in coverage?

Why would the Republican Leadership want a comparison between a Republican bill that will force seniors into private HMO's and restrict patients' choice of drugs and pharmacies and a Democratic Substitute that guarantees affordable, dependable, comprehensive drug coverage at a uniform price while preserving freedom of choice for seniors?

Why should seniors in different states pay different premiums for the exact same benefits as the Republican bill will permit?

Now some will in this body will contend that a real comprehensive prescription drug benefit through Medicare is simply not affordable. I say that anybody that can find the funds to grant the bloated tax relief for the rich that this House has provided, including $1.2 trillion in estate tax relief for the millionaires in this country, surely can find a way to pay for a real prescription drug benefit. It's simply a matter of our priorities.

Mr. Speaker, the affordability of providing a real prescription drug benefit is a fair subject for debate and should be debated. But this surely is a reason why the Democratic Substitute needs to be debated and voted upon. It is not a reason to keep the Democratic Substitute from the floor. If a Member of this body believes that we can not afford the real prescription drug benefit that the Democratic Substitute provides, then I say: vote against it.

So the reasons for the Republican Leadership's approach to this issue are clear as they are deplorable. They want a press release for the fall elections, not a real drug benefit and they don't want to take the heat that would come from a side by side comparison of the Republican ''pretend'' bill and the Democratic Substitute.

I urge all my Colleagues. Reject this unfair, one-sided process. Let's have a full and fair debate and produce a real prescription drug benefit. Defeat the proposed rule; pass a fair rule that allows a Democratic Substitute; Vote for the Democratic Substitute and reject the Republican Leadership's bill.

Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from Texas (Ms. EDDIE BERNICE JOHNSON).

(Ms. EDDIE BERNICE JOHNSON of Texas asked and was given permission to revise and extend her remarks.)

Ms. EDDIE BERNICE JOHNSON of Texas. Mr. Speaker, I express my opposition to this bill because it does hurt senior women, in particular, and is another big windfall for the corporate industry.

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

Ms. LOFGREN. Mr. Speaker, I rise to express my opposition to this bogus bill that will hurt older women.

Mr. Speaker, today, prescription drugs play a larger role in modern medicine than ever before. Prescription drugs are used as complements to surgical procedures, as substitutes for surgery, and to help reduce future health risks and treat many chronic health conditions. Yet those who need them the most, older adults, and we know that the majority of seniors are women, often find themselves without either affordable prescription drugs coverage or the means to pay for their prescription drugs needs.

Women on average live longer and are more likely to suffer from prolonged chronic illness. In fact, women on Medicare spend nearly 20% more for prescription drugs than men. And—with women's poverty rates twice that of men, prescription drug costs take a bigger bite out of women's limited income.

It is a shame that we are not considering a real prescription drug benefit today, one that would benefit all seniors. Under the Republican bill, the more a senior woman spends for prescription drugs, the less coverage she gets. For some reason, the Republican bill forces seniors, your mother, your grandmother, to pay a higher percentage of costs as their needs increase. Mr. Speaker, does this makes any sense?

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

(Ms. MILLENDER-MCDONALD asked and was given permission to revise and extend her remarks.)

Ms. MILLENDER-MCDONALD. Mr. Speaker, I express my opposition to this bill that is particularly harmful to senior women.

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

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

Ms. BERKLEY. Mr. Speaker, I express my opposition to this shameful bill that is particularly harmful to the senior women in my district.

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, I express my opposition to this bill.

(The following sentence was delivered in Spanish.)

Mr. Speaker, for all of the old women who can hear me loud and clear, this is another tactic for the Republicans to take away your medication.

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

Ms. KAPTUR. Mr. Speaker, I ask unanimous consent to revise and extend my remarks.

Mr. Speaker, I express my strong opposition to this pitiful bill that denies senior women across America access to affordable prescription drugs because the Republicans gave all the money away to companies like Enron in tax cuts, and they were not deserved.

Mr. CUNNINGHAM. Mr. Speaker, I object.

The SPEAKER pro tempore. An objection is heard to the last request to revise and extend.

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

(Ms. HOOLEY of Oregon asked and was given permission to revise and extend her remarks.)

Ms. HOOLEY of Oregon. Mr. Speaker, I rise against the Republican no-benefit prescription drug proposal that is harmful to seniors in my State.

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 express my opposition to this unacceptable bill that is particularly harmful to senior women in my district.

Mr. Speaker, I rise today to talk about H.R. 4954, the Medicare Modernization and Prescription Drug Act and its implications for our seniors. In particular, I would like to discuss how women fare under this proposal before us.

Women are literally the face of Medicare. They comprise 58 percent of the Medicare

population at age 65 and represent 71 percent of beneficiaries at age 85. Any potential prescription drug plan must be evaluated with regard to its impact on women—if it works for women, it works for everyone.

When Medicare was established in the 1960s, the biggest need was insurance coverage for hospital stays and doctor visits, not prescription drugs. The focus then was on providing relief for acute conditions, not chronic.

Today more than 88 percent of Medicare's 42 million beneficiaries use prescription drugs. The average senior takes four prescriptions daily and fills an average of 18 prescriptions a year.

The use of prescription drugs is more pronounced among women. Beginning at midlife, women have a higher incidence of chronic illness than men. The average woman age 65 and over lives nearly seven years longer than the average man and relies on Medicare for her health insurance coverage for more years.

While most women on Medicare use prescription drugs regularly, over ¼ of these beneficiaries—nearly six million women—lack any prescription drug coverage.

Out-of-pocket spending for prescription drugs place a disproportionate burden on older women who have retirement incomes that are roughly half than those of men. In 2000, the average income for women over 65 was $15,638, compared to $29,329 for men.

Even though women have significantly smaller incomes than men, they spend a larger proportion of their income on out-of-pocket health costs. Women over 65 spend 20 percent in comparison to the 17 percent spent by men. These expenses increase to 27 percent for women 85 and older.

Older women are one of our nation's most vulnerable groups and providing affordable prescription drug coverage is critical to improving their quality of life.

Unfortunately, the proposal before us today does not achieve this objective. This legislation does not guarantee any specific benefit. Instead, the bill provides subsidies to insurance companies to provide private insurance to seniors. The coverage and $33 premium mentioned today would only be available to beneficiaries who can find a private plan that offers it. All these figures depend on what HMOs and private drug insurance plans want to charge.

H.R. 4954 provides less than one-quarter of the amount seniors are estimated to pay for prescription drugs over 10 years. In fact, it leaves seniors wholly responsible for costs between $2000 and $3700. Nearly half of all seniors' annual drug costs are above $2000. I cannot support a plan that subjects seniors to a gap in coverage. These seniors will not receive any help with their drug bills for at least part of the year, even though they continue to pay premiums.

I am committed to passing a fair prescription drug plan under Medicare that does not stifle innovation or eliminate choice in coverage. Seniors need assistance in order to obtain prescription drugs to treat or prevent illness.

In addition, I am disappointed that today's activities will not include a discussion of an alternative bill. As our senior population continues to grow, we must take a comprehensive look at all of our options in order to provide seniors with real benefits.

Instead of H.R. 4954, I support a meaningful prescription drug benefit that does not handicap our seniors at a time when they most need assistance. The plan I support builds on the existing Medicare system and provides seniors with guaranteed benefits, premiums, and cost sharing for all beneficiaries. Not estimates. The federal government would use the collective bargaining clout of all Medicare beneficiaries to negotiate fair drug prices and these savings would be passed on to our seniors.

American seniors want, need, and deserve real prescription drug coverage. The Medicare Modernization and Prescription Drug Act establishes a complex program that offers modest benefits at most.

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 express my opposition to this sham bill that is a giveaway to the pharmaceutical industry at the expense of seniors and especially women in our country.

Mr. Speaker, I rise today in opposition to this legislation. While we all agree that today's elderly need and deserve a prescription drug benefit, I am afraid this proposal is not the answer.

If we are lucky enough, our parents are still with us. And we know how they can live longer and more active lives with the new medical treatments that exist today. Some of our parents already face—and some of us in the not so distant future may face—the issue of drug affordability—drugs that help us to live life to the fullest.

We are in the middle of a health care crisis in this Nation. Drug prices rose 17 percent last year alone—after five years of double-digit spikes. The prices of popular and heavily-marketed drugs increased even more—an incredible 34 percent.

No one doubts that something must be done—and fast. But passing legislation that makes two wrongs does not make a right. As Ranking member of the Small Business Committee, I want to point out how this plan fails in two critical ways.

First, it fails our seniors. It does nothing to provide a comprehensive, affordable drug benefit with Medicare. Second, it fails small community pharmacists. These pharmacists serve a vital purpose in our communities. The corner drug stores anchor our neighborhoods and the local pharmacist counsels our seniors about their medications.

Once again, through the lens of this proposal, we see who the Republicans care about most—big business—the pharmaceuticals, the health care companies. Not the little people—seniors citizens that give so much back to our communities and the corner drug stores they visit and depend on each and every day.

Mr. Speaker, this is a bad plan. It enriches a handful of corporations at the expense of seniors and the small businesses across the country that serve them—without even delivering on the promise of comprehensive, affordable prescription drug coverage.

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

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

Ms. RIVERS. Mr. Speaker, I express my opposition to this terrible bill that is particularly harmful to senior women.

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

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

Ms. WATSON of California. Mr. Speaker, I rise to express my opposition to this most deceptive bill that is particularly harmful to my 92-year-old mother and other senior women.

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

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

Mrs. CLAYTON. Mr. Speaker, I express my opposition to this sham bill that is particularly harmful to older women who live longer, have more diseases, have less money, and need prescription drugs that they can afford.

Women live longer, suffer from more diseases, have less money when they retire and must pay more for their prescriptions. 65 percent of Social Security recipients are women—75 percent of the low income retired persons are women. The majority of those need real prescription help, not this bill which does nothing to help sick older women.

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 to express my opposition to this bill, which I deem to be a betrayal of the women of the Greatest Generation.

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

The Republican bill that is on the floor today forces seniors to shop around for prescription drug coverage through Medicare HMOs and private insurance plans. 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 for the exact same benefit. These geographic disparities are simply unacceptable.

There are no assurances in this bill that prescription drugs will be affordable. In fact, this bill would cover less than one-fifth of the estimated drug costs of Medicare beneficiaries over the next ten years. In addition, there is a huge gap in coverage. Seniors who need more than 2,000 worth of drugs a year must pay 100% out-of-pocket, and keep paying premiums, until they reach the $3,700 out-of-pocket cap. Millions of seniors will fall into this gaping hole. I believe all seniors deserve affordable prescription drug coverage, and we

should not help some seniors cover their drug costs while leaving others out in the cold.

Seniors will not be guaranteed access to the drugs they need or to their local pharmacies. The bill would allow private insurance plans to limit access to covered drugs, even if the drugs are on an approved list. Seniors would be restricted to certain pharmacy providers or would be forced to pay higher costs to use the pharmacy of their choice, even a pharmacy they have been using for years. I know many seniors in my district who have developed relationships with their pharmacists over the years and would hate to have to go to another provider or pay extra to keep going to their same trusted pharmacist.

I hear from seniors in my district who cannot afford their prescriptions. They send me receipts for their drug bills and ask me how they are supposed to afford their rising drug costs on a fixed budget. They take less than the required dosage to save money, which puts their health at even greater risk.

I support the Democratic proposal that adds 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 guarantees 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. Savings will then be passed on to seniors. Unlike the Republican bill, there are no gaps in coverage in the Democratic proposal. Coverage is provided for any drug a senior's doctor prescribes. Seniors will be able to choose where to fill their prescriptions and will not have to join an HMO or a private insurance plan to get drug coverage. This is the proposal seniors have been waiting for. Unfortunately, it is not the proposal that was brought to the floor today.

Today we are voting on a bill that is a sad mockery of what the 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 big drug companies. Close ties to the pharmaceutical industry have influenced this bill at the expense of our seniors. That 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. I urge my colleagues to vote against H.R. 4954.

□ 2115

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 in opposition to this pathetic excuse for a bill that is particularly harmful to senior women and to persons with disabilities.

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

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

Ms. SANCHEZ. Mr. Speaker, I rise in opposition to this sham bill that is particularly harmful to senior women, the heart and the soul of our families.

Mr. Speaker, I rise today to express my strong opposition to the Republican prescription drug bill, H.R. 4954. This bill, while unfair to millions of seniors, is particularly harmful to women.

Women make up a large portion of consumers purchasing prescription drugs. For this reason alone, women's health care needs must be considered as we debate prescription drug proposals. And unfortunately, I am hard-pressed to find many of my women colleagues who were consulted as this bill was drafted. It is no surprise, therefore, that this GOP bill ignores health problems unique to women.

At least one-third of Medicare beneficiaries, many of them women, do not have coverage for drugs—and others are forced to create a patchwork of coverage that simply doesn't get the job done. Too often, women and seniors are left choosing between food and medicine.

Thanks to Medicare, millions of women have dignity and security in their retirement years. Millions of women have avoided poverty and lived better lives. But today, with all of the incredible medical advances coupled with the rising cost of prescription drugs, it's vital that the country pull together to pass a meaningful Medicare prescription drug plan for all women—and all senior citizens.

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

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in opposition to this destructive insurance protection act that hurts the grandmothers, mothers, aunts and sisters and all of seniors and those disabled and provides zero benefits to Americans.

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

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

Mrs. MALONEY of New York. Mr. Speaker, I rise in opposition to this rule that would not allow a Democratic substitute and to the underlying bill.

I rise against the rule and the Republican bill. I regret for America's seniors that a Democratic alternative was not allowed. Medicare provides health care coverage to forty million retired and disabled Americans.

For decades, Medicare has worked to provide needed, lifesaving health care to millions, but it is missing a fundamental component: a prescription drug benefit.

If we have courage, this Congress can make history and give our nation's seniors what they desperately need: a real, and meaningful prescription drug plan.

I am proud to join my Democratic colleagues, led by Mr. DINGELL, Mr. RANGEL, Mr. STARK, and Mr. BROWN, as an original cosponsor of H.R. 5019, the ''Medicare Prescription Drug Benefit and Discount Act.''

I come to the floor to discuss two points:

Number 1: unlike the Republican drug plan, the Democratic plan is simple because it builds upon a proven model—Medicare.

Just like seniors pay a Part B premium today for doctor visits, under our plan, seniors would pay a voluntary Part D premium of $25 per month for drug coverage. For that, Medicare or the government will pay 80 percent of drug costs after a $100 deductible. And no senior will have to pay more than $2,000 in costs per year.

There is an urgent need for this plan. The most recent data indicates that almost 40 percent of seniors—an estimated 11 milion—have no drug coverage. Problems are particularly acute for low income seniors and seniors over the age of 85 (the majority whom are women). Additionally, those older Americans who do have coverage find that their coverage is often inadequate for their needs.

The Democratic plan is a real plan with real numbers, not estimates.

Point 2: the Republican plan does nothing to bring down the cost of prescription drugs. The Democratic plan is the only plan that provides real Medicare prescription drug coverage for our seniors by stopping soaring drug costs.

Under the buying power of Medicare, through competition and bargaining we can rein in drug costs. Prescription drug costs are too high for our older Americans. They need help now!

For instance, let's look at the cost of Prevacid. Prevacid is an ulcer medication, and the second most widely used drug by American seniors. The cost for this prescription is on average $137.54 per month in New York City—but only $45.02 in the United Kingdom, a price differential of 206 percent.

Or look at Celebrex, a popular arthritis medication and a drug needed by many older women, especially, since older women are stricken more often than men by arthritis. According to a Government Reform Committee report released by Mr. WEINER and myself, a monthly supply of this drug costs $86.26 in New York City. In France, a monthly supply of Celebrex costs only $30.60. This is a price differential of 182 percent. Seniors in New York City without drug coverage must pay almost three times as much as purchasers in France.

Prices for prescriptions have risen 10 percent per year for the last several years, leading to over $37 billion in profits last year for the giant drug companies. While these corporations wallow in their spoils, seniors suffer without coverage.

Mr. Speaker, we must pass the Democratic prescription drug plan without delay. It is built on a proven model, Medicare. The Republican plan only offers gap-ridden coverage. The Republican bill is about privatization. The Republican plan is all about election year politics.

For the sake of our seniors, we must pass the Democratic plan, and we must pass it now.

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, on behalf of seniors in my district, particularly women, and in particular veterans, I express my strong opposition to this bill.

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

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

Ms. DEGETTE. Mr. Speaker, I rise in opposition to this rule on behalf of the senior women in my district and around this country who live longer than men and pay far more money for prescription drugs.

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 enter my objection and opposition to this irresponsible bill that will do nothing to help the senior women of this country.

Every day, millions of American seniors are forced to choose between buying prescription drugs and buying food. The Republican leadership in Congress has responded to this crisis with H.R. 4954, a prescription drug bill that does nothing to help them.

The Republican bill would force seniors who want prescription drug coverage to get it from private insurance companies, but the bill provides no guarantee that insurance companies will offer prescription drug policies. Even the Health Insurance Association of America has admitted that insurance companies will not offer drug-only policies. So the Republican plan is guaranteed to fail.

Furthermore, even if prescription drug policies do become available, the premiums, deductibles and co-payments will vary widely. Low-income seniors could be denied the drugs they need if they cannot afford the co-payments. For many middle-income seniors, the benefits would be so limited that it would not be worthwhile for them to enroll. H.R. 4954 is a poor excuse for a prescription drug plan for our nation's senior citizens.

The Democrats have proposed a prescription drug plan that would provide a guaranteed prescription drug benefit under Medicare to all seniors who want one.

This bill would ensure that all seniors who choose to participate would pay the same low premiums and receive the same benefits.

Beneficiaries could choose to obtain their prescriptions from any willing pharmacy and would be guaranteed coverage for any drug their doctor prescribes.

Premiums and co-payments would be waived for seniors who are living under 150% of the poverty level.

The bill would use the collective bargaining clout of all 40 million Medicare beneficiaries to negotiate fair and reasonable drug prices.

Finally, no senior would have to pay more than $2 thousand per year in out-of-pocket expenses for the prescriptions they need.

It is time that Congress make prescription drugs available to all seniors who need them. I urge my colleagues to oppose H.R. 4954 and support the Democratic plan to provide guaranteed prescription drug coverage to all seniors who desire it.

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

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

Ms. MCKINNEY. Mr. Speaker, I rise in opposition to this bill which is a sham and does nothing for seniors in my district, in my State and in my country.

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

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

Ms. ESHOO. Mr. Speaker, I rise to express my opposition to the bill that will be considered this evening on behalf of my constituents, especially the senior women that I represent. They deserve a great deal more and much better and all the women of the country do.

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

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

Ms. PELOSI. Mr. Speaker, I rise in opposition to this sham bill which is a cruel hoax on the American people, especially cruel to America's senior women who raised our families and deserve better.

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, I rise in opposition to this insurance industry, pharmaceutical written bill that does not drive down the cost of prescription drugs or cover most of America's seniors and is very harmful to women in this country, those tomorrow, and those who are in older generations.

Mr. LINDER. Mr. Speaker, I, too, enjoyed that parade; and I particularly enjoyed the fact that they had not a particular thing to say about the bill. To say something about impact the bill and how it impacts women, I yield such time as she may consume to the gentlewoman from Connecticut (Mrs. JOHNSON), who wrote the bill.

Mrs. JOHNSON of Connecticut. Mr. Speaker, we have had a parade of my colleagues from the other side claim that this legislation is harmful to senior women. I wonder how they could have so lost touch with the lives of women in America and women in their districts. This bill represents the greatest leap forward in women's health since the passage of Medicare.

I was polite to you, and I ask that you be polite to me.

For the very first time, women, particularly low-income women, will have their prescriptions covered. Perhaps you did not read the bill. You know and I know that women live longer than men. The great majority of seniors are women. Perhaps you did not know that retired women are living on half the income of retired men, that the average income of retired men in America is $30,000 and the average income of retired women is $15,000 and of retired women over 85 is $10,000.

Under this bill those low-income women will receive 100 percent of the costs of their drugs, of their premiums, of the deductible, and of the co-insurance up to maybe 2 to $5. They will have a right to charge that much co-insurance. That is an incredible boon to these women. They will have the security of knowing that every dollar of their prescription costs up to $2,000 will be covered if your income is under 175 percent of poverty, and that is 44 percent of all seniors.

Yes, this is a wonderful thing for women in America. Yes, this bill is a giant step forward for seniors in America. Yes, this is the greatest leap forward for women in health care since the founding of Medicare. And once you have read the bill, I will be happy to talk with you about details. But there can be no arguing with the fact that the first $2,000 of drug expense for people under 175 percent of poverty is completely covered and, by saving the State $40 billion, they will be able to go up that ladder of income.

So let us try to talk about the facts tonight, let us have a little less theater, let us have a little more discussion about the details of the legislation, and let us try to do America proud as we talk about the need for prescription drugs in Medicare.

Mr. THOMAS. Mr. Speaker, will the gentlewoman yield?

Mrs. JOHNSON of Connecticut. I yield to the gentleman from California.

Mr. THOMAS. As women enter their senior years, in terms of the problems they have with osteoporosis, do we include in this bill additional money to assist in mammography?

Mrs. JOHNSON of Connecticut. We certainly do. We fix all the problems with reimbursements for mammography so they will be more accessible to the women of America. Furthermore, we provide access for something that is extremely important to women, more important to women than men, and that is access to disease management plans to manage chronic illness. It is women who are plagued with four, five, and six chronic illnesses.

Mr. THOMAS. Mr. Speaker, will the gentlewoman yield?

Mrs. JOHNSON of Connecticut. I yield to the gentleman from California.

Mr. THOMAS. Is it not true that during their working lives men very often have physicals? In fact, it is oftentimes part of their professional occupation to get a physical periodically, and many times women who are not working do not get that physical?

Mrs. JOHNSON of Connecticut. Absolutely.

Mr. THOMAS. Is it not true in this bill that, for the first time, every senior who becomes Medicare eligible, that means every woman, gets a free physical?

Mrs. JOHNSON of Connecticut. Every woman gets a free physical under this bill, and for the first time they have an option for a plan that provides entirely free preventative benefits across the board to men and women.

So this is an enormous advancement for women because women are the ones who get the poorest health care throughout their lives, and they will have an option to a plan that has free preventive benefits across the board and, if they choose it, and they will all get a free baseline physical when they enter Medicare. Yes, a great advancement for senior women.

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

Mr. MCGOVERN. Mr. Speaker, I rise in strong opposition to this sham bill and to this woefully inadequate bill offered by the majority.

Every Member of this House knows that the number one issue facing senior citizens is the soaring cost of prescription drugs. Our seniors need relief and real relief now.

My Republicans colleagues go on about how they support giving our seniors relief, and then they send this poor excuse for a benefit bill to the House floor. This guarantees seniors nothing, nothing. It is a bad bill. And to make matters worse, the gentlewoman from Connecticut (Mrs. JOHNSON) gets up and tells us how wonderful and strong her bill is. Yet she and the Republican leadership make it unamendable. No substitute. No amendments. No bipartisanship. Two hours total debate. That is it.

How sad. How outrageous. If there ever should have been an open and fair process, it should have been today. There were even good Republican amendments that were offered before the Committee on Rules that were ruled out of order. But, no, you are afraid you might lose because deep in your hearts you know that your bill is nothing more than a political soundbite and you deserve to lose.

Vote ''no'' on this rule and vote ''no'' on this bad bill.

Mr. LINDER. Mr. Speaker, I yield 3 minutes to the gentlewoman from West Virginia (Mrs. CAPITO).

Mrs. CAPITO. Mr. Speaker, I stand before you today to offer my remarks on the prescription drug plan.

On May 1, 2002, four of my constituents boarded a bus, traveled from Martinsburg, West Virginia, to Washington, D.C., to offer their voice and their story on how the prescription drug dilemma has reshaped their lives. That day I heard each of their voices; and, unfortunately, it is a voice I hear and we all hear all too often.

At each of the town meetings I have had the majority of the questions deal with the high cost of prescription drugs. After one particular town meeting a young lady approached me. She showed me a list of prescription drugs that her mother was taking and the cost of each drug listed besides it. Looking at the list my heart sank. These figures were staggering. Additionally, because of the high cost of her mother's medication, lack of Medicare coverage for her mother, this young woman who had a family of her own was paying for her mother's medication.

Is this right, Mr. Speaker? No, it is not.

Our seniors deserve the peace of mind of knowing that they can and will be able to afford their prescriptions. Anxiety over the affordability of prescribed medications should not spoil one's golden years. That is why I am standing here tonight.

I am choosing to stand here and tell you that Medicare needs to offer prescription drug benefit. To be blunt, we need to offer it. We needed to offer it yesterday or the day before or the day before. This situation should be resolved.

It is our duty as representatives to represent the people's voice, and their voice says now is the time. I urge all of my colleagues to stand up, pass this rule, pass the Medicare prescription drug legislation which is extremely beneficial to the senior women of America.

Ms. SLAUGHTER. Mr. Speaker, I yield 3 minutes to the gentleman from New York (Mr. RANGEL).

Mr. RANGEL. Mr. Speaker, this rule does not allow Democrats an opportunity to say that we think we have a better idea. The majority found it very difficult to get enough votes to support the pharmaceutical industry, but it would just seem to me that it is not a rule against Democrats. It is not a rule even against the integrity of the House. It is a rule against the senior citizens who really deserve better treatment than they are getting.

Mr. Speaker, I yield to the gentleman from Maryland (Mr. HOYER).

Mr. HOYER. Mr. Speaker, I thank the distinguished ranking member of the Committee on Ways and Means.

There may be no more serious issue that we consider on the floor of this House this year. The gentlewoman from West Virginia (Mrs. CAPITO) that just spoke said why it was so important. She is right. This issue is critically important to the women that she mentioned, critically important to the individuals that the gentlewoman from Connecticut (Mrs. JOHNSON) mentioned, and I would say critically important to the citizens that every one of the women on this side of the aisle represent and came and said they were concerned about and, therefore, are not supporting this rule.

The gentlewoman from Connecticut said she was polite to those people, and she was. But I suggest to the gentlewoman that this rule is not polite. This rule denigrates the importance and seriousness of this issue.

When your side took over in 1995, Gerald Solomon, the then-chairman of the Committee on Rules, said this, ''The guiding principals will be openness and fairness. The Rules Committee will no longer rig the procedure to contrive a pre-determined outcome. From now on the Rules Committee will clear the stage for debate and let the House work its will.''

You have, of course, retreated from that statement. You have not honored the seriousness of this issue.

□ 2130

The gentlewoman from Connecticut who the gentleman from California (Mr. THOMAS) says wrote this bill will not have the opportunity to defend this bill against an alternative that can be fully debated as to whether or not the seniors to whom she refers will, in fact, be protected.

The gentlewoman served with Bill Gradison. Bill Gradison for those who are relatively new to the House was a member of the Committee on Ways and Means and one of the senior members of the Committee on Ways and Means, and then Bill Gradison left here, and he went to head up the Insurance Industries Association in this country.

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

Mr. HOYER. Mr. Speaker, he went to the insurance industry and what does Bill Gradison say, a Republican, not a Democrat, a member of the Committee on Ways and Means, retired, what does he say? A member representing the insurance agency, he says this bill will not work. That is what Bill Gradison says, and the shame on this democratic body is that an issue that all of us agree is so critically important will not be fully debated consistent with the principle that Mr. Solomon enunciated in 1995 when the reformers took over this House.

How sad it is, how sad it is that we come here at this hour to debate one of America's most important issues, affecting millions and millions and millions of people. All of us, all of us have heard the lament of those individuals, be they female or male, who cannot pay their prescription drugs. It is our duty to reject this rule and to have a full and fair debate, consistent with the Solomon principles.

Mr. LINDER. Mr. Speaker, I am pleased to yield 2 minutes to the gentlewoman from Virginia (Mrs. JO ANN DAVIS).

Mrs. JO ANN DAVIS of Virginia. Mr. Speaker, I rise to speak in support of the rule. For years I have been an avid supporter of prescription drug coverage for senior citizens. Why? Because I have a mom whose prescription drugs amount to over 50 percent of her Social Security check.

Today, I rise to speak for all of those who have moms and dads on Medicare.

The minority does not have a serious bill. They have a $1 trillion election year gimmick that will bankrupt Medicare.

This is a good and fair rule because it allows a vote on the only credible plan that has been carefully and thoughtfully designed to help seniors by lowering drug costs, guaranteeing coverage and providing choices.

Under the Republican plan, every senior will be eligible for coverage. We guarantee this coverage. It cannot be taken away. The Democrat plan, however, phases out coverage. It is essentially an experiment. Mr. Speaker, seniors cannot afford an experiment. They need real, credible coverage that they can rely on.

This bill will help our seniors. This is a good rule for a long-awaited and much-needed legislation and we must pass it. I urge my colleagues to join me in voting ''yes'' on the rule and ''yes'' on final passage of the bill for my mom and everyone's mom and dad that is on Medicare.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentleman from New Jersey (Mr. MENENDEZ).

Mr. MENENDEZ. Mr. Speaker, I rise on behalf of my 83-year-old mother and millions like her across this country who work for decades, in her case, in the factories of New Jersey, now has Alzheimer's and spends over half of her Social Security check on prescription drugs and but for my sister and my assistance would not live with the dignity that she deserves. There is a difference between Republicans and Democrats on prescription drugs, and that is why Republicans will not even let us debate our proposal here on the floor of the House of Representatives.

The denial of a vote on the Democratic proposal for a universal, affordable, guaranteed benefit under Medicare is a corruption of this institution by the Republican majority, by the way, for an industry that has given them millions in campaign contributions.

There is a difference in who benefits. Democrats cover all seniors. My colleagues subsidize big insurance companies and cover less than a quarter of seniors' costs. There is a difference in what seniors will pay. Democrats guarantee a $25 monthly premium with low out-of-pocket expenses. My colleagues leave those decisions to the whims of corporations. Plenty of opportunity for more corporate greed.

No senior in America should have to choose between paying their rent, putting food on the table, and having access to life-enhancing drugs.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LATOURETTE). The Chair would ask the courtesy of all Members in not exceeding the time that has been yielded to them.

Mr. LINDER. Mr. Speaker, I yield 2 minutes to the gentleman from Iowa (Mr. LATHAM).

Mr. LATHAM. Mr. Speaker, I thank the gentleman from Georgia for yielding me the time, and I thank the Speaker for this time.

This is a long time coming. This is so important for people like my mother who is 85 years old, living in a town of 168 people in Alexander, Iowa. This is not only a bill that is going to help her to be able to afford her prescription drugs and to enhance her length of life and quality of life; but just as importantly, in rural America, this bill is going to make sure that there is access to quality health care in rural America.

There is a lot of work that has gone into this bill, and I would like to see any other proposal out there that has brought together so many people when we look at the American Hospital Association, the AMA, the physical therapists, the National Association of Home Care, the National Rural Health Care Association, all coming together in support of this very, very important legislation.

Mr. Speaker, I have been very proud to serve on the Speaker's Prescription Drug Action Team, and I want to thank the Speaker and all the chairmen of the committees that have worked so hard on this bill and to the successful end which is really going to address the problems that we have.

I also want to congratulate my three Republican colleagues from Iowa (Mr. LEACH), (Mr. NUSSLE), and (Mr. GANSKE) for working as a team to try and make sure that we did get relief in Iowa. We have the lowest reimbursement for our hospitals in the country by a wide margin. This bill is going to take a giant step toward keeping those rural hospitals open, to keep the kind of high-quality health care providers on the job and serving in Iowa. It is absolutely critical that we continue to have the physicians, the nurses, the home health care folks available for my mother.

Mr. Speaker, this is a great evening, and I support the rule and the bill.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, some of the comments that are being made by my colleagues on the other side, both on the floor and in the Committee on Rules, have been very upsetting to me.

I rise in opposition to the rule, but I heard the gentlewoman from Virginia just say that the rule was fair because it allows an up-or-down vote on what is the only good bill dealing with prescription drugs. That is not what fairness is about. That is not what democracy is about.

I asked this morning in the Committee on Rules that the Democratic substitute and three other amendments that would lead to price reductions and another amendment that would provide a guaranteed Medicare benefit be placed in order. All were denied. My colleague may not agree with me, but the gentlewoman from Virginia should not suggest that the only thing that should be considered is what they think is the right thing. That is not the way a democracy operates.

The other thing that upset me was that I heard the gentlewoman from Connecticut say that we should just read the bill. Let me tell my colleague, I read the bill. We have not had a lot of time to read the Republican bill, but I read it. There is nothing in it. It is not a Medicare benefit. It does not guarantee any benefit. It does not tell us what the premium is going to be. It does not tell us what the deductible is going to be. It does not tell us anything about whether it is going to be available anywhere, and there is no price reduction.

The gentlewoman from Connecticut mentioned the passage of Medicare, but she was very proud of the fact this morning in the Committee on Rules that this was not a Medicare bill and that it operated through private insurance and through market competition and was not part of Medicare because she said that Medicare oftentimes does not work now and we need to change it.

Then the gentleman from Georgia actually said in response to the gentleman from Massachusetts (Mr. MCGOVERN) when I spoke about how we wanted a Medicare guarantee and we wanted this to be under Medicare, the gentleman from Massachusetts (Mr. MCGOVERN) said it is unfortunate that the gentleman from Georgia (Mr. LINDER) made a reference to the Medicare prescription drug program as a Soviet-style model program, and the gentleman from Georgia (Mr. LINDER) said, well, it is; and he said it several times.

The problem is that the Republicans do not like Medicare. They do not want this to be a Medicare program because they never liked Medicare, and they want it to wither on the vine, and they do not want to provide any benefit for senior citizens in this country.

Mr. LINDER. Mr. Speaker, I yield myself such time as I may consume. That was some of the gentleman's more interesting prose. I am sure there is a kernel of thought in there, but I did not detect it.

Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. THOMAS), the chairman of the Committee on Ways and Means.

Mr. THOMAS. Mr. Speaker, the parade on the other side of the aisle which repeated the mantra that it was a sham bill, cruel hoax, harmful to women and the disabled, in case anybody really thinks that is true, I am wondering why then when we look at the more than 90 organizations that support this bill, have names such as the Visiting Nurses Association, the Pennsylvania Women's Health Alliance, the National Spinal Cord Injury Association, the National Coalition for Women With Heart Disease, the National Alliance for the Mentally Ill of Pennsylvania, American Parkinson's Association of Vermont, the Epilepsy Foundation of Mississippi, having someone parade to the microphone and repeat some mantra, as though it was

some kind of a fixed statement that meant anything really does embarrass me, when if we look at the organizations and more that I just repeated who every day help the people that my colleagues say are not helped are for this bill. Someone is wrong, and it is not them.

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

The Democrats are standing with AARP, the National Committee to Preserve Social Security and Medicare, the Alliance for Retired Americans, National Council on the Aging, National Senior Citizens Law Center, Families USA, the National Partnership for Women and Families, the AFL and countless others who represent America's 40 million Medicare beneficiaries.

Mr. Speaker, I yield 3 minutes to the gentleman from Michigan (Mr. DINGELL).

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

Mr. DINGELL. Mr. Speaker, I thank the distinguished gentlewoman for yielding me the time.

We have got a remarkable thing here before us, a closed rule. We have got a bill on which there were never any hearings, a bill that just drips defects, a bill that is opposed by almost everybody that knows anything about pharmaceuticals and about the needs of the senior citizens and a bill that is opposed by every single responsible major organization of senior citizens.

We cannot offer amendments to it. They cannot be cut-and-bite amendments. There is no possibility of us offering a substitute to it. This is what my colleagues call democracy on that side of the aisle? This is the way we treat the concerns and the rights and the interests of our senior citizens? I wonder how many of them like what they are seeing tonight on television as they watch this body engage in debate which is at best fraudulent and which is at worst just plain outrageous.

The hard fact of the matter is we cannot offer amendments on this side at all, but we can bring to attention the fact that this is going to significantly damage, if not in fact destroy, most of the plans that on behalf of industry and labor offer to retirees the right to have prescription pharmaceuticals as a part of the medical care program of the company which offers that particular benefit.

That is an outrage. There is no way that we can address here what the amount is that is going to be charged for the program. In other words, in this legislation, there is nothing anywhere which tells how much the senior citizen is going to pay to whom for what. That is all left up to some kind of nebulous understanding between the Secretary and an insurance company. There is no correction for that particular problem.

Is that bad? Of course. But there is worse. There is not a nickel's worth of subsidy for the health care of a senior citizen in this legislation. Do my colleagues know where the money goes in the legislation that is before us? To an insurance company. The insurance company can offer whatever benefits it wants or no benefits, but it is going to get a big fat subsidy.

With companies like Arthur Andersen I am sure that we will have an accounting system which will make that look good, but the simple fact of the matter is the benefits that are going to come under this legislation are not going to come to citizens. They are going to go to a bunch of cold-hearted, steely-eyed insurance companies that are going to be interested in maximizing benefits. In fact, there is not one plan which will be offered by insurance companies that is not going to be heavily subsidized.

Mr. Speaker, I rise in strong opposition to this abominable closed rule. On the most important issue to face this Congress, the Republican leadership has decided to prevent a single amendment to be offered, and in particular, a Democratic substitute.

There is no secret why we Democrats are not being allowed to offer a substitute, even a substitute that requires no waivers of the rules. It is not because our substitute has no merit. It is because it has so much merit, it would pass.

Let me explain why the rule needs to be defeated so that we can offer the Democratic substitute.

Unlike the bill introduced by our Republican colleagues, our substitute can be simply explained, because it is built on a simple, known, and effective model—Medicare itself.

Just like seniors pay a voluntary premium for Part B medical costs such as doctor visits, our bill provides for a voluntary Part D drug premium of $25 per month. For that, the Government will pay 80% of drug costs after a $100 deductible. And no senior will have to pay more than $2,000 in costs per year.

These are real numbers, not estimates. The benefits and the $25 monthly premium are specified on the first page of the substitute. Unfortunately, there are no such guarantees in the Republican bill.

On top of that, we will be arming seniors with the most potent protection from soaring drug costs. Forty million seniors banded together under the buying power of Medicare, we can begin to use the necessary bargaining power to rein in high drug prices.

This is not price controls; it is competition and bargaining. We saw that the Government was effective in negotiating a competitive price for the prescription drug Cipro during the anthrax outbreak. Why shouldn't we do the same for other life saving drugs for seniors?

In contrast to our simple and effective prescription drug benefit, the Republican bill is a complex scheme that would make Rube Goldberg blush. In fact, it is not a drug benefit at all. It is a host of subsidies to private insurers in the hope that they will offer a drug-only benefit to seniors. Will they? Time and again they have told us "no."

Why would the Republicans put forward such a model? Well, quite simply they have a larger agenda—they want to privatize all of Medicare, and this is just another step. That is the only reason why seniors are not even given a choice of getting the benefit through their traditional Medicare provider.

Any why don't they endorse our plan? Our plan is simple; it is comprehensive; it is what seniors want. The Republicans have raised just one issue: they say it costs too much. Well, I can tell you that we can afford it. It is just a matter of priorities.

Should that priority be making the estate tax repeal on the wealthiest people permanent, which will cost $750 billion in the decade that the permanent repeal is effective, or should it be enacting a critical health program that will help all of our seniors?

Our prescription drug benefit has the strong support of organizations representing millions of seniors, such as the National Committee to Preserve Social Security and Medicare, the alliance for Retired Americans, the National Council on Aging, and AARP. They recognize our benefit is a good value for seniors.

The substitute also includes provisions to shore up the Medicare fee-for-service system such as increased payments to hospitals, doctors, and nursing homes. Senior citizens and individuals with disabilities depend on Medicare fee-for-service an ensuring its continued viability has always been a priority for Democrats.

It is a good substitute, and I hope my colleagues will vote against the rule, so that it can be offered.

□ 2145

Mr. LINDER. Mr. Speaker, I yield 1 minute to the gentleman from Mississippi (Mr. PICKERING).

Mr. PICKERING. Mr. Speaker, I rise in proud support of the rule and the effort of this body. It is an historic opportunity for us.

If we put the politics and the extreme language aside, these are the facts: $350 billion will go to our seniors for prescription drugs, to our rural hospitals, to our health community centers, to those who need it most.

In my home State of Mississippi, 55 percent of all seniors live at the rate that will get the fixed income assistance, which means no deductible, no premium, only a copayment of $2 to $5 per prescription drug, an enormous benefit for the seniors who need it most. Fifty-five percent of seniors in Mississippi.

If we look at those who have catastrophic occurrences in their life, when drug costs exceed $3,700, they will see no cost over that. Those most in need will be helped. It is responsible, it is reasonable, it is right. I urge the Members to follow and support the rule.

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

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

Mr. HONDA. Mr. Speaker, I rise to express my opposition of this prescription drug proposal.

Mr. Speaker, the elderly and disabled have waited long enough for a prescription drug benefit in Medicare and for relief from the high cost of prescription drug prices. While the Republicans have been busy voting on permanent tax cuts and attending lavish fundraisers

by the pharmaceutical industry, seniors throughout the country have been waiting for Congress to take action. All seniors need relief from prescription drug prices, and they need it now.

However, the Republican prescription drug bill completely fails the test of a real Medicare drug benefit. The Republican bill has no guaranteed minimum benefit, no guaranteed, affordable monthly premium, and no guarantee of fair drug prices. To add insult to injury, their bill leaves a huge coverage gap. Seniors who need more than $2,000 worth of drugs must pay one hundred percent out-of-pocket, and keep paying premiums, until they reach the $3,700 out-of-pocket cap.

Mr. Speaker, the Democrats have an alternative we had hoped to offer. Under the Democratic plan, seniors and individuals with disabilities will be able to keep making the choices that matter. Seniors will not be forced to join an HMO. They will not be forced to join a private insurance plan that will restrict their access to needed drugs, deny coverage for the medicine their doctors prescribe, or force them to change pharmacies. And unlike the Republican plan, our plan has no gap—beneficiaries will always have coverage.

But the Republican Leadership is denying Democrats the opportunity to offer our alternative. They are denying our right to participate in a fair, democratic debate about prescription drugs. The time is now for a real, meaningful, and affordable Medicare prescription drug benefit. Unfortunately, it looks like this Republican-led House won't be providing one anytime soon.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentlewoman from California (Mrs. CAPPS).

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

Mr. Speaker, I acknowledge my sisters in Congress as we rise in opposition to this terrible rule.

One of the proudest days of my life was when I was sworn into this body, the symbol of our democracy. But today I am sad for the House and for this country. The process the majority has used to produce their Medicare bill is completely contrary to the principles of our constitution. A bill was rammed through committee that will not give seniors an affordable, reliable, comprehensive benefit; seniors, most of whom are women.

Now the majority is refusing to allow a free and fair debate on the issue. Why? They know their bill will not work. They know seniors will not get affordable drug coverage from insurance companies, and they know so many seniors will get no help with their medications, and they are afraid they would lose.

I can accept losing in a fair fight, but I cannot accept this anti-democratic attempt to muzzle fair debate. We should reject this rule, have a full debate on the needs of our seniors, and pass a real prescription drug benefit.

Mr. LINDER. Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Minnesota (Mr. KENNEDY).

(Mr. KENNEDY of Minnesota asked and was given permission to revise and extend his remarks.)

Mr. KENNEDY of Minnesota. Mr. Speaker, this bill is important and overdue for our Nation's 13 million seniors. Our seniors deserve prescription drug coverage now. They do not deserve the Democrat's election-year gimmick.

The average senior saves 44 percent on current drug costs under our plan. Mr. Speaker, our plan gives seniors immediate relief from the rising cost of prescription drugs by providing a discount of up to 25 percent off the top of the overall drug cost.

Just last week, Health and Human Services Secretary Tommy Thompson released a study showing our plan would save seniors more money than our friends on the other side of the aisle. In addition to the immediate discount and cost sharing, our plan includes catastrophic protection, 100 percent prescription drug coverage for low-income seniors, and more Medicare choices and savings.

I support the passage of this bill and this rule, and I urge my colleagues to do the same.

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

Mr. BONIOR. Mr. Speaker, about 2 weeks ago, I got on a bus with some seniors from my State of Michigan, and we went over to Ontario, Canada, to buy some prescription drugs. They got these drugs at 60, 70, 80, 90, 110 percent less than what they would have to pay in the United States, drugs like Lipitor and Celebrex.

They deserve a secure retirement. A secure retirement means not having to choose between medication and rent, medication and food, medication and transportation. It also means not having to go to another country to buy medicines that they need. That is an outrage.

We have the power in this institution to change that. We have had the power to change that for the last 8 years, and we have not done a damn thing about it, if my colleagues will pardon my language.

The Republicans have turned a blind eye to the plight of our mothers and our fathers and our grandparents. They have been blinded by the money and the power of the pharmaceutical lobby, and the Republicans are putting up roadblocks to prescription drugs time after time after time.

It is time for real reform, not a sham proposal. I ask my colleagues to open their eyes to the reality of what is happening in the country and give us some decent options to vote on.

Mr. LINDER. Mr. Speaker, I yield myself such time as I may consume to remind my friend from Michigan that, about 10 years ago, they had the power to change it with overwhelming majorities in both bodies and the Presidency, and they chose not to do it then, too.

Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. BARTON).

(Mr. BARTON of Texas asked and was given permission to revise and extend his remarks.)

Mr. BARTON of Texas. Mr. Speaker, I rise in support of the rule, even though I had an amendment that I would have liked to have offered that was not made in order on prescription drug savings accounts.

This is not the fairest rule. We could have made in order a Democratic alternative. But for a first start, I think it is a fair enough rule.

This is a good plan that will be on the floor. It spends $350 billion over 10 years to provide a prescription drug benefit and some Medicare reforms for the providers. The drug benefit comes to a population where we have about 30 million senior citizens on Medicare, and 70 percent of those seniors have some prescription drug coverage under private medigap policies. Of those that do not have any prescription drug benefits, 50 percent of them have drug costs that are less than $1,000 a year, and only about 700,000 have drug costs that are over $5,000 a year.

Now, if you are one of those 700,000 or it is your mother or your father, your grandmother, your grandfather, your aunt or your uncle, that is a big problem. But to say that a prescription drug benefit that is going to provide $31 billion a year to provide coverage for prescription drugs is not at least a good start, I think is just flat hypocritical.

Now, I think we can do more. I would like for us to do more. I would like to, at some point in time, make in order an option for those that want to use a prescription drug savings account to have that option; and, hopefully, later this year, we will get that.

I would point out that if the plan that is before us were to become law and it is a bad plan, it is optional. There is nothing mandatory about this plan that is going to be on the floor.

I would also point out that the provider benefits in the bill, which are over $4 billion a year, there is almost universal support for in the provider community.

So this is a good start. I would hope we would vote for the rule and have the debate.

Ms. SLAUGHTER. Mr. Speaker, may I inquire as to the time remaining on both sides?

The SPEAKER pro tempore (Mr. LATOURETTE). The gentlewoman from New York (Ms. SLAUGHTER) has 10 minutes remaining, and the gentleman from Georgia (Mr. LINDER) has 11 minutes remaining.

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

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

Last week, the Committee on Energy and Commerce was marking up the prescription drug bill. Last Wednesday, we stopped at 5 p.m. in the afternoon when we should have been working into the evening. Why? Because my friends on that side of the aisle went to a Republican fund-raiser underwritten by the prescription drug companies.

The Chair of that dinner was the CEO of a British drug company who donated $250,000 to the Republican Party. There were hundreds of thousands of other dollars donated by drug companies that night.

The next day, Mr. Speaker, when we went back for the markup, every amendment that Democrats offered that the drug companies did not like, surprise, was voted down. An amendment that said seniors should get the same drug benefits that Members of Congress get was voted down on a party line vote because the drug company sat in the back of the room and said no.

Every amendment we voted on that the drug companies did not like, to close the gap in all the out-of-pocket expenses that seniors had to pay, if the drug companies did not like it, they sat back in the back of the room and said no.

Vote for the Democratic plan written for seniors.

The SPEAKER pro tempore. The gentleman's time has expired.

Mr. BROWN of Ohio. Vote ''no'' on the Republican plan written by the drug companies for the drug companies.

The SPEAKER pro tempore. The gentleman's time has expired.

Ms. SLAUGHTER. I was going to yield that gentleman another 30 seconds.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore. Members need to heed the gavel, and the Chair would respectfully ask that, when the gravel is pounding, the Members cease speaking so that the gentlewoman from New York (Ms. SLAUGHTER) could yield additional time, which is her desire.

Mr. LINDER. Mr. Speaker, I am pleased to yield 2 minutes to my friend, the gentleman from Florida (Mr. WELDON).

Mr. WELDON of Florida. Mr. Speaker, as many of my colleagues in this body know, I practiced internal medicine for many years before coming to the House. Indeed, I still see patients about once a month at the veterans' clinic in my congressional district. I lived this problem on a daily basis. I practiced internal medicine. Mainly what I did was I wrote prescriptions mainly for senior citizens, and I dealt personally with the struggles that many of them face in paying for their drugs.

My primary concern is getting a bill, and frankly I was very disappointed we did not get a bill 2 years ago, and I think the reason we did not get a bill is because some people thought they could capitalize on it in the campaign, and I have to honestly say this is deja vu all over again. We are starting out very, very poorly.

I have heard that they have not had a chance. We had two committees mark up this bill. The Committee on Ways and Means spent 13 hours on it. They were in until 2 a.m. The Committee on Energy and Commerce went all night. We hear these claims that the pharmaceutical company is giving us all this money. Do I assume the Democratic party has never taken any pharmaceutical money?

I will tell the Members what we need. We need a plan. We need some kind of plan, and this is step one. We have to go to conference with the Senate. Then we have to negotiate in conference, and many of you people who are over there demagogueing this issue are going to be in that conference committee. We are going to have plenty of opportunities to get a very, very good bill to help our seniors.

But if we keep on with this attitude, I am going to tell my folks back home, forget it. It is going to be kicked off into the campaign again. People are going to hope they are going to get an advantage, and I do not think anybody is going to get an advantage, and the people who are going to suffer are the senior citizens.

I want to say one other thing. We do not want a plan that stifles innovation. If you stifle innovation, I can tell you I used to write prescriptions for people and give them to them, new pills that kept them alive, and without those pills, they would have died.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentlewoman from Florida (Mrs. THURMAN).

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

Mr. Speaker, I want the people of the fifth district's voices to be heard tonight, too. First of all, I want to say that this debate tonight is not about the provider givebacks in this bill. This debate is about the most important issue facing the American people and the issue that every Member of this Congress and including the President ran on in the last election.

And let us make it clear, today I went to the Committee on Rules because the people in the fifth district said to me, we want the cost of drugs down, we are tired of seeing on the TV people going to Canada to buy their medicines cheaper, or why is it that industrialized nations, our competitors, are buying their drugs at a lesser cost?

Just to give you some examples, how about Zocor? In industrialized nations their average pricing is about $65. In the fifth district, it is $104. We need to bring these costs down.

Mr. LINDER. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from Illinois (Mr. SHIMKUS).

Mr. SHIMKUS. Mr. Speaker, I wish my friend, the gentleman from Maryland (Mr. HOYER), was here because he played the Solomon card, and I have great respect for Jerry Solomon, and I say semper fi to Jerry, who is probably watching these proceedings and chuckling.

Mr. Speaker, I support this rule. We labored hard for over 25 hours in the Committee on Energy and Commerce, and I know my friends on the Committee on Ways and Means worked deeply as hard. It is not a perfect bill. In fact, the bill coming to the floor stripped out my language on orphan drugs, help for Lou Gehrig's disease, Crohn's disease and Tourette's disease.

But this bill has some positive aspects. First, it fits within the budget. This is critical because any amendment either on the floor would add to the bill which would strip it on a budget point of order or it would shortchange the prescription drug benefit or shortchange the hospital benefits.

Illinois offers a pharmaceutical assistance program for dual eligibles. This bill will assume Federal responsibility for dual eligibles, saving Illinois $2 billion over 8 years.

□ 2200

Individuals who make 175 percent of poverty level will receive full cost-sharing assistance. This covers 34 percent of Illinois' Medicare population, 549,000 people. It increases payments to all hospitals in 2003. It increases payments to community hospitals. It increases DSH payments, adds a 10 percent increase to rural home health care agencies, increases by 10 percent hospice payments.

Mr. Speaker, it is a finely crafted bill that went through the committee process. It is not a perfect bill. It is a bill that we can pass on the floor tonight. I commend my colleagues and look forward to passing this bill.

Ms. SLAUGHTER. Mr. Speaker, I yield 2 minutes to the gentlewoman from California (Ms. PELOSI), the Democratic whip.

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

Mr. Speaker, 37 years ago when Medicare first came into existence, there was a big fight over it. The Democrats wholeheartedly supported it. The Republicans opposed it. They still oppose Medicare.

Over the years, they have made statements to that effect. Newt Gingrich when he was Speaker said that he would like to see Medicare, in his words, wither on the vine. And the Republican leader of the House, the gentleman from Texas (Mr. ARMEY) said that Medicare should be no part of a free world. In the debate in the Committee on Rules last night, the gentleman from Georgia (Mr. LINDER) referred to it as a Soviet-style model, what the Democrats were proposing. A Soviet-style model.

They did not support it then. They do not support it now. It is no wonder they have proposed this cruel hoax on America's seniors. To pretend they have a prescription drug benefit that is a guarantee is simply not true. They offer no guarantee, merely a suggestion.

The Republican bill does not contain any defined premium or assurances that prescription drugs will be affordable. In the one State where such a program exists, the monthly premium is $85 per month. That is in Nevada.

Less than one-fifth of the estimated cost of Medicare beneficiaries over the next 10 years will be covered in this bill. The Republican bill does not provide guaranteed access to the drugs seniors need or access to their local pharmacy.

If we had been allowed to present a substitute tonight, which this rule prevents, the Democratic substitute would have provided a guaranteed, affordable prescription drug benefit for all seniors that will amount to an entitlement under Medicare. The gentleman from Texas (Mr. BARTON) said before this is optional; it is not mandatory. He said that himself on the floor here.

Mr. Speaker, imagine a situation where we could have prescription drug benefits for all of our seniors, the quality of life that it would produce, and the cost savings to our budget.

Mr. LINDER. Mr. Speaker, I yield myself 30 seconds to point out a couple of things in the previous statement.

Mr. Speaker, Mr. Gingrich did not ever say Medicare would wither on the vine. This was played out on CNN very clearly when they played the whole statement, not the botched statement the Democrats have been running. He said if we bring competition into the system, the Health Care Financing Administration would wither on the vine.

Secondly, I will point out that the Democrats had a majority here for 40 years. When I first came here, they had a huge majority in both bodies, and the President was a Democratic; and they did not even offer one. I think it is fair to say that the Republicans are making the effort.

Mr. Speaker, I yield 1 minute to the gentlewoman from Pennsylvania (Ms. HART).

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

Ms. HART. Mr. Speaker, I rise in support of the rule and urge Members to also support the bill.

The Centers for Medicaid and Medicare Services did a poll checking out this bill. They estimated that virtually all of the Medicare beneficiaries, that is at least 95 percent of them, would opt for this drug coverage. I doubt that 95 percent of Medicare recipients would be interested in their proposal, but this proposal provides seniors with coverage for prescription drugs that they cannot get today. That means the choice they currently make of leaving that prescription drug bag on the counter because they cannot afford it or paying for it and taking it home is no longer a choice they have to make. They pay for it because they have coverage, they take it home, and their health improves.

All of the senior citizens that I have met with in my district have been asking me to please help them get the coverage for the prescription drugs they need to stay healthy and out of the hospital. That is all they ask. The women and the men. That is what we give them in our bill. I urge support.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentleman from New York (Mr. NADLER).

Mr. NADLER. Mr. Speaker, what we have on the floor today is a pitiful, pathetic, puny, pretend plan; a pretend plan that pretends to offer seniors prescription drug care, prescription drugs; but what it really does is gives a lot of money to the insurance companies and says please, we hope you will do something for our seniors, maybe. That is all it is.

They are too something, I will not say what because my words might be taken down, but they will not permit the Democratic plan, which is a straight plan for Medicare to pay for 80 percent of the cost of prescription drugs, to be offered on this floor because they do not have confidence that they could win the debate. They will not permit the two plans to be offered on this floor to be debated because they are afraid in the light of day if the American people see it, they would say, We want a plan. We want what they call the Soviet-style plan, which is what they characterize Medicare as for the last 40 years.

They did not want it then. They still do not want it. And they certainly do not want Medicare coverage for prescription drugs. They want to give more money to the insurance companies and say we hope they will provide it. Fat chance.

Mr. LINDER. Mr. Speaker, I yield 1 minute to the gentleman from Kentucky (Mr. FLETCHER).

Mr. FLETCHER. Mr. Speaker, this evening we are addressing one of the most pressing health care issues in America. I am very disappointed that my colleagues on the other side of the aisle, when we marked up the budget, they absolutely set aside no amount of money, zippo. They did nothing to set aside any money for prescription drugs for seniors. There was no plan in order to provide the funding for the plan that they offered in the committee; and it was a $973 billion plan offered in the committee. There was no way of paying for it. This burden was going to be on our children and grandchildren, and the other side of the aisle offered no single way of paying for it.

Mr. Speaker, they talked about taxes, but they did not offer the tax increase that would have been required. Are they taking it from Social Security? That is where it would have had to come from. Now they talk about controlling cost.

We eliminated the best prices which eliminated the floor. Congressional Budget Office estimates this has the most cost-controlling policy of any plan offered. That means we are going to provide the most competitive prices for drugs. I encourage Members to support the rule and the bill.

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

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

Mr. Speaker, this rule is a fraud. This bill is a fraud. They have come to the floor and said that they are going to do something about prescription drugs for our seniors. Not a dime of this money goes to buy any medicine. It goes to the insurance companies.

I wondered, as I listened to this debate this evening, if my colleagues on the other side of the aisle have bought into the philosophy of that old philosopher and spiritual leader, Brother Dave Gardner, who said, ''When you get a man down, kick him because it gives him incentive to rise above himself.''

They have got our senior citizens down, and now they want to kick them. The Greatest Generation that lived through the Depression, fought World War II and built this Nation, and now we are going to just kick them one more time. And if we cannot kick them, we are going to trick them and try to make them think that we are going to buy them some prescription medicine. This bill does not buy them anything.

Mr. Speaker, this rule should not pass and this bill should not pass because everyone who votes for it is going to have to live forever with the fact that they mistreated our senior citizens, the Greatest Generation one more time.

Mr. LINDER. Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. CUNNINGHAM).

Mr. CUNNINGHAM. Mr. Speaker, I would like to speak to my colleagues on the other side of the aisle. The gentlewoman from New York (Ms. SLAUGHTER) and I have been friends for a long time. I have a mom. I have a grandmother that is 93 years old. I have a mother-in-law and two daughters. They just left topside.

What we resent on this side, and they know the gamesmanship when they had the majority, but the inferences that Republicans do not care about our families is wrong. We do. I would give my life for my family. And I would not give a dime to drug companies if I thought it was going to hurt.

Let me give an example. I had pneumonia a couple of years ago; and when I went to the doctor, the price of Augmentin was $110. My wife had prescription drug insurance through the school system where she is a teacher. That drug instead of $110 was $17. That is the free market private system, and we want more and more people to be included in that.

Now, I understand if the other side of the aisle wants a government-controlled health care plan like the former First Lady tried to do with health care. That is their prerogative, but we think that is wrong. We do care about our people. No child should have to apologize because they go to get a drug, and like the President sat right up here, President Clinton, and we take care of that. But to give the inference that Republicans do not care about our families is wrong because we do. We care very much.

I would also say that the gentlewoman from California (Ms. PELOSI), who spoke previously, since 1988, every single year she voted to take 100 percent of the money out of the Social Security trust fund, and here is the documentation.

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentlewoman from Texas (Ms. JACKSON-LEE).

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, I am told that our physicians take a Hippocratic oath, and that oath says when someone is in need and trusts the physician, do no harm.

I am sad to say that the insurance companies and the Republicans have gotten together, and they are doing great harm. The Republican insurance protection act: value, zero. Zero benefits. Zero to Mom, zero to Dad, zero benefits to the disabled. It is a shame. Realize that our sick seniors are on a roller coaster. Their premiums are not guaranteed, deductibles are high. She is not assured that she will be able to buy the drugs at the pharmacy she trusts, and she gets nothing for a big part of the year, even though she keeps paying premiums.

Mr. Speaker, the Member from Florida said everybody takes money, the Democrats took money. But the Democrats did not take $31 million 5 days before we were supposed to come to the floor of the House and deny us a substitute in order for us to be able to debate this bill on behalf of the American people.

Mr. LINDER. Mr. Speaker, I yield 1 minute to the gentleman from Georgia (Mr. KINGSTON).

Mr. KINGSTON. Mr. Speaker, after looking at this issue from many different angles and for many different weeks, I am going to support this rule. There is a lot more left to do that I am going to be a part of, and I am proud to see that a number of our Members of our leadership have agreed to in terms of addressing and lowering the cost of prescription drugs. But as I listen to this rhetoric tonight, and so much of it is totally uncalled for, one has to believe the statement made in the New Republic in June that the Democrats want this issue on the table because it is an election year, they do not want the bill, they want the issue. I am listening to this, and I know there are a lot of Democrats who want the policy, but I cannot help but think tonight that the Democrats want the politics.

□ 2215

You have to ask yourself, where is your plan? Where is your plan? We know that Mr. DASCHLE and some of the folks across the hall have one, but it is a trillion-dollar plan which will bankrupt Medicare. As you say, you do not like our plan. Well, our plan does not bankrupt Medicare. If you want to protect Medicare, why do you want to bankrupt it?

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LATOURETTE). The Chair would again ask all Members to yield to the gavel.

Ms. SLAUGHTER. Mr. Speaker, we had a plan. We had a fine plan. We just could not bring it out here before the American people.

Mr. Speaker, I yield 1½ minutes to the gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. I thank the gentlewoman for yielding me this time.

Mr. Speaker, I rise this evening in opposition to this rule. There is something very, very, very wrong in this House; and my Republican colleagues know it. You know it because you always speak of choice. You always speak about competition. You are always talking about new ideas. But you will not allow them to come to the floor of the House of Representatives.

I represent 650,000 people. The gentleman that just came to the podium said, ''Where is your plan?'' It is right here. But you are afraid to debate it. Why do you not stand up, be men and women, and debate it? Do not be afraid of ideas. So we will protest.

You know that the Democrats since the 1960s and before that have had a love affair with Medicare. You will never drive a wedge between us and Medicare. That is what we wanted to offer. We wanted to bring our plan to the floor of the House. Perhaps you have the votes to beat that, but the disgrace is that you waved the flag and then you waived the democratic rules.

Shame on you. Shame on you for doing that. Go home and explain that to good Republicans, to good independents and to the Democrats in your district. They would never, ever accept that. That is why there is frustration and anger on this side. We can debate these things, but you are afraid to. You do not want to hear an idea, you do not want to hear about choice, and you do not want to hear about competition.

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

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

We have had an interesting debate here. We had a parade of female Democrats march down citing the mantra that this bill does nothing for senior women. In fact, not one of them spoke with any particularity to the bill. We had the gentlewoman from Connecticut (Mrs. JOHNSON) step up right after that and list time after time after time where this was of benefit for women across the country and most particularly low-income women.

Women have been abused by our social service programs from Social Security through Medicare. This is the first time that any party or any Congress has made an effort to fix that. This is a genuine improvement on this current circumstance.

Facts do not cease to exist just because they are ignored.

It was a fact that, some time ago, the Democrats controlled this body for 40 years and controlled the White House from time to time in the midst of that and never once put forth this important program.

It was a fact that when I came here in 1993 they had overwhelming majorities and a President who was enthusiastic about taking over the health care system. But they did not ever put on the floor for a discussion or debate any prescription drug program for either side to consider.

It is a fact that the Democrats had an opportunity to put forth a program that fit within the budget agreement that was passed by this House, a discipline that this body and this side of the House took seriously. We put forth a bill that fit within the discipline. They did not. This is our proposal. This is our rule. We urge support for it.

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

The previous question was ordered.

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.

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.

The vote was taken by electronic device, and there were—yeas 218, nays 213, not voting 4, as follows:

[Roll No. 280]

YEAS—218

Aderholt	Culberson	Hastert
Akin	Cunningham	Hastings (WA)
Armey	Davis, Jo Ann	Hayes
Bachus	Davis, Tom	Hayworth
Baker	Deal	Hefley
Ballenger	DeLay	Herger
Barr	DeMint	Hilleary
Bartlett	Diaz-Balart	Hobson
Barton	Doolittle	Hoekstra
Bass	Dreier	Horn
Bereuter	Duncan	Hostettler
Biggert	Dunn	Houghton
Bilirakis	Ehlers	Hulshof
Blunt	Ehrlich	Hunter
Boehlert	Emerson	Hyde
Boehner	English	Isakson
Bonilla	Everett	Issa
Bono	Ferguson	Jenkins
Boozman	Flake	Johnson (CT)
Brady (TX)	Fletcher	Johnson (IL)
Brown (SC)	Foley	Johnson, Sam
Bryant	Forbes	Keller
Burr	Fossella	Kelly
Burton	Frelinghuysen	Kennedy (MN)
Buyer	Gallegly	Kerns
Callahan	Ganske	King (NY)
Calvert	Gekas	Kingston
Camp	Gibbons	Kirk
Cannon	Gilchrest	Knollenberg
Cantor	Gillmor	Kolbe
Capito	Gilman	LaHood
Castle	Goode	Latham
Chabot	Goodlatte	LaTourette
Chambliss	Goss	Leach
Coble	Graham	Lewis (CA)
Collins	Granger	Lewis (KY)
Combest	Graves	Linder
Cooksey	Green (WI)	LoBiondo
Cox	Greenwood	Lucas (OK)
Crane	Grucci	Manzullo
Crenshaw	Hansen	McCrery
Cubin	Hart	McHugh

McInnis
McKeon
Mica
Miller, Dan
Miller, Gary
Miller, Jeff
Moran (KS)
Myrick
Nethercutt
Ney
Northup
Norwood
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Reynolds
Riley
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schaffer
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Stump
Sullivan
Sununu
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
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NAYS—213

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Inslee
Israel
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Jackson (IL)
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Jefferson
John
Johnson, E. B.
Jones (NC)
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Kennedy (RI)
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Kilpatrick
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Menendez
Millender-McDonald
Miller, George
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Moran (VA)
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NOT VOTING—4

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Roukema
Traficant

□ 2243

Mr. WEINER, Ms. KAPTUR, and Mr. BECERRA changed their vote from ''yea'' to ''nay.''

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.

□ 2245

Mrs. JOHNSON of Connecticut. Mr. Speaker, pursuant to House Resolution 465, I call up the bill (H.R. 4954) 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 and reform payments and the regulatory structure of the Medicare Program, and for other purposes, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. THORNBERRY). Pursuant to House Resolution 465, the bill is considered as read for amendment.

The text of H.R. 4954 is as follows:

H.R. 4954

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

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Modernization and Prescription Drug Act of 2002''.

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

(c) BIPA; SECRETARY.—In this Act:

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

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

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

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

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Sec. 101. Establishment of a medicare prescription drug benefit.

''PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

''Sec. 1860A. Benefits; eligibility; enrollment; and coverage period.

''Sec. 1860B. Requirements for qualified prescription drug coverage.

''Sec. 1860C. Beneficiary protections for qualified prescription drug coverage.

''Sec. 1860D. Requirements for prescription drug plan (PDP) sponsors; contracts; establishment of standards.

''Sec. 1860E. Process for beneficiaries to select qualified prescription drug coverage.

''Sec. 1860F. Submission of bids.

''Sec. 1860G. Premium and cost-sharing subsidies for low-income individuals.

''Sec. 1860H. Subsidies for all medicare beneficiaries for qualified prescription drug coverage.

''Sec. 1860I. Medicare Prescription Drug Trust Fund.

''Sec. 1860J. Definitions; treatment of references to provisions in part C.

Sec. 102. Offering of qualified prescription drug coverage under the Medicare+Choice program.

Sec. 103. Medicaid amendments.

Sec. 104. Medigap transition.

Sec. 105. Medicare prescription drug discount card endorsement program.

TITLE II—MEDICARE+CHOICE REVITALIZATION AND MEDICARE+CHOICE COMPETITION PROGRAM

Subtitle A—Medicare+Choice Revitalization

Sec. 201. Medicare+Choice improvements.

Sec. 202. Making permanent change in Medicare+Choice reporting deadlines and annual, coordinated election period.

Sec. 203. Avoiding duplicative State regulation.

Sec. 204. Specialized Medicare+Choice plans for special needs beneficiaries.

Sec. 205. Medicare MSAs.

Sec. 206. Extension of reasonable cost and SHMO contracts.

Subtitle B—Medicare+Choice Competition Program

Sec. 211. Medicare+Choice competition program.

Sec. 212. Demonstration program for competitive-demonstration areas.

Sec. 213. Conforming amendments.

TITLE III—RURAL HEALTH CARE IMPROVEMENTS

Sec. 301. Reference to full market basket increase for sole community hospitals.

Sec. 302. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.

Sec. 303. 2-year phased-in increase in the standardized amount in rural and small urban areas to achieve a single, uniform standardized amount.

Sec. 304. More frequent update in weights used in hospital market basket.

Sec. 305. Improvements to critical access hospital program.

Sec. 306. Extension of temporary increase for home health services furnished in a rural area.

Sec. 307. Reference to 10 percent increase in payment for hospice care furnished in a frontier area and rural hospice demonstration project.

Sec. 308. Reference to priority for hospitals located in rural or small urban areas in redistribution of unused graduate medical education residencies.

Sec. 309. GAO study of geographic differences in payments for physicians' services.

Sec. 310. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.

TITLE IV—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

Sec. 401. Revision of acute care hospital payment updates.
Sec. 402. 2-year increase in level of adjustment for indirect costs of medical education (IME).
Sec. 403. Recognition of new medical technologies under inpatient hospital PPS.
Sec. 404. Phase-in of Federal rate for hospitals in Puerto Rico.
Sec. 405. Reference to provision relating to enhanced disproportionate share hospital (DSH) payments for rural hospitals and urban hospitals with fewer than 100 beds.
Sec. 406. Reference to provision relating to 2-year phased-in increase in the standardized amount in rural and small urban areas to achieve a single, uniform standardized amount.
Sec. 407. Reference to provision for more frequent updates in the weights used in hospital market basket.
Sec. 408. Reference to provision making improvements to critical access hospital program.for more frequent updates in the weights used in hospital market basket.

Subtitle B—Skilled Nursing Facility Services

Sec. 411. Payment for covered skilled nursing facility services.

Subtitle C—Hospice

Sec. 421. Coverage of hospice consultation services.
Sec. 422. 10 percent increase in payment for hospice care furnished in a frontier area.
Sec. 423. Rural hospice demonstration project.

Subtitle D—Other Provisions

Sec. 431. Demonstration project for use of recovery audit contractors for part A services.

TITLE V—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

Sec. 501. Revision of updates for physicians' services.
Sec. 502. Studies on access to physicians' services.
Sec. 503. MedPAC report on payment for physicians' services.

Subtitle B—Other Services

Sec. 511. Competitive acquisition of certain items and services.
Sec. 512. Payment for ambulance services.
Sec. 513. 1-year extension of moratorium on therapy caps; provisions relating to reports.
Sec. 514. Accelerated implementation of 20 percent coinsurance for hospital outpatient department (OPD) services; other OPD provisions.
Sec. 515. Coverage of an initial preventive physical examination.
Sec. 516. Renal dialysis services.

TITLE VI—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

Sec. 601. Elimination of 15 percent reduction in payment rates under the prospective payment system.
Sec. 602. Establishment of reduced copayment for a home health service episode of care for certain beneficiaries.
Sec. 603. Update in home health services.
Sec. 604. OASIS Task Force; suspension of certain OASIS data collection requirements pending Task Force submittal of report.
Sec. 605. MedPAC study on medicare margins of home health agencies.

Subtitle B—Direct Graduate Medical Education

Sec. 611. Extension of update limitation on high cost programs.
Sec. 612. Redistribution of unused resident positions.

Subtitle C—Other Provisions

Sec. 621. Modifications to Medicare Payment Advisory Commission (MedPAC).
Sec. 622. Demonstration project for disease management for certain medicare beneficiaries with diabetes.
Sec. 623. Demonstration project for medical adult day care services.

TITLE VII—MEDICARE BENEFITS ADMINISTRATION

Sec. 701. Establishment of Medicare Benefits Administration.

TITLE VIII—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

Sec. 801. Construction; definition of supplier.
Sec. 802. Issuance of regulations.
Sec. 803. Compliance with changes in regulations and policies.
Sec. 804. Reports and studies relating to regulatory reform.

Subtitle B—Contracting Reform

Sec. 811. Increased flexibility in medicare administration.
Sec. 812. Requirements for information security for medicare administrative contractors.

Subtitle C—Education and Outreach

Sec. 821. Provider education and technical assistance.
Sec. 822. Small provider technical assistance demonstration program.
Sec. 823. Medicare provider ombudsman; medicare beneficiary ombudsman.
Sec. 824. Beneficiary outreach demonstration program.

Subtitle D—Appeals and Recovery

Sec. 831. Transfer of responsibility for medicare appeals.
Sec. 832. Process for expedited access to review.
Sec. 833. Revisions to medicare appeals process.
Sec. 834. Prepayment review.
Sec. 835. Recovery of overpayments.
Sec. 836. Provider enrollment process; right of appeal.
Sec. 837. Process for correction of minor errors and omissions on claims without pursuing appeals process.
Sec. 838. Prior determination process for certain items and services; advance beneficiary notices.

Subtitle E—Miscellaneous Provisions

Sec. 841. Policy development regarding evaluation and management (E & M) documentation guidelines.
Sec. 842. Improvement in oversight of technology and coverage.
Sec. 843. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.
Sec. 844. EMTALA improvements.
Sec. 845. Emergency Medical Treatment and Active Labor Act (EMTALA) Technical Advisory Group.
Sec. 846. Authorizing use of arrangements with other hospice programs to provide core hospice services in certain circumstances.
Sec. 847. Application of OSHA bloodborne pathogens standard to certain hospitals.
Sec. 848. BIPA-related technical amendments and corrections.
Sec. 849. Conforming authority to waive a program exclusion.
Sec. 850. Treatment of certain dental claims.
Sec. 851. Annual publication of list of national coverage determinations.

TITLE IX—MEDICAID, PUBLIC HEALTH, AND OTHER HEALTH PROVISIONS

Subtitle A—Medicaid Provisions

Sec. 901. National Bipartisan Commission on the Future of Medicaid.
Sec. 902. GAO study on medicaid drug payment system.

Subtitle B—Internet Pharmacies

Sec. 911. Findings.
Sec. 912. Amendment to Federal Food, Drug, and Cosmetic Act.
Sec. 913. Public education.
Sec. 914. Study regarding coordination of regulatory activities.
Sec. 915. Effective date.

Subtitle C—Promotion of Electronic Prescription

Sec. 921. Program of grants to health care providers to implement electronic prescription drug programs.

Subtitle D—Treatment of Rare Diseases

Sec. 931. NIH Office of Rare Diseases at National Institutes of Health.
Sec. 932. Rare disease regional centers of excellence.

Subtitle E—Other Provisions Relating to Drugs

Sec. 941. GAO study regarding direct-to-consumer advertising of prescription drugs.
Sec. 942. Certain health professions programs regarding practice of pharmacy.

''SUBPART 3—PHARMACIST WORKFORCE PROGRAMS

''Sec. 771. Public service announcements.
''Sec. 772. Demonstration project.
''Sec. 773. Information technology.
''Sec. 774. Authorization of appropriations.

TITLE X—HEALTH-CARE RELATED TAX PROVISIONS

Sec. 1001. Eligibility for Archer MSA's extended to account holders of Medicare+Choice MSA's.
Sec. 1002. Adjustment of employer contributions to Combined Benefit Fund to reflect medicare prescription drug subsidy payments.
Sec. 1003. Expansion of human clinical trials qualifying for orphan drug credit.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 101. ESTABLISHMENT OF A MEDICARE PRESCRIPTION DRUG BENEFIT.

(a) IN GENERAL.—Title XVIII is amended—

(1) by redesignating part D as part E; and

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

''PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

"SEC. 1860A. BENEFITS; ELIGIBILITY; ENROLLMENT; AND COVERAGE PERIOD.

''(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN

PLANS.—Subject to the succeeding provisions of this part, each individual who is entitled to benefits under part A or is enrolled under part B is entitled to obtain qualified prescription drug coverage (described in section 1860B(a)) as follows:

''(1) MEDICARE+CHOICE PLAN.—If the individual is eligible to enroll in a Medicare+Choice plan that provides qualified prescription drug coverage under section 1851(j), the individual may enroll in the plan and obtain coverage through such plan.

''(2) PRESCRIPTION DRUG PLAN.—If the individual is not enrolled in a Medicare+Choice plan that provides qualified prescription drug coverage, the individual may enroll under this part in a prescription drug plan (as defined in section 1860J(a)(5)).

Such individuals shall have a choice of such plans under section 1860E(d).

''(b) GENERAL ELECTION PROCEDURES.—

''(1) IN GENERAL.—An individual eligible to make an election under subsection (a) may elect to enroll in a prescription drug plan under this part, or elect the option of qualified prescription drug coverage under a Medicare+Choice plan under part C, and to change such election only in such manner and form as may be prescribed by regulations of the Administrator of the Medicare Benefits Administration (appointed under section 1808(b)) (in this part referred to as the 'Medicare Benefits Administrator') and only during an election period prescribed in or under this subsection.

''(2) ELECTION PERIODS.—

''(A) IN GENERAL.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the Medicare+Choice program under section 1851(e), including—

''(i) annual coordinated election periods; and

''(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a Medicare+Choice election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug plan under this part at the time of the election of coverage under the original fee-for-service plan.

''(B) INITIAL ELECTION PERIODS.—

''(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2004, there shall be an initial election period of 6 months beginning on that date.

''(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

''(C) ADDITIONAL SPECIAL ELECTION PERIODS.—The Administrator shall establish special election periods—

''(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in subsection (c)(2)(C);

''(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B;

''(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Administrator may provide; and

''(iv) in cases of individuals (as determined by the Administrator) who become eligible for prescription drug assistance under title XIX under section 1935(d).

''(c) GUARANTEED ISSUE; COMMUNITY RATING; AND NONDISCRIMINATION.—

''(1) GUARANTEED ISSUE.—

''(A) IN GENERAL.—An eligible individual who is eligible to elect qualified prescription drug coverage under a prescription drug plan or Medicare+Choice plan at a time during which elections are accepted under this part with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

''(B) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to PDP sponsors under this subsection.

''(2) COMMUNITY-RATED PREMIUM.—

''(A) IN GENERAL.—In the case of an individual who maintains (as determined under subparagraph (C)) continuous prescription drug coverage since the date the individual first qualifies to elect prescription drug coverage under this part, a PDP sponsor or Medicare+Choice organization offering a prescription drug plan or Medicare+Choice plan that provides qualified prescription drug coverage and in which the individual is enrolled may not deny, limit, or condition the coverage or provision of covered prescription drug benefits or increase the premium under the plan based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act or any other factor.

''(B) LATE ENROLLMENT PENALTY.—In the case of an individual who does not maintain such continuous prescription drug coverage (as described in subparagraph (C)), a PDP sponsor or Medicare+Choice organization may (notwithstanding any provision in this title) adjust the premium otherwise applicable or impose a pre-existing condition exclusion with respect to qualified prescription drug coverage in a manner that reflects additional actuarial risk involved. Such a risk shall be established through an appropriate actuarial opinion of the type described in subparagraphs (A) through (C) of section 2103(c)(4).

''(C) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

''(i) COVERAGE UNDER PRESCRIPTION DRUG PLAN OR MEDICARE+CHOICE PLAN.—Qualified prescription drug coverage under a prescription drug plan or under a Medicare+Choice plan.

''(ii) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

''(iii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan as defined in section 1860H(f)(1), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(iv) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)), but only if the policy was in effect on January 1, 2005, and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(v) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(vi) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(D) CERTIFICATION.—For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in subparagraph (C).

''(E) DISCLOSURE.—

''(i) IN GENERAL.—Each entity that offers coverage of the type described in clause (iii), (iv), (v), or (vi) of subparagraph (C) shall provide for disclosure, consistent with standards established by the Administrator, of whether such coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(ii) WAIVER OF LIMITATIONS.—An individual may apply to the Administrator to waive the requirement that coverage of such type provide benefits at least equivalent to the benefits under a qualified prescription drug plan, if the individual establishes that the individual was not adequately informed that such coverage did not provide such level of benefits.

''(F) CONSTRUCTION.—Nothing in this section shall be construed as preventing the disenrollment of an individual from a prescription drug plan or a Medicare+Choice plan based on the termination of an election described in section 1851(g)(3), including for non-payment of premiums or for other reasons specified in subsection (d)(3), which takes into account a grace period described in section 1851(g)(3)(B)(i).

''(3) NONDISCRIMINATION.—A PDP sponsor offering a prescription drug plan shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

''(d) EFFECTIVE DATE OF ELECTIONS.—

''(1) IN GENERAL.—Except as provided in this section, the Administrator shall provide that elections under subsection (b) take effect at the same time as the Administrator

provides that similar elections under section 1851(e) take effect under section 1851(f).

''(2) NO ELECTION EFFECTIVE BEFORE 2005.—In no case shall any election take effect before January 1, 2005.

''(3) TERMINATION.—The Administrator shall provide for the termination of an election in the case of—

''(A) termination of coverage under both part A and part B; and

''(B) termination of elections described in section 1851(g)(3) (including failure to pay required premiums).

''SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) REQUIREMENTS.—

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

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

''(B) ACTUARIALLY EQUIVALENT COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered outpatient drugs which meets the alternative coverage requirements of subsection (c) and access to negotiated prices under subsection (d), but only if it is approved by the Administrator, as provided under subsection (c).

''(2) PERMITTING ADDITIONAL OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered outpatient drugs that exceeds the coverage required under paragraph (1), but any such additional coverage shall be limited to coverage of covered outpatient drugs.

''(B) DISAPPROVAL AUTHORITY.—The Administrator shall review the offering of qualified prescription drug coverage under this part or part C. If the Administrator finds that, in the case of a qualified prescription drug coverage under a prescription drug plan or a Medicare+Choice plan, that the organization or sponsor offering the coverage is engaged in activities intended to discourage enrollment of classes of eligible medicare beneficiaries obtaining coverage through the plan on the basis of their higher likelihood of utilizing prescription drug coverage, the Administrator may terminate the contract with the sponsor or organization under this part or part C.

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

''(b) STANDARD COVERAGE.—For purposes of this part, the 'standard coverage' is coverage of covered outpatient drugs (as defined in subsection (f)) that meets the following requirements:

''(1) DEDUCTIBLE.—The coverage has an annual deductible—

''(A) for 2005, that is equal to $250; or

''(B) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (5) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''(2) LIMITS ON COST-SHARING.—

''(A) IN GENERAL.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) as follows:

''(i) FIRST COPAYMENT RANGE.—For costs above the annual deductible specified in paragraph (1) and up to amount specified in subparagraph (C), the cost-sharing—

''(I) is equal to 20 percent; or

''(II) is actuarially equivalent (using processes established under subsection (e)) to an average expected payment of 20 percent of such costs.

''(ii) SECONDARY COPAYMENT RANGE.—For costs above the amount specified in subparagraph (C) and up to the initial coverage limit, the cost-sharing—

''(I) is equal to 50 percent; or

''(II) is actuarially consistent (using processes established under subsection (e)) with an average expected payment of 50 percent of such costs.

''(B) USE OF TIERED COPAYMENTS.—Nothing in this part shall be construed as preventing a PDP sponsor from applying tiered copayments, so long as such tiered copayments are consistent with subparagraph (A).

''(C) INITIAL COPAYMENT THRESHOLD.—The amount specified in this subparagraph—

''(i) for 2005, is equal to $1,000; or

''(ii) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under clause (ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''(3) INITIAL COVERAGE LIMIT.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (above the annual deductible)—

''(A) for 2005, that is equal to $2,000; or

''(B) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $25 shall be rounded to the nearest multiple of $25.

''(4) CATASTROPHIC PROTECTION.—

''(A) IN GENERAL.—Notwithstanding paragraph (3), the coverage provides benefits with no cost-sharing after the individual has incurred costs (as described in subparagraph (C)) for covered outpatient drugs in a year equal to the annual out-of-pocket threshold specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET THRESHOLD.—For purposes of this part, the 'annual out-of-pocket threshold' specified in this subparagraph—

''(i) for 2005, is equal to $4,500; or

''(ii) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under clause (ii) that is not a multiple of $100 shall be rounded to the nearest multiple of $100.

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

''(i) incurred costs shall only include costs incurred for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3); and

''(ii) such costs shall be treated as incurred only if they are paid by the individual, under section 1860G, or under title XIX and the individual is not reimbursed (through insurance or otherwise) by another person for such costs.

''(5) ANNUAL PERCENTAGE INCREASE.—For purposes of this part, the annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs in the United States for medicare beneficiaries, as determined by the Administrator for the 12-month period ending in July of the previous year.

''(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A prescription drug plan or Medicare+Choice plan may provide a different prescription drug benefit design from the standard coverage described in subsection (b) so long as the following requirements are met and the plan applies for, and receives, the approval of the Administrator for such benefit design:

''(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

''(A) ASSURING EQUIVALENT VALUE OF TOTAL COVERAGE.—The actuarial value of the total coverage (as determined under subsection (e)) is at least equal to the actuarial value (as so determined) of standard coverage.

''(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (e)) exceeds the actuarial value of the subsidy payments under section 1860H with respect to such coverage.

''(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (e)), to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (b)(3), of an amount equal to at least the sum of the following products:

''(i) FIRST COPAYMENT RANGE.—The product of—

''(I) the amount by which the initial copayment threshold described in subsection (b)(2)(C) exceeds the deductible described in subsection (b)(1); and

''(II) 100 percent minus the cost-sharing percentage specified in subsection (b)(2)(A)(i)(I).

''(ii) SECONDARY COPAYMENT RANGE.—The product of—

''(I) the amount by which the initial coverage limit described in subsection (b)(3) exceeds the initial copayment threshold described in subsection (b)(2)(C); and

''(II) 100 percent minus the cost-sharing percentage specified in subsection (b)(2)(A)(ii)(I).

''(2) CATASTROPHIC PROTECTION.—The coverage provides for beneficiaries the catastrophic protection described in subsection (b)(4).

''(d) ACCESS TO NEGOTIATED PRICES.—

''(1) IN GENERAL.—Under qualified prescription drug coverage offered by a PDP sponsor or a Medicare+Choice organization, the sponsor or organization shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of cost-sharing or an initial coverage limit (described in subsection (b)(3)). Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated by a prescription drug plan under this part, the requirements of section 1927 shall not apply to such drugs.

''(2) DISCLOSURE.—The PDP sponsor or Medicare+Choice organization shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts or rebates made available to the sponsor or organization by a manufacturer are passed through to enrollees through

pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Administrator under this paragraph in the same manner as such provisions apply to information disclosed under such section.

''(e) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

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

''(A) for determining the actuarial valuation of prescription drug coverage, including—

''(i) an actuarial valuation of standard coverage and of the reinsurance subsidy payments under section 1860H;

''(ii) the use of generally accepted actuarial principles and methodologies; and

''(iii) applying the same methodology for determinations of alternative coverage under subsection (c) as is used with respect to determinations of standard coverage under subsection (b); and

''(B) for determining annual percentage increases described in subsection (b)(5).

''(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), PDP sponsors and Medicare+Choice organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values.

''(f) COVERED OUTPATIENT DRUGS DEFINED.—

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

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

''(3) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully appealed under section 1860C(f)(2).

''(4) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered outpatient drug—

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

''(B) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860C(f).

''SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) GUARANTEED ISSUE, COMMUNITY-RELATED PREMIUMS, ACCESS TO NEGOTIATED PRICES, AND NONDISCRIMINATION.—For provisions requiring guaranteed issue, community-rated premiums, access to negotiated prices, and nondiscrimination, see sections 1860A(c)(1), 1860A(c)(2), 1860B(d), and 1860F(b), respectively.

''(b) DISSEMINATION OF INFORMATION.—

''(1) GENERAL INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

''(A) Access to covered outpatient drugs, including access through pharmacy networks.

''(B) How any formulary used by the sponsor functions.

''(C) Co-payments and deductible requirements, including the identification of the tiered or other co-payment level applicable to each drug (or class of drugs).

''(D) Grievance and appeals procedures.

''(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll under a prescription drug plan, the PDP sponsor shall provide the information described in section 1852(c)(2) (other than subparagraph (D)) to such individual.

''(3) RESPONSE TO BENEFICIARY QUESTIONS.—Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information to enrollees upon request. The sponsor shall make available on a timely basis, through an Internet website and in writing upon request, information on specific changes in its formulary.

''(4) CLAIMS INFORMATION.—Each PDP sponsor offering a prescription drug plan must furnish to enrolled individuals in a form easily understandable to such individuals an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice of the benefits in relation to initial coverage limit and annual out-of-pocket threshold for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(c) ACCESS TO COVERED BENEFITS.—

''(1) ASSURING PHARMACY ACCESS.—

''(A) IN GENERAL.—The PDP sponsor of the prescription drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Administrator and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(e) that ensure such convenient access.

''(B) USE OF POINT-OF-SERVICE SYSTEM.—A PDP sponsor shall establish an optional point-of-service method of operation under which—

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

''(ii) the plan may charge beneficiaries through adjustments in premiums and co-payments any additional costs associated with the point-of-service option.

The additional copayments so charged shall not count toward the application of section 1860B(b).

''(2) USE OF STANDARDIZED TECHNOLOGY.—

''(A) IN GENERAL.—The PDP sponsor of a prescription drug plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860B(d) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug plan.

''(B) STANDARDS.—

''(i) DEVELOPMENT.—The Administrator shall provide for the development of national standards relating to a standardized format for the card or other technology referred to in subparagraph (A). Such standards shall be compatible with standards established under part C of title XI.

''(ii) APPLICATION OF ADVISORY TASK FORCE.—The advisory task force established under subsection (d)(3)(B)(ii) shall provide recommendations to the Administrator under such subsection regarding the standards developed under clause (i).

''(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a PDP sponsor of a prescription drug plan uses a formulary, the following requirements must be met:

''(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The sponsor must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least one physician and at least one pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a physician or a pharmacist (or both).

''(B) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

''(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs (although not necessarily for all drugs within such categories and classes).

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

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

''(F) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see subsections (e) and (f).

''(d) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(1) IN GENERAL.—The PDP sponsor shall have in place with respect to covered outpatient drugs—

''(A) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

''(B) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in paragraph (2) and for years beginning with 2006, an electronic prescription program described in paragraph (3); and

''(C) a program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing a PDP sponsor from applying cost management tools (including differential payments) under all methods of operation.

''(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to assure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered outpatient drugs under the prescription drug plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

''(B) ELEMENTS.—Such program may include—

''(i) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

''(ii) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

''(iii) detection of patterns of overuse and underuse of prescription drugs.

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

''(D) CONSIDERATIONS IN PHARMACY FEES.—The PDP sponsor of a prescription drug program shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

''(3) ELECTRONIC PRESCRIPTION PROGRAM.—

''(A) IN GENERAL.—An electronic prescription drug program described in this paragraph is a program that includes at least the following components, consistent with national standards established under subparagraph (B):

''(i) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—Prescriptions are only received electronically, except in emergency cases and other exceptional circumstances recognized by the Administrator.

''(ii) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL.—The program provides, upon transmittal of a prescription by a prescribing health care professional, for transmittal by the pharmacist to the professional of information that includes—

''(I) information (to the extent available and feasible) on the 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.

''(B) STANDARDS.—

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

''(ii) ADVISORY TASK FORCE.—In developing such standards and the standards described in subsection (c)(2)(B)(i) the Administrator shall establish a task force that includes representatives of physicians, hospitals, pharmacists, and technology experts and representatives 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 systems reduce medication errors and can be readily implemented by physicians and hospitals.

''(III) Efforts to develop a common software platform for computerized prescribing.

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

''(V) 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 Administrator shall constitute the task force under clause (ii) by not later than April 1, 2003.

''(II) Such task force shall submit recommendations to Administrator by not later than January 1, 2004.

''(III) The Administrator shall develop and promulgate the national standards referred to in clause (ii) by not later than July 1, 2004.

''(C) REFERENCE TO AVAILABILITY OF GRANT FUNDS.—Grant funds are authorized under section 399O of the Public Health Service Act to provide assistance to health care providers in implementing electronic prescription drug programs.

''(4) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug plans under this part with respect to the following requirements, in the same manner as they apply to Medicare+Choice plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

''(A) Paragraph (1) (including quality assurance), including medication therapy management program under paragraph (2).

''(B) Subsection (c)(1) (relating to access to covered benefits).

''(C) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

''(5) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each PDP sponsor shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered outpatient drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

''(e) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

''(1) IN GENERAL.—Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the sponsor provides covered benefits) and enrollees with prescription drug plans of the sponsor under this part in accordance with section 1852(f).

''(2) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—A PDP sponsor shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(3) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug plan offered by a PDP sponsor that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(f) APPEALS.—

''(1) IN GENERAL.—Subject to paragraph (2), a PDP sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(2) FORMULARY DETERMINATIONS.—An individual who is enrolled in a prescription drug plan offered by a PDP sponsor may appeal to obtain coverage for a covered outpatient drug that is not on a formulary of the sponsor if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(g) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—A PDP sponsor shall meet the requirements of section 1852(h) with respect to enrollees under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to enrollees under part C.

"SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG PLAN (PDP) SPONSORS; CONTRACTS; ESTABLISHMENT OF STANDARDS.

''(a) GENERAL REQUIREMENTS.—Each PDP sponsor of a prescription drug plan shall meet the following requirements:

''(1) LICENSURE.—Subject to subsection (c), the sponsor is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a prescription drug plan.

''(2) ASSUMPTION OF FINANCIAL RISK.—

''(A) IN GENERAL.—Subject to subparagraph (B) and section 1860E(d)(2), the entity assumes full financial risk on a prospective basis for qualified prescription drug coverage that it offers under a prescription drug plan and that is not covered under section 1860H.

''(B) REINSURANCE PERMITTED.—The entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrolled member under this part.

''(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the case of a sponsor that is not described in paragraph (1), the sponsor shall meet solvency standards established by the Administrator under subsection (d).

''(b) CONTRACT REQUIREMENTS.—

''(1) IN GENERAL.—The Administrator shall not permit the election under section 1860A of a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1860G or 1860H, unless the Administrator has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than one prescription drug plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(2) NEGOTIATION REGARDING TERMS AND CONDITIONS.—The Administrator shall have the same authority to negotiate the terms and conditions of prescription drug plans under this part as the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code. In negotiating the terms and conditions regarding premiums for which information is submitted under section 1860F(a)(2), the Administrator shall take into account the subsidy payments under section 1860H and the adjusted community rate (as defined in section 1854(f)(3)) for the benefits covered.

''(3) INCORPORATION OF CERTAIN MEDICARE+CHOICE CONTRACT REQUIREMENTS.—The following provisions of section 1857 shall apply, subject to subsection (c)(5), to contracts under this section in the same manner as they apply to contracts under section 1857(a):

''(A) MINIMUM ENROLLMENT.—Paragraphs (1) and (3) of section 1857(b).

''(B) CONTRACT PERIOD AND EFFECTIVENESS.—Paragraphs (1) through (3) and (5) of section 1857(c).

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

''(D) ADDITIONAL CONTRACT TERMS.—Section 1857(e); except that in applying section 1857(e)(2) under this part—

''(i) such section shall be applied separately to costs relating to this part (from costs under part C);

''(ii) in no case shall the amount of the fee established under this subparagraph for a plan exceed 20 percent of the maximum amount of the fee that may be established under subparagraph (B) of such section; and

''(iii) no fees shall be applied under this subparagraph with respect to Medicare+Choice plans.

''(E) INTERMEDIATE SANCTIONS.—Section 1857(g).

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

''(4) RULES OF APPLICATION FOR INTERMEDIATE SANCTIONS.—In applying paragraph (3)(E)—

''(A) the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part; and

''(B) the reference in section 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall not be applied.

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

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

''(2) GROUNDS FOR APPROVAL.—The grounds for approval under this paragraph are the grounds for approval described in subparagraph (B), (C), and (D) of section 1855(a)(2), and also include the application by a State of any grounds other than those required under Federal law.

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

''(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) does not deem the entity to meet other requirements imposed under this part for a PDP sponsor.

''(5) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying provisions of section 1855(a)(2) under this subsection to prescription drug plans and PDP sponsors—

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

''(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d).

''(d) SOLVENCY STANDARDS FOR NON-LICENSED SPONSORS.—

''(1) ESTABLISHMENT.—The Administrator shall establish, by not later than October 1, 2003, financial solvency and capital adequacy standards that an entity that does not meet the requirements of subsection (a)(1) must meet to qualify as a PDP sponsor under this part.

''(2) COMPLIANCE WITH STANDARDS.—Each PDP sponsor that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Administrator shall establish certification procedures for such PDP sponsors with respect to such solvency standards in the manner described in section 1855(c)(2).

''(e) OTHER STANDARDS.—The Administrator shall establish by regulation other standards (not described in subsection (d)) for PDP sponsors and plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by October 1, 2003.

''(f) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency, except as provided in subsection (d)) with respect to prescription drug plans which are offered by PDP sponsors under this part.

''(2) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to premiums paid to PDP sponsors for prescription drug plans under this part, or with respect to any payments made to such a sponsor by the Administrator under this part.

''SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) IN GENERAL.—The Administrator shall establish a process for the selection of the prescription drug plan or Medicare+Choice plan which offer qualified prescription drug coverage through which eligible individuals elect qualified prescription drug coverage under this part.

''(b) ELEMENTS.—Such process shall include the following:

''(1) Annual, coordinated election periods, in which such individuals can change the qualifying plans through which they obtain coverage, in accordance with section 1860A(b)(2).

''(2) Active dissemination of information to promote an informed selection among qualifying plans based upon price, quality, and other features, in the manner described in (and in coordination with) section 1851(d), including the provision of annual comparative information, maintenance of a toll-free hotline, and the use of non-Federal entities.

''(3) Coordination of elections through filing with a Medicare+Choice organization or a PDP sponsor, in the manner described in (and in coordination with) section 1851(c)(2).

''(c) MEDICARE+CHOICE ENROLLEE IN PLAN OFFERING PRESCRIPTION DRUG COVERAGE MAY ONLY OBTAIN BENEFITS THROUGH THE PLAN.—An individual who is enrolled under a Medicare+Choice plan that offers qualified prescription drug coverage may only elect to receive qualified prescription drug coverage under this part through such plan.

''(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

''(1) CHOICE OF AT LEAST TWO PLANS IN EACH AREA.—

''(A) IN GENERAL.—The Administrator shall assure that each individual who is entitled to benefits under part A or enrolled under part B and who is residing in an area in the United States has available, consistent with subparagraph (B), a choice of enrollment in at least two qualifying plans (as defined in paragraph (5)) in the area in which the individual resides, at least one of which is a prescription drug plan.

''(B) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in subparagraph (A) is not satisfied with respect to an area if only one PDP sponsor or Medicare+Choice organization offers all the qualifying plans in the area.

''(2) GUARANTEEING ACCESS TO COVERAGE.—In order to assure access under paragraph (1) and consistent with paragraph (3), the Administrator may provide financial incentives (including partial underwriting of risk) for a PDP sponsor to expand the service area under an existing prescription drug plan to adjoining or additional areas or to establish such a plan (including offering such a plan on a regional or nationwide basis), but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

''(3) LIMITATION ON AUTHORITY.—In exercising authority under this subsection, the Administrator—

''(A) shall not provide for the full underwriting of financial risk for any PDP sponsor;

''(B) shall not provide for any underwriting of financial risk for a public PDP sponsor with respect to the offering of a nationwide prescription drug plan; and

''(C) shall seek to maximize the assumption of financial risk by PDP sponsors or Medicare+Choice organizations.

''(4) REPORTS.—The Administrator shall, in each annual report to Congress under section 1808(f), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to minimize the exercise of such authority, including minimizing the assumption of financial risk.

''(5) QUALIFYING PLAN DEFINED.—For purposes of this subsection, the term 'qualifying plan' means a prescription drug plan or a Medicare+Choice plan that includes qualified prescription drug coverage.

''SEC. 1860F. SUBMISSION OF BIDS.

''(a) SUBMISSION OF BIDS AND RELATED INFORMATION.—

''(1) IN GENERAL.—Each PDP sponsor shall submit to the Administrator information of the type described in paragraph (2) in the same manner as information is submitted by a Medicare+Choice organization under section 1854(a)(1).

''(2) TYPE OF INFORMATION.—The information described in this paragraph is the following:

''(A) Information on the qualified prescription drug coverage to be provided.

''(B) Information on the actuarial value of the coverage.

''(C) Information on the bid for the coverage, including an actuarial certification of—

''(i) the actuarial basis for such bid;

''(ii) the portion of such bid attributable to benefits in excess of standard coverage; and

''(iii) the reduction in such bid resulting from the subsidy payments provided under section 1860H.

''(D) Such other information as the Administrator may require to carry out this part.

''(3) REVIEW.—The Administrator shall review the information filed under paragraph (2) for the purpose of conducting negotiations under section 1860D(b)(2).

''(b) UNIFORM BID.—

''(1) IN GENERAL.—The bid for a prescription drug plan under this section may not vary among individuals enrolled in the plan in the same service area.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing the imposition of a late enrollment penalty under section 1860A(c)(2)(B).

''(c) COLLECTION.—

''(1) USE OF ELECTRONIC FUNDS TRANSFER MECHANISM OR, AT BENEFICIARY'S OPTION, WITHHOLDING FROM SOCIAL SECURITY PAYMENT.—In accordance with regulations, a PDP sponsor may encourage that enrollees under a plan make payment of the premium established by the plan under this part through an electronic funds transfer mechanism, such as automatic charges of an account at a financial institution or a credit or debit card account, or, at the option of an enrollee, through withholding from benefit payments in the manner provided under section 1840 with respect to monthly premiums under section 1839. All such amounts shall be credited to the Medicare Prescription Drug Trust Fund.

''(2) OFFSETTING.—Reductions in premiums for coverage under parts A and B as a result of a selection of a Medicare+Choice plan may be used to reduce the premium otherwise imposed under paragraph (1).

''(3) PAYMENT OF PLANS.—PDP plans shall receive payment based on bid amounts in the same manner as Medicare+Choice organizations receive payment based on bid amounts under section 1853(a)(1)(A)(ii) except that such payment shall be made from the Medicare Prescription Drug Trust Fund.

''(d) ACCEPTANCE OF BENCHMARK AMOUNT AS FULL PREMIUM FOR SUBSIDIZED LOW-INCOME INDIVIDUALS IF NO STANDARD (OR EQUIVALENT) COVERAGE IN AN AREA.—

''(1) IN GENERAL.—If there is no standard prescription drug coverage (as defined in paragraph (2)) offered in an area, in the case of an individual who is eligible for a premium subsidy under section 1860G and resides in the area, the PDP sponsor of any prescription drug plan offered in the area (and any Medicare+Choice organization that offers qualified prescription drug coverage in the area) shall accept the benchmark bid amount (under section 1860G(b)(2)) as payment in full for the premium charge for qualified prescription drug coverage.

''(2) STANDARD PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this subsection, the term 'standard prescription drug coverage' means qualified prescription drug coverage that is standard coverage or that has an actuarial value equivalent to the actuarial value for standard coverage.

"SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS.

''(a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF FEDERAL POVERTY LEVEL.—

''(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual (as defined in paragraph (4)) who is determined to have income that does not exceed 150 percent of the Federal poverty level, the individual is entitled under this section—

''(A) to an income-related premium subsidy equal to 100 percent of the amount described in subsection (b)(1); and

''(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860B(b) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that do not exceed $2 for a multiple source or generic drug (as described in section 1927(k)(7)(A)) and $5 for a non-preferred drug.

''(2) SLIDING SCALE PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME ABOVE 150, BUT BELOW 175 PERCENT, OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual who is determined to have income that exceeds 150 percent, but does not exceed 175 percent, of the Federal poverty level, the individual is entitled under this section to—

''(A) an income-related premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in subsection (b)(1) for individuals with incomes at 150 percent of such level to 0 percent of such amount for individuals with incomes at 175 percent of such level; and

''(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860B(b) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that do not exceed $2 for a multiple source or generic drug (as described in section 1927(k)(7)(A)) and $5 for a non-preferred drug.

''(3) CONSTRUCTION.—Nothing in this section shall be construed as preventing a PDP sponsor from reducing to 0 the cost-sharing otherwise applicable to generic drugs.

''(4) 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 eligible to elect, and has elected, to obtain qualified prescription drug coverage under this part;

''(ii) has income below 175 percent of the Federal poverty line; and

''(iii) meets the resources requirement described in section 1905(p)(1)(C).

''(B) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy eligible individual and the amount of such individual's income shall be determined under the State medicaid plan for the State under section 1935(a). In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Administrator.

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

''(i) income shall be determined in 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.

''(D) 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(e).

''(E) TREATMENT OF CONFORMING MEDIGAP POLICIES.—For purposes of this section, the term 'qualified prescription drug coverage' includes a medicare supplemental policy described in section 1860H(b)(4).

''(5) INDEXING DOLLAR AMOUNTS.—

''(A) FOR 2006.—The dollar amounts applied under paragraphs (1)(B) and (2)(B) for 2006 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2006.

''(B) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraphs (1)(B) and (2)(B) for a year after 2006 shall be the amounts (under this paragraph) applied under paragraph (1)(B) or (2)(B) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved.

''(b) PREMIUM SUBSIDY AMOUNT.—

''(1) IN GENERAL.—The premium subsidy amount described in this subsection for an individual residing in an area is the benchmark bid amount (as defined in paragraph (2)) for qualified prescription drug coverage offered by the prescription drug plan or the Medicare+Choice plan in which the individual is enrolled.

''(2) BENCHMARK BID AMOUNT DEFINED.—For purposes of this subsection, the term 'benchmark bid amount' means, with respect to qualified prescription drug coverage offered under—

''(A) a prescription drug plan that—

''(i) provides standard coverage (or alternative prescription drug coverage the actuarial value is equivalent to that of standard coverage), the bid amount for enrollment under the plan under this part (determined without regard to any subsidy under this section or any late enrollment penalty under section 1860A(c)(2)(B)); or

''(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the bid amount described in clause (i) multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage; or

''(B) a Medicare+Choice plan, the portion of the bid amount that is attributable to statutory drug benefits (described in section 1853(a)(1)(A)(ii)(II)).

''(c) RULES IN APPLYING COST-SHARING SUBSIDIES.—

''(1) IN GENERAL.—In applying subsections (a)(1)(B) and (a)(2)(B), nothing in this part shall be construed as preventing a plan or provider from waiving or reducing the amount of cost-sharing otherwise applicable.

''(2) LIMITATION ON CHARGES.—In the case of an individual receiving cost-sharing subsidies under subsection (a)(1)(B) or (a)(2)(B), the PDP sponsor may not charge more than $5 per prescription.

''(3) APPLICATION OF INDEXING RULES.—The provisions of subsection (a)(4) shall apply to the dollar amount specified in paragraph (2) in the same manner as they apply to the dollar amounts specified in subsections (a)(1)(B) and (a)(2)(B).

''(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator 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 prescription drug plan or is enrolled in a Medicare+Choice plan under which qualified prescription drug coverage is provided—

''(1) the Administrator provides for a notification of the PDP sponsor or Medicare+Choice organization involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

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

''(3) the Administrator periodically and on a timely basis reimburses the sponsor or organization for the amount of such reductions.

The reimbursement under paragraph (3) with respect to cost-sharing subsidies may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

''(e) RELATION TO MEDICAID PROGRAM.—

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

''(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for prescribed drugs provided under the medicaid program under title XIX.

''(3) COORDINATION.—The Administrator 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 Administrator shall involve the Secretary, the States, the data processing industry, pharmacists, and pharmaceutical manufacturers, and other experts.

''SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENEFICIARIES FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for all medicare beneficiaries, to reduce adverse selection among prescription drug plans and Medicare+Choice plans that provide qualified prescription drug coverage, and to promote the participation of PDP sponsors under this part, the Administrator shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the following subsidies:

''(1) DIRECT SUBSIDY.—In the case of an individual enrolled in a prescription drug plan, Medicare+Choice plan, or qualified retiree prescription drug plan, a direct subsidy equal to a percentage (specified by the Administrator consistent with subsection (d)(2)) of an amount equal to the actuarial value of the standard drug coverage provided under the respective plan.

''(2) SUBSIDY THROUGH REINSURANCE.—The reinsurance payment amount (as defined in subsection (c)) for excess costs incurred in providing qualified prescription drug coverage—

''(A) for individuals enrolled with a prescription drug plan under this part;

''(B) for individuals enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; and

''(C) for individuals who are enrolled in a qualified retiree prescription drug plan.

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

''(b) QUALIFYING ENTITY DEFINED.—For purposes of this section, the term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

''(1) A PDP sponsor offering a prescription drug plan under this part.

''(2) A Medicare+Choice organization that provides qualified prescription drug coverage under a Medicare+Choice plan under part C.

''(3) The sponsor of a qualified retiree prescription drug plan (as defined in subsection (f)).

''(c) REINSURANCE PAYMENT AMOUNT.—

''(1) IN GENERAL.—Subject to subsection (d)(2) and paragraph (4), the reinsurance payment amount under this subsection for a qualifying covered individual (as defined in subsection (g)(1)) for a coverage year (as defined in subsection (g)(2)) is equal to the sum of the following:

''(A) For the portion of the individual's gross covered prescription drug costs (as defined in paragraph (3)) for the year that exceeds the initial copayment threshold specified in section 1860B(b)(2)(C), but does not exceed the initial coverage limit specified in section 1860B(b)(3), an amount equal to 30 percent of the allowable costs (as defined in paragraph (2)) attributable to such gross covered prescription drug costs.

''(B) For the portion of the individual's gross covered prescription drug costs for the year that exceeds the annual out-of-pocket threshold specified in 1860B(b)(4)(B), an amount equal to 80 percent of the allowable costs attributable to such gross covered prescription drug costs.

''(2) ALLOWABLE COSTS.—For purposes of this section, the term 'allowable costs' means, with respect to gross covered prescription drug costs under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid (net of average percentage rebates) under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

''(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term 'gross covered prescription drug costs' means, with respect to an enrollee with a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan (including costs attributable to administrative costs) for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

''(4) INDEXING DOLLAR AMOUNTS.—

''(A) AMOUNTS FOR 2005.—The dollar amounts applied under paragraph (1) for 2005 shall be the dollar amounts specified in such paragraph.

''(B) FOR 2006.—The dollar amounts applied under paragraph (1) for 2006 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2006.

''(C) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraph (1) for a year after 2006 shall be the amounts (under this paragraph) applied under paragraph (1) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved.

''(D) ROUNDING.—Any amount, determined under the preceding provisions of this paragraph for a year, which is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''(d) ADJUSTMENT OF PAYMENTS.—

''(1) ESTIMATION OF PAYMENTS.—The Administrator shall estimate—

''(A) the total payments to be made (without regard to this subsection) during a year under this section; and

''(B) the total payments to be made by qualifying entities for standard coverage under plans described in subsection (b) during the year.

''(2) ADJUSTMENT.—The Administrator shall proportionally adjust the payments made under this section for a coverage year in such manner so that—

''(A) the total of the payments made for the year under this section is equal to 65 percent of the total payments described in paragraph (1)(B) during the year; and

''(B) the ratio of the total of the payments made for direct subsidies under subsection (a)(1) for the year to the total of the payments made for reinsurance subsidies for the year under subsection (a)(2) is equal to the ratio of 35 to 30.

''(3) RISK ADJUSTMENT.—To the extent the Administrator determines it appropriate to avoid risk selection, the payments made for direct subsidies under subsection (a)(1) are subject to adjustment based upon risk factors specified by the Administrator.

''(e) PAYMENT METHODS.—

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

''(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Medicare Prescription Drug Trust Fund.

''(f) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'qualified retiree prescription drug plan' means employment-based retiree health coverage (as defined in paragraph (3)(A)) if, with respect to an individual enrolled (or eligible to be enrolled) under this part who is covered under the plan, the following requirements are met:

''(A) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Administrator may require, that the coverage meets or exceeds the requirements for qualified prescription drug coverage.

''(B) AUDITS.—The sponsor (and the plan) shall maintain, and afford the Administrator access to, such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, and the accuracy of payments made.

''(C) PROVISION OF CERTIFICATION OF PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for issuance of certifications of the type described in section 1860A(c)(2)(D).

''(2) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to an individual who is enrolled under a qualified retiree prescription drug plan unless the individual is—

''(A) enrolled under this part;

''(B) is covered under the plan; and

''(C) is eligible to obtain qualified prescription drug coverage under section 1860A but did not elect such coverage under this part (either through a prescription drug plan or through a Medicare+Choice plan).

''(3) DEFINITIONS.—As used in this section:

''(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for individuals enrolled under this part (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

''(B) SPONSOR.—The term 'sponsor' means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

''(g) GENERAL DEFINITIONS.—For purposes of this section:

''(1) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

''(A) is enrolled with a prescription drug plan under this part;

''(B) is enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; or

''(C) is enrolled for benefits under this title and is covered under a qualified retiree prescription drug plan.

''(2) COVERAGE YEAR.—The term 'coverage year' means a calendar year in which covered outpatient drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

''SEC. 1860I. MEDICARE PRESCRIPTION DRUG TRUST FUND.

''(a) IN GENERAL.—There is created on the books of the Treasury of the United States a trust fund to be known as the 'Medicare Prescription Drug Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. Except as otherwise provided in this section, the provisions of subsections (b) through (i) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund under such section.

''(b) PAYMENTS FROM TRUST FUND.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Administrator certifies are necessary to make—

''(A) payments under section 1860G (relating to low-income subsidy payments);

''(B) payments under section 1860H (relating to subsidy payments); and

''(C) payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Trust Fund to the Grants to States for Medicaid account amounts the Administrator certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

''(c) DEPOSITS INTO TRUST FUND.—

''(1) LOW-INCOME TRANSFER.—There is hereby transferred to the Trust Fund, from amounts appropriated for Grants to States for Medicaid, amounts equivalent to the aggregate amount of the reductions in payments under section 1903(a)(1) attributable to the application of section 1935(c).

''(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund, an amount equivalent to the amount of payments made from the Trust Fund under subsection (b), reduced by the amount transferred to the Trust Fund under paragraph (1).

''(d) RELATION TO SOLVENCY REQUIREMENTS.—Any provision of law that relates to the solvency of the Trust Fund under this part shall take into account the Trust Fund and amounts receivable by, or payable from, the Trust Fund.

''SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C.

''(a) DEFINITIONS.—For purposes of this part:

''(1) COVERED OUTPATIENT DRUGS.—The term 'covered outpatient drugs' is defined in section 1860B(f).

''(2) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means such limit as established under section 1860B(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

''(3) MEDICARE PRESCRIPTION DRUG TRUST FUND.—The term 'Medicare Prescription Drug Trust Fund' means the Trust Fund created under section 1860I(a).

''(4) PDP SPONSOR.—The term 'PDP sponsor' means an entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

''(5) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' means health benefits coverage that—

''(A) is offered under a policy, contract, or plan by a PDP sponsor pursuant to, and in accordance with, a contract between the Administrator and the sponsor under section 1860D(b);

''(B) provides qualified prescription drug coverage; and

''(C) meets the applicable requirements of the section 1860C for a prescription drug plan.

''(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' is defined in section 1860B(a).

''(7) STANDARD COVERAGE.—The term 'standard coverage' is defined in section 1860B(b).

''(b) APPLICATION OF MEDICARE+CHOICE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a prescription drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

''(1) any reference to a Medicare+Choice plan included a reference to a prescription drug plan;

''(2) any reference to a provider-sponsored organization included a reference to a PDP sponsor;

''(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D(b); and

''(4) any reference to part C included a reference to this part.''.

(b) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS PART D.—Any reference in law (in effect before the date of the enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

(2) CONFORMING AMENDMENT PERMITTING WAIVER OF COST-SHARING.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

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

(B) by striking the period at the end of subparagraph (F) and inserting ''; and''; and

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

''(G) the waiver or reduction of any cost-sharing imposed under part D of title XVIII.''.

(3) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this subtitle.

(c) STUDY ON TRANSITIONING PART B PRESCRIPTION DRUG COVERAGE.—Not later than January 1, 2004, the Medicare Benefits Administrator shall submit a report to Congress that makes recommendations regarding methods for providing benefits under part D of title XVIII of the Social Security Act for outpatient prescription drugs for which benefits are provided under part B of such title.

SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE UNDER THE MEDICARE+CHOICE PROGRAM.

(a) IN GENERAL.—Section 1851 (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

''(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

''(1) OFFER OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—A Medicare+Choice organization may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee under a Medicare+Choice plan unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed as—

''(i) requiring a Medicare+Choice plan to include coverage of qualified prescription drug coverage; or

''(ii) permitting a Medicare+Choice organization from providing such coverage to an individual who has not elected such coverage under section 1860A(b).

For purposes of this part, an individual who has not elected qualified prescription drug coverage under section 1860A(b) shall be treated as being ineligible to enroll in a Medicare+Choice plan under this part that offers such coverage.

''(2) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a Medicare+Choice organization under a Medicare+Choice plan, the organization and plan shall meet the requirements of section 1860C, including requirements relating to information dissemination and grievance and appeals, in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D and shall submit to the Administrator the information described in section 1860F(a)(2). The Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

''(3) AVAILABILITY OF PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME ENROLLEES AND DIRECT AND REINSURANCE SUBSIDY PAYMENTS FOR ORGANIZATIONS.—For provisions—

''(A) providing premium and cost-sharing subsidies to low-income individuals receiving qualified prescription drug coverage through a Medicare+Choice plan, see section 1860G; and

''(B) providing a Medicare+Choice organization with direct and insurance subsidy payments for providing qualified prescription drug coverage under this part, see section 1860H.

''(4) TRANSITION IN INITIAL ENROLLMENT PERIOD.—Notwithstanding any other provision of this part, the annual, coordinated election period under subsection (e)(3)(B) for 2005 shall be the 6-month period beginning with November 2004.

''(5) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in section 1860B.''.

(b) CONFORMING AMENDMENTS.—Section 1851 (42 U.S.C. 1395w–21) is amended—

(1) in subsection (a)(1)—

(A) by inserting ''(other than qualified prescription drug benefits)'' after ''benefits'';

(B) by striking the period at the end of subparagraph (B) and inserting a comma; and

(C) by adding after and below subparagraph (B) the following:

''and may elect qualified prescription drug coverage in accordance with section 1860A.''; and

(2) in subsection (g)(1), by inserting ''and section 1860A(c)(2)(B)'' after ''in this subsection''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to coverage provided on or after January 1, 2005.

SEC. 103. MEDICAID AMENDMENTS.

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

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

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

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

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

''(66) provide for making eligibility determinations under section 1935(a).''.

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

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

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

''SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

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

''(1) make determinations of eligibility for premium and cost-sharing subsidies under (and in accordance with) section 1860G;

''(2) inform the Administrator of the Medicare Benefits Administration of such determinations in cases in which such eligibility is established; and

''(3) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860G).

''(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 2005, 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 2006 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) 2006 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 Administrator 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.''.

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PREMIUM AND 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(c)(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:

''(c) 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 2005) the amount computed under this subsection is equal to the product of the following:

''(A) MEDICARE SUBSIDIES.—The total amount of payments made in the quarter under section 1860G (relating to premium and cost-sharing prescription drug subsidies for low-income medicare beneficiaries) that are attributable to individuals who are residents of the State and are entitled to benefits with respect to prescribed drugs under the State plan under this title (including such a plan operating under a waiver under section 1115).

''(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) 2005 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.''.

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

''(d) ADDITIONAL PROVISIONS.—

''(1) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to qualified prescription drug coverage under a prescription drug plan under part D of title XVIII (or under a Medicare+Choice plan under part C of such title) and medical assistance for 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 the prescription drug plan or the Medicare+Choice plan selected by the individual.

''(2) CONDITION.—A State may require, as a condition for the receipt of medical assistance under this title with respect to prescription drug benefits for an individual eligible to obtain qualified prescription drug coverage described in paragraph (1), that the individual elect qualified prescription drug coverage under section 1860A.''.

(d) TREATMENT OF TERRITORIES.—

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

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

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

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

''(e) 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), 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 with respect to the provision of covered outpatient drugs (as defined in section 1860B(f)) to low-income medicare beneficiaries; 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) 2005, is equal to $20,000,000; 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 1860B(b)(5) for the year involved.

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

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

SEC. 104. MEDIGAP TRANSITION.

(a) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) COVERAGE OF PRESCRIPTION DRUGS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, except as provided in paragraph (3) no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under this section on or after January 1, 2005, to an individual unless it replaces a medicare supplemental policy that was issued to that individual and that provided some coverage of expenses for prescription drugs.

''(2) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN PRESCRIPTION DRUG COVERAGE UNDER PART D.—

''(A) IN GENERAL.—The issuer of a medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as 'A', 'B', 'C', 'D', 'E', 'F', or 'G' (under the standards established under subsection (p)(2)) and that is offered and is available for issuance to new enrollees by such issuer;

''(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the

policy not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

''(B) INDIVIDUAL COVERED.—An individual described in this subparagraph is an individual who—

''(i) enrolls in a prescription drug plan under part D; and

''(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as 'H', 'I', or 'J' under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

''(C) ENFORCEMENT.—The provisions of paragraph (4) of subsection (s) shall apply with respect to the requirements of this paragraph in the same manner as they apply to the requirements of such subsection.

''(3) NEW STANDARDS.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Medicare Modernization and Prescription Drug Act of 2002, with respect to policies issued to individuals who are enrolled under part D, the changes in standards shall provide for at least two benefit packages (other than the core benefit package) that may provide for coverage of cost-sharing with respect to qualified prescription drug coverage under such part, except that such coverage may not cover the prescription drug deductible under such part. Two benefit packages shall be consistent with the following:

''(A) FIRST NEW POLICY.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

''(i) Coverage of 50 percent of the cost-sharing otherwise applicable, except coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

''(ii) No coverage of the part B deductible.

''(iii) Coverage for all hospital coinsurance for long stays (as in the current core benefit package).

''(iv) A limitation on annual out-of-pocket expenditures to $4,000 in 2005 (or, in a subsequent year, to such limitation for the previous year increased by an appropriate inflation adjustment specified by the Secretary).

''(B) SECOND NEW POLICY.—The policy described in this subparagraph has the same benefits as the policy described in subparagraph (A), except as follows:

''(i) Substitute '75 percent' for '50 percent' in clause (i) of such subparagraph.

''(ii) Substitute '$2,000' for '$4,000' in clause (iv) of such subparagraph.

''(4) CONSTRUCTION.—Any provision in this section or in a medicare supplemental policy relating to guaranteed renewability of coverage shall be deemed to have been met through the offering of other coverage under this subsection.''.

SEC. 105. MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM.

Title XVIII is amended by inserting after section 1806 the following new section:

''MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM

''SEC. 1807. (a) IN GENERAL.—The Secretary (or the Medicare Benefits Administrator pursuant to section 1808(c)(3)(C)) shall establish a program—

''(1) to endorse prescription drug discount card programs that meet the requirements of this section; and

''(2) to make available to medicare beneficiaries information regarding such endorsed programs.

''(b) REQUIREMENTS FOR ENDORSEMENT.—The Secretary may not endorse a prescription drug discount card program under this section unless the program meets the following requirements:

''(1) SAVINGS TO MEDICARE BENEFICIARIES.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

''(2) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The program applies to drugs that are available other than solely through mail order.

''(3) BENEFICIARY SERVICES.—The program provides pharmaceutical support services, such as education and counseling, and services to prevent adverse drug interactions.

''(4) INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

''(5) DEMONSTRATED EXPERIENCE.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

''(6) QUALITY ASSURANCE.—The entity has in place adequate procedures for assuring quality service under the program.

''(7) ADDITIONAL BENEFICIARY PROTECTIONS.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

''(c) PROGRAM OPERATION.—The Secretary shall operate the program under this section consistent with the following:

''(1) PROMOTION OF INFORMED CHOICE.—In order to promote informed choice among endorsed prescription drug discount card programs, the Secretary shall provide for the dissemination of information which compares the costs and benefits of such programs in a manner coordinated with the dissemination of educational information on Medicare+Choice plans under part C.

''(2) OVERSIGHT.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed programs with the requirements of this section, including verification of the discounts and services provided.

''(3) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the 1-800-medicare toll free telephone number for the receipt and response to inquiries and complaints concerning the program and programs endorsed under this section.

''(4) DISQUALIFICATION FOR ABUSIVE PRACTICES.—The Secretary shall revoke the endorsement of a program that the Secretary determines no longer meets the requirements of this section or that has engaged in false or misleading marketing practices.

''(5) ENROLLMENT PRACTICES.—A medicare beneficiary may not be enrolled in more than one endorsed program at any time.

''(d) TRANSITION.—The Secretary shall provide for an appropriate transition and discontinuation of the program under this section at the time prescription drug benefits first become available under part D.

''(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the program under this section.''.

TITLE II—MEDICARE+CHOICE REVITALIZATION AND MEDICARE+CHOICE COMPETITION PROGRAM

Subtitle A—Medicare+Choice Revitalization

SEC. 201. MEDICARE+CHOICE IMPROVEMENTS.

(a) EQUALIZING PAYMENTS BETWEEN FEE-FOR-SERVICE AND MEDICARE+CHOICE.—

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

''(D) BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

''(i) IN GENERAL.—For 2003 and 2004, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for the Medicare+Choice payment area for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare+Choice plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

''(ii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.''.

(2) CONFORMING AMENDMENT.—Such section is further amended, in the matter before subparagraph (A), by striking ''or (C)'' and inserting ''(C), or (D)''.

(b) REVISION OF BLEND.—

(1) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)) is amended by inserting ''who (with respect to determinations for 2003 and for 2004) are enrolled in a Medicare+Choice plan'' after ''the average number of medicare beneficiaries''.

(2) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(A) in paragraph (1)(A), by inserting ''(for a year before 2003)'' after ''multiplied''; and

(B) in paragraph (5), by inserting ''(before 2003)'' after ''for each year''.

(c) REVISION IN MINIMUM PERCENTAGE INCREASE FOR 2003 AND 2004.—Section 1853(c)(1)(C) (42 U.S.C. 1395w–23(c)(1)(C)) is amended by striking clause (iv) and inserting the following:

''(iv) For 2002, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2001.

''(v) For 2003 and 2004, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(iv) For 2005 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.''.

(d) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICARE+CHOICE PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is amended—

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

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

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the

area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2003), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(e) ANNOUNCEMENT OF REVISED MEDICARE+CHOICE PAYMENT RATES.—Within 2 weeks after the date of the enactment of this Act, the Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties) Medicare+Choice capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2003, revised in accordance with the provisions of this section.

(f) MEDPAC STUDY OF AAPCC.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that assesses the method used for determining the adjusted average per capita cost (AAPCC) under section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)). Such study shall examine—

(A) the bases for variation in such costs between different areas, including differences in input prices, utilization, and practice patterns;

(B) the appropriate geographic area for payment under the Medicare+Choice program under part C of title XVIII of such Act; and

(C) the accuracy of risk adjustment methods in reflecting differences in costs of providing care to different groups of beneficiaries served under such program.

(2) REPORT.—Not later than 9 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under paragraph (1). Such report shall include recommendations regarding changes in the methods for computing the adjusted average per capita cost among different areas.

SEC. 202. MAKING PERMANENT CHANGE IN MEDICARE+CHOICE REPORTING DEADLINES AND ANNUAL, COORDINATED ELECTION PERIOD.

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

(b) DELAY IN ANNUAL, COORDINATED ELECTION PERIOD.—Section 1851(e)(3)(B) (42 U.S.C. 1395w–21(e)(3)(B)), as amended by section 532(c)(1)(A) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended by striking ''and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005'' and inserting '', the month of November before such year and with respect to 2003 and any subsequent year''.

(c) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—Section 1853(b)(1) (42 U.S.C. 1395w–23(b)(1)), as amended by section 532(d)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended by striking ''and after 2005 not later than March 1 before the calendar year concerned and for 2004 and 2005'' and inserting ''not later than March 1 before the calendar year concerned and for 2004 and each subsequent year''.

(d) REQUIRING PROVISION OF AVAILABLE INFORMATION COMPARING PLAN OPTIONS.—The first sentence of section 1851(d)(2)(A)(ii) (42 U.S.C. 1395w–21(d)(2)(A)(ii)) is amended by inserting before the period the following: ''to the extent such information is available at the time of preparation of materials for the mailing''.

SEC. 203. AVOIDING DUPLICATIVE STATE REGULATION.

(a) IN GENERAL.—Section 1856(b)(3) (42 U.S.C. 1395w–26(b)(3)) is amended to read as follows:

''(3) RELATION TO STATE LAWS.—The standards established under this subsection shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to Medicare+Choice plans which are offered by Medicare+Choice organizations under this part.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 204. SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.

(a) TREATMENT AS COORDINATED CARE PLAN.—Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is amended by adding at the end the following new sentence: ''Specialized Medicare+Choice plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.''.

(b) SPECIALIZED MEDICARE+CHOICE PLAN FOR SPECIAL NEEDS BENEFICIARIES DEFINED.—Section 1859(b) (42 U.S.C. 1395w–29(b)) is amended by adding at the end the following new paragraph:

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

''(A) IN GENERAL.—The term 'specialized Medicare+Choice plan for special needs beneficiaries' means a Medicare+Choice plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

''(B) SPECIAL NEEDS BENEFICIARY.—The term 'special needs beneficiary' means a Medicare+Choice eligible individual who—

''(i) is institutionalized (as defined by the Secretary);

''(ii) is entitled to medical assistance under a State plan under title XIX; or

''(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized Medicare+Choice plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.''.

(c) RESTRICTION ON ENROLLMENT PERMITTED.—Section 1859 (42 U.S.C. 1395w–29) is amended by adding at the end the following new subsection:

''(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2007, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs beneficiaries.''.

(d) REPORT TO CONGRESS.—Not later than December 31, 2005, the Medicare Benefits Administrator shall submit to Congress a report that assesses the impact of specialized Medicare+Choice plans for special needs beneficiaries on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the medicare program as a result of amendments made by subsections (a), (b), and (c).

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a), (b), and (c) shall take effect upon the date of the enactment of this Act.

(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.—No later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue final regulations to establish requirements for special needs beneficiaries under section 1859(b)(4)(B)(iii) of the Social Security Act, as added by subsection (b).

SEC. 205. MEDICARE MSAS.

(a) EXEMPTION FROM QUALITY ASSURANCE PROGRAM REQUIREMENT.—

(1) IN GENERAL.—Section 1852(e)(1) (42 U.S.C. 1395w–22(e)(1)) is amended by inserting ''(other than MSA plans)'' after ''Medicare+Choice plans''.

(2) CONFORMING AMENDMENTS.—Section 1852 (42 U.S.C. 1395w–22) is amended—

(A) in subsection (c)(1)(I), by inserting before the period at the end the following: ''if required under such section''; and

(B) in subparagraphs (A) and (B) of subsection (e)(2), by striking '', a non-network MSA plan,'' and '', NON-NETWORK MSA PLANS,'' each place it appears.

(b) MAKING PROGRAM PERMANENT AND ELIMINATING CAP.—Section 1851(b)(4) (42 U.S.C. 1395w–21(b)(4)) is amended—

(1) in the heading of subparagraph (A), by striking ''ON A DEMONSTRATION BASIS'';

(2) by striking the first sentence of subparagraph (A); and

(3) by striking the second sentence of subparagraph (C).

(c) APPLYING LIMITATIONS ON BALANCE BILLING.—Section 1852(k)(1) (42 U.S.C. 1395w–22(k)(1)) is amended by inserting ''or with an organization offering a MSA plan'' after ''section 1851(a)(2)(A)''.

(d) ADDITIONAL AMENDMENT.—Section 1851(e)(5)(A) (42 U.S.C. 1395w–21(e)(5)(A)) is amended—

(1) by adding ''or'' at the end of clause (i);

(2) by striking '', or'' at the end of clause (ii) and inserting a semicolon; and

(3) by striking clause (iii).

SEC. 206. EXTENSION OF REASONABLE COST AND SHMO CONTRACTS.

(a) REASONABLE COST CONTRACTS.—

(1) IN GENERAL.—Section 1876(h)(5)(C) (42 U.S.C. 1395mm(h)(5)(C)) is amended—

(A) by inserting ''(i)'' after ''(C)'';

(B) by inserting before the period the following: '', except (subject to clause (ii)) in the case of a contract for an area which is not covered in the service area of 1 or more coordinated care Medicare+Choice plans under part C''; and

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

''(ii) In the case in which—

''(I) a reasonable cost reimbursement contract includes an area in its service area as of a date that is after December 31, 2003;

''(II) such area is no longer included in such service area after such date by reason of the operation of clause (i) because of the inclusion of such area within the service area of a Medicare+Choice plan; and

''(III) all Medicare+Choice plans subsequently terminate coverage in such area;

such reasonable cost reimbursement contract may be extended and renewed to cover such area (so long as it is not included in the service area of any Medicare+Choice plan).''.

(2) STUDY.—The Medicare Benefits Administrator shall conduct a study of an appropriate transition for plans offered under reasonable cost contracts under section 1876 of the Social Security Act on and after January 1, 2005. Such a transition may take into account whether there are one or more coordinated care Medicare+Choice plans being offered in the areas involved. Not later than February 1, 2004, the Administrator shall submit to Congress a report on such study and shall include recommendations regarding any changes in the amendment made by

paragraph (1) as the Administrator determines to be appropriate.

(b) EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION (SHMO) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—Section 4018(b)(1) of the Omnibus Budget Reconciliation Act of 1987 is amended by striking ''the date that is 30 months after the date that the Secretary submits to Congress the report described in section 4014(c) of the Balanced Budget Act of 1997'' and inserting ''December 31, 2004''.

(2) SHMOS OFFERING MEDICARE+CHOICE PLANS.—Nothing in such section 4018 shall be construed as preventing a social health maintenance organization from offering a Medicare+Choice plan under part C of title XVIII of the Social Security Act.

Subtitle B—Medicare+Choice Competition Program

SEC. 211. MEDICARE+CHOICE COMPETITION PROGRAM.

(a) SUBMISSION OF BID AMOUNTS.—Section 1854 (42 U.S.C. 1395w–24) is amended—

(1) by amending the heading to read as follows:

''SUBMISSION OF BID AMOUNTS'';

(2) in subsection (a)(1)(A)—

(A) by striking ''(A)'' and inserting ''(A)(i) if the following year is before 2005,''; and

(B) by inserting before the semicolon at the end the following: '' or (ii) if the following year is 2005 or later, the information described in paragraph (6)(A)''; and

(3) by adding at the end of subsection (a) the following:

''(6) SUBMISSION OF BID AMOUNTS BY MEDICARE+CHOICE ORGANIZATIONS.—

''(A) INFORMATION TO BE SUBMITTED.—The information described in this subparagraph is as follows:

''(i) The monthly aggregate bid amount for provision of all items and services under this part and the actuarial basis for determining such amount.

''(ii) The proportions of such bid amount that are attributable to—

''(I) the provision of statutory non-drug benefits (such portion referred to in this part as the 'unadjusted non-drug monthly bid amount');

''(II) the provision of statutory prescription drug benefits; and

''(III) the provision of non-statutory benefits;

and the actuarial basis for determining such proportions.

''(iii) Such additional information as the Administrator may require to verify the actuarial bases described in clauses (i) and (ii).

''(B) STATUTORY BENEFITS DEFINED.—For purposes of this part:

''(i) The term 'statutory non-drug benefits' means benefits under parts A and B.

''(ii) The term 'statutory prescription drug benefits' means benefits under part D.

''(iii) The term 'statutory benefits' means statutory prescription drug benefits and statutory non-drug benefits.

''(C) ACCEPTANCE AND NEGOTIATION OF BID AMOUNTS.—The Administrator has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportion described in subparagraph (A)(ii)). The Administrator may reject such a bid amount or proportion if the Administrator determines that such amount or proportion is not supported by the actuarial bases provided under subparagraph (A).''.

(b) PROVIDING FOR BENEFICIARY SAVINGS FOR CERTAIN PLANS.—

(1) IN GENERAL.—Section 1854(b) (42 U.S.C. 1395w–24(b)) is amended—

(A) by adding at the end of paragraph (1) the following new subparagraph:

''(C) BENEFICIARY REBATE RULE.—

''(i) REQUIREMENT.—The Medicare+Choice plan shall provide to the enrollee a monthly rebate equal to 75 percent of the average per capita savings (if any) described in paragraph (3) applicable to the plan and year involved.

''(iii) FORM OF REBATE.—A rebate required under this subparagraph shall be provided—

''(I) through the crediting of the amount of the rebate towards the Medicare+Choice monthly supplementary beneficiary premium or the premium imposed for prescription drug coverage under part D;

''(II) through a direct monthly payment (through electronic funds transfer or otherwise); or

''(III) through other means approved by the Medicare Benefits Administrator,

or any combination thereof.''; and

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

''(3) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for a Medicare+Choice plan and year is computed as follows:

''(A) DETERMINATION OF STATE-WIDE AVERAGE RISK ADJUSTMENT.—

''(i) IN GENERAL.—The Medicare Benefits Administrator shall determine, at the same time rates are promulgated under section 1853(b)(1) (beginning with 2005), for each State the average of the risk adjustment factors to be applied to enrollees under section 1853(a)(1)(A) in that State. In the case of a State in which a Medicare+Choice plan was offered in the previous year, the Administrator may compute such average based upon risk adjustment factors applied in that State in a previous year.

''(ii) TREATMENT OF NEW STATES.—In the case of a State in which no Medicare+Choice plan was offered in the previous year, the Administrator shall estimate such average. In making such estimate, the Administrator may use average risk adjustment factors applied to comparable States or applied on a national basis.

''(B) DETERMINATION OF RISK ADJUSTED BENCHMARK AND RISK-ADJUSTED BID.—For each Medicare+Choice plan offered in a State, the Administrator shall—

''(i) adjust the fee-for-service area-specific non-drug benchmark amount by the applicable average risk adjustment factor computed under subparagraph (A); and

''(ii) adjust the unadjusted non-drug monthly bid amount by such applicable average risk adjustment factor.

''(C) DETERMINATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—The average per capita monthly savings described in this subparagraph is equal to the amount (if any) by which—

''(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i), exceeds

''(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

''(D) AUTHORITY TO DETERMINE RISK ADJUSTMENT FOR AREAS OTHER THAN STATES.—The Administrator may provide for the determination and application of risk adjustment factors under this paragraph on the basis of areas other than States.''.

(2) COMPUTATION OF FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG BENCHMARK.—Section 1853 (42 U.S.C. 1395w–23) is amended by adding at the end the following new subsection:

''(j) COMPUTATION OF FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG BENCHMARK AMOUNT.—For purposes of this part, the term 'fee-for-service area-specific non-drug benchmark amount' means, with respect to a Medicare+Choice payment area for a month in a year, an amount equal to the greater of the following (but in no case less than 1/12 of the rate computed under subsection (c)(1), without regard to subparagraph (A), for the year):

''(1) BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS IN THE AREA.—An amount equal to 1/12 of 100 percent (for 2005 through 2007, or 95 percent for 2008 and years thereafter) of the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for the Medicare+Choice payment area, for the area and the year involved, for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare+Choice plan under this part for the year, and adjusted to exclude from such cost the amount the Medicare Benefits Administrator estimates is payable for costs described in subclauses (I) and (II) of subsection (c)(3)(C)(i) for the year involved and also adjusted in the manner described in subsection (c)(1)(D)(ii) (relating to inclusion of costs of VA and DOD military facility services to medicare-eligible beneficiaries).

''(2) MINIMUM MONTHLY AMOUNT.—The minimum amount specified in this paragraph is the amount specified in subsection (c)(1)(B)(iv) for the year involved.''.

(c) PAYMENT OF PLANS BASED ON BID AMOUNTS.—

(1) IN GENERAL.—Section 1853(a)(1)(A) (42 U.S.C. 1395w–23) is amended by striking ''in an amount'' and all that follows and inserting the following: ''in an amount determined as follows:

''(i) PAYMENT BEFORE 2005.—For years before 2005, the payment amount shall be equal to 1/12 of the annual Medicare+Choice capitation rate (as calculated under subsection (c)) with respect to that individual for that area, reduced by the amount of any reduction elected under section 1854(f)(1)(E) and adjusted under clause (iii).

''(ii) PAYMENT FOR STATUTORY NON-DRUG BENEFITS BEGINNING WITH 2005.—For years beginning with 2005—

''(I) PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C), the payment under this subsection is equal to the unadjusted non-drug monthly bid amount, adjusted under clause (iii), plus the amount of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year.

''(II) PLANS WITH BIDS AT OR ABOVE BENCHMARK.—In the case of a plan for which there are no average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the fee-for-service area-specific non-drug benchmark amount, adjusted under clause (iii).

''(iii) DEMOGRAPHIC ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—The Administrator shall adjust the payment amount under clause (i), the unadjusted non-drug monthly bid amount under clause (ii)(I), and the fee-for-service area-specific non-drug benchmark amount under clause (ii)(II) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Administrator determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Administrator may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

''(iv) REFERENCE TO SUBSIDY PAYMENT FOR STATUTORY DRUG BENEFITS.—In the case in which an enrollee is enrolled under part D, the Medicare+Choice organization also is entitled to a subsidy payment amount under section 1860H.''.

(d) CONFORMING AMENDMENTS.—

(1) PROTECTION AGAINST BENEFICIARY SELECTION.—Section 1852(b)(1)(A) (42 U.S.C. 1395w–22(b)(1)(A)) is amended by adding at the end the following: ''The Administrator shall not approve a plan of an organization if the Administrator determines that the benefits are designed to substantially discourage enrollment by certain Medicare+Choice eligible individuals with the organization.''.

(2) CONFORMING AMENDMENT TO PREMIUM TERMINOLOGY.—Subparagraphs (A) and (B) of section 1854(b)(2) (42 U.S.C. 1395w–24(b)(2)) are amended to read as follows:

''(A) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM.—The term 'Medicare+Choice monthly basic beneficiary premium' means, with respect to a Medicare+Choice plan—

''(i) described in section 1853(a)(1)(A)(ii)(I) (relating to plans providing rebates), zero; or

''(ii) described in section 1853(a)(1)(A)(ii)(II), the amount (if any) by which the unadjusted non-drug monthly bid amount exceeds the fee-for-service area-specific non-drug benchmark amount.

''(B) MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term 'Medicare+Choice monthly supplemental beneficiary premium' means, with respect to a Medicare+Choice plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under such section to the provision of nonstatutory benefits.''.

(3) REQUIREMENT FOR UNIFORM BID AMOUNTS.—Section 1854(c) (42 U.S.C. 1395w–24(c)) is amended to read as follows:

''(c) UNIFORM BID AMOUNTS.—The Medicare+Choice monthly bid amount submitted under subsection (a)(6) of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan.''.

(4) PERMITTING BENEFICIARY REBATES.—

(A) Section 1851(h)(4)(A) (42 U.S.C. 1395w–21(h)(4)(A)) is amended by inserting ''except as provided under section 1854(b)(1)(C)'' after ''or otherwise''.

(B) Section 1854(d) (42 U.S.C. 1395w–24(d)) is amended by inserting '', except as provided under subsection (b)(1)(C),'' after ''and may not provide''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to payments and premiums for months beginning with January 2005.

SEC. 212. DEMONSTRATION PROGRAM FOR COMPETITIVE-DEMONSTRATION AREAS.

(a) IDENTIFICATION OF COMPETITIVE-DEMONSTRATION AREAS FOR DEMONSTRATION PROGRAM; COMPUTATION OF CHOICE NON-DRUG BENCHMARKS.—Section 1853, as amended by section 211(b)(2), is amended by adding at the end the following new subsection:

''(k) ESTABLISHMENT OF COMPETITIVE DEMONSTRATION PROGRAM.—

''(1) DESIGNATION OF COMPETITIVE-DEMONSTRATION AREAS AS PART OF PROGRAM.—

''(A) IN GENERAL.—For purposes of this part, the Administrator shall establish a demonstration program under which the Administrator designates Medicare+Choice areas as competitive-demonstration areas consistent with the following limitations:

''(i) LIMITATION ON NUMBER OF AREAS THAT MAY BE DESIGNATED.—The Administrator may not designate more than 4 areas as competitive-demonstration areas.

''(ii) LIMITATION ON PERIOD OF DESIGNATION OF ANY AREA.—The Administrator may not designate any area as a competitive-demonstration area for a period of more than 2 years.

The Administrator has the discretion to decide whether or not to designate as a competitive-demonstration area an area that qualifies for such designation.

''(B) QUALIFICATIONS FOR DESIGNATION.—For purposes of this title, a Medicare+Choice area (which is a metropolitan statistical area or other area with a substantial number of Medicare+Choice enrollees) may not be designated as a 'competitive-demonstration area' for a 2-year period beginning with a year unless the Administrator determines, by such date before the beginning of the year as the Administrator determines appropriate, that—

''(i) there will be offered during the open enrollment period under this part before the beginning of the year at least 2 Medicare+Choice plans (in addition to the fee-for-service program under parts A and B), each offered by a different Medicare+Choice organization; and

''(ii) during March of the previous year at least 50 percent of the number of Medicare+Choice eligible individuals who reside in the area were enrolled in a Medicare+Choice plan.

''(2) CHOICE NON-DRUG BENCHMARK AMOUNT.—For purposes of this part, the term 'choice non-drug benchmark amount' means, with respect to a Medicare+Choice payment area for a month in a year, the sum of the 2 components described in paragraph (3) for the area and year. The Administrator shall compute such benchmark amount for each competitive-demonstration area before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2005) in which it is designated as such an area.

''(3) 2 COMPONENTS.—For purposes of paragraph (2), the 2 components described in this paragraph for an area and a year are the following:

''(A) FEE-FOR-SERVICE COMPONENT WEIGHTED BY NATIONAL FEE-FOR-SERVICE MARKET SHARE.—The product of the following:

''(i) NATIONAL FEE-FOR-SERVICE MARKET SHARE.—The national fee-for-service market share percentage (determined under paragraph (5)) for the year.

''(ii) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG BID.—The fee-for-service area-specific non-drug bid (as defined in paragraph (6)) for the area and year.

''(B) M+C COMPONENT WEIGHTED BY NATIONAL MEDICARE+CHOICE MARKET SHARE.—The product of the following:

''(i) NATIONAL MEDICARE+CHOICE MARKET SHARE.—1 minus the national fee-for-service market share percentage for the year.

''(ii) WEIGHTED AVERAGE OF PLAN BIDS IN AREA.—The weighted average of the plan bids for the area and year (as determined under paragraph (4)(A)).

''(4) DETERMINATION OF WEIGHTED AVERAGE BIDS FOR AN AREA.—

''(A) IN GENERAL.—For purposes of paragraph (3)(B)(ii), the weighted average of plan bids for an area and a year is the sum of the following products for Medicare+Choice plans described in subparagraph (C) in the area and year:

''(i) PROPORTION OF EACH PLAN'S ENROLLEES IN THE AREA.—The number of individuals described in subparagraph (B), divided by the total number of such individuals for all Medicare+Choice plans described in subparagraph (C) for that area and year.

''(ii) MONTHLY NON-DRUG BID AMOUNT.—The unadjusted non-drug monthly bid amount.

''(B) COUNTING OF INDIVIDUALS.—The Administrator shall count, for each Medicare+Choice plan described in subparagraph (C) for an area and year, the number of individuals who reside in the area and who were enrolled under such plan under this part during March of the previous year.

''(C) EXCLUSION OF PLANS NOT OFFERED IN PREVIOUS YEAR.—For an area and year, the Medicare+Choice plans described in this subparagraph are plans that are offered in the area and year and were offered in the area in March of the previous year.

''(5) COMPUTATION OF NATIONAL FEE-FOR-SERVICE MARKET SHARE PERCENTAGE.—The Administrator shall determine, for a year, the proportion (in this subsection referred to as the 'national fee-for-service market share percentage') of Medicare+Choice eligible individuals who during March of the previous year were not enrolled in a Medicare+Choice plan.

''(6) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG BID.—For purposes of this part, the term 'fee-for-service area-specific non-drug bid' means, for an area and year, the amount described in section 1853(j)(1) for the area and year, except that any reference to a percent of less than 100 percent shall be deemed a reference to 100 percent.''.

(b) APPLICATION OF CHOICE NON-DRUG BENCHMARK IN COMPETITIVE-DEMONSTRATION AREAS.—

(1) IN GENERAL.—Section 1854 is amended—

(A) in subsection (b)(1)(C)(i), as added by section 211(b)(1)(A), by striking ''(i) REQUIREMENT.—If'' and inserting ''(i) REQUIREMENT FOR NON-COMPETITIVE-DEMONSTRATION AREAS.—In the case of a Medicare+Choice payment area that is not a competitive-demonstration area designated under section 1853(k)(1), if'';

(B) in subsection (b)(1)(C), as so added, by inserting after clause (i) the following new clause:

''(ii) REQUIREMENT FOR COMPETITIVE-DEMONSTRATION AREAS.—In the case of a Medicare+Choice payment area that is designated as a competitive-demonstration area under section 1853(k)(1), if there are average per capita monthly savings described in paragraph (4) for a Medicare+Choice plan and year, the Medicare+Choice plan shall provide to the enrollee a monthly rebate equal to 75 percent of such savings.'';

(C) by adding at the end of subsection (b), as amended by section 211(b)(1), the following new paragraph:

''(4) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS FOR COMPETITIVE-DEMONSTRATION AREAS.—For purposes of paragraph (1)(C)(ii), the average per capita monthly savings referred to in such paragraph for a Medicare+Choice plan and year shall be computed in the same manner as the average per capita monthly savings is computed under paragraph (3) except that the reference to the fee-for-service area-specific non-drug benchmark in paragraph (3)(B)(i) (or to the benchmark amount as adjusted under paragraph (3)(C)(i)) is deemed to be a reference to the choice non-drug benchmark amount (or such amount as adjusted in the manner described in paragraph (3)(B)(i)).''; and

(D) in subsection (d), as amended by section 211(d)(4), by inserting ''and subsection (b)(1)(D)'' after ''subsection (b)(1)(C),''.

(2) CONFORMING AMENDMENTS.—

(A) PAYMENT OF PLANS.—Section 1853(a)(1)(A)(ii), as amended by section 211(c)(1), is amended—

(i) in subclause (I), by inserting ''(or, in the case of a competitive-demonstration area, the choice non-drug benchmark amount)'' after ''benchmark amount''; and

(ii) in subclauses (I) and (II), by inserting ''(or, in the case of a competitive-demonstration area, described in section 1854(b)(4))'' after ''section 1854(b)(1)(C)''.

(B) DEFINITION OF MONTHLY BASIC PREMIUM.—Section 1854(b)(2)(A)(ii), as amended by section 211(d)(2), is amended by inserting ''(or, in the case of a competitive-demonstration area, the choice non-drug benchmark amount)'' after ''benchmark amount''.

(c) PREMIUM ADJUSTMENT.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

''(h)(1) In the case of an individual who resides in a competitive-demonstration area designated under section 1851(k)(1) and who is not enrolled in a Medicare+Choice plan under part C, the monthly premium otherwise applied under this part (determined without regard to subsections (b) and (f) or any adjustment under this subsection) shall be adjusted as follows: If the fee-for-service area-specific non-drug bid (as defined in section 1853(k)(6)) for the Medicare+Choice area in which the individual resides for a month—

''(A) does not exceed the choice non-drug benchmark (as determined under section 1853(k)(2)) for such area, the amount of the premium for the individual for the month shall be reduced by an amount equal to 75 percent of the amount by which such benchmark exceeds such fee-for-service bid; or

''(B) exceeds such choice non-drug benchmark, the amount of the premium for the individual for the month shall be adjusted to ensure that—

''(i) the sum of the amount of the adjusted premium and the choice non-drug benchmark for the area, is equal to

''(ii) the sum of the unadjusted premium plus amount of the fee-for-service area-specific non-drug bid for the area.

''(2) Nothing in this subsection shall be construed as preventing a reduction under paragraph (1)(A) in the premium otherwise applicable under this part to zero or from requiring the provision of a rebate to the extent such premium would otherwise be required to be less than zero.

''(3) The adjustment in the premium under this subsection shall be effected in such manner as the Medicare Benefits Administrator determines appropriate.

''(4) In order to carry out this subsection (insofar as it is effected through the manner of collection of premiums under 1840(a)), the Medicare Benefits Administrator shall transmit to the Commissioner of Social Security—

''(A) at the beginning of each year, the name, social security account number, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year; and

''(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.''.

(d) CONFORMING AMENDMENT.—Section 1844(c) (42 U.S.C. 1395w(c)) is amended by inserting ''and without regard to any premium adjustment effected under section 1839(h)'' before the period at the end.

(e) REPORT ON DEMONSTRATION PROGRAM.—Not later than 6 months after the date on which the designation of the 4th competitive-demonstration area under section 1851(k)(1) of the Social Security Act ends, the Medicare Payment Advisory Commission shall submit to Congress a report on the impact of the demonstration program under the amendments made by this section, including such impact on premiums of medicare beneficiaries, savings to the medicare program, and on adverse selection.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to payments and premiums for periods beginning on or after January 1, 2005.

SEC. 213. CONFORMING AMENDMENTS.

(a) CONFORMING AMENDMENTS RELATING TO BIDS.—

(1) Section 1854 (42 U.S.C. 1395w–24) is amended—

(A) in the heading by inserting ''AND BID AMOUNTS'' after ''PREMIUMS'';

(B) in the heading of subsection (a), by inserting ''AND BID AMOUNTS'' after ''PREMIUMS''; and

(C) in subsection (a)(5)(A), by inserting ''paragraphs (2), (3), and (4) of'' after ''filed under''.

(b) ADDITIONAL CONFORMING AMENDMENTS.—

(1) ANNUAL DETERMINATION AND ANNOUNCEMENT OF CERTAIN FACTORS.—Section 1853(b) (42 U.S.C. 1395w–23(b)) is amended—

(A) in paragraph (1), by striking ''the calendar year concerned'' and all that follows and inserting the following: ''the calendar year concerned with respect to each Medicare+Choice payment area, the following:

''(A) PRE-COMPETITION INFORMATION.—For years before 2005, the following:

''(i) MEDICARE+CHOICE CAPITATION RATES.—The annual Medicare+Choice capitation rate for each Medicare+Choice payment area for the year.

''(ii) ADJUSTMENT FACTORS.—The risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

''(B) COMPETITION INFORMATION.—For years beginning with 2005, the following:

''(i) BENCHMARKS.—The fee-for-service area-specific non-drug benchmark under section 1853(j) and, if applicable, the choice non-drug benchmark under section 1853(k)(2), for the year involved and, if applicable, the national fee-for-service market share percentage.

''(ii) ADJUSTMENT FACTORS.—The adjustment factors applied under section 1853(a)(1)(A)(iii) (relating to demographic adjustment), section 1853(a)(1)(B) (relating to adjustment for end-stage renal disease), and section 1853(a)(3) (relating to health status adjustment).

''(iii) PROJECTED FEE-FOR-SERVICE BID.—In the case of a competitive area, the projected fee-for-service area-specific non-drug bid (as determined under subsection (k)(6)) for the area.

''(iv) INDIVIDUALS.—The number of individuals counted under subsection (k)(4)(B) and enrolled in each Medicare+Choice plan in the area.''; and

(B) in paragraph (3), by striking ''in sufficient detail'' and all that follows up to the period at the end.

(2) REPEAL OF PROVISIONS RELATING TO ADJUSTED COMMUNITY RATE (ACR).—

(A) IN GENERAL.—Subsections (e) and (f) of section 1854 (42 U.S.C. 1395w–24) are repealed.

(B) CONFORMING AMENDMENT.—Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking '', and to reflect'' and all that follows and inserting a period.

(3) PROSPECTIVE IMPLEMENTATION OF NATIONAL COVERAGE DETERMINATIONS.—Section 1852(a)(5) (42 U.S.C. 1395w–22(a)(5)) is amended to read as follows:

''(5) PROSPECTIVE IMPLEMENTATION OF NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall only implement a national coverage determination that will result in a significant change in the costs to a Medicare+Choice organization in a prospective manner that applies to announcements made under section 1853(b) after the date of the implementation of the determination.''.

(4) PERMITTING GEOGRAPHIC ADJUSTMENT TO CONSOLIDATE MULTIPLE MEDICARE+CHOICE PAYMENT AREAS IN A STATE INTO A SINGLE STATEWIDE MEDICARE+CHOICE PAYMENT AREA.—Section 1853(d)(3) (42 U.S.C. 1395w–23(e)(3)) is amended—

(A) by amending clause (i) of subparagraph (A) to read as follows:

''(i) to a single statewide Medicare+Choice payment area,''; and

(B) by amending subparagraph (B) to read as follows:

''(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Medicare Benefits Administrator shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to payments and premiums for periods beginning on or after January 1, 2005.

TITLE III—RURAL HEALTH CARE IMPROVEMENTS

SEC. 301. REFERENCE TO FULL MARKET BASKET INCREASE FOR SOLE COMMUNITY HOSPITALS.

For provision eliminating any reduction from full market basket in the update for inpatient hospital services for sole community hospitals, see section 401.

SEC. 302. ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

(a) BLENDING OF PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by adding at the end the following new clause:

''(xiv)(I) In the case of discharges in a fiscal year beginning on or after October 1, 2002, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the old blend proportion (specified under subclause (III)) of the disproportionate share adjustment percentage otherwise determined under the respective clause and 100 percent minus such old blend proportion of the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

''(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 10 percent for a hospital that is not classified as a rural referral center under subparagraph (C).

''(III) For purposes of subclause (I), the old blend proportion for fiscal year 2003 is 80 percent, for each subsequent year (through 2006) is the old blend proportion under this subclause for the previous year minus 20 percentage points, and for each year beginning with 2007 is 0 percent.''.

(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in each of subclauses (II), (III), (IV), (V), and (VI) of clause (iv), by inserting ''subject to clause (xiv) and'' before ''for discharges occurring'';

(B) in clause (viii), by striking ''The formula'' and inserting ''Subject to clause (xiv), the formula''; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking ''For purposes'' and inserting ''Subject to clause (xiv), for purposes''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to discharges occurring on or after October 1, 2002.

SEC. 303. 2-YEAR PHASED-IN INCREASE IN THE STANDARDIZED AMOUNT IN RURAL AND SMALL URBAN AREAS TO ACHIEVE A SINGLE, UNIFORM STANDARDIZED AMOUNT.

Section 1886(d)(3)(A)(iv) (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking ''(iv) For discharges'' and inserting ''(iv)(I) Subject to the succeeding provisions of this clause, for discharges''; and

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

''(II) For discharges occurring during fiscal year 2003, the average standardized amount for hospitals located other than in a large urban area shall be increased by ½ of the difference between the average standardized amount determined under subclause (I) for hospitals located in large urban areas for such fiscal year and such amount determined (without regard to this subclause) for other hospitals for such fiscal year.

''(III) For discharges occurring in a fiscal year beginning with fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in any area within the United States and within each region equal to the average standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for hospitals located in any area) increased by the applicable percentage increase under subsection (b)(3)(B)(i).''.

SEC. 304. 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 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, 2003, 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. 305. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) REINSTATEMENT OF PERIODIC INTERIM PAYMENT (PIP).—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

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

(2) by adding ''and'' at the end of subparagraph (D); and

(3) by inserting after subparagraph (D) the following new subparagraph:

''(E) inpatient critical access hospital services;''.

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

(c) FLEXIBILITY IN BED LIMITATION FOR HOSPITALS WITH STRONG SEASONAL CENSUS FLUCTUATIONS.—Section 1820 (42 U.S.C. 1395i–4) is amended—

(1) in subsection (c)(2)(B)(iii), by inserting ''subject to paragraph (3)'' after ''(iii) provides'';

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

''(3) INCREASE IN MAXIMUM NUMBER OF BEDS FOR HOSPITALS WITH STRONG SEASONAL CENSUS FLUCTUATIONS.—

''(A) IN GENERAL.—In the case of a hospital that demonstrates that it meets the standards established under subparagraph (B), the bed limitations otherwise applicable under paragraph (2)(B)(iii) and subsection (f) shall be increased by 5 beds.

''(B) STANDARDS.—The Secretary shall specify standards for determining whether a critical access hospital has sufficiently strong seasonal variations in patient admissions to justify the increase in bed limitation provided under subparagraph (A).''; and

(3) in subsection (f), by adding at the end the following new sentence: ''The limitations in numbers of beds under the first sentence are subject to adjustment under subsection (c)(3).''.

(d) 5-YEAR EXTENSION OF THE AUTHORIZATION FOR APPROPRIATIONS FOR GRANT PROGRAM.—Section 1820(j) (42 U.S.C. 1395i–4(j)) is amended by striking ''through 2002'' and inserting ''through 2007''.

(e) EFFECTIVE DATES.—

(1) REINSTATEMENT OF PIP.—The amendments made by subsection (a) shall apply to payments made on or after January 1, 2003.

(2) PHYSICIAN PAYMENT ADJUSTMENT CONDITION.—The amendment made by subsection (b) 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).

(3) FLEXIBILITY IN BED LIMITATION.—The amendments made by subsection (c) shall apply to designations made on or after January 1, 2003, but shall not apply to critical access hospitals that were designated as of such date.

SEC. 306. EXTENSION OF TEMPORARY INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—Section 508(a) BIPA (114 Stat. 2763A–533) is amended—

(1) by striking ''24-MONTH INCREASE BEGINNING APRIL 1, 2001'' and inserting ''IN GENERAL''; and

(2) by striking ''April 1, 2003'' and inserting ''January 1, 2005''.

(b) CONFORMING AMENDMENT.—Section 547(c)(2) of BIPA (114 Stat. 2763A–553) is amended by striking ''the period beginning on April 1, 2001, and ending on September 30, 2002,'' and inserting ''a period under such section''.

SEC. 307. REFERENCE TO 10 PERCENT INCREASE IN PAYMENT FOR HOSPICE CARE FURNISHED IN A FRONTIER AREA AND RURAL HOSPICE DEMONSTRATION PROJECT.

For—

(1) provision of 10 percent increase in payment for hospice care furnished in a frontier area, see section 422; and

(2) provision of a rural hospice demonstration project, see section 423.

SEC. 308. REFERENCE TO PRIORITY FOR HOSPITALS LOCATED IN RURAL OR SMALL URBAN AREAS IN REDISTRIBUTION OF UNUSED GRADUATE MEDICAL EDUCATION RESIDENCIES.

For provision providing priority for hospitals located in rural or small urban areas in redistribution of unused graduate medical education residencies, see section 612.

SEC. 309. 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. 310. 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)) is amended—

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

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

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

''(G) any remuneration between a public or nonprofit private health center entity described under clause (i) or (ii) of section 1905(1)(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)(G) of the Social Security Act, as added by subsection (a), for health center entity arrangements to the antikickback penalties.

(B) FACTORS TO CONSIDER.—The Secretary shall consider the following factors, among others, in establishing 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 expands or enhances 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.

TITLE IV—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

SEC. 401. REVISION OF ACUTE CARE HOSPITAL PAYMENT UPDATES.

Subclause (XVIII) of section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended to read as follows:

''(XVIII) for fiscal year 2003, the market basket percentage increase for sole community hospitals and such increase minus 0.25 percentage points for other hospitals, and''.

SEC. 402. 2-YEAR INCREASE IN LEVEL OF ADJUSTMENT FOR INDIRECT COSTS OF MEDICAL EDUCATION (IME).

Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI) by striking ''and'' at the end;

(2) by redesignating subclause (VII) as subclause (IX);

(3) in subclause (VIII) as so redesignated, by striking ''2002'' and inserting ''2004''; and

(4) by inserting after subclause (VI) the following new subclause:

''(VII) during fiscal year 2003, 'c' is equal to 1.47;

''(VIII) during fiscal year 2004, 'c' is equal to 1.45; and''.

SEC. 403. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PPS.

(a) IMPROVING TIMELINESS OF DATA COLLECTION.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended by adding at the end the following new clause:

''(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.''.

(b) ELIGIBILITY STANDARD.—

(1) MINIMUM PERIOD FOR RECOGNITION OF NEW TECHNOLOGIES.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)) is amended—

(A) by inserting ''(I)'' after ''(vi)''; and

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

''(II) Under such criteria, a service or technology shall not be denied treatment as a new service or technology on the basis of the period of time in which the service or technology has been in use if such period ends before the end of the 2-to-3-year period that begins on the effective date of implementation of a code under ICD–9–CM (or a successor coding methodology) that enables the identification of a significant sample of specific discharges in which the service or technology has been used.''.

(2) ADJUSTMENT OF THRESHOLD.—Section 1886(d)(5)(K)(ii)(I) (42 U.S.C. 1395ww(d)(5)(K)(ii)(I)) is amended by inserting ''(applying a threshold specified by the Secretary that is the lesser of 50 percent of the national average standardized amount for operating costs of inpatient hospital services for all hospitals and all diagnosis-related groups or one standard deviation for the diagnosis-related group involved)'' after ''is inadequate''.

(3) CRITERION FOR SUBSTANTIAL IMPROVEMENT.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)), as amended by paragraph (1), is further amended by adding at the end the following subclause:

''(III) The Secretary shall by regulation provide for further clarification of the criteria applied to determine whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries. Under such criteria, in determining whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries, the Secretary shall deem a service or technology as meeting such requirement if the service or technology is a drug or biological that is designated under section 506 or 526 of the Federal Food, Drug, and Cosmetic Act, approved under section 314.510 or 601.41 of title 21, Code of Federal Regulations, or designated for priority review when the marketing application for such drug or biological was filed or is a medical device for which an exemption has been granted under section 520(m) of such Act, for which priority review has been provided under section 515(d)(5) of such Act, or is a substantially equivalent device for which an expedited review is provided under section 513(f) of such Act.''.

(4) PROCESS FOR PUBLIC INPUT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended by paragraph (1), is amended—

(A) in clause (i), by adding at the end the following: ''Such mechanism shall be modified to meet the requirements of clause (viii).''; and

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

''(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology not described in the second sentence of clause (vi)(III) represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries as follows:

''(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

''(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

''(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, medicare beneficiaries, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.''.

(c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is further amended by adding at the end the following new clause:

''(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. In such case, no add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).''.

(d) IMPROVEMENT IN PAYMENT FOR NEW TECHNOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after ''the estimated average cost of such service or technology'' the following: ''(based on the marginal rate applied to costs under subparagraph (A))''.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The Secretary shall implement the amendments made by this section so that they apply to classification for fiscal years beginning with fiscal year 2004.

(2) RECONSIDERATIONS OF APPLICATIONS FOR FISCAL YEAR 2003 THAT ARE DENIED.—In the case of an application for a classification of a medical service or technology as a new medical service or technology under section 1886(d)(5)(K) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was filed for fiscal year 2003 and that is denied—

(A) the Secretary shall automatically reconsider the application as an application for fiscal year 2004 under the amendments made by this section; and

(B) the maximum time period otherwise permitted for such classification of the service or technology shall be extended by 12 months.

SEC. 404. PHASE-IN OF FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)'' and inserting ''the applicable Puerto Rico percentage (specified in subparagraph (E))''; and

(B) in clause (ii), by striking ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)'' and inserting ''the applicable Federal percentage (specified in subparagraph (E))''; and

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

''(E) For purposes of subparagraph (A), for discharges occurring—

''(i) between October 1, 1987, and September 30, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

''(ii) on or after October 1, 1997, and before October 1, 2003, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

''(iii) during fiscal year 2004, the applicable Puerto Rico percentage is 45 percent and the applicable Federal percentage is 55 percent;

''(iv) during fiscal year 2005, the applicable Puerto Rico percentage is 40 percent and the applicable Federal percentage is 60 percent;

''(v) during fiscal year 2006, the applicable Puerto Rico percentage is 35 percent and the applicable Federal percentage is 65 percent;

''(vi) during fiscal year 2007, the applicable Puerto Rico percentage is 30 percent and the applicable Federal percentage is 70 percent; and

''(vii) on or after October 1, 2007, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.''.

SEC. 405. REFERENCE TO PROVISION RELATING TO ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

For provision enhancing disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds, see section 302.

SEC. 406. REFERENCE TO PROVISION RELATING TO 2-YEAR PHASED-IN INCREASE IN THE STANDARDIZED AMOUNT IN RURAL AND SMALL URBAN AREAS TO ACHIEVE A SINGLE, UNIFORM STANDARDIZED AMOUNT.

For provision phasing in over a 2-year period an increase in the standardized amount for rural and small urban areas to achieve a single, uniform, standardized amount, see section 303.

SEC. 407. REFERENCE TO PROVISION FOR MORE FREQUENT UPDATES IN THE WEIGHTS USED IN HOSPITAL MARKET BASKET.

For provision providing for more frequent updates in the weights used in hospital market basket, see section 304.

SEC. 408. REFERENCE TO PROVISION MAKING IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

For provision providing making improvements to critical access hospital program, see section 305.

Subtitle B—Skilled Nursing Facility Services

SEC. 411. PAYMENT FOR COVERED SKILLED NURSING FACILITY SERVICES.

(a) TEMPORARY INCREASE IN NURSING COMPONENT OF PPS FEDERAL RATE.—Section 312(a) of BIPA is amended by adding at the end the following new sentence: ''The Secretary of Health and Human Services shall increase by 8 percent the nursing component of the case-mix adjusted Federal prospective payment rate specified in Tables 3 and 4 of the final rule published in the Federal Register by the Health Care Financing Administration on July 31, 2000 (65 Fed. Reg. 46770) and as subsequently updated under section 1888(e)(4)(E)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)), effective for services furnished on or after October 1, 2002, and before October 1, 2005.''.

(b) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—

(1) IN GENERAL.—Paragraph (12) of section 1888(e) (42 U.S.C. 1395yy(e)) is amended to read as follows:

''(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

''(A) IN GENERAL.—Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable shall be increased by 128 percent to reflect increased costs associated with such residents.

''(B) SUNSET.—Subparagraph (A) shall not apply on and after such date as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 2003.

Subtitle C—Hospice

SEC. 421. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking ''and'' at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting ''; and''; and

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

''(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not have previously received services under this paragraph, services that are furnished by a physician who is the medical director or an employee of a hospice program and that consist of—

''(A) an evaluation of the individual's need for pain and symptom management;

''(B) counseling the individual with respect to end-of-life issues and care options; and

''(C) advising the individual regarding advanced care planning.''.

(b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this part shall be equal to an amount equivalent to the amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity under the fee schedule established under section 1848(b), other than the portion of such amount attributable to the practice expense component.''.

(c) CONFORMING AMENDMENT.—Section 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended by inserting before the comma at the end the following: ''and services described in section 1812(a)(5)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2004.

SEC. 422. 10 PERCENT INCREASE IN PAYMENT FOR HOSPICE CARE FURNISHED IN A FRONTIER AREA.

(a) IN GENERAL.—Section 1814(i)(1) (42 U.S.C. 1395f(i)(1)) is amended by adding at the end the following new subparagraph:

''(D) With respect to hospice care furnished in a frontier area on or after January 1, 2003, and before January 1, 2008, the payment rates otherwise established for such care shall be increased by 10 percent. For purposes of this subparagraph, the term 'frontier area' means a county in which the population density is less than 7 persons per square mile.''.

(b) REPORT ON COSTS.—Not later than January 1, 2007, the Comptroller General of the United States shall submit to Congress a report on the costs of furnishing hospice care in frontier areas. Such report shall include recommendations regarding the appropriateness of extending, and modifying, the payment increase provided under the amendment made by subsection (a).

SEC. 423. RURAL HOSPICE DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary shall conduct a demonstration project for the delivery of hospice care to medicare beneficiaries in rural areas. Under the project medicare beneficiaries who are unable to receive hospice care in the home for lack of an appropriate caregiver are provided such care in a facility of 20 or fewer beds which offers, within its walls, the full range of services provided by hospice programs under section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)).

(b) SCOPE OF PROJECT.—The Secretary shall conduct the project under this section with respect to no more than 3 hospice programs over a period of not longer than 5 years each.

(c) COMPLIANCE WITH CONDITIONS.—Under the demonstration project—

(1) the hospice program shall comply with otherwise applicable requirements, except that it shall not be required to offer services outside of the home or to meet the requirements of section 1861(dd)(2)(A)(iii) of the Social Security Act; and

(2) payments for hospice care shall be made at the rates otherwise applicable to such care under title XVIII of such Act.

The Secretary may require the program to comply with such additional quality assurance standards for its provision of services in its facility as the Secretary deems appropriate.

(d) REPORT.—Upon completion of the project, the Secretary shall submit a report to Congress on the project and shall include in the report recommendations regarding extension of such project to hospice programs serving rural areas.

Subtitle D—Other Provisions

SEC. 431. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under this section (in this section referred to as the ''project'') to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying and recouping overpayments under the medicare program for services for which payment is made under part A of title XVIII of the Social Security Act. Under the project—

(1) payment may be made to such a contractor on a contingent basis;

(2) a percentage of the amount recovered may be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) the Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which overpayments arise.

(b) SCOPE AND DURATION.—The project shall cover at least 2 States and at least 3 contractors and shall last for not longer than 3 years.

(c) WAIVER.—The Secretary of Health and Human Services shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS.—

(1) IN GENERAL.—The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has knowledge of and experience with the payment rules and regulations under the medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) INELIGIBILITY OF CERTAIN CONTRACTORS.—The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act, or any other entity that carries out the type of activities with respect to providers of services under part A that would constitute a conflict of interest, as determined by the Secretary.

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY WITH PRIVATE INSURERS.—In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those entities that the Secretary determines have demonstrated proficiency in recovery audits with private insurers or under the medicaid program under title XIX of such Act.

(e) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the medicare program and recommendations on the cost-effectiveness of extending or expanding the project.

TITLE V—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

SEC. 501. REVISION OF UPDATES FOR PHYSICIANS' SERVICES.

(a) UPDATE FOR 2003 THROUGH 2005.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraphs:

''(5) UPDATE FOR 2003.—The update to the single conversion factor established in paragraph (1)(C) for 2003 is 2 percent.

''(6) SPECIAL RULES FOR UPDATE FOR 2004 AND 2005.—The following rules apply in determining the update adjustment factors under paragraph (4)(B) for 2004 and 2005:

''(A) USE OF 2002 DATA IN DETERMINING ALLOWABLE COSTS.—

''(i) The reference in clause (ii)(I) of such paragraph to April 1, 1996, is deemed to be a reference to January 1, 2002.

''(ii) The allowed expenditures for 2002 is deemed to be equal to the actual expenditures for physicians' services furnished during 2002, as estimated by the Secretary.

''(B) 1 PERCENTAGE POINT INCREASE IN GDP UNDER SGR.—The annual average percentage growth in real gross domestic product per capita under subsection (f)(2)(C) for each of 2003, 2004, and 2005 is deemed to be increased by 1 percentage point.''.

(2) CONFORMING AMENDMENT.—Paragraph (4)(B) of such section is amended, in the matter before clause (i), by inserting ''and paragraph (6)'' after ''subparagraph (D)''.

(b) USE OF 10-YEAR ROLLING AVERAGE IN COMPUTING GROSS DOMESTIC PRODUCT.—

(1) IN GENERAL.—Section 1848(f)(2)(C) (42 U.S.C. 1395w–4(f)(2)(C)) is amended—

(A) by striking ''projected'' and inserting ''annual average''; and

(B) by striking ''from the previous applicable period to the applicable period involved'' and inserting ''during the 10-year period ending with the applicable period involved''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to computations of the sustainable growth rate for years beginning with 2002.

(c) ELIMINATION OF TRANSITIONAL ADJUSTMENT.—Section 1848(d)(4)(F) (42 U.S.C. 1395w–4(d)(4)(F)) is amended by striking ''subparagraph (A)'' and all that follows and inserting ''subparagraph (A), for each of 2001 and 2002, of −0.2 percent.''

SEC. 502. STUDIES ON ACCESS TO PHYSICIANS' SERVICES.

(a) GAO STUDY ON BENEFICIARY ACCESS TO PHYSICIANS' SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on access of medicare beneficiaries to physicians' services under the medicare program. The study shall include—

(A) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the medicare program;

(B) an examination of changes in the use by beneficiaries of physicians' services over time;

(C) an examination of the extent to which physicians are not accepting new medicare beneficiaries as patients.

(2) REPORT.—Not later than 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 paragraph (1). The report shall include a determination whether—

(A) data from claims submitted by physicians under part B of the medicare program indicate potential access problems for medicare beneficiaries in certain geographic areas; and

(B) access by medicare beneficiaries to physicians' services may have improved, remained constant, or deteriorated over time.

(b) STUDY AND REPORT ON SUPPLY OF PHYSICIANS.—

(1) STUDY.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on the adequacy of the supply of physicians (including specialists) in the United States and the factors that affect such supply.

(2) REPORT TO CONGRESS.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the results of the study described in paragraph (1), including any recommendations for legislation.

SEC. 503. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS' SERVICES.

Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the effect of refinements to the practice expense component of payments for physicians' services in the case of services for which there are no physician work relative value units, after the transition to a full resource-based payment system in 2002, under section 1848 of the Social Security Act (42 U.S.C. 1395w–4). Such report shall examine the following matters by physician specialty:

(1) The effect of such refinements on payment for physicians' services.

(2) The interaction of the practice expense component with other components of and adjustments to payment for physicians' services under such section.

(3) The appropriateness of the amount of compensation by reason of such refinements.

(4) The effect of such refinements on access to care by medicare beneficiaries to physicians' services.

(5) The effect of such refinements on physician participation under the medicare program.

Subtitle B—Other Services

SEC. 511. COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES.

(a) IN GENERAL.—Section 1847 (42 U.S.C. 1395w–3) is amended to read as follows:

''COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES

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

''(1) IMPLEMENTATION OF PROGRAMS.—

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

''(B) PHASED-IN IMPLEMENTATION.—The programs shall be phased-in among competitive acquisition areas over a period of not longer than 3 years in a manner so that the competition under the programs occurs in—

''(i) at least ⅓ of such areas in 2004; and

''(ii) at least ⅔ of such areas in 2005.

''(C) WAIVER OF CERTAIN PROVISIONS.—In carrying out the programs, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

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

''(A) DURABLE MEDICAL EQUIPMENT AND INHALATION DRUGS USED IN CONNECTION WITH DURABLE MEDICAL EQUIPMENT.—Covered items (as defined in section 1834(a)(13)) for which payment is otherwise made under section 1834(a), other than items used in infusion, and inhalation drugs used in conjunction with durable medical equipment.

''(B) OFF-THE-SHELF ORTHOTICS.—Orthotics (described in section 1861(s)(9)) for which payment is otherwise made under section 1834(h) which require minimal self-adjustment for appropriate use and does not require expertise in trimming, bending, molding, assembling, or customizing to fit to the patient.

''(3) EXEMPTION AUTHORITY.—In carrying out the programs under this section, the Secretary may exempt—

''(A) areas that are not competitive due to low population density; and

''(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

''(b) PROGRAM REQUIREMENTS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among entities supplying items and services described in subsection (a)(2) for each competitive acquisition area in which the program is implemented under subsection (a) with respect to such items and services.

''(2) CONDITIONS FOR AWARDING CONTRACT.—

''(A) IN GENERAL.—The Secretary may not award a contract to any entity under the competition conducted in an competitive acquisition area pursuant to paragraph (1) to furnish such items or services unless the Secretary finds all of the following:

''(i) The entity meets quality and financial standards specified by the Secretary or developed by accreditation entities or organizations recognized by the Secretary.

''(ii) The total amounts to be paid under the contract (including costs associated with the administration of the contract) are expected to be less than the total amounts that would otherwise be paid.

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

''(iv) Beneficiary liability is limited to the applicable percentage of contract award price.

''(B) QUALITY STANDARDS.—The quality standards specified under subparagraph (A)(i) shall not be less than the quality standards that would otherwise apply if this section did not apply and shall include consumer services standards. The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of physicians, practitioners, and suppliers to review (and advise the Secretary concerning) such quality standards.

''(3) CONTENTS OF CONTRACT.—

''(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

''(B) TERM OF CONTRACTS.—The Secretary shall rebid contracts under this section not less often than once every 3 years.

''(4) LIMIT ON NUMBER OF CONTRACTORS.—

''(A) IN GENERAL.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In awarding contracts, the Secretary shall take into account the ability bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of beneficiaries for such items or services in the geographic area covered under the contract on a timely basis.

''(B) MULTIPLE WINNERS.—The Secretary shall award contracts to more than one entity submitting a bid in each area for an item or service.

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

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

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

''(6) AUTHORITY TO CONTRACT FOR EDUCATION, OUTREACH AND COMPLAINT SERVICES.—

The Secretary may enter into a contract with an appropriate entity to address complaints from beneficiaries who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to such beneficiaries with respect to the program.

''(c) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual management report on the programs under this section. Each such report shall include information on savings, reductions in cost-sharing, access to items and services, and beneficiary satisfaction.

''(d) DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

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

''(A) for which payment is otherwise made under section 1833(h) or 1834(d)(1) (relating to colorectal cancer screening tests); and

''(B) which are furnished without a face-to-face encounter between the individual and the hospital or physician ordering the tests.

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

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

''(A) an initial report on the project not later than December 31, 2004; and

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

(b) CONTINUATION OF CERTAIN DEMONSTRATION PROJECTS.—Notwithstanding the amendment made by subsection (a), with respect to demonstration projects implemented by the Secretary under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) (relating to the establishment of competitive acquisition areas) that was in effect on the day before the date of the enactment of this Act, each such demonstration project may continue under the same terms and conditions applicable under that section as in effect on that date.

(c) REPORT ON DIFFERENCES IN PAYMENT FOR LABORATORY SERVICES.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that analyzes differences in reimbursement between public and private payors for clinical diagnostic laboratory services.

SEC. 512. PAYMENT FOR AMBULANCE SERVICES.

(a) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended—

(1) in paragraph (2)(E), by inserting ''consistent with paragraph (10)'' after ''in an efficient and fair manner'';

(2) by redesignating the paragraph (8) added by section 221(a) of BIPA as paragraph (9); and

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

''(10) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of service furnished in a year before January 1, 2007, the portion of the payment amount that is based on the fee schedule shall not be less than the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

''(A) For 2003, the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

''(B) For 2004, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

''(C) For 2005, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

''(D) For 2006, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the 9 Census divisions using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.''.

(b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—Section 1834(l), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

''(11) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after January 1, 2003, and before January 1, 2008, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the payment per mile otherwise applicable to such miles.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to ambulance services furnished on or after January 1, 2003.

SEC. 513. 1-YEAR EXTENSION OF MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO REPORTS.

(a) 1-YEAR EXTENSION OF MORATORIUM ON THERAPY CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking ''and 2002'' and inserting ''2002 and 2003''.

(b) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES.—Not later than December 31, 2002, the Secretary shall submit to Congress the reports required under section 4541(d)(2) of the Balanced Budget Act of 1997 (relating to alternatives to a single annual dollar cap on outpatient therapy) and under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (relating to utilization patterns for outpatient therapy).

(c) IDENTIFICATION OF CONDITIONS AND DISEASES JUSTIFYING WAIVER OF THERAPY CAP.—

(1) STUDY.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to identify conditions or diseases that should justify conducting an assessment of the need to waive the therapy caps under section 1833(g)(4) of the Social Security Act (42 U.S.C. 1395l(g)(4)).

(2) REPORTS TO CONGRESS.—Not later than July 1, 2003, the Secretary shall submit to Congress a preliminary report on the conditions and diseases identified under paragraph (1) and not later than September 1, 2003, a final report on the conditions and diseases so identified.

(d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL THERAPIST SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on access to physical therapist services in States authorizing such services without a physician referral and in States that require such a physician referral. The study shall—

(A) examine the use of and referral patterns for physical therapist services for patients age 50 and older in States that authorize such services without a physician referral and in States that require such a physician referral;

(B) examine the use of and referral patterns for physical therapist services for patients who are medicare beneficiaries; and

(C) examine the delivery of physical therapists' services within the facilities of Department of Defense; and

(D) analyze the potential impact on medicare beneficiaries and on expenditures under the medicare program of eliminating the need for a physician referral for physical therapist services under the medicare program.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than 1 year after the date of the enactment of this Act.

SEC. 514. ACCELERATED IMPLEMENTATION OF 20 PERCENT COINSURANCE FOR HOSPITAL OUTPATIENT DEPARTMENT (OPD) SERVICES; OTHER OPD PROVISIONS.

(a) ACCELERATED IMPLEMENTATION OF COINSURANCE REDUCTIONS.—Section 1833(t)(8)(C)(ii) (42 U.S.C. 1395l(t)(8)(C)(ii)) is amended by striking subclauses (III) through (V) and inserting the following:

''(III) For procedures performed in 2004, 45 percent.

''(IV) For procedures performed in 2005, 40 percent.

''(V) For procedures performed in 2006, 2007, 2008 and 2009, 35 percent.

''(VI) For procedures performed in 2010, 30 percent.

''(VII) For procedures performed in 2011, 25 percent.

''(VIII) For procedures performed in 2012 and thereafter, 20 percent.''.

(b) TREATMENT OF TEMPERATURE MONITORED CRYOABLATION.—

(1) IN GENERAL.—Section 1833(t)(6)(A)(ii) (42 U.S.C. 1395l(t)(6)(A)(ii)) is amended by striking ''or temperature monitored cryoablation''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to payment for services furnished on or after January 1, 2003.

SEC. 515. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), is amended—

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V), by inserting ''and'' at the end; and

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

''(W) an initial preventive physical examination (as defined in subsection (ww));''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Initial Preventive Physical Examination

''(ww) The term 'initial preventive physical examination' means physicians' services consisting of a physical examination with the goal of health promotion and disease detection and includes items and services specified by the Secretary in regulations.''.

(c) PAYMENT AS PHYSICIANS' SERVICES.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) by inserting ''(2)(W),'' after ''(2)(S),''.

(d) OTHER CONFORMING AMENDMENTS.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

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

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

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

''(J) in the case of an initial preventive physical examination, which is performed not later than 6 months after the date the individual's first coverage period begins under part B;''; and

(2) in paragraph (7), by striking ''or (H)'' and inserting ''(H), or (J)''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004, but only for individuals whose coverage period begins on or after such date.

SEC. 516. RENAL DIALYSIS SERVICES.

(a) REPORT ON DIFFERENCES IN COSTS IN DIFFERENT SETTINGS.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report containing—

(1) an analysis of the differences in costs of providing renal dialysis services under the medicare program in home settings and in facility settings;

(2) an assessment of the percentage of overhead costs in home settings and in facility settings; and

(3) an evaluation of whether the charges for home dialysis supplies and equipment are reasonable and necessary.

(b) RESTORING COMPOSITE RATE EXCEPTIONS FOR PEDIATRIC FACILITIES.—

(1) IN GENERAL.—Section 422(a)(2) of BIPA is amended—

(A) in subparagraph (A), by striking ''and (C)'' and inserting '', (C), and (D)'';

(B) in subparagraph (B), by striking ''In the case'' and inserting ''Subject to subparagraph (D), in the case''; and

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

''(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term 'pediatric facility' means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.''.

(2) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by striking ''The Secretary'' and inserting ''Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary''.

(c) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES FURNISHED IN 2004.—Notwithstanding any other provision of law, with respect to payment under part B of title XVIII of the Social Security Act for renal dialysis services furnished in 2004, the composite payment rate otherwise established under section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)) shall be increased by 1.2 percent.

TITLE VI—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 601. ELIMINATION OF 15 PERCENT REDUCTION IN PAYMENT RATES UNDER THE PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C. 1395fff(b)(3)(A)) is amended to read as follows:

''(A) INITIAL BASIS.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts) as follows:

''(i) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2001 shall be equal to the total amount that would have been made if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been enacted.

''(ii) For fiscal year 2002 and for the first quarter of fiscal year 2003, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for the previous fiscal year, updated under subparagraph (B).

''(iii) For 2003, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for fiscal year 2002, updated under subparagraph (B) for 2003.

''(iv) For 2004 and each subsequent year, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for the previous year, updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the amendments made by section 501 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554).

SEC. 602. ESTABLISHMENT OF REDUCED COPAYMENT FOR A HOME HEALTH SERVICE EPISODE OF CARE FOR CERTAIN BENEFICIARIES.

(a) PART A.—

(1) IN GENERAL.—Section 1813(a) (42 U.S.C. 1395e(a)) is amended by adding at the end the following new paragraph:

''(5)(A)(i) Subject to clause (ii), the amount payable for home health services furnished to the individual under this title for each episode of care beginning in a year (beginning with 2003) shall be reduced by a copayment equal to the copayment amount specified in subparagraph (B)(ii) such year.

''(ii) The copayment under clause (i) shall not apply—

''(I) in the case of an individual who has been determined to be a qualified medicare beneficiary (as defined in section 1905(p)(1)) or otherwise to be entitled to medical assistance under section 1902(a)(10)(A) or 1902(a)(10)(C); and

''(II) in the case of an episode of care which consists of 4 or fewer visits.

''(B)(i) The Secretary shall estimate, before the beginning of each year (beginning with 2003), the national average payment under this title per episode for home health services projected for the year involved.

''(ii) For each year the copayment amount under this clause is equal to 1.5 percent of the national average payment estimated for the year involved under clause (i). Any amount determined under the preceding sentence which is not a multiple of $5 shall be rounded to the nearest multiple of $5.

''(iii) There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the estimation of average payment under clause (i).''.

(2) TIMELY IMPLEMENTATION.—Unless the Secretary of Health and Human Services otherwise provides on a timely basis, the copayment amount specified under section 1813(a)(5)(B)(ii) of the Social Security Act (as added by paragraph (1)) for 2003 shall be deemed to be $40.

(b) CONFORMING PROVISIONS.—

(1) Section 1833(a)(2)(A) (42 U.S.C. 1395l(a)(2)(A)) is amended by inserting ''less the copayment amount applicable under section 1813(a)(5)'' after ''1895''.

(2) Section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended—

(A) by striking ''or coinsurance'' and inserting '', coinsurance, or copayment''; and

(B) by striking ''or (a)(4)'' and inserting ''(a)(4), or (a)(5)''.

SEC. 603. UPDATE IN HOME HEALTH SERVICES.

(a) CHANGE TO CALENDAR YEAR UPDATE.—

(1) IN GENERAL.—Section 1895(b) (42 U.S.C. 1395fff(b)(3)) is amended—

(A) in paragraph (3)(B)(i)—

(i) by striking ''each fiscal year (beginning with fiscal year 2002)'' and inserting ''fiscal year 2002 and for each subsequent year (beginning with 2003)''; and

(ii) by inserting ''or year'' after ''the fiscal year'';

(B) in paragraph (3)(B)(ii)—

(i) in subclause (II), by striking ''fiscal year'' and inserting ''year'' and by redesignating such subclause as subclause (III); and

(ii) in subclause (I), by striking ''each of fiscal years 2002 and 2003'' and inserting the following: ''fiscal year 2002, the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points;

''(II) 2003'';

(C) in paragraph (3)(B)(iii), by inserting ''or year'' after ''fiscal year'' each place it appears;

(D) in paragraph (3)(B)(iv)—

(i) by inserting ''or year'' after ''fiscal year'' each place it appears; and

(ii) by inserting ''or years'' after ''fiscal years''; and

(E) in paragraph (5), by inserting ''or year'' after ''fiscal year''.

(2) TRANSITION RULE.—The standard prospective payment amount (or amounts) under section 1895(b)(3) of the Social Security Act for the calendar quarter beginning on October 1, 2002, shall be such amount (or amounts) for the previous calendar quarter.

(b) CHANGES IN UPDATES FOR 2003, 2004, AND 2005.—Section 1895(b)(3)(B)(ii) (42 U.S.C. 1395fff(b)(3)(B)(ii)), as amended by subsection (a)(1)(B), is amended—

(1) in subclause (II), by striking ''the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points'' and inserting ''2.0 percentage points'';

(2) by striking ''or'' at the end of subclause (II);

(3) by redesignating subclause (III) as subclause (V); and

(4) by inserting after subclause (II) the following new subclause:

''(III) 2004, 1.0 percentage points;

''(IV) 2005, the home health market basket percentage increase (as defined in clause (iii)) minus 0.8 percentage points; or''.

(c) PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1895(b)(5) (42 U.S.C. 1395fff(b)(5)) is amended ''5 percent'' and inserting ''3 percent''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to years beginning with 2003.

SEC. 604. OASIS TASK FORCE; SUSPENSION OF CERTAIN OASIS DATA COLLECTION REQUIREMENTS PENDING TASK FORCE SUBMITTAL OF REPORT.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish and appoint a task force (to be known as the ''OASIS Task Force'') to examine the data collection and reporting requirements under OASIS. For purposes of this section, the term ''OASIS'' means the Outcome and Assessment Information Set required by reason of section 4602(e) of Balanced Budget Act of 1997 (42 U.S.C. 1395fff note).

(b) COMPOSITION.—The OASIS Task Force shall be composed of the following:

(1) Staff of the Centers for Medicare & Medicaid Services with expertise in post-acute care.

(2) Representatives of home health agencies.

(3) Health care professionals and research and health care quality experts outside the Federal Government with expertise in post-acute care.

(4) Advocates for individuals requiring home health services.

(c) DUTIES.—

(1) REVIEW AND RECOMMENDATIONS.—The OASIS Task Force shall review and make recommendations to the Secretary regarding changes in OASIS to improve and simplify data collection for purposes of—

(A) assessing the quality of home health services; and

(B) providing consistency in classification of patients into home health resource groups (HHRGs) for payment under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(2) SPECIFIC ITEMS.—In conducting the review under paragraph (1), the OASIS Task Force shall specifically examine—

(A) the 41 outcome measures currently in use;

(B) the timing and frequency of data collection; and

(C) the collection of information on comorbidities and clinical indicators.

(3) REPORT.—The OASIS Task Force shall submit a report to the Secretary containing its findings and recommendations for changes in OASIS by not later than 18 months after the date of the enactment of this Act.

(d) SUNSET.—The OASIS Task Force shall terminate 60 days after the date on which the report is submitted under subsection (c)(2).

(e) NONAPPLICATION OF FACA.—The provisions of the Federal Advisory Committee Act shall not apply to the OASIS Task Force.

(f) SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS PENDING TASK FORCE REPORT.—

(1) IN GENERAL.—During the period described in paragraph (2), the Secretary of Health and Human Services may not require, under section 4602(e) of the Balanced Budget Act of 1997 or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act.

(2) PERIOD OF SUSPENSION.—The period described in this paragraph—

(A) begins on January 1, 2003, and

(B) ends on the last day of the 2nd month beginning after the date the report is submitted under subsection (c)(2).

SEC. 605. MEDPAC STUDY ON MEDICARE MARGINS OF HOME HEALTH AGENCIES.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of payment margins of home health agencies under the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Such study shall examine whether systematic differences in payment margins are related to differences in case mix (as measured by home health resource groups (HHRGs)) among such agencies. The study shall use the partial or full-year cost reports filed by home health agencies.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study under subsection (a).

Subtitle B—Direct Graduate Medical Education

SEC. 611. EXTENSION OF UPDATE LIMITATION ON HIGH COST PROGRAMS.

Section 1886(h)(2)(D)(iv) (42 U.S.C. 1395ww(h)(2)(D)(iv)) is amended—

(1) in subclause (I)—

(A) by striking ''AND 2002'' and inserting ''THROUGH 2012'';

(B) by striking ''during fiscal year 2001 or fiscal year 2002'' and inserting ''during the period beginning with fiscal year 2001 and ending with fiscal year 2012''; and

(C) by striking ''subject to subclause (III),'';

(2) by striking subclause (II); and

(3) in subclause (III)—

(A) by redesignating such subclause as subclause (II); and

(B) by striking ''or (II)''.

SEC. 612. 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), by inserting ''subject to subparagraph (I),'' after ''October 1, 1997,'';

(2) in subparagraph (H), 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, 2003, 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, 2001.

''(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, 2002.

''(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, 2003, 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, 2004.

''(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) NO APPLICATION OF INCREASE 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 clause (i) of subparagraph (I) of subsection (h)(4) shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subparagraph (F) of such subsection, but the provisions of clause (ii) of such subparagraph shall not apply.''.

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2004, 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)).

Subtitle C—Other Provisions

SEC. 621. MODIFICATIONS TO MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXAMINATION OF BUDGET CONSEQUENCES.—Section 1805(b) (42 U.S.C. 1395b–6(b)) is amended by adding at the end the following new paragraph:

''(8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.''.

(b) CONSIDERATION OF EFFICIENT PROVISION OF SERVICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–6(b)(2)(B)(i)) is amended by inserting ''the efficient provision of'' after ''expenditures for''.

(c) ADDITIONAL REPORTS.—

(1) DATA NEEDS AND SOURCES.—The Medicare Payment Advisory Commission shall conduct a study, and submit a report to Congress by not later than June 1, 2003, on the need for current data, and sources of current

data available, to determine the solvency and financial circumstances of hospitals and other medicare providers of services.

(2) USE OF TAX-RELATED RETURNS.—Using return information provided under Form 990 of the Internal Revenue Service, the Commission shall submit to Congress, by not later than June 1, 2003, a report on the following:

(A) Investments and capital financing of hospitals participating under the medicare program and related foundations.

(B) Access to capital financing for private and for not-for-profit hospitals.

SEC. 622. DEMONSTRATION PROJECT FOR DISEASE MANAGEMENT FOR CERTAIN MEDICARE BENEFICIARIES WITH DIABETES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under this section (in this section referred to as the ''project'') to demonstrate the impact on costs and health outcomes of applying disease management to certain medicare beneficiaries with diagnosed diabetes. In no case may the number of participants in the project exceed 30,000 at any time.

(b) VOLUNTARY PARTICIPATION.—

(1) ELIGIBILITY.—Medicare beneficiaries are eligible to participate in the project only if—

(a) they are Hispanic, as determined by the Secretary;

(A) they meet specific medical criteria demonstrating the appropriate diagnosis and the advanced nature of their disease;

(B) their physicians approve of participation in the project; and

(C) they are not enrolled in a Medicare+Choice plan.

(2) BENEFITS.—A medicare beneficiary who is enrolled in the project shall be eligible—

(A) for disease management services related to their diabetes; and

(B) for payment for all costs for prescription drugs without regard to whether or not they relate to the diabetes, except that the project may provide for modest cost-sharing with respect to prescription drug coverage.

(c) CONTRACTS WITH DISEASE MANAGEMENT ORGANIZATIONS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall carry out the project through contracts with up to three disease management organizations. The Secretary shall not enter into such a contract with an organization unless the organization demonstrates that it can produce improved health outcomes and reduce aggregate medicare expenditures consistent with paragraph (2).

(2) CONTRACT PROVISIONS.—Under such contracts—

(A) such an organization shall be required to provide for prescription drug coverage described in subsection (b)(2)(B);

(B) such an organization shall be paid a fee negotiated and established by the Secretary in a manner so that (taking into account savings in expenditures under parts A and B of the medicare program under title XVIII of the Social Security Act) there will be no net increase, and to the extent practicable, there will be a net reduction in expenditures under the medicare program as a result of the project; and

(C) such an organization shall guarantee, through an appropriate arrangement with a reinsurance company or otherwise, the prohibition on net increases in expenditures described in subparagraph (B).

(3) PAYMENTS.—Payments to such organizations shall be made in appropriate proportion from the Trust Funds established under title XVIII of the Social Security Act.

(4) WORKING GROUP.—The Secretary shall establish within the Department of Health and Human Services a working group consisting of employees of the Department to carry out the following:

(A) To oversee the project.

(B) To establish policy and criteria for medicare disease management programs within the Department, including the establishment of policy and criteria for such programs.

(C) To identify targeted medical conditions and targeted individuals.

(D) To select areas in which such programs are carried out.

(E) To monitor health outcomes under such programs.

(F) To measure the effectiveness of such programs in meeting any budget neutrality requirements.

(G) Otherwise to serve as a central focal point within the Department for dissemination of information on medicare disease management programs.

(d) APPLICATION OF MEDIGAP PROTECTIONS TO DEMONSTRATION PROJECT ENROLLEES.—(1) Subject to paragraph (2), the provisions of section 1882(s)(3) (other than clauses (i) through (iv) of subparagraph (B)) and 1882(s)(4) of the Social Security Act shall apply to enrollment (and termination of enrollment) in the demonstration project under this section, in the same manner as they apply to enrollment (and termination of enrollment) with a Medicare+Choice organization in a Medicare+Choice plan.

(2) In applying paragraph (1)—

(A) any reference in clause (v) or (vi) of section 1882(s)(3)(B) of such Act to 12 months is deemed a reference to the period of the demonstration project; and

(B) the notification required under section 1882(s)(3)(D) of such Act shall be provided in a manner specified by the Secretary of Health and Human Services.

(e) DURATION.—The project shall last for not longer than 3 years.

(f) WAIVER.—The Secretary of Health and Human Services shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (c)(3).

(g) REPORT.—The Secretary of Health and Human Services shall submit to Congress an interim report on the project not later than 2 years after the date it is first implemented and a final report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on costs and health outcomes and recommendations on the cost-effectiveness of extending or expanding the project.

(h) GAO STUDY ON DISEASE MANAGEMENT PROGRAMS.—The Comptroller General of the United States shall conduct a study that compares disease management programs under title XVIII of the Social Security Act with such programs conducted in the private sector, including the prevalence of such programs and programs for case management. The study shall identify the cost-effectiveness of such programs and any savings achieved by such programs. The Comptroller General shall submit a report on such study to Congress by not later than 18 months after the date of the enactment of this Act.

SEC. 623. DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY CARE SERVICES.

(a) ESTABLISHMENT.—Subject to the succeeding provisions of this section, the Secretary of Health and Human Services shall establish a demonstration project (in this section referred to as the ''demonstration project'') under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day care facility, to provide medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

(b) PAYMENT.—

(1) IN GENERAL.—The amount of payment for an episode of care for home health services, a portion of which consists of substitute medical adult day care services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 u.s.c. 1395fff). In no case may a home health agency, or a medical adult day care facility under arrangements with a home health agency, separately charge a beneficiary for medical adult day care services furnished under the plan of care.

(2) BUDGET NEUTRALITY FOR DEMONSTRATION PROJECT.—Notwithstanding any other provision of law, the Secretary shall provide for an appropriate reduction in the aggregate amount of additional payments made under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to reflect any increase in amounts expended from the Trust Funds as a result of the demonstration project conducted under this section.

(c) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in not more than 5 sites in States selected by the Secretary that license or certify providers of services that furnish medical adult day care services.

(d) DURATION.—The Secretary shall conduct the demonstration project for a period of 3 years.

(e) VOLUNTARY PARTICIPATION.—Participation of medicare beneficiaries in the demonstration project shall be voluntary. The total number of such beneficiaries that may participate in the project at any given time may not exceed 15,000.

(f) PREFERENCE IN SELECTING AGENCIES.—In selecting home health agencies to participate under the demonstration project, the Secretary shall give preference to those agencies that—

(1) are currently licensed or certified to furnish medical adult day care services; and

(2) have furnished medical adult day care services to medicare beneficiaries for a continuous 2-year period before the beginning of the demonstration project.

(g) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act as may be necessary for the purposes of carrying out the demonstration project, other than waiving the requirement that an individual be homebound in order to be eligible for benefits for home health services.

(h) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the clinical and cost effectiveness of the demonstration project. Not later 30 months after the commencement of the project, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the project as compared to such outcomes and costs to beneficiaries receiving only home health services for the same health conditions.

(2) Such recommendations regarding the extension, expansion, or termination of the project as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

(1) HOME HEALTH AGENCY.—The term ''home health agency'' has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(2) MEDICAL ADULT DAY CARE FACILITY.—The term ''medical adult day care facility'' means a facility that—

(A) has been licensed or certified by a State to furnish medical adult day care services in the State for a continuous 2-year period;

(B) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(C) meets such standards established by the Secretary to assure quality of care and such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility; and

(D) provides medical adult day care services.

(3) MEDICAL ADULT DAY CARE SERVICES.—The term ''medical adult day care services'' means—

(A) home health service items and services described in paragraphs (1) through (7) of section 1861(m) furnished in a medical adult day care facility;

(B) a program of supervised activities furnished in a group setting in the facility that—

(i) meet such criteria as the Secretary determines appropriate; and

(ii) is designed to promote physical and mental health of the individuals; and

(C) such other services as the Secretary may specify.

(4) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means an individual entitled to benefits under part A of this title, enrolled under part B of this title, or both.

TITLE VII—MEDICARE BENEFITS ADMINISTRATION

SEC. 701. ESTABLISHMENT OF MEDICARE BENEFITS ADMINISTRATION.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 105, is amended by inserting after 1806 the following new section:

''MEDICARE BENEFITS ADMINISTRATION

''SEC. 1808. (a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an agency to be known as the Medicare Benefits Administration.

''(b) ADMINISTRATOR; DEPUTY ADMINISTRATOR; CHIEF ACTUARY.—

''(1) ADMINISTRATOR.—

''(A) IN GENERAL.—The Medicare Benefits Administration shall be headed by an administrator to be known as the 'Medicare Benefits Administrator' (in this section referred to as the 'Administrator') who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall be in direct line of authority to the Secretary.

''(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Administration, and shall have authority and control over all personnel and activities thereof.

''(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administration. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

''(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Administration as the Administrator considers necessary or appropriate, except as specified in this section.

''(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administration as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

''(2) DEPUTY ADMINISTRATOR.—

''(A) IN GENERAL.—There shall be a Deputy Administrator of the Medicare Benefits Administration who shall be appointed by the President, by and with the advice and consent of the Senate.

''(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be Acting Administrator of the Administration during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

''(3) CHIEF ACTUARY.—

''(A) IN GENERAL.—There is established in the Administration the position of Chief Actuary. The Chief Actuary shall be appointed by, and in direct line of authority to, the Administrator of such Administration. The Chief Actuary shall be appointed from among individuals who have demonstrated, by their education and experience, superior expertise in the actuarial sciences. The Chief Actuary may be removed only for cause.

''(B) COMPENSATION.—The Chief Actuary shall be compensated at the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

''(C) DUTIES.—The Chief Actuary shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence.

''(4) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

''(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

''(1) DUTIES.—

''(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

''(i) negotiating, entering into, and enforcing, contracts with plans for the offering of Medicare+Choice plans under part C, including the offering of qualified prescription drug coverage under such plans; and

''(ii) negotiating, entering into, and enforcing, contracts with PDP sponsors for the offering of prescription drug plans under part D.

''(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or part D, including demonstration projects carried out in part or in whole under such parts, the programs of all-inclusive care for the elderly (PACE program) under section 1894, the social health maintenance organization (SHMO) demonstration projects (referred to in section 4104(c) of the Balanced Budget Act of 1997), and through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved).

''(C) PRESCRIPTION DRUG CARD.—The Administrator shall carry out section 1807 (relating to the medicare prescription drug discount card endorsement program).

''(D) NONINTERFERENCE.—In carrying out its duties with respect to the provision of qualified prescription drug coverage to beneficiaries under this title, the Administrator may not—

''(i) require a particular formulary or institute a price structure for the reimbursement of covered outpatient drugs;

''(ii) interfere in any way with negotiations between PDP sponsors and Medicare+Choice organizations and drug manufacturers, wholesalers, or other suppliers of covered outpatient drugs; and

''(iii) otherwise interfere with the competitive nature of providing such coverage through such sponsors and organizations.

''(E) ANNUAL REPORTS.—Not later March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of parts C and D during the previous fiscal year.

''(2) STAFF.—

''(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, without regard to chapter 31 of title 5, United States Code, other than sections 3110 and 3112, such officers and employees as are necessary to administer the activities to be carried out through the Medicare Benefits Administration. The Administrator shall employ staff with appropriate and necessary expertise in negotiating contracts in the private sector.

''(B) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

''(i) IN GENERAL.—The staff of the Medicare Benefits Administration shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 (other than section 5101) and chapter 53 (other than section 5301) of such title (relating to classification and schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(C) LIMITATION ON FULL-TIME EQUIVALENT STAFFING FOR CURRENT CMS FUNCTIONS BEING TRANSFERRED.—The Administrator may not employ under this paragraph a number of full-time equivalent employees, to carry out functions that were previously conducted by the Centers for Medicare & Medicaid Services and that are conducted by the Administrator by reason of this section, that exceeds the number of such full-time equivalent employees authorized to be employed by the Centers for Medicare & Medicaid Services to

conduct such functions as of the date of the enactment of this Act.

''(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

''(A) IN GENERAL.—The Secretary, the Administrator, and the Administrator of the Centers for Medicare & Medicaid Services shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare & Medicaid Services to the Administrator as is appropriate to carry out the purposes of this section.

''(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator of the Medicare Benefits Administration such information and data in the possession of the Administrator of the Centers for Medicare & Medicaid Services as the Administrator of the Medicare Benefits Administration requires to carry out the duties described in paragraph (1).

''(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Centers for Medicare & Medicaid Services is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Centers for Medicare & Medicaid Services in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

''(d) OFFICE OF BENEFICIARY ASSISTANCE.—

''(1) ESTABLISHMENT.—The Secretary shall establish within the Medicare Benefits Administration an Office of Beneficiary Assistance to coordinate functions relating to outreach and education of medicare beneficiaries under this title, including the functions described in paragraph (2). The Office shall be separate operating division within the Administration.

''(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

''(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate, directly or through contract, to medicare beneficiaries, by mail, by posting on the Internet site of the Medicare Benefits Administration and through a toll-free telephone number, information with respect to the following:

''(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

''(ii) Benefits, and limitations on payment under parts A and B, including information on medicare supplemental policies under section 1882.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, D, and medicare supplemental policies with benefits under Medicare+Choice plans under part C.

''(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the Medicare+Choice program under part C, and the Voluntary Prescription Drug Benefit Program under part D.

''(e) MEDICARE POLICY ADVISORY BOARD.—

''(1) ESTABLISHMENT.—There is established within the Medicare Benefits Administration the Medicare Policy Advisory Board (in this section referred to the 'Board'). The Board shall advise, consult with, and make recommendations to the Administrator of the Medicare Benefits Administration with respect to the administration of parts C and D, including the review of payment policies under such parts.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress and to the Administrator of the Medicare Benefits Administration such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

''(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

''(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C and D for services furnished to medicare beneficiaries.

''(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement to efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

''(iii) IMPLEMENTATION OF RISK-ADJUSTMENT.—Evaluation of the implementation under section 1853(a)(3)(C) of the risk adjustment methodology to payment rates under that section to Medicare+Choice organizations offering Medicare+Choice plans that accounts for variations in per capita costs based on health status and other demographic factors.

''(iv) DISEASE MANAGEMENT PROGRAMS.—Recommendations on the incorporation of disease management programs under parts C and D.

''(v) RURAL ACCESS.—Recommendations to improve competition and access to plans under parts C and D in rural areas.

''(C) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

''(3) DUTY OF ADMINISTRATOR OF MEDICARE BENEFITS ADMINISTRATION.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator of the Medicare Benefits Administration shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

''(4) MEMBERSHIP.—

''(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of seven members to be appointed as follows:

''(i) Three members shall be appointed by the President.

''(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairmen and the ranking minority members of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives.

''(iii) Two members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Senate Committee on Finance.

''(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

''(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

''(5) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(6) TERMS OF OFFICE.—

''(A) IN GENERAL.—The term of office of members of the Board shall be 3 years.

''(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

''(i) one shall be appointed for a term of 1 year;

''(ii) three shall be appointed for terms of 2 years; and

''(iii) three shall be appointed for terms of 3 years.

''(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

''(D) VACANCY.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

''(7) CHAIR.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

''(8) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than three times during each fiscal year.

''(9) DIRECTOR AND STAFF.—

''(A) APPOINTMENT OF DIRECTOR.—The Board shall have a Director who shall be appointed by the Chair.

''(B) IN GENERAL.—With the approval of the Board, the Director may appoint, without regard to chapter 31 of title 5, United States Code, such additional personnel as the Director considers appropriate.

''(C) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

''(i) IN GENERAL.—The Director and staff of the Board shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 and chapter 53 of such title (relating to classification and schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(D) ASSISTANCE FROM THE ADMINISTRATOR OF THE MEDICARE BENEFITS ADMINISTRATION.—The Administrator of the Medicare Benefits Administration shall make available to the Board such information and other assistance as it may require to carry out its functions.

''(10) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account), such sums as are necessary to carry out this section.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) TIMING OF INITIAL APPOINTMENTS.—The Administrator and Deputy Administrator of the Medicare Benefits Administration may not be appointed before March 1, 2003.

(3) DUTIES WITH RESPECT TO ELIGIBILITY DETERMINATIONS AND ENROLLMENT.—The Administrator of the Medicare Benefits Administration shall carry out enrollment under title XVIII of the Social Security Act, make eligibility determinations under such title, and carry out part C of such title for years beginning or after January 1, 2005.

(4) TRANSITION.—Before the date the Administrator of the Medicare Benefits Administration is appointed and assumes responsibilities under this section and section 1807 of the Social Security Act, the Secretary of Health and Human Services shall provide for the conduct of any responsibilities of such Administrator that are otherwise provided under law.

(c) MISCELLANEOUS ADMINISTRATIVE PROVISIONS.—

(1) ADMINISTRATOR AS MEMBER OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—Section 1817(b) and section 1841(b) (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking ''and the Secretary of Health and Human Services, all ex officio,'' and inserting ''the Secretary of Health and Human Services, and the Administrator of the Medicare Benefits Administration, all ex officio,''.

(2) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES; LEVEL FOR MEDICARE BENEFITS ADMINISTRATOR.—

(A) IN GENERAL.—Section 5314 of title 5, United States Code, by adding at the end the following:

''Administrator of the Centers for Medicare & Medicaid Services .

''Administrator of the Medicare Benefits Administration.''.

(B) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking ''Administrator of the Health Care Financing Administration.''.

(C) EFFECTIVE DATE.—The amendments made by this paragraph take effect on January 1, 2003.

TITLE VIII—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

SEC. 801. CONSTRUCTION; DEFINITION OF SUPPLIER.

(a) CONSTRUCTION.—Nothing in this title shall be construed—

(1) to compromise or affect existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act); or

(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.

Furthermore, the consolidation of medicare administrative contracting set forth in this Act does not constitute consolidation of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund or reflect any position on that issue.

(b) DEFINITION OF SUPPLIER.—Section 1861 (42 U.S.C. 1395x) is amended by inserting after subsection (c) the following new subsection:

''Supplier

''(d) The term 'supplier' means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.''.

SEC. 802. ISSUANCE OF REGULATIONS.

(a) CONSOLIDATION OF PROMULGATION TO ONCE A MONTH.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

''(d)(1) Subject to paragraph (2), the Secretary shall issue proposed or final (including interim final) regulations to carry out this title only on one business day of every month.

''(2) The Secretary may issue a proposed or final regulation described in paragraph (1) on any other day than the day described in paragraph (1) if the Secretary—

''(A) finds that issuance of such regulation on another day is necessary to comply with requirements under law; or

''(B) finds that with respect to that regulation the limitation of issuance on the date described in paragraph (1) is contrary to the public interest.

If the Secretary makes a finding under this paragraph, the Secretary shall include such finding, and brief statement of the reasons for such finding, in the issuance of such regulation.

''(3) The Secretary shall coordinate issuance of new regulations described in paragraph (1) relating to a category of provider of services or suppliers based on an analysis of the collective impact of regulatory changes on that category of providers or suppliers.''.

(2) GAO REPORT ON PUBLICATION OF REGULATIONS ON A QUARTERLY BASIS.—Not later than 3 years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the feasibility of requiring that regulations described in section 1871(d) of the Social Security Act be promulgated on a quarterly basis rather than on a monthly basis.

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to regulations promulgated on or after the date that is 30 days after the date of the enactment of this Act.

(b) REGULAR TIMELINE FOR PUBLICATION OF FINAL RULES.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

''(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

''(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

''(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

''(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act. The Secretary shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.

(c) LIMITATIONS ON NEW MATTER IN FINAL REGULATIONS.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)), as amended by subsection (b), is further amended by adding at the end the following new paragraph:

''(4) If the Secretary publishes notice of proposed rulemaking relating to a regulation (including an interim final regulation), insofar as such final regulation includes a provision that is not a logical outgrowth of such notice of proposed rulemaking, that provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to final regulations published on or after the date of the enactment of this Act.

SEC. 803. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh), as amended by section 802(a), is amended by adding at the end the following new subsection:

''(e)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

''(i) such retroactive application is necessary to comply with statutory requirements; or

''(ii) failure to apply the change retroactively would be contrary to the public interest.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(e)(1), as added by subsection (a), is amended by adding at the end the following:

''(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

''(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to

comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

''(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

(c) RELIANCE ON GUIDANCE.—

(1) IN GENERAL.—Section 1871(e), as added by subsection (a), is further amended by adding at the end the following new paragraph:

''(2)(A) If—

''(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1889(g)) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

''(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing; and

''(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any sanction (including any penalty or requirement for repayment of any amount) if the provider of services or supplier reasonably relied on such guidance.

''(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act but shall not apply to any sanction for which notice was provided on or before the date of the enactment of this Act.

SEC. 804. REPORTS AND STUDIES RELATING TO REGULATORY REFORM.

(a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the medicare program under title XVIII of the Social Security Act. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than January 1, 2004.

(b) REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by section 803(a), is amended by adding at the end the following new subsection:

''(f)(1) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

''(2) In preparing a report under paragraph (1), the Secretary shall collect—

''(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman and the Medicare Provider Ombudsman with respect to such areas of inconsistency and conflict; and

''(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

''(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.''.

Subtitle B—Contracting Reform

SEC. 811. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

''CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

''SEC. 1874A. (a) AUTHORITY.—

''(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

''(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

''(A) the entity has demonstrated capability to carry out such function;

''(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

''(C) the entity has sufficient assets to financially support the performance of such function; and

''(D) the entity meets such other requirements as the Secretary may impose.

''(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

''(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

''(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.

''(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:

''(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals.

''(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

''(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns or problems.

''(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services or suppliers.

''(E) COMMUNICATION WITH PROVIDERS.—Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

''(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions relating to provider education, training, and technical assistance.

''(G) ADDITIONAL FUNCTIONS.—Performing such other functions as are necessary to carry out the purposes of this title.

''(5) RELATIONSHIP TO MIP CONTRACTS.—

''(A) NONDUPLICATION OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

''(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

''(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

''(b) CONTRACTING REQUIREMENTS.—

''(1) USE OF COMPETITIVE PROCEDURES.—

''(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

''(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every five years.

''(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The

Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and suppliers affected by such transfer, and contact information for the contractors involved).

''(D) INCENTIVES FOR QUALITY.—The Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

''(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

''(3) PERFORMANCE REQUIREMENTS.—

''(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—In developing contract performance requirements, the Secretary shall develop performance requirements applicable to functions described in subsection (a)(4).

''(B) CONSULTATION.— In developing such requirements, the Secretary may consult with providers of services and suppliers, organizations representing individuals entitled to benefits under part A or enrolled under part B, or both, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

''(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

''(i) shall reflect the performance requirements developed under subparagraph (A), but may include additional performance requirements;

''(ii) shall be used for evaluating contractor performance under the contract; and

''(iii) shall be consistent with the written statement of work provided under the contract.

''(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

''(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

''(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

''(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

''(c) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

''(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

''(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

''(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by the individual under this section.

''(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

''(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless in connection with such payment or in the supervision of or selection of such officer the medicare administrative contractor acted with gross negligence.

''(4) INDEMNIFICATION BY SECRETARY.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

''(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

''(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

''(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate such settlement or compromise. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement or compromise of a proceeding described in such subparagraph are conditioned upon prior written approval by the Secretary of the final settlement or compromise.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

''(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.''.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART A''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking ''agreement under this section'' and inserting ''contract under section 1874A that provides for making payments under this part''.

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking ''An agreement with an agency or organization under this section'' and inserting ''A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part''; and

(B) by striking ''such agency or organization'' and inserting ''such medicare administrative contractor'' each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART B''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking ''carriers'' and inserting ''medicare administrative contractors''; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking ''Each such contract shall provide that the carrier'' and inserting ''The Secretary'';

(ii) by striking ''will'' the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting ''shall'';

(iii) in subparagraph (B), in the matter before clause (i), by striking ''to the policyholders and subscribers of the carrier'' and

inserting ''to the policyholders and subscribers of the medicare administrative contractor'';

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking ''if it makes determinations or payments with respect to physicians' services,''; and

(II) by striking ''carrier'' and inserting ''medicare administrative contractor'';

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking ''and shall contain'' and all that follows through the period; and

(ix) in the seventh sentence, by inserting ''medicare administrative contractor,'' after ''carrier,''; and

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(F) in paragraph (7), by striking ''the carrier'' and inserting ''the Secretary'' each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B),'' and inserting ''contract under section 1874A that provides for making payments under this part'';

(C) in paragraph (3)(A), by striking ''subsection (a)(1)(B)'' and inserting ''section 1874A(a)(3)(B)'';

(D) in paragraph (4), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(E) by striking paragraphs (5) and (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking ''carrier or carriers'' and inserting ''medicare administrative contractor or contractors''.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking ''Each carrier having an agreement with the Secretary under subsection (a)'' and inserting ''The Secretary''; and

(ii) by striking ''Each such carrier'' and inserting ''The Secretary'';

(B) in paragraph (3)(A)—

(i) by striking ''a carrier having an agreement with the Secretary under subsection (a)'' and inserting ''medicare administrative contractor having a contract under section 1874A that provides for making payments under this part''; and

(ii) by striking ''such carrier'' and inserting ''such contractor'';

(C) in paragraph (3)(B)—

(i) by striking ''a carrier'' and inserting ''a medicare administrative contractor'' each place it appears; and

(ii) by striking ''the carrier'' and inserting ''the contractor'' each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking ''carriers'' and inserting ''medicare administrative contractors'' each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(B) in paragraph (2), by striking ''carrier'' and inserting ''medicare administrative contractor''.

(9) Subsection (p)(3)(A) is amended by striking ''carrier'' and inserting ''medicare administrative contractor''.

(10) Subsection (q)(1)(A) is amended by striking ''carrier''.

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2004, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this Act, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2009.

(D) WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—During the period beginning on the date of the enactment of this Act and before the date specified under subparagraph (A), the Secretary may enter into new agreements under section 1816 of the Social Security Act (42 U.S.C. 1395h) without regard to any of the provider nomination provisions of such section.

(2) GENERAL TRANSITION RULES.—The Secretary shall take such steps, consistent with paragraph (1)(B) and (1)(C), as are necessary to provide for an appropriate transition from contracts under section 1816 and section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER ROLLOVER CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in such provisions.

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to an appropriate medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) REPORTS ON IMPLEMENTATION.—

(1) PLAN FOR IMPLEMENTATION.—By not later than October 1, 2003, the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2007, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

SEC. 812. REQUIREMENTS FOR INFORMATION SECURITY FOR MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 811(a)(1), is amended by adding at the end the following new subsection:

''(e) REQUIREMENTS FOR INFORMATION SECURITY.—

''(1) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under section 3534(b)(2) of title 44, United States Code (other than requirements under subparagraphs (B)(ii), (F)(iii), and (F)(iv) of such section).

''(2) INDEPENDENT AUDITS.—

''(A) PERFORMANCE OF ANNUAL EVALUATIONS.—Each year a medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this title. The evaluation shall—

''(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

''(ii) test the effectiveness of information security control techniques for an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44, United States Code) relating to such functions under this title and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines.

''(B) DEADLINE FOR INITIAL EVALUATION.—

''(i) NEW CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant subparagraph (A) shall be completed prior to commencing such functions.

''(ii) OTHER CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted pursuant subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

''(C) REPORTS ON EVALUATIONS.—

''(i) TO THE INSPECTOR GENERAL.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services.

''(ii) TO CONGRESS.—The Inspector General of Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations.''.

(b) APPLICATION OF REQUIREMENTS TO FISCAL INTERMEDIARIES AND CARRIERS.—

(1) IN GENERAL.—The provisions of section 1874A(e)(2) of the Social Security Act (other than subparagraph (B)), as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(2) DEADLINE FOR INITIAL EVALUATION.—In the case of such a fiscal intermediary or carrier with an agreement or contract under such respective section in effect as of the date of the enactment of this Act, the first evaluation under section 1874A(e)(2)(A) of the Social Security Act (as added by subsection (a)), pursuant to paragraph (1), shall be completed (and a report on the evaluation submitted to the Secretary) by not later than 1 year after such date.

Subtitle C—Education and Outreach

SEC. 821. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—The Social Security Act is amended by inserting after section 1888 the following new section:

''PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

''SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(3) REPORT.—Not later than October 1, 2003, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 811(a)(1) and as amended by section 812(a), is amended by adding at the end the following new subsection:

''(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—In order to give medicare administrative contractors an incentive to implement effective education and outreach programs for providers of services and suppliers, the Secretary shall develop and implement a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.''.

(2) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(f) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(3) GAO REPORT ON ADEQUACY OF METHODOLOGY.—Not later than October 1, 2003, the Comptroller General of the United States shall submit to Congress and to the Secretary a report on the adequacy of the methodology under section 1874A(f)) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

(4) REPORT ON USE OF METHODOLOGY IN ASSESSING CONTRACTOR PERFORMANCE.—Not later than October 1, 2003, the Secretary shall submit to Congress a report that describes how the Secretary intends to use such methodology in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses. The report shall include an analysis of the sources of identified errors and potential changes in systems of contractors and rules of the Secretary that could reduce claims error rates.

(c) PROVISION OF ACCESS TO AND PROMPT RESPONSES FROM MEDICARE ADMINISTRATIVE CONTRACTORS.—

(1) IN GENERAL.—Section 1874A, as added by section 811(a)(1) and as amended by section 812(a) and subsection (b), is further amended by adding at the end the following new subsection:

''(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS OF SERVICES AND SUPPLIERS.—

''(1) COMMUNICATION STRATEGY.—The Secretary shall develop a strategy for communications with individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this title.

''(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

''(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, a toll-free telephone number at which such individuals, providers of services and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

''(4) MONITORING OF CONTRACTOR RESPONSES.—

''(A) IN GENERAL.—Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

''(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

''(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

''(B) DEVELOPMENT OF STANDARDS.—

''(i) IN GENERAL.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

''(ii) EVALUATION.—In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.''.

''(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect October 1, 2003.

(3) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(g) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsections:

''(b) ENHANCED EDUCATION AND TRAINING.—

''(1) ADDITIONAL RESOURCES.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) $25,000,000 for each of fiscal years 2004 and 2005 and such sums as may be necessary for succeeding fiscal years.

''(2) USE.—The funds made available under paragraph (1) shall be used to increase the conduct by medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

''(c) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

''(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)).

''(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

''(A) a provider of services with fewer than 25 full-time-equivalent employees; or

''(B) a supplier with fewer than 10 full-time-equivalent employees.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2003.

(e) REQUIREMENT TO MAINTAIN INTERNET SITES.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (d), is further amended by adding at the end the following new subsection:

''(d) INTERNET SITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet site which—

''(1) provides answers in an easily accessible format to frequently asked questions, and

''(2) includes other published materials of the contractor,

that relate to providers of services and suppliers under the programs under this title (and title XI insofar as it relates to such programs).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2003.

(f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (d) and (e), is further amended by adding at the end the following new subsections:

''(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

''(f) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

''(g) DEFINITIONS.—For purposes of this section, the term 'medicare contractor' includes the following:

''(1) A medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1816 and a carrier with a contract under section 1842.

''(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this title or title IX with respect to such activities and such provider of services or supplier.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 822. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under medicare program under title XVIII of the Social Security Act (including provisions of title XI of such Act insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

(2) FORMS OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph is—

(A) evaluation and recommendations regarding billing and related systems; and

(B) information and assistance regarding policies and procedures under the medicare program, including coding and reimbursement.

(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term ''small providers of services or suppliers'' means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(b) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary shall enter into contracts with qualified organizations (such as peer review organizations or entities described in section 1889(g)(2) of the Social Security Act, as inserted by section 5(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

(c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a direct and in-person examination of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

(d) AVOIDANCE OF RECOVERY ACTIONS FOR PROBLEMS IDENTIFIED AS CORRECTED.—The Secretary shall provide that, absent evidence of fraud and notwithstanding any other provision of law, any errors found in a compliance review for a small provider of services or supplier that participates in the demonstration program shall not be subject to recovery action if the technical assistance personnel under the program determine that—

(1) the problem that is the subject of the compliance review has been corrected to their satisfaction within 30 days of the date of the visit by such personnel to the small provider of services or supplier; and

(2) such problem remains corrected for such period as is appropriate.

The previous sentence applies only to claims filed as part of the demonstration program and lasts only for the duration of such program and only as long as the small provider of services or supplier is a participant in such program.

(e) GAO EVALUATION.—Not later than 2 years after the date of the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether claims error rates are reduced for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

(f) FINANCIAL PARTICIPATION BY PROVIDERS.—The provision of technical assistance to a small provider of services or supplier under the demonstration program is conditioned upon the small provider of services or supplier paying an amount estimated (and disclosed in advance of a provider's or supplier's participation in the program) to be equal to 25 percent of the cost of the technical assistance.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the demonstration program—

(1) for fiscal year 2004, $1,000,000, and

(2) for fiscal year 2005, $6,000,000.

SEC. 823. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: ''; MEDICARE PROVIDER OMBUDSMAN'';

(2) by inserting ''PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)'' after ''(a)'';

(3) in paragraph (1), as so redesignated under paragraph (2), by striking ''in this section'' and inserting ''in this subsection'';

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

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

''(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Provider Ombudsman. The Ombudsman shall—

''(1) provide assistance, on a confidential basis, to providers of services and suppliers with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

''(2) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

''(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

''(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.''.

(b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII, as amended by sections 105 and 701, is amended by inserting after section 1808 the following new section:

''MEDICARE BENEFICIARY OMBUDSMAN

''SEC. 1809. (a) IN GENERAL.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

''(b) DUTIES.—The Medicare Beneficiary Ombudsman shall—

''(1) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

''(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

''(A) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary; and

''(B) assistance to such individuals with any problems arising from disenrollment from a Medicare+Choice plan under part C; and

''(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

The Ombudsman shall not serve as an advocate for any increases in payments or new

coverage of services, but may identify issues and problems in payment or coverage policies.

''(c) WORKING WITH HEALTH INSURANCE COUNSELING PROGRAMS.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 4360 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding Medicare+Choice plans and changes to those plans. Nothing in this subsection shall preclude further collaboration between the Ombudsman and such programs.''.

(c) DEADLINE FOR APPOINTMENT.—The Secretary shall appoint the Medicare Provider Ombudsman and the Medicare Beneficiary Ombudsman, under the amendments made by subsections (a) and (b), respectively, by not later than 1 year after the date of the enactment of this Act.

(d) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5) and section 1809 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2003 and each succeeding fiscal year.

(e) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-MEDICARE).—

(1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: ''The Secretary shall provide, through the toll-free number 1-800-MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.''.

(2) MONITORING ACCURACY.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study to monitor the accuracy and consistency of information provided to individuals entitled to benefits under part A or enrolled under part B, or both, through the toll-free number 1-800-MEDICARE, including an assessment of whether the information provided is sufficient to answer questions of such individuals. In conducting the study, the Comptroller General shall examine the education and training of the individuals providing information through such number.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A).

SEC. 824. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both, regarding the medicare program at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by individuals referred to in subsection (a).

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) DURATION.—The demonstration program shall be conducted over a 3-year period.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and satisfaction of those individuals referred to in subsection (a) with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local offices of the Social Security Administration.

(2) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local offices of the Social Security Administration.

Subtitle D—Appeals and Recovery

SEC. 831. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) TRANSITION PLAN.—

(1) IN GENERAL.—Not later than October 1, 2003, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) GAO EVALUATION.—The Comptroller General of the United States shall evaluate the plan and, not later than the date that is 6 months after the date on which the plan is received by the Comptroller General, shall submit to Congress a report on such evaluation.

(b) TRANSFER OF ADJUDICATION AUTHORITY.—

(1) IN GENERAL.—Not earlier than July 1, 2004, and not later than October 1, 2004, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described in such subsection from the Social Security Administration to the Secretary.

(2) ASSURING INDEPENDENCE OF JUDGES.—The Secretary shall assure the independence of administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Centers for Medicare & Medicaid Services and its contractors.

(3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall provide for an appropriate geographic distribution of administrative law judges performing the administrative law judge functions transferred under paragraph (1) throughout the United States to ensure timely access to such judges.

(4) HIRING AUTHORITY.—Subject to the amounts provided in advance in appropriations Act, the Secretary shall have authority to hire administrative law judges to hear such cases, giving priority to those judges with prior experience in handling medicare appeals and in a manner consistent with paragraph (3), and to hire support staff for such judges.

(5) FINANCING.—Amounts payable under law to the Commissioner for administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall become payable to the Secretary for the functions so transferred.

(6) SHARED RESOURCES.—The Secretary shall enter into such arrangements with the Commissioner as may be appropriate with respect to transferred functions of administrative law judges to share office space, support staff, and other resources, with appropriate reimbursement from the Trust Funds described in paragraph (5).

(c) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to ensure timely action on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (as amended by section 521 of BIPA, 114 Stat. 2763A–534), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums as are necessary for fiscal year 2004 and each subsequent fiscal year to—

(1) increase the number of administrative law judges (and their staffs) under subsection (b)(4);

(2) improve education and training opportunities for administrative law judges (and their staffs); and

(3) increase the staff of the Departmental Appeals Board.

(d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of BIPA (114 Stat. 2763A–543), is amended by striking ''of the Social Security Administration''.

SEC. 832. PROCESS FOR EXPEDITED ACCESS TO REVIEW.

(a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—Section 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA, is amended—

(1) in paragraph (1)(A), by inserting '', subject to paragraph (2),'' before ''to judicial review of the Secretary's final decision'';

(2) in paragraph (1)(F)—

(A) by striking clause (ii);

(B) by striking ''PROCEEDING'' and all that follows through ''DETERMINATION'' and inserting ''DETERMINATIONS AND RECONSIDERATIONS''; and

(C) by redesignating subclauses (I) and (II) as clauses (i) and (ii) and by moving the indentation of such subclauses (and the matter that follows) 2 ems to the left; and

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

''(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

''(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or both, who has filed an appeal under paragraph (1) may obtain access to judicial review when a review panel (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that no entity in the administrative appeals process has the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may

make such request only once with respect to a question of law or regulation in a case of an appeal.

''(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review panel that no review panel has the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review panel shall require for purposes of making such determination, such review panel shall make a determination on the request in writing within 60 days after the date such review panel receives the request and such accompanying documents and materials. Such a determination by such review panel shall be considered a final decision and not subject to review by the Secretary.

''(C) ACCESS TO JUDICIAL REVIEW.—

''(i) IN GENERAL.—If the appropriate review panel—

''(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that no review panel has the authority to decide; or

''(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

''(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

''(I) clause (i)(I), within 60 days of date of the determination described in such subparagraph; or

''(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

''(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

''(iv) INTEREST ON AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier seeks judicial review pursuant to this paragraph, the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund and by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this Act.

''(D) REVIEW PANELS.—For purposes of this subsection, a 'review panel' is a panel consisting of 3 members (who shall be administrative law judges, members of the Departmental Appeals Board, or qualified individuals associated with a qualified independent contractor (as defined in subsection (c)(2)) or with another independent entity) designated by the Secretary for purposes of making determinations under this paragraph.''.

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting ''(A)'' after ''(h)(1)''; and

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

''(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2003.

(d) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.—

(1) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which the remedy of termination of participation, or a remedy described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) which is applied on an immediate basis, has been imposed. Under such process priority shall be provided in cases of termination.

(2) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such additional sums for fiscal year 2004 and each subsequent fiscal year as may be necessary. The purposes for which such amounts are available include increasing the number of administrative law judges (and their staffs) and the appellate level staff at the Departmental Appeals Board of the Department of Health and Human Services and educating such judges and staffs on long-term care issues.

SEC. 833. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by BIPA and as amended by section 832(a), is further amended by adding at the end the following new paragraph:

''(3) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE BY PROVIDERS.—A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2003.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended by BIPA, is amended by inserting ''(including the medical records of the individual involved)'' after ''clinical experience''.

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)), as amended by BIPA, is amended by adding at the end the following new paragraph:

''(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall include—

''(A) the specific reasons for the determination, including—

''(i) upon request, the provision of the policy, manual, or regulation used in making the determination; and

''(ii) as appropriate in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination;

''(B) the procedures for obtaining additional information concerning the determination or redetermination; and

''(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.

The written notice on a redetermination shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both.''.

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is amended—

(A) by inserting ''be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)'' after ''in writing, ''; and

(B) by inserting ''and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section'' after ''such decision, ''.

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)), as amended by BIPA, is amended—

(A) in the heading, by inserting ''; NOTICE'' after ''SECRETARY''; and

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

''(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

''(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

''(B) the procedures for obtaining additional information concerning the decision; and

''(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.''.

(4) SUBMISSION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by striking ''prepare'' and inserting ''submit'' and by striking ''with respect to'' and all that follows through ''and relevant policies''.

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(3) (42 U.S.C. 1395ff(c)(3)), as amended by BIPA, is amended—

(A) in subparagraph (A), by striking ''sufficient training and expertise in medical science and legal matters'' and inserting ''sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing''; and

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

''(K) INDEPENDENCE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

''(I) is not a related party (as defined in subsection (g)(5));

''(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

''(III) does not otherwise have a conflict of interest with such a party.

''(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

''(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.''.

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff), as amended by BIPA, is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

''(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).''; and

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

''(g) QUALIFICATIONS OF REVIEWERS.—

''(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

''(A) each individual conducting a review shall meet the qualifications of paragraph (2);

''(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

''(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), each reviewing professional meets the qualifications described in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), each reviewing professional shall be a physician (allopathic or osteopathic).

''(2) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

''(i) not be a related party (as defined in paragraph (5));

''(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

''(iii) not otherwise have a conflict of interest with such a party.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

''(I) the individual is not involved in the provision of items or services in the case under review;

''(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, (or authorized representative) and neither party objects; and

''(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of having such staff privileges if the existence of such privileges is disclosed to the Secretary and such individual (or authorized representative), and neither party objects; or

''(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term 'participation agreement' means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

''(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

''(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be—

''(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

''(B) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.

''(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving a specific individual entitled to benefits under part A or enrolled under part B, or both, any of the following:

''(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

''(B) The individual (or authorized representative).

''(C) The health care professional that provides the items or services involved in the case.

''(D) The institution at which the items or services (or treatment) involved in the case are provided.

''(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

''(F) Any other party determined under any regulations to have a substantial interest in the case involved.''.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, (114 Stat. 2763A–534).

(4) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by paragraph (2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 834. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 811(a)(1) and as amended by sections 812(b), 821(b)(1), and 831(c)(1), is further amended by adding at the end the following new subsection:

''(h) CONDUCT OF PREPAYMENT REVIEW.—

''(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

''(A) IN GENERAL.—A medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

''(B) USE OF STANDARD PROTOCOLS WHEN CONDUCTING PREPAYMENT REVIEWS.—When a medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

''(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

''(D) RANDOM PREPAYMENT REVIEW.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.

''(2) LIMITATIONS ON NON-RANDOM PREPAYMENT REVIEW.—

''(A) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by that provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined in subsection (i)(3)(A)).

''(B) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect 1 year after the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(h) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify.

(c) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(h) of the Social Security Act, as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

SEC. 835. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

''(f) RECOVERY OF OVERPAYMENTS.—

''(1) USE OF REPAYMENT PLANS.—

''(A) IN GENERAL.—If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this title would constitute a hardship (as defined in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of

such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

''(B) HARDSHIP.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

''(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

''(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year.

''(ii) RULE OF APPLICATION.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this title during the previous year or was paid under this title only during a portion of that year.

''(iii) TREATMENT OF PREVIOUS OVERPAYMENTS.—If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

''(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

''(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

''(ii) there is an indication of fraud or abuse committed against the program.

''(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

''(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

''(2) LIMITATION ON RECOUPMENT.—

''(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

''(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

''(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(g).

''(3) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless—

''(A) there is a sustained or high level of payment error (as defined by the Secretary by regulation); or

''(B) documented educational intervention has failed to correct the payment error (as determined by the Secretary).

''(4) PROVISION OF SUPPORTING DOCUMENTATION.—In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

''(5) CONSENT SETTLEMENT REFORMS.—

''(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

''(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services or supplier a consent settlement, the Secretary shall—

''(i) communicate to the provider of services or supplier—

''(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

''(II) the nature of the problems identified in such evaluation; and

''(III) the steps that the provider of services or supplier should take to address the problems; and

''(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

''(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

''(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

''(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

''(I) the opportunity for a statistically valid random sample; or

''(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

''(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

''(6) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

''(7) PAYMENT AUDITS.—

''(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this title, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

''(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this title, the contractor shall—

''(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

''(ii) inform the provider of services or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary);

''(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

''(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

''(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

''(8) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.''.

(b) EFFECTIVE DATES AND DEADLINES.—

(1) USE OF REPAYMENT PLANS.—Section 1893(f)(1) of the Social Security Act, as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act.

(2) LIMITATION ON RECOUPMENT.—Section 1893(f)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

(3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

(4) PROVISION OF SUPPORTING DOCUMENTATION.—Section 1893(f)(4) of the Social Security Act, as added by subsection (a), shall take effect on the date of the enactment of this Act.

(5) CONSENT SETTLEMENT.—Section 1893(f)(5) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

(6) NOTICE OF OVERUTILIZATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish the process for notice of overutilization of billing codes under section 1893A(f)(6) of the Social Security Act, as added by subsection (a).

(7) PAYMENT AUDITS.—Section 1893A(f)(7) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

(8) STANDARD FOR ABNORMAL BILLING PATTERNS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act, as added by subsection (a).

SEC. 836. PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) by adding at the end of the heading the following: ''; ENROLLMENT PROCESSES''; and

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

''(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

''(1) ENROLLMENT PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title.

''(B) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

''(C) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

''(2) HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.''.

(b) EFFECTIVE DATES.—

(1) ENROLLMENT PROCESS.—The Secretary shall provide for the establishment of the enrollment process under section 1866(j)(1) of the Social Security Act, as added by subsection (a)(2), within 6 months after the date of the enactment of this Act.

(2) CONSULTATION.—Section 1866(j)(1)(C) of the Social Security Act, as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made on or after January 1, 2003.

(3) HEARING RIGHTS.—Section 1866(j)(2) of the Social Security Act, as added by subsection (a)(2), shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary specifies.

SEC. 837. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(g) of the Social Security Act, as inserted by section 821(a)(1)) and representatives of providers of services and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

SEC. 838. PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES; ADVANCE BENEFICIARY NOTICES.

(a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as amended by sections 521 and 522 of BIPA and section 833(d)(2)(B), is further amended by adding at the end the following new subsection:

''(h) PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.—

''(1) ESTABLISHMENT OF PROCESS.—

''(A) IN GENERAL.—With respect to a medicare administrative contractor that has a contract under section 1874A that provides for making payments under this title with respect to eligible items and services described in subparagraph (C), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

''(B) ELIGIBLE REQUESTER.—For purposes of this subsection, each of the following shall be an eligible requester:

''(i) A physician, but only with respect to eligible items and services for which the physician may be paid directly.

''(ii) An individual entitled to benefits under this title, but only with respect to an item or service for which the individual receives, from the physician who may be paid directly for the item or service, an advance beneficiary notice under section 1879(a) that payment may not be made (or may no longer be made) for the item or service under this title.

''(C) ELIGIBLE ITEMS AND SERVICES.—For purposes of this subsection and subject to paragraph (2), eligible items and services are items and services which are physicians' services (as defined in paragraph (4)(A) of section 1848(f) for purposes of calculating the sustainable growth rate under such section).

''(2) SECRETARIAL FLEXIBILITY.—The Secretary shall establish by regulation reasonable limits on the categories of eligible items and services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the dollar amount involved with respect to the item or service, administrative costs and burdens, and other relevant factors.

''(3) REQUEST FOR PRIOR DETERMINATION.—

''(A) IN GENERAL.—Subject to paragraph (2), under the process established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of an eligible item or service involved as to whether the item or service is covered under this title consistent with the applicable requirements of section 1862(a)(1)(A) (relating to medical necessity).

''(B) ACCOMPANYING DOCUMENTATION.—The Secretary may require that the request be accompanied by a description of the item or service, supporting documentation relating to the medical necessity for the item or service, and any other appropriate documentation. In the case of a request submitted by an eligible requester who is described in paragraph (1)(B)(ii), the Secretary may require that the request also be accompanied by a copy of the advance beneficiary notice involved.

''(4) RESPONSE TO REQUEST.—

''(A) IN GENERAL.—Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

''(i) the item or service is so covered;

''(ii) the item or service is not so covered; or

''(iii) the contractor lacks sufficient information to make a coverage determination.

If the contractor makes the determination described in clause (iii), the contractor shall include in the notice a description of the additional information required to make the coverage determination.

''(B) DEADLINE TO RESPOND.—Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

''(C) INFORMING BENEFICIARY IN CASE OF PHYSICIAN REQUEST.—In the case of a request in which an eligible requester is not the individual described in paragraph (1)(B)(ii), the process shall provide that the individual to whom the item or service is proposed to be furnished shall be informed of any determination described in clause (ii) (relating to a determination of non-coverage) and the right (referred to in paragraph (6)(B)) to obtain the item or service and have a claim submitted for the item or service.

''(5) EFFECT OF DETERMINATIONS.—

''(A) BINDING NATURE OF POSITIVE DETERMINATION.—If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

''(B) NOTICE AND RIGHT TO REDETERMINATION IN CASE OF A DENIAL.—

''(i) IN GENERAL.—If the contractor makes the determination described in paragraph (4)(A)(ii)—

''(I) the eligible requester has the right to a redetermination by the contractor on the determination that the item or service is not so covered; and

''(II) the contractor shall include in notice under paragraph (4)(A) a brief explanation of the basis for the determination, including on what national or local coverage or noncoverage determination (if any) the determination is based, and the right to such a redetermination.

''(ii) DEADLINE FOR REDETERMINATIONS.—The contractor shall complete and provide notice of such redetermination within the same time period as the time period applicable to the contractor providing notice of redeterminations relating to a claim for benefits under subsection (a)(3)(C)(ii).

''(6) LIMITATION ON FURTHER REVIEW.—

''(A) IN GENERAL.—Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (and redeterminations made under paragraph (5)(B)), relating to pre-service claims are not subject to further administrative appeal or judicial review under this section or otherwise.

''(B) DECISION NOT TO SEEK PRIOR DETERMINATION OR NEGATIVE DETERMINATION DOES NOT IMPACT RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—Nothing in this subsection shall be construed as affecting the right of an individual who—

''(i) decides not to seek a prior determination under this subsection with respect to items or services; or

''(ii) seeks such a determination and has received a determination described in paragraph (4)(A)(ii)),

from receiving (and submitting a claim for) such items services and from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section. Failure to seek a prior determination under this subsection with respect to items and services shall not be taken into account in such administrative or judicial review.

''(C) NO PRIOR DETERMINATION AFTER RECEIPT OF SERVICES.—Once an individual is provided items and services, there shall be no prior determination under this subsection with respect to such items or services.''.

(b) EFFECTIVE DATE; TRANSITION.—

(1) EFFECTIVE DATE.—The Secretary shall establish the prior determination process

under the amendment made by subsection (a) in such a manner as to provide for the acceptance of requests for determinations under such process filed not later than 18 months after the date of the enactment of this Act.

(2) TRANSITION.—During the period in which the amendment made by subsection (a) has become effective but contracts are not provided under section 1874A of the Social Security Act with medicare administrative contractors, any reference in section 1869(g) of such Act (as added by such amendment) to such a contractor is deemed a reference to a fiscal intermediary or carrier with an agreement under section 1816, or contract under section 1842, respectively, of such Act.

(3) LIMITATION ON APPLICATION TO SGR.—For purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)), the amendment made by subsection (a) shall not be considered to be a change in law or regulation.

(c) PROVISIONS RELATING TO ADVANCE BENEFICIARY NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—

(1) DATA COLLECTION.—The Secretary shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (4)) has been provided and on instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

(2) OUTREACH AND EDUCATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the medicare program.

(3) GAO REPORT REPORT ON USE OF ADVANCE BENEFICIARY NOTICES.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices.

(4) GAO REPORT ON USE OF PRIOR DETERMINATION PROCESS.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

(A) information concerning the types of procedures for which a prior determination has been sought, determinations made under the process, and changes in receipt of services resulting from the application of such process; and

(B) an evaluation of whether the process was useful for physicians (and other suppliers) and beneficiaries, whether it was timely, and whether the amount of information required was burdensome to physicians and beneficiaries.

(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term ''advance beneficiary notice'' means a written notice provided under section 1879(a) of the Social Security Act (42 U.S.C. 1395pp(a)) to an individual entitled to benefits under part A or B of title XVIII of such Act before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service believes that payment will not be made for some or all of such items or services under such title.

Subtitle E—Miscellaneous Provisions

SEC. 841. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES.

(a) IN GENERAL.—The Secretary may not implement any new documentation guidelines for evaluation and management physician services under the title XVIII of the Social Security Act on or after the date of the enactment of this Act unless the Secretary—

(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;

(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

(3) has conducted appropriate and representative pilot projects under subsection (b) to test modifications to the evaluation and management documentation guidelines;

(4) finds that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

(5) has established, and is implementing, a program to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

(b) PILOT PROJECTS TO TEST EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES.—

(1) IN GENERAL.—The Secretary shall conduct under this subsection appropriate and representative pilot projects to test new evaluation and management documentation guidelines referred to in subsection (a).

(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(A) be voluntary;

(B) be of sufficient length as determined by the Secretary to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

(C) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

(3) RANGE OF PILOT PROJECTS.—Of the pilot projects conducted under this subsection—

(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to definitions published in the Current Procedures Terminology (CPT) code book of the American Medical Association;

(B) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

(D) at least one shall be conducted in a setting where physicians bill under physicians' services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

(4) BANNING OF TARGETING OF PILOT PROJECT PARTICIPANTS.—Data collected under this subsection shall not be used as the basis for overpayment demands or post-payment audits. Such limitation applies only to claims filed as part of the pilot project and lasts only for the duration of the pilot project and only as long as the provider is a participant in the pilot project.

(5) STUDY OF IMPACT.—Each pilot project shall examine the effect of the new evaluation and management documentation guidelines on—

(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

(6) PERIODIC REPORTS.—The Secretary shall submit to Congress periodic reports on the pilot projects under this subsection.

(c) OBJECTIVES FOR EVALUATION AND MANAGEMENT GUIDELINES.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

(3) increase accuracy by reviewers; and

(4) educate both physicians and reviewers.

(d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOCUMENTATION FOR PHYSICIAN CLAIMS.—

(1) STUDY.—The Secretary shall carry out a study of the matters described in paragraph (2).

(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are—

(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which payment is made under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(3) CONSULTATION WITH PRACTICING PHYSICIANS.—In designing and carrying out the study under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

(4) APPLICATION OF HIPAA UNIFORM CODING REQUIREMENTS.—In developing an alternative system under paragraph (2), the Secretary shall consider requirements of administrative simplification under part C of title XI of the Social Security Act.

(5) REPORT TO CONGRESS.—(A) Not later than October 1, 2004, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall conduct an analysis of the results of the study included in the report under subparagraph (A) and shall submit a report on such analysis to Congress.

(e) STUDY ON APPROPRIATE CODING OF CERTAIN EXTENDED OFFICE VISITS.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2004, the Secretary shall submit a report to Congress on such study and shall include recommendations on how to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

(f) DEFINITIONS.—In this section—

(1) the term ''rural area'' has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act, 42 U.S.C. 1395ww(d)(2)(D); and

(2) the term ''teaching settings'' are those settings described in section 415.150 of title 42, Code of Federal Regulations.

SEC. 842. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) IMPROVED COORDINATION BETWEEN FDA AND CMS ON COVERAGE OF BREAKTHROUGH MEDICAL DEVICES.—

(1) IN GENERAL.—Upon request by an applicant and to the extent feasible (as determined by the Secretary), the Secretary shall, in the case of a class III medical device that is subject to premarket approval under section 515 of the Federal Food, Drug, and Cosmetic Act, ensure the sharing of appropriate information from the review for application for premarket approval conducted by the Food and Drug Administration for coverage decisions under title XVIII of the Social Security Act.

(2) PUBLICATION OF PLAN.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to appropriate Committees of Congress a report that contains the plan for improving such coordination and for shortening the time lag between the premarket approval by the Food and Drug Administration and coding and coverage decisions by the Centers for Medicare & Medicaid Services.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as changing the criteria for coverage of a medical device under title XVIII of the Social Security Act nor premarket approval by the Food and Drug Administration and nothing in this subsection shall be construed to increase premarket approval application requirements under the Federal Food, Drug, and Cosmetic Act.

(b) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Section 1868 (42 U.S.C. 1395ee), as amended by section 821(a), is amended by adding at the end the following new subsection:

''(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

''(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

''(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

''(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

''(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.''.

(c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA COLLECTION FOR USE IN THE MEDICARE INPATIENT PAYMENT SYSTEM.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter time frame by the Centers for Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using of quarterly samples or special surveys or any other methods. The study shall include an analysis of whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

(2) REPORT.—By not later than October 1, 2003, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

(d) IOM STUDY ON LOCAL COVERAGE DETERMINATIONS.—

(1) STUDY.—The Secretary shall enter into an arrangement with the Institute of Medicine of the National Academy of Sciences under which the Institute shall conduct a study on local coverage determinations (including the application of local medical review policies) under the medicare program under title XVIII of the Social Security Act. Such study shall examine—

(A) the consistency of the definitions used in such determinations;

(B) the types of evidence on which such determinations are based, including medical and scientific evidence;

(C) the advantages and disadvantages of local coverage decisionmaking, including the flexibility it offers for ensuring timely patient access to new medical technology for which data are still be collected;

(D) the manner in which the local coverage determination process is used to develop data needed for a national coverage determination, including the need for collection of such data within a protocol and informed consent by individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both; and

(E) the advantages and disadvantages of maintaining local medicare contractor advisory committees that can advise on local coverage decisions based on an open, collaborative public process.

(2) REPORT.—Such arrangement shall provide that the Institute shall submit to the Secretary a report on such study by not later than 3 years after the date of the enactment of this Act. The Secretary shall promptly transmit a copy of such report to Congress.

(e) METHODS FOR DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

''(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2004 (in this paragraph referred to as 'new tests').

''(B) Determinations under subparagraph (A) shall be made only after the Secretary—

''(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

''(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

''(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to receive such comments and recommendations (and data on which the recommendations are based);

''(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

''(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

''(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

''(i) set forth the criteria for making determinations under subparagraph (A); and

''(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

''(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

''(E) For purposes of this paragraph:

''(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

''(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).''.

SEC. 843. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) IN GENERAL.—The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) REFERENCE LABORATORY SERVICES DESCRIBED.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

SEC. 844. EMTALA IMPROVEMENTS.

(a) PAYMENT FOR EMTALA-MANDATED SCREENING AND STABILIZATION SERVICES.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

''(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint)

at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2003.

(b) NOTIFICATION OF PROVIDERS WHEN EMTALA INVESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42 U.S.C. 1395dd(d)) is amended by adding at the end the following new paragraph:

''(4) NOTICE UPON CLOSING AN INVESTIGATION.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.''.

(c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN EMTALA CASES INVOLVING TERMINATION OF PARTICIPATION.—

(1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—

(A) in the first sentence, by inserting ''or in terminating a hospital's participation under this title'' after ''in imposing sanctions under paragraph (1)''; and

(B) by adding at the end the following new sentences: ''Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the report on the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

SEC. 845. EMERGENCY MEDICAL TREATMENT AND ACTIVE LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP.

(a) ESTABLISHMENT.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the ''Advisory Group'') to review issues related to the Emergency Medical Treatment and Active Labor Act (EMTALA) and its implementation. In this section, the term ''EMTALA'' refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

(1) shall review EMTALA regulations;

(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) ADMINISTRATIVE MATTERS.—

(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

(2) MEETINGS.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 846. AUTHORIZING USE OF ARRANGEMENTS WITH OTHER HOSPICE PROGRAMS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following new subparagraph:

''(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.''.

(b) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(4) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 847. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (R), by striking ''and'' at the end;

(B) in subparagraph (S), by striking the period at the end and inserting '', and''; and

(C) by inserting after subparagraph (S) the following new subparagraph:

''(T) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated).''; and

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

''(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(T) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

''(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(T) by a hospital that is subject to the provisions of such Act.

''(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.''.

(b) EFFECTIVE DATE.—The amendments made by this subsection (a) shall apply to hospitals as of July 1, 2003.

SEC. 848. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) TECHNICAL AMENDMENTS RELATING TO ADVISORY COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking ''established under section 1114(f)''; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking ''under subsection (f)''; and

(ii) by striking ''section 1862(a)(1)'' and inserting ''subsection (a)(1)''.

(b) TERMINOLOGY CORRECTIONS.—(1) Section 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by section 521 of BIPA, is amended—

(A) in subclause (III), by striking ''policy'' and inserting ''determination''; and

(B) in subclause (IV), by striking ''medical review —policies'' and inserting ''coverage determinations''.

(2) Section 1852(a)(2)(C) (42 U.S.C. 1395w–22(a)(2)(C)) is amended by striking ''policy'' and ''POLICY'' and inserting ''determination'' each place it appears and ''DETERMINATION'', respectively.

(c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is amended—

(1) in subparagraph (A)(iv), by striking ''subclause –(I), (II), or (III)'' and inserting ''clause (i), (ii), or (iii)'';

(2) in subparagraph (B), by striking ''clause (i)(IV)'' and ''clause (i)(III)'' and inserting ''subparagraph (A)(iv)'' and ''subparagraph (A)(iii)'', respectively; and

(3) in subparagraph (C), by striking ''clause (i)'', ''subclause (IV)'' and ''subparagraph (A)'' and inserting ''subparagraph (A)'', ''clause (iv)'' and ''paragraph (1)(A)'', respectively each place it appears.

(d) OTHER CORRECTIONS.—Effective as if included in the enactment of section 521(c) of BIPA, section 1154(e) (42 U.S.C. 1320c–3(e)) is amended by striking paragraph (5).

(e) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall be effective as if included in the enactment of BIPA.

SEC. 849. CONFORMING AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: ''Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.''.

SEC. 850. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

''(d)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

''(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.

SEC. 851. ANNUAL PUBLICATION OF LIST OF NATIONAL COVERAGE DETERMINATIONS.

The Secretary shall provide, in an appropriate annual publication available to the public, a list of national coverage determinations made under title XVIII of the Social Security Act in the previous year and information on how to get more information with respect to such determinations.

TITLE IX—MEDICAID, PUBLIC HEALTH, AND OTHER HEALTH PROVISIONS

Subtitle A—Medicaid Provisions

SEC. 901. NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICAID.

(a) ESTABLISHMENT.—There is established a commission to be known as the National Bipartisan Commission on the Future of Medicaid (in this section referred to as the ''Commission'').

(b) DUTIES OF THE COMMISSION.—The Commission shall—

(1) review and analyze the long-term financial condition of the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(2) identify the factors that are causing, and the consequences of, increases in costs under the medicaid program, including—

(A) the impact of these cost increases upon State budgets, funding for other State programs, and levels of State taxes necessary to fund growing expenditures under the medicaid program;

(B) the financial obligations of the Federal government arising from the Federal matching requirement for expenditures under the medicaid program; and

(C) the size and scope of the current program and how the program has evolved over time;

(3) analyze potential policies that will ensure both the financial integrity of the medicaid program and the provision of appropriate benefits under such program;

(4) make recommendations for establishing incentives and structures to promote enhanced efficiencies and ways of encouraging innovative State policies under the medicaid program;

(5) make recommendations for establishing the appropriate balance between benefits covered, payments to providers, State and Federal contributions and, where appropriate, recipient cost-sharing obligations;

(6) make recommendations on the impact of promoting increased utilization of competitive, private enterprise models to contain program cost growth, through enhanced utilization of private plans, pharmacy benefit managers, and other methods currently being used to contain private sector healthcare costs;

(7) make recommendations on the financing of prescription drug benefits currently covered under medicaid programs, including analysis of the current Federal manufacturer rebate program, its impact upon both private market prices as well as those paid by other government purchasers, recent State efforts to negotiate additional supplemental manufacturer rebates and the ability of pharmacy benefit managers to lower drug costs;

(8) review and analyze such other matters relating to the medicaid program as the Commission deems appropriate; and

(9) analyze the impact of impending demographic changes upon medicaid benefits, including long term care services, and make recommendations for how best to appropriately divide State and Federal responsibilities for funding these benefits.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 17 members, of whom—

(A) four shall be appointed by the President;

(B) six shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 4 shall be of the same political party;

(C) six shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 4 shall be of the same political party; and

(D) one, who shall serve as Chairman of the Commission, appointed jointly by the President, Majority Leader of the Senate, and the Speaker of the House of Representatives.

(2) DEADLINE FOR APPOINTMENT.—Members of the Commission shall be appointed by not later than December 1, 2002.

(3) TERMS OF APPOINTMENT.—The term of any appointment under paragraph (1) to the Commission shall be for the life of the Commission.

(4) MEETINGS.—The Commission shall meet at the call of its Chairman or a majority of its members.

(5) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(6) VACANCIES.—A vacancy on the Commission shall be filled in the same manner in which the original appointment was made not later than 30 days after the Commission is given notice of the vacancy and shall not affect the power of the remaining members to execute the duties of the Commission.

(7) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(8) EXPENSES.—Each member of the Commission shall receive travel expenses and per diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(d) STAFF AND SUPPORT SERVICES.—

(1) EXECUTIVE DIRECTOR.—

(A) APPOINTMENT.—The Chairman shall appoint an executive director of the Commission.

(B) COMPENSATION.—The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

(2) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

(3) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(e) POWERS OF COMMISSION.—

(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(2) STUDIES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE AND OFFICE OF THE CHIEF ACTUARY OF HCFA.—

(A) The Director of the Congressional Budget Office or the Chief Actuary of the Centers for Medicare & Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.

(f) REPORT.—Not later than March 1, 2004, the Commission shall submit a report to the President and Congress which shall contain a detailed statement of only those recommendations, findings, and conclusions of the Commission.

(g) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report required in subsection (f).

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,500,000 to carry out this section.

SEC. 902. GAO STUDY ON MEDICAID DRUG PAYMENT SYSTEM.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the reimbursement under the medicaid program for covered outpatient drugs. Such study shall examine—

(1) the extent to which such reimbursements for a drug exceed the acquisition costs for that drug;

(2) the services and resources associated with dispensing a prescription and any additional payments available to compensate for expenses for these services and resources; and

(3) efforts undertaken by States to change the levels of such reimbursement and the price data they use in effecting such change.

(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) and shall include in such report such recommendations for changes for legislative or administrative action regarding medicaid reimbursement methodologies for outpatient prescription drugs, and their application to the medicare program, as the Comptroller General deems appropriate.

Subtitle B—Internet Pharmacies

SEC. 911. FINDINGS.

The Congress finds as follows:

(1) Legitimate Internet sellers of prescription drugs can offer substantial benefits to consumers. These potential benefits include convenience, privacy, valuable information, competitive prices, and personalized services.

(2) Unlawful Internet sellers of prescription drugs may dispense inappropriate, contaminated, counterfeit, or subpotent prescription drugs that could put at risk the health and safety of consumers.

(3) Unlawful Internet sellers have exposed consumers to significant health risks by knowingly filling invalid prescriptions, such as prescriptions based solely on an online questionnaire, or by dispensing prescription drugs without any prescription.

(4) Consumers may have difficulty distinguishing legitimate from unlawful Internet sellers, as well as foreign from domestic Internet sellers, of prescription drugs.

SEC. 912. AMENDMENT TO FEDERAL FOOD, DRUG, AND COSMETIC ACT.

(a) IN GENERAL.—Chapter V of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 351 et seq.) is amended by inserting after section 503A the following:

"SEC. 503B. INTERNET PRESCRIPTION DRUG SALES.

''(a) DEFINITIONS.—For purposes of this section:

''(1) CONSUMER.—The term 'consumer' means a person (other than an entity licensed or otherwise authorized under Federal or State law as a pharmacy or to dispense or distribute prescription drugs) that purchases or seeks to purchase prescription drugs through the Internet.

''(2) HOME PAGE.—The term 'home page' means the entry point or main web page for an Internet site.

''(3) INTERNET.—The term 'Internet' means collectively the myriad of computer and telecommunications facilities, including equipment and operating software, which comprise the interconnected worldwide network of networks that employ the Transmission Control Protocol/Internet Protocol, or any predecessor or successor protocols to such protocol, to communicate information of all kinds by wire or radio, including electronic mail.

''(4) INTERSTATE INTERNET SELLER.—

''(A) IN GENERAL.—The term 'interstate Internet seller' means a person whether in the United States or abroad, that engages in, offers to engage in, or causes the delivery or sale of a prescription drug through the Internet and has such drug delivered directly to the consumer via the Postal Service, or any private or commercial interstate carrier to a consumer in the United States who is residing in a State other than the State in which the seller's place of business is located. This definition excludes a person who only delivers a prescription drug to a consumer, such as an interstate carrier service.

''(B) EXEMPTION.—With respect to the consumer involved, the term 'interstate Internet seller' does not include a person described in subparagraph (A) whose place of business is located within 75 miles of the consumer.

''(5) LINK.—The term 'link' means either a textual or graphical marker on a web page that, when clicked on, takes the consumer to another part of the Internet, such as to another web page or a different area on the same web page, or from an electronic message to a web page.

''(6) PHARMACY.—The term 'pharmacy' means any place licensed or otherwise authorized as a pharmacy under State law.

''(7) PRESCRIBER.—The term 'prescriber' means an individual, licensed or otherwise authorized under applicable Federal and State law to issue prescriptions for prescription drugs.

''(8) PRESCRIPTION DRUG.—The term 'prescription drug' means a drug under section 503(b)(1).

''(9) VALID PRESCRIPTION.—The term 'valid prescription' means a prescription that meets the requirements of section 503(b)(1) and other applicable Federal and State law.

''(10) WEB SITE; SITE.—The terms 'web site' and 'site' mean a specific location on the Internet that is determined by Internet protocol numbers or by a domain name.

''(b) REQUIREMENTS FOR INTERSTATE INTERNET SELLERS.—

''(1) IN GENERAL.—Each interstate Internet seller shall comply with the requirements of this subsection with respect to the sale of, or the offer to sell, prescription drugs through the Internet and shall at all times display on its web site information in accordance with paragraph (2).

''(2) WEB SITE DISCLOSURE INFORMATION.—An interstate Internet seller shall post in a visible and clear manner (as determined by regulation) on the home page of its web site, or on a page directly linked to such home page—

''(A) the street address of the interstate Internet seller's place of business, and the telephone number of such place of business;

''(B) each State in which the interstate Internet seller is licensed or otherwise authorized as a pharmacy, or if the interstate Internet seller is not licensed or otherwise authorized by a State as a pharmacy, each State in which the interstate Internet seller is licensed or otherwise authorized to dispense prescription drugs, and the type of State license or authorization;

''(C) in the case of an interstate Internet seller that makes referrals to or solicits on behalf of a prescriber, the name of each prescriber, the street address of each such prescriber's place of business, the telephone number of such place of business, each State in which each such prescriber is licensed or otherwise authorized to prescribe prescription drugs, and the type of such license or authorization; and

''(D) a statement that the interstate Internet seller will dispense prescription drugs only upon a valid prescription.

''(3) DATE OF POSTING.—Information required to be posted under paragraph (2) shall be posted by an interstate Internet seller—

''(A) not later than 90 days after the effective date of this section if the web site of such seller is in operation as of such date; or

''(B) on the date of the first day of operation of such seller's web site if such site goes into operation after such date.

''(4) QUALIFYING STATEMENTS.—An interstate Internet seller shall not indicate in any manner that posting disclosure information on its web site signifies that the Federal Government has made any determination on the legitimacy of the interstate Internet seller or its business.

''(5) DISCLOSURE TO STATE LICENSING BOARDS.—An interstate Internet seller licensed or otherwise authorized to dispense prescription drugs in accordance with applicable State law shall notify each State entity that granted such licensure or authorization that it is an interstate Internet seller, the name of its business, the Internet address of its business, the street address of its place of business, and the telephone number of such place of business.

''(6) REGULATIONS.—The Secretary is authorized to promulgate such regulations as are necessary to carry out the provisions of this subsection. In issuing such regulations, the Secretary—

''(A) shall take into consideration disclosure formats used by existing interstate Internet seller certification programs; and

''(B) shall in defining the term 'place of business' include provisions providing that such place is a single location at which employees of the business perform job functions, and not a post office box or similar locale.''.

(b) PROHIBITED ACTS.—Section 301 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 331) is amended by adding at the end the following:

''(bb) The failure to post information required under section 503B(b)(2) or for knowingly making a materially false statement when posting such information as required under such section or violating section 503B(b)(4).''.

SEC. 913. PUBLIC EDUCATION.

The Secretary of Health and Human Services shall engage in activities to educate the public about the dangers of purchasing prescription drugs from unlawful Internet

sources. The Secretary should educate the public about effective public and private sector consumer protection efforts, as appropriate, with input from the public and private sectors, as appropriate.

SEC. 914. STUDY REGARDING COORDINATION OF REGULATORY ACTIVITIES.

Not later than 180 days after the date of enactment of this Act, the Secretary of Health and Human Services, after consultation with the Attorney General, shall submit to Congress a report providing recommendations for coordinating the activities of Federal agencies regarding interstate Internet sellers that operate from foreign countries and for coordinating the activities of the Federal Government with the activities of governments of foreign countries regarding such interstate Internet sellers.

SEC. 915. EFFECTIVE DATE.

The amendments made by this subtitle shall take effect 1 year after the date of enactment of this Act, except that the authority of the Secretary of Health and Human Services to commence the process of rulemaking is effective on the date of enactment of this Act.

Subtitle C—Promotion of Electronic Prescription

SEC. 921. PROGRAM OF GRANTS TO HEALTH CARE PROVIDERS TO IMPLEMENT ELECTRONIC PRESCRIPTION DRUG PROGRAMS.

Part P of title III of the Public Health Service Act is amended by inserting after section 399N the following new section:

"SEC. 399O. GRANTS TO HEALTH CARE PROVIDERS TO IMPLEMENT ELECTRONIC PRESCRIPTION DRUG PROGRAMS

''(a) IN GENERAL.—The Secretary is authorized to make grants for the purpose of assisting health care providers who prescribe drugs and biologicals in implementing electronic prescription programs described in section 1860C(d)(3) of the Social Security Act.

''(b) APPLICATION.—No grant may be made under this section except pursuant to a grant application that is submitted in a time, manner, and form approved by the Secretary.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for fiscal year 2004, such sums as may be appropriate to carry out this section.''.

Subtitle D—Treatment of Rare Diseases

SEC. 931. NIH OFFICE OF RARE DISEASES AT NATIONAL INSTITUTES OF HEALTH.

Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.), as amended by Public Law 107–84, is amended by inserting after section 404E the following:

''OFFICE OF RARE DISEASES

''SEC. 404F. (a) ESTABLISHMENT.—There is established within the Office of the Director of NIH an office to be known as the Office of Rare Diseases (in this section referred to as the 'Office'), which shall be headed by a Director (in this section referred to as the 'Director'), appointed by the Director of NIH.

''(b) DUTIES.—

''(1) IN GENERAL.—The Director of the Office shall carry out the following:

''(A) The Director shall recommend an agenda for conducting and supporting research on rare diseases through the national research institutes and centers. The agenda shall provide for a broad range of research and education activities, including scientific workshops and symposia to identify research opportunities for rare diseases.

''(B) The Director shall, with respect to rare diseases, promote coordination and cooperation among the national research institutes and centers and entities whose research is supported by such institutes.

''(C) The Director, in collaboration with the directors of the other relevant institutes and centers of the National Institutes of Health, may enter into cooperative agreements with and make grants for regional centers of excellence on rare diseases in accordance with section 404G.

''(D) The Director shall promote the sufficient allocation of the resources of the National Institutes of Health for conducting and supporting research on rare diseases.

''(E) The Director shall promote and encourage the establishment of a centralized clearinghouse for rare and genetic disease information that will provide understandable information about these diseases to the public, medical professionals, patients and families.

''(F) The Director shall biennially prepare a report that describes the research and education activities on rare diseases being conducted or supported through the national research institutes and centers, and that identifies particular projects or types of projects that should in the future be conducted or supported by the national research institutes and centers or other entities in the field of research on rare diseases.

''(G) The Director shall prepare the NIH Director's annual report to Congress on rare disease research conducted by or supported through the national research institutes and centers.

''(2) PRINCIPAL ADVISOR REGARDING ORPHAN DISEASES.—With respect to rare diseases, the Director shall serve as the principal advisor to the Director of NIH and shall provide advice to other relevant agencies. The Director shall provide liaison with national and international patient, health and scientific organizations concerned with rare diseases.

''(c) DEFINITION.—For purposes of this section, the term 'rare disease' means any disease or condition that affects less than 200,000 persons in the United States.

''(d) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as already have been appropriated for fiscal year 2002, and $4,000,000 for each of the fiscal years 2003 through 2006.''.

SEC. 932. RARE DISEASE REGIONAL CENTERS OF EXCELLENCE.

Title IV of the Public Health Service Act (42 U.S.C. 281 et seq.), as amended by section 1021, is further amended by inserting after section 404F the following:

''RARE DISEASE REGIONAL CENTERS OF EXCELLENCE

''SEC. 404G. (a) COOPERATIVE AGREEMENTS AND GRANTS.—

''(1) IN GENERAL.—The Director of the Office of Rare Diseases (in this section referred to as the 'Director'), in collaboration with the directors of the other relevant institutes and centers of the National Institutes of Health, may enter into cooperative agreements with and make grants to public or private nonprofit entities to pay all or part of the cost of planning, establishing, or strengthening, and providing basic operating support for regional centers of excellence for clinical research into, training in, and demonstration of diagnostic, prevention, control, and treatment methods for rare diseases.

''(2) POLICIES.—A cooperative agreement or grant under paragraph (1) shall be entered into in accordance with policies established by the Director of NIH.

''(b) COORDINATION WITH OTHER INSTITUTES.—The Director shall coordinate the activities under this section with similar activities conducted by other national research institutes, centers and agencies of the National Institutes of Health and by the Food and Drug Administration to the extent that such institutes, centers and agencies have responsibilities that are related to rare diseases.

''(c) USES FOR FEDERAL PAYMENTS UNDER COOPERATIVE AGREEMENTS OR GRANTS.—Federal payments made under a cooperative agreement or grant under subsection (a) may be used for—

''(1) staffing, administrative, and other basic operating costs, including such patient care costs as are required for research;

''(2) clinical training, including training for allied health professionals, continuing education for health professionals and allied health professions personnel, and information programs for the public with respect to rare diseases; and

''(3) clinical research and demonstration programs.

''(d) PERIOD OF SUPPORT; ADDITIONAL PERIODS.—Support of a center under subsection (a) may be for a period of not to exceed 5 years. Such period may be extended by the Director for additional periods of not more than 5 years if the operations of such center have been reviewed by an appropriate technical and scientific peer review group established by the Director and if such group has recommended to the Director that such period should be extended.

''(e) AUTHORIZATION OF APPROPRIATIONS.—For the purpose of carrying out this section, there are authorized to be appropriated such sums as already have been appropriated for fiscal year 2002, and $20,000,000 for each of the fiscal years 2003 through 2006.''.

Subtitle E—Other Provisions Relating to Drugs

SEC. 941. GAO STUDY REGARDING DIRECT-TO-CONSUMER ADVERTISING OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study for the purpose of determining—

(1) whether and to what extent there have been increases in utilization rates of prescription drugs that are attributable to guidance regarding direct-to-consumer advertising of such drugs that has been issued by the Food and Drug Administration under section 502(n) of the Federal Food, Drug, and Cosmetic Act; and

(2) if so, whether and to what extent such increased utilization rates have resulted in increases in the costs of public or private health plans, health insurance, or other health programs.

(b) CERTAIN DETERMINATIONS.—The study under subsection (a) shall include determinations of the following:

(1) The extent to which advertisements referred to in such subsection have resulted in effective consumer education about the prescription drugs involved, including an understanding of the risks of the drugs relative to the benefits.

(2) The extent of consumer satisfaction with such advertisements.

(3) The extent of physician satisfaction with the advertisements, including determining whether physicians believe that the advertisements interfere with the exercise of their medical judgment by influencing consumers to prefer advertised drugs over alternative therapies.

(4) The extent to which the advertisements have resulted in increases in health care costs for taxpayers, for employers, or for consumers due to consumer decisions to seek advertised drugs rather than lower-costs alternative therapies.

(5) The extent to which the advertisements have resulted in decreases in health care costs for taxpayers, for employers, or for consumers due to decreased hospitalization rates, fewer physician visits (not related to hospitalization), lower treatment costs, or reduced instances of employee absences to

care for family members with diseases or disorders.

(c) REPORT.—Not later than two years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to the Congress a report providing the findings of the study under subsection (a).

SEC. 942. CERTAIN HEALTH PROFESSIONS PROGRAMS REGARDING PRACTICE OF PHARMACY.

Part E of title VII of the Public Health Service Act (42 U.S.C. 294n et seq.) is amended by adding at the end the following subpart:

"Subpart 3—Pharmacist Workforce Programs

"SEC. 771. PUBLIC SERVICE ANNOUNCEMENTS.

''(a) PUBLIC SERVICE ANNOUNCEMENTS.—

''(1) IN GENERAL.—The Secretary shall develop and issue public service announcements that advertise and promote the pharmacist profession, highlight the advantages and rewards of being a pharmacist, and encourage individuals to enter the pharmacist profession.

''(2) METHOD.—The public service announcements described in subsection (a) shall be broadcast through appropriate media outlets, including television or radio, in a manner intended to reach as wide and diverse an audience as possible.

''(b) STATE AND LOCAL PUBLIC SERVICE ANNOUNCEMENTS.—

''(1) IN GENERAL.—The Secretary shall award grants to entities to support State and local advertising campaigns through appropriate media outlets to promote the pharmacist profession, highlight the advantages and rewards of being a pharmacist, and encourage individuals to enter the pharmacist profession.

''(2) USE OF FUNDS.—An entity that receives a grant under subsection (a) shall use funds received through such grant to acquire local television and radio time, place advertisements in local newspapers, and post information on billboards or on the Internet, in order to—

''(A) advertise and promote the pharmacist profession;

''(B) promote pharmacist education programs;

''(C) inform the public of public assistance regarding such education programs;

''(D) highlight individuals in the community that are presently practicing as pharmacists to recruit new pharmacists; and

''(E) provide any other information to recruit individuals for the pharmacist profession.

''(3) METHOD.—The campaigns described in subsection (a) shall be broadcast on television or radio, placed in newspapers as advertisements, or posted on billboards or the Internet, in a manner intended to reach as wide and diverse an audience as possible.

"SEC. 772. DEMONSTRATION PROJECT.

''(a) IN GENERAL.—The Secretary shall establish a demonstration project to enhance the participation of individuals who are pharmacists in the National Health Service Corps Loan Repayment Program described in section 338B.

''(b) SERVICES.—Services that may be provided by pharmacists pursuant to the demonstration project established under this section include medication therapy management services to assure that medications are used appropriately by patients, to enhance patients' understanding of the appropriate use of medications, to increase patients' adherence to prescription medication regimens, to reduce the risk of adverse events associated with medications, and to reduce the need for other costly medical services through better management of medication therapy. Such services may include case management, disease management, drug therapy management, patient training and education, counseling, drug therapy problem resolution, medication administration, the provision of special packaging, or other services that enhance the use of prescription medications.

''(c) PROCEDURE.—The Secretary may not provide assistance to an individual under this section unless the individual agrees to comply with all requirements described in sections 338B and 338D.

''(d) LIMITATIONS.—The demonstration project described in this section shall provide for the participation of—

''(1) individuals to provide services in rural and urban areas; and

''(2) enough individuals to allow the Secretary to properly analyze the effectiveness of such project.

''(e) DESIGNATIONS.—The demonstration project described in this section, and any pharmacists who are selected to participate in such project, shall not be considered by the Secretary in the designation of a health professional shortage area under section 332 during fiscal years 2003 through 2005.

''(f) RULE OF CONSTRUCTION.—This section shall not be construed to require any State to participate in the project described in this section.

''(g) REPORT.—The Secretary shall prepare and submit a report on the project to—

''(A) the Committee on Health, Education, Labor, and Pensions of the Senate;

''(B) the Subcommittee on Labor, Health and Human Services, and Education of the Committee on Appropriations of the Senate;

''(C) the Committee on Energy and Commerce of the House of Representatives; and

''(D) the Subcommittee on Labor, Health and Human Services, and Education of the Committee on Appropriations of the House of Representatives.

"SEC. 773. INFORMATION TECHNOLOGY.

''(a) GRANTS AND CONTRACTS.—The Secretary may make awards of grants or contracts to qualifying schools of pharmacy for the purpose of assisting such schools in acquiring and installing computer-based systems to provide pharmaceutical education. Education provided through such systems may be graduate education, professional education, or continuing education. The computer-based systems may be designed to provide on-site education, or education at remote sites (commonly referred to as distance learning), or both.

''(b) QUALIFYING SCHOOL OF PHARMACY.—For purposes of this section, the term 'qualifying school of pharmacy' means a school of pharmacy (as defined in section 799B) that requires students to serve in a clinical rotation in which pharmacist services are part of the curriculum.

"SEC. 774. AUTHORIZATION OF APPROPRIATIONS.

''For the purpose of carrying out this subpart, there are authorized to be appropriated such sums as may be necessary for each of the fiscal years 2003 through 2006.''.

TITLE X—HEALTH-CARE RELATED TAX PROVISIONS

SEC. 1001. ELIGIBILITY FOR ARCHER MSA'S EXTENDED TO ACCOUNT HOLDERS OF MEDICARE+CHOICE MSA'S.

(a) IN GENERAL.—Subparagraph (B) of section 220(c)(2) of the Internal Revenue Code of 1986 is amended by adding at the end the following new clause:

''(iii) MEDICARE+CHOICE MSA'S.—In the case of an individual who is covered under an MSA plan (as defined in section 1859(b)(3) of the Social Security Act) which such individual elected under section 1851(a)(2)(B) of such Act—

''(I) such plan shall be treated as a high deductible health plan for purposes of this section,

''(II) subsection (b)(2)(A) shall be applied by substituting '100 percent' for '65 percent' with respect to such individual,

''(III) with respect to such individual, the limitation under subsection (d)(1)(A)(ii) shall be 100 percent of the highest annual deductible limitation under section 1859(b)(3)(B) of the Social Security Act,

''(IV) paragraphs (4), (5), and (7) of subsection (b) and paragraph (1)(A)(iii) of this subsection shall not apply with respect to such individual, and

''(V) the limitation which would (but for this subclause) apply under subsection (b)(1) with respect to such individual for any taxable year shall be reduced (but not below zero) by the amount which would (but for subsection 106(b)) be includible in such individual's gross income for the taxable year.''.

(b) ACCOUNTS NOT COUNTED AGAINST NUMERICAL LIMITS.—

(1) IN GENERAL.—Paragraph (3) of section 220(j) of such Code is amended—

(A) in the heading, by striking ''PREVIOUSLY UNINSURED'' and inserting ''CERTAIN'',

(B) in subparagraph (A), by striking ''by not counting the Archer MSA of any previously uninsured individual.'' and inserting ''by not counting—

''(i) the Archer MSA of any previously uninsured individual, and

''(ii) the Archer MSA of any eligible individual who qualifies as such an individual by reason of subsection (c)(2)(B)(iii).''.

(2) REPORTING REQUIREMENT.—Subparagraph (A) of section 220(j)(4) of such Code is amended in clause (ii) by striking ''and'' at the end, in clause (iii) by striking the period and inserting '', and'', and by adding at the end the following new clause:

''(iv) the number of such accounts which are accounts of eligible individuals who qualify as such individuals by reason of subsection (c)(2)(B)(iii).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2002.

SEC. 1002. ADJUSTMENT OF EMPLOYER CONTRIBUTIONS TO COMBINED BENEFIT FUND TO REFLECT MEDICARE PRESCRIPTION DRUG SUBSIDY PAYMENTS.

Section 9704(b) of the Internal Revenue Code of 1986 (relating to health benefit premium) is amended by adding at the end the following new paragraph:

''(4) ADJUSTMENTS FOR MEDICARE PRESCRIPTION DRUG SUBSIDIES.—The trustees of the Combined Fund shall decrease the per beneficiary premium for each plan year in which a subsidy payment is provided to it under section 1860H of the Social Security Act by the amount which would place the Combined Fund in the same financial position as if such subsidy payment had not been received.''.

SEC. 1003. EXPANSION OF HUMAN CLINICAL TRIALS QUALIFYING FOR ORPHAN DRUG CREDIT.

(a) IN GENERAL.—Paragraph (2) of section 45C(b) of the Internal Revenue Code of 1986 is amended by adding at the end the following new subparagraph:

''(C) TREATMENT OF CERTAIN EXPENSES INCURRED BEFORE DESIGNATION.—For purposes of subparagraph (A)(ii)(I), if a drug is designated under section 526 of the Federal Food, Drug, and Cosmetic Act not later than the due date (including extensions) for filing the return of tax under this subtitle for the taxable year in which the application for such designation of such drug was filed, such drug shall be treated as having been designated on the date that such application was filed.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to expenses incurred after the date of the enactment of this Act.

The SPEAKER pro tempore. In lieu of the amendment recommended by the Committee on Ways and Means, the amendment in the nature of a substitute printed in House Report 107–553 is adopted.

The text of the amendment in the nature of a substitute printed in House Report 107–553 is as follows:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Modernization and Prescription Drug Act of 2002''.

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

(c) BIPA; SECRETARY.—In this Act:

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

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

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

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

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Sec. 101. Establishment of a medicare prescription drug benefit.

''PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

''Sec. 1860A. Benefits; eligibility; enrollment; and coverage period.
''Sec. 1860B. Requirements for qualified prescription drug coverage.
''Sec. 1860C. Beneficiary protections for qualified prescription drug coverage.
''Sec. 1860D. Requirements for prescription drug plan (PDP) sponsors; contracts; establishment of standards.
''Sec. 1860E. Process for beneficiaries to select qualified prescription drug coverage.
''Sec. 1860F. Submission of bids and premiums.
''Sec. 1860G. Premium and cost-sharing subsidies for low-income individuals.
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TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 101. ESTABLISHMENT OF A MEDICARE PRESCRIPTION DRUG BENEFIT.

(a) IN GENERAL.—Title XVIII is amended—

(1) by redesignating part D as part E; and

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

''PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

''SEC. 1860A. BENEFITS; ELIGIBILITY; ENROLLMENT; AND COVERAGE PERIOD.

''(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—Subject to the succeeding provisions of this part, each individual who is entitled to benefits under part A or is enrolled under part B is entitled to obtain qualified prescription drug coverage (described in section 1860B(a)) as follows:

''(1) MEDICARE+CHOICE PLAN.—If the individual is eligible to enroll in a Medicare+Choice plan that provides qualified prescription drug coverage under section 1851(j), the individual may enroll in the plan and obtain coverage through such plan.

''(2) PRESCRIPTION DRUG PLAN.—If the individual is not enrolled in a Medicare+Choice plan that provides qualified prescription drug coverage, the individual may enroll under this part in a prescription drug plan (as defined in section 1860J(a)(5)).

Such individuals shall have a choice of such plans under section 1860E(d).

''(b) GENERAL ELECTION PROCEDURES.—

''(1) IN GENERAL.—An individual eligible to make an election under subsection (a) may elect to enroll in a prescription drug plan under this part, or elect the option of qualified prescription drug coverage under a Medicare+Choice plan under part C, and to change such election only in such manner and form as may be prescribed by regulations of the Administrator of the Medicare Benefits Administration (appointed under section 1808(b)) (in this part referred to as the 'Medicare Benefits Administrator') and only during an election period prescribed in or under this subsection.

''(2) ELECTION PERIODS.—

''(A) IN GENERAL.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the Medicare+Choice program under section 1851(e), including—

''(i) annual coordinated election periods; and

''(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of a Medicare+Choice election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug plan under this part at the time of the election of coverage under the original fee-for-service plan.

''(B) INITIAL ELECTION PERIODS.—

''(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of November 1, 2004, there shall be an initial election period of 6 months beginning on that date.

''(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

''(C) ADDITIONAL SPECIAL ELECTION PERIODS.—The Administrator shall establish special election periods—

''(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in subsection (c)(2)(C);

''(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B;

''(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Administrator may provide; and

''(iv) in cases of individuals (as determined by the Administrator) who become eligible for prescription drug assistance under title XIX under section 1935(d).

''(3) INFORMATION ON PLANS.—Information described in section 1860C(b)(1) on prescription drug plans shall be made available during open enrollment periods.

''(c) GUARANTEED ISSUE; COMMUNITY RATING; AND NONDISCRIMINATION.—

''(1) GUARANTEED ISSUE.—

''(A) IN GENERAL.—An eligible individual who is eligible to elect qualified prescription drug coverage under a prescription drug plan or Medicare+Choice plan at a time during which elections are accepted under this part with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

''(B) MEDICARE+CHOICE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to PDP sponsors under this subsection.

''(2) COMMUNITY-RATED PREMIUM.—

''(A) IN GENERAL.—In the case of an individual who maintains (as determined under subparagraph (C)) continuous prescription drug coverage since the date the individual first qualifies to elect prescription drug coverage under this part, a PDP sponsor or Medicare+Choice organization offering a prescription drug plan or Medicare+Choice plan that provides qualified prescription drug coverage and in which the individual is enrolled may not deny, limit, or condition the coverage or provision of covered prescription drug benefits or vary or increase the premium under the plan based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act or any other factor.

''(B) LATE ENROLLMENT PENALTY.—In the case of an individual who does not maintain such continuous prescription drug coverage (as described in subparagraph (C)), a PDP sponsor or Medicare+Choice organization may (notwithstanding any provision in this title) adjust the premium otherwise applicable or impose a pre-existing condition exclusion with respect to qualified prescription drug coverage in a manner that reflects additional actuarial risk involved. Such a risk shall be established through an appropriate actuarial opinion of the type described in subparagraphs (A) through (C) of section 2103(c)(4).

''(C) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

''(i) COVERAGE UNDER PRESCRIPTION DRUG PLAN OR MEDICARE+CHOICE PLAN.—Qualified prescription drug coverage under a prescription drug plan or under a Medicare+Choice plan.

''(ii) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

''(iii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan as defined in section 1860H(f)(1), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(iv) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)), but only if the policy was in effect on January 1, 2005, and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(v) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(vi) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(D) CERTIFICATION.—For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in subparagraph (C).

''(E) DISCLOSURE.—

''(i) IN GENERAL.—Each entity that offers coverage of the type described in clause (iii), (iv), (v), or (vi) of subparagraph (C) shall provide for disclosure, consistent with standards established by the Administrator, of whether such coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(ii) WAIVER OF LIMITATIONS.—An individual may apply to the Administrator to waive the requirement that coverage of such type provide benefits at least equivalent to the benefits under a qualified prescription drug plan, if the individual establishes that the individual was not adequately informed that such coverage did not provide such level of benefits.

''(F) CONSTRUCTION.—Nothing in this section shall be construed as preventing the disenrollment of an individual from a prescription drug plan or a Medicare+Choice plan based on the termination of an election described in section 1851(g)(3), including for non-payment of premiums or for other reasons specified in subsection (d)(3), which takes into account a grace period described in section 1851(g)(3)(B)(i).

''(3) NONDISCRIMINATION.—A PDP sponsor offering a prescription drug plan shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

''(d) EFFECTIVE DATE OF ELECTIONS.—

''(1) IN GENERAL.—Except as provided in this section, the Administrator shall provide that elections under subsection (b) take effect at the same time as the Administrator provides that similar elections under section 1851(e) take effect under section 1851(f).

''(2) NO ELECTION EFFECTIVE BEFORE 2005.—In no case shall any election take effect before January 1, 2005.

''(3) TERMINATION.—The Administrator shall provide for the termination of an election in the case of—

''(A) termination of coverage under both part A and part B; and

''(B) termination of elections described in section 1851(g)(3) (including failure to pay required premiums).

''SEC. 1860B. REQUIREMENTS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) REQUIREMENTS.—

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

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

''(B) ACTUARIALLY EQUIVALENT COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered outpatient drugs which meets the alternative coverage requirements of subsection (c) and access to negotiated prices under subsection (d), but only if it is approved by the Administrator, as provided under subsection (c).

''(2) PERMITTING ADDITIONAL OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered outpatient drugs that exceeds the coverage required under paragraph (1), but any such additional coverage shall be limited to coverage of covered outpatient drugs.

''(B) DISAPPROVAL AUTHORITY.—The Administrator shall review the offering of qualified prescription drug coverage under this part or part C. If the Administrator finds that, in the case of a qualified prescription drug coverage under a prescription drug plan or a Medicare+Choice plan, that the organization or sponsor offering the coverage is engaged in activities intended to discourage enrollment of classes of eligible medicare beneficiaries obtaining coverage through the plan on the basis of their higher likelihood of utilizing prescription drug coverage, the Administrator may terminate the contract with the sponsor or organization under this part or part C.

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

''(b) STANDARD COVERAGE.—For purposes of this part, the 'standard coverage' is coverage of covered outpatient drugs (as defined in subsection (f)) that meets the following requirements:

''(1) DEDUCTIBLE.—The coverage has an annual deductible—

''(A) for 2005, that is equal to $250; or

''(B) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (5) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''(2) LIMITS ON COST-SHARING.—

''(A) IN GENERAL.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) as follows:

''(i) FIRST COPAYMENT RANGE.—For costs above the annual deductible specified in paragraph (1) and up to amount specified in subparagraph (C), the cost-sharing—

''(I) is equal to 20 percent; or

''(II) is actuarially equivalent (using processes established under subsection (e)) to an average expected payment of 20 percent of such costs.

''(ii) SECONDARY COPAYMENT RANGE.—For costs above the amount specified in subparagraph (C) and up to the initial coverage limit, the cost-sharing—

''(I) is equal to 50 percent; or

''(II) is actuarially consistent (using processes established under subsection (e)) with an average expected payment of 50 percent of such costs.

''(B) USE OF TIERED COPAYMENTS.—Nothing in this part shall be construed as preventing a PDP sponsor from applying tiered copayments, so long as such tiered copayments are consistent with subparagraph (A).

''(C) INITIAL COPAYMENT THRESHOLD.—The amount specified in this subparagraph—

''(i) for 2005, is equal to $1,000; or

''(ii) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under clause (ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''(3) INITIAL COVERAGE LIMIT.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes—

''(A) for 2005, that is equal to $2,000; or

''(B) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $25 shall be rounded to the nearest multiple of $25.

''(4) CATASTROPHIC PROTECTION.—

''(A) IN GENERAL.—Notwithstanding paragraph (3), the coverage provides benefits with no cost-sharing after the individual has incurred costs (as described in subparagraph (C)) for covered outpatient drugs in a year equal to the annual out-of-pocket threshold specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET THRESHOLD.—For purposes of this part, the 'annual out-of-pocket threshold' specified in this subparagraph—

''(i) for 2005, is equal to $3,700; or

''(ii) for a subsequent year, is equal to the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under clause (ii) that is not a multiple of $100 shall be rounded to the nearest multiple of $100.

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

''(i) incurred costs shall only include costs incurred for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3); and

''(ii) such costs shall be treated as incurred only if they are paid by the individual (or by another individual, such as a family member, on behalf of the individual), under section 1860G, or under title XIX and the individual (or other individual) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement for such costs.

''(5) ANNUAL PERCENTAGE INCREASE.—For purposes of this part, the annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs in the United States for medicare beneficiaries, as determined by the Administrator for the 12-month period ending in July of the previous year.

''(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A prescription drug plan or Medicare+Choice plan may provide a different prescription drug benefit design from the standard coverage described in subsection (b) so long as the Administrator determines (based on an actuarial analysis by the Administrator) that the following requirements are met and the plan applies for, and receives, the approval of the Administrator for such benefit design:

''(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

''(A) ASSURING EQUIVALENT VALUE OF TOTAL COVERAGE.—The actuarial value of the total coverage (as determined under subsection (e)) is at least equal to the actuarial value (as so determined) of standard coverage.

''(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (e)) exceeds the actuarial value of the subsidy payments under section 1860H with respect to such coverage.

''(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (e)), to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (b)(3), of an amount equal to at least the sum of the following products:

''(i) FIRST COPAYMENT RANGE.—The product of—

''(I) the amount by which the initial copayment threshold described in subsection (b)(2)(C) exceeds the deductible described in subsection (b)(1); and

''(II) 100 percent minus the cost-sharing percentage specified in subsection (b)(2)(A)(i)(I).

''(ii) SECONDARY COPAYMENT RANGE.—The product of—

''(I) the amount by which the initial coverage limit described in subsection (b)(3) exceeds the initial copayment threshold described in subsection (b)(2)(C); and

''(II) 100 percent minus the cost-sharing percentage specified in subsection (b)(2)(A)(ii)(I).

''(2) CATASTROPHIC PROTECTION.—The coverage provides for beneficiaries the catastrophic protection described in subsection (b)(4).

''(d) ACCESS TO NEGOTIATED PRICES.—

''(1) IN GENERAL.—Under qualified prescription drug coverage offered by a PDP sponsor or a Medicare+Choice organization, the sponsor or organization shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of cost-sharing or an initial coverage limit (described in subsection (b)(3)). Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated by a prescription drug plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated by a prescription drug plan under this part, by a Medicare+Choice plan with respect to covered outpatient drugs, or by a qualified retiree prescription drug plan (as defined in section 1860H(f)(1)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

''(2) DISCLOSURE.—The PDP sponsor or Medicare+Choice organization shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts or rebates made available to the sponsor or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Administrator under this paragraph in the same manner as such provisions apply to information disclosed under such section.

''(e) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

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

''(A) for determining the actuarial valuation of prescription drug coverage, including—

''(i) an actuarial valuation of standard coverage and of the reinsurance subsidy payments under section 1860H;

''(ii) the use of generally accepted actuarial principles and methodologies; and

''(iii) applying the same methodology for determinations of alternative coverage under subsection (c) as is used with respect to determinations of standard coverage under subsection (b); and

''(B) for determining annual percentage increases described in subsection (b)(5).

''(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), PDP sponsors and Medicare+Choice organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values, but the Administrator shall determine whether such actuarial values meet the requirements under subsection (c)(1).

''(f) COVERED OUTPATIENT DRUGS DEFINED.—

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

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

''(3) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully appealed under section 1860C(f)(2).

''(4) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug plan or Medicare+Choice plan may exclude from qualified prescription drug coverage any covered outpatient drug—

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

''(B) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860C(f).

''SEC. 1860C. BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) GUARANTEED ISSUE, COMMUNITY-RATED PREMIUMS, ACCESS TO NEGOTIATED PRICES, AND NONDISCRIMINATION.—For provisions requiring guaranteed issue, community-rated premiums, access to negotiated prices, and nondiscrimination, see sections 1860A(c)(1), 1860A(c)(2), 1860B(d), and 1860F(b), respectively.

''(b) DISSEMINATION OF INFORMATION.—

''(1) GENERAL INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

''(A) Access to covered outpatient drugs, including access through pharmacy networks.

''(B) How any formulary used by the sponsor functions, including the drugs included in the formulary.

''(C) Co-payments and deductible requirements, including the identification of the tiered or other co-payment level applicable to each drug (or class of drugs).

''(D) Grievance and appeals procedures.

Such information shall also be made available on request to prospective enrollees during annual open enrollment periods.

''(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual

eligible to enroll under a prescription drug plan, the PDP sponsor shall provide the information described in section 1852(c)(2) (other than subparagraph (D)) to such individual.

''(3) RESPONSE TO BENEFICIARY QUESTIONS.—Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information to enrollees upon request. The sponsor shall make available on a timely basis, through an Internet website and in writing upon request, information on specific changes in its formulary.

''(4) CLAIMS INFORMATION.—Each PDP sponsor offering a prescription drug plan must furnish to enrolled individuals in a form easily understandable to such individuals an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice of the benefits in relation to initial coverage limit and annual out-of-pocket threshold for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(c) ACCESS TO COVERED BENEFITS.—

''(1) ASSURING PHARMACY ACCESS.—

''(A) IN GENERAL.—The PDP sponsor of the prescription drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Administrator and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established under section 1860D(e) that ensure such convenient access.

''(B) USE OF POINT-OF-SERVICE SYSTEM.—A PDP sponsor shall establish an optional point-of-service method of operation under which—

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

''(ii) the plan may charge beneficiaries through adjustments in premiums and copayments any additional costs associated with the point-of-service option.

The additional copayments so charged shall not count toward the application of section 1860B(b).

''(2) USE OF STANDARDIZED TECHNOLOGY.—

''(A) IN GENERAL.—The PDP sponsor of a prescription drug plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrolled beneficiary to assure access to negotiated prices under section 1860B(d) for the purchase of prescription drugs for which coverage is not otherwise provided under the prescription drug plan.

''(B) STANDARDS.—

''(i) DEVELOPMENT.—The Administrator shall provide for the development of national standards relating to a standardized format for the card or other technology referred to in subparagraph (A). Such standards shall be compatible with standards established under part C of title XI.

''(ii) APPLICATION OF ADVISORY TASK FORCE.—The advisory task force established under subsection (d)(3)(B)(ii) shall provide recommendations to the Administrator under such subsection regarding the standards developed under clause (i).

''(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a PDP sponsor of a prescription drug plan uses a formulary, the following requirements must be met:

''(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The sponsor must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least one practicing physician and at least one practicing pharmacist both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are a practicing physician or a practicing pharmacist (or both).

''(B) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, pharmacoeconomic studies, outcomes research data, and such other information as the committee determines to be appropriate.

''(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs (although not necessarily for all drugs within such categories and classes).

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

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

''(F) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see subsections (e) and (f).

''(d) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(1) IN GENERAL.—The PDP sponsor shall have in place with respect to covered outpatient drugs—

''(A) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

''(B) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in paragraph (2) and for years beginning with 2006, an electronic prescription program described in paragraph (3); and

''(C) a program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing a PDP sponsor from applying cost management tools (including differential payments) under all methods of operation.

''(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(A) IN GENERAL.—A medication therapy management program described in this paragraph is a program of drug therapy management and medication administration that is designed to assure, with respect to beneficiaries with chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered outpatient drugs under the prescription drug plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

''(B) ELEMENTS.—Such program may include—

''(i) enhanced beneficiary understanding of such appropriate use through beneficiary education, counseling, and other appropriate means;

''(ii) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other appropriate means; and

''(iii) detection of patterns of overuse and underuse of prescription drugs.

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

''(D) CONSIDERATIONS IN PHARMACY FEES.—The PDP sponsor of a prescription drug program shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

''(3) ELECTRONIC PRESCRIPTION PROGRAM.—

''(A) IN GENERAL.—An electronic prescription drug program described in this paragraph is a program that includes at least the following components, consistent with national standards established under subparagraph (B):

''(i) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—Prescriptions are only received electronically, except in emergency cases and other exceptional circumstances recognized by the Administrator.

''(ii) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL.—The program provides, upon transmittal of a prescription by a prescribing health care professional, for transmittal by the pharmacist to the professional of information that includes—

''(I) information (to the extent available and feasible) on the 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.

''(B) STANDARDS.—

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

''(ii) ADVISORY TASK FORCE.—In developing such standards and the standards described in subsection (c)(2)(B)(i) the Administrator shall establish a task force that includes representatives of physicians, hospitals, pharmacists, and technology experts and representatives 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 systems reduce medication errors and can be readily implemented by physicians and hospitals.

''(III) Efforts to develop a common software platform for computerized prescribing.

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

''(V) 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 Administrator shall constitute the task force under clause (ii) by not later than April 1, 2003.

''(II) Such task force shall submit recommendations to Administrator by not later than January 1, 2004.

''(III) The Administrator shall develop and promulgate the national standards referred to in clause (ii) by not later than January 1, 2005.

''(C) REFERENCE TO AVAILABILITY OF GRANT FUNDS.—Grant funds are authorized under section 399O of the Public Health Service Act to provide assistance to health care providers in implementing electronic prescription drug programs.

''(4) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug plans under this part with respect to the following requirements, in the same manner as they apply to Medicare+Choice plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

''(A) Paragraph (1) (including quality assurance), including medication therapy management program under paragraph (2).

''(B) Subsection (c)(1) (relating to access to covered benefits).

''(C) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

''(5) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each PDP sponsor shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered outpatient drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

''(e) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

''(1) IN GENERAL.—Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the sponsor provides covered benefits) and enrollees with prescription drug plans of the sponsor under this part in accordance with section 1852(f).

''(2) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—A PDP sponsor shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(3) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug plan offered by a PDP sponsor that provides for tiered cost-sharing for drugs included within a formulary and provides lower cost-sharing for preferred drugs included within the formulary, an individual who is enrolled in the plan may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(f) APPEALS.—

''(1) IN GENERAL.—Subject to paragraph (2), a PDP sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(2) FORMULARY DETERMINATIONS.—An individual who is enrolled in a prescription drug plan offered by a PDP sponsor may appeal to obtain coverage for a covered outpatient drug that is not on a formulary of the sponsor if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(g) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—A PDP sponsor shall meet the requirements of section 1852(h) with respect to enrollees under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to enrollees under part C.

''SEC. 1860D. REQUIREMENTS FOR PRESCRIPTION DRUG PLAN (PDP) SPONSORS; CONTRACTS; ESTABLISHMENT OF STANDARDS.

''(a) GENERAL REQUIREMENTS.—Each PDP sponsor of a prescription drug plan shall meet the following requirements:

''(1) LICENSURE.—Subject to subsection (c), the sponsor is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a prescription drug plan.

''(2) ASSUMPTION OF FINANCIAL RISK FOR UNSUBSIDIZED COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B) and section 1860E(d)(2), the entity assumes full financial risk on a prospective basis for qualified prescription drug coverage that it offers under a prescription drug plan and that is not covered under section 1860H.

''(B) REINSURANCE PERMITTED.—The entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrolled member under this part.

''(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the case of a sponsor that is not described in paragraph (1), the sponsor shall meet solvency standards established by the Administrator under subsection (d).

''(b) CONTRACT REQUIREMENTS.—

''(1) IN GENERAL.—The Administrator shall not permit the election under section 1860A of a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1860G or 1860H, unless the Administrator has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than one prescription drug plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(2) NEGOTIATION REGARDING TERMS AND CONDITIONS.—The Administrator shall have the same authority to negotiate the terms and conditions of prescription drug plans under this part as the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code. In negotiating the terms and conditions regarding premiums for which information is submitted under section 1860F(a)(2), the Administrator shall take into account the subsidy payments under section 1860H and the adjusted community rate (as defined in section 1854(f)(3)) for the benefits covered.

''(3) INCORPORATION OF CERTAIN MEDICARE+CHOICE CONTRACT REQUIREMENTS.—The following provisions of section 1857 shall apply, subject to subsection (c)(5), to contracts under this section in the same manner as they apply to contracts under section 1857(a):

''(A) MINIMUM ENROLLMENT.—Paragraphs (1) and (3) of section 1857(b).

''(B) CONTRACT PERIOD AND EFFECTIVENESS.—Paragraphs (1) through (3) and (5) of section 1857(c).

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

''(D) ADDITIONAL CONTRACT TERMS.—Section 1857(e); except that in applying section 1857(e)(2) under this part—

''(i) such section shall be applied separately to costs relating to this part (from costs under part C);

''(ii) in no case shall the amount of the fee established under this subparagraph for a plan exceed 20 percent of the maximum amount of the fee that may be established under subparagraph (B) of such section; and

''(iii) no fees shall be applied under this subparagraph with respect to Medicare+Choice plans.

''(E) INTERMEDIATE SANCTIONS.—Section 1857(g).

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

''(4) RULES OF APPLICATION FOR INTERMEDIATE SANCTIONS.—In applying paragraph (3)(E)—

''(A) the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part; and

''(B) the reference in section 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall not be applied.

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

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

''(2) GROUNDS FOR APPROVAL.—The grounds for approval under this paragraph are the grounds for approval described in subparagraph (B), (C), and (D) of section 1855(a)(2), and also include the application by a State of any grounds other than those required under Federal law.

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

''(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) does not deem the entity to meet other requirements imposed under this part for a PDP sponsor.

''(5) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying provisions of section 1855(a)(2) under this subsection to prescription drug plans and PDP sponsors—

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

''(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d).

''(d) SOLVENCY STANDARDS FOR NON-LICENSED SPONSORS.—

''(1) ESTABLISHMENT.—The Administrator shall establish, by not later than October 1, 2003, financial solvency and capital adequacy standards that an entity that does not meet the requirements of subsection (a)(1) must meet to qualify as a PDP sponsor under this part.

''(2) COMPLIANCE WITH STANDARDS.—Each PDP sponsor that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Administrator shall establish certification procedures for such PDP sponsors with respect to such solvency standards in the manner described in section 1855(c)(2).

''(e) OTHER STANDARDS.—The Administrator shall establish by regulation other standards (not described in subsection (d))

for PDP sponsors and plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by October 1, 2003.

''(f) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency, except as provided in subsection (d)) with respect to prescription drug plans which are offered by PDP sponsors under this part.

''(2) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to premiums paid to PDP sponsors for prescription drug plans under this part, or with respect to any payments made to such a sponsor by the Administrator under this part.

''SEC. 1860E. PROCESS FOR BENEFICIARIES TO SELECT QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) IN GENERAL.—The Administrator shall establish a process for the selection of the prescription drug plan or Medicare+Choice plan which offer qualified prescription drug coverage through which eligible individuals elect qualified prescription drug coverage under this part.

''(b) ELEMENTS.—Such process shall include the following:

''(1) Annual, coordinated election periods, in which such individuals can change the qualifying plans through which they obtain coverage, in accordance with section 1860A(b)(2).

''(2) Active dissemination of information to promote an informed selection among qualifying plans based upon price, quality, and other features, in the manner described in (and in coordination with) section 1851(d), including the provision of annual comparative information, maintenance of a toll-free hotline, and the use of non-Federal entities.

''(3) Coordination of elections through filing with a Medicare+Choice organization or a PDP sponsor, in the manner described in (and in coordination with) section 1851(c)(2).

''(c) MEDICARE+CHOICE ENROLLEE IN PLAN OFFERING PRESCRIPTION DRUG COVERAGE MAY ONLY OBTAIN BENEFITS THROUGH THE PLAN.—An individual who is enrolled under a Medicare+Choice plan that offers qualified prescription drug coverage may only elect to receive qualified prescription drug coverage under this part through such plan.

''(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

''(1) CHOICE OF AT LEAST TWO PLANS IN EACH AREA.—

''(A) IN GENERAL.—The Administrator shall assure that each individual who is entitled to benefits under part A or enrolled under part B and who is residing in an area in the United States has available, consistent with subparagraph (B), a choice of enrollment in at least two qualifying plans (as defined in paragraph (5)) in the area in which the individual resides, at least one of which is a prescription drug plan.

''(B) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in subparagraph (A) is not satisfied with respect to an area if only one PDP sponsor or Medicare+Choice organization offers all the qualifying plans in the area.

''(2) GUARANTEEING ACCESS TO COVERAGE.—In order to assure access under paragraph (1) and consistent with paragraph (3), the Administrator may provide financial incentives (including partial underwriting of risk) for a PDP sponsor to expand the service area under an existing prescription drug plan to adjoining or additional areas or to establish such a plan (including offering such a plan on a regional or nationwide basis), but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

''(3) LIMITATION ON AUTHORITY.—In exercising authority under this subsection, the Administrator—

''(A) shall not provide for the full underwriting of financial risk for any PDP sponsor;

''(B) shall not provide for any underwriting of financial risk for a public PDP sponsor with respect to the offering of a nationwide prescription drug plan; and

''(C) shall seek to maximize the assumption of financial risk by PDP sponsors or Medicare+Choice organizations.

''(4) REPORTS.—The Administrator shall, in each annual report to Congress under section 1808(f), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to minimize the exercise of such authority, including minimizing the assumption of financial risk.

''(5) QUALIFYING PLAN DEFINED.—For purposes of this subsection, the term 'qualifying plan' means a prescription drug plan or a Medicare+Choice plan that includes qualified prescription drug coverage.

''SEC. 1860F. SUBMISSION OF BIDS AND PREMIUMS.

''(a) SUBMISSION OF BIDS, PREMIUMS, AND RELATED INFORMATION.—

''(1) IN GENERAL.—Each PDP sponsor shall submit to the Administrator the information described in paragraph (2) in the same manner as information is submitted by a Medicare+Choice organization under section 1854(a)(1).

''(2) INFORMATION SUBMITTED.—The information described in this paragraph is the following:

''(A) COVERAGE PROVIDED.—Information on the qualified prescription drug coverage to be provided.

''(B) ACTUARIAL VALUE.—Information on the actuarial value of the coverage.

''(C) BID AND PREMIUM.—Information on the bid and the premium for the coverage, including an actuarial certification of—

''(i) the actuarial basis for such bid and premium;

''(ii) the portion of such bid and premium attributable to benefits in excess of standard coverage; and

''(iii) the reduction in such bid and premium resulting from the subsidy payments provided under section 1860H.

''(D) ADDITIONAL INFORMATION.—Such other information as the Administrator may require to carry out this part.

''(3) REVIEW OF INFORMATION AND APPROVAL OF PREMIUMS.—The Administrator shall review the information filed under paragraph (2) for the purpose of conducting negotiations under section 1860D(b)(2). The Administrator, using the information provided (including the actuarial certification under paragraph (2)(C)) shall approve the premium submitted under this subsection only if the premium accurately reflects both (A) the actuarial value of the benefits provided, and (B) the 67 percent subsidy provided under section 1860H for the standard benefit. The Administrator shall apply actuarial principles to approval of a premium under this part in a manner similar to the manner in which those principles are applied in establishing the monthly part B premium under section 1839.

''(b) UNIFORM BID AND PREMIUM.—

''(1) IN GENERAL.—The bid and premium for a prescription drug plan under this section may not vary among individuals enrolled in the plan in the same service area.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing the imposition of a late enrollment penalty under section 1860A(c)(2)(B).

''(c) COLLECTION.—

''(1) BENEFICIARY'S OPTION OF PAYMENT THROUGH WITHHOLDING FROM SOCIAL SECURITY PAYMENT OR USE OF ELECTRONIC FUNDS TRANSFER MECHANISM.—In accordance with regulations, a PDP sponsor shall permit each enrollee, at the enrollee's option, to make payment of premiums under this part through withholding from benefit payments in the manner provided under section 1840 with respect to monthly premiums under section 1839 or through an electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account) or otherwise. All such amounts shall be credited to the Medicare Prescription Drug Trust Fund.

''(2) OFFSETTING.—Reductions in premiums for coverage under parts A and B as a result of a selection of a Medicare+Choice plan may be used to reduce the premium otherwise imposed under paragraph (1).

''(3) PAYMENT OF PLANS.—PDP plans shall receive payment based on bid amounts in the same manner as Medicare+Choice organizations receive payment based on bid amounts under section 1853(a)(1)(A)(ii) except that such payment shall be made from the Medicare Prescription Drug Trust Fund.

''(d) ACCEPTANCE OF BENCHMARK AMOUNT AS FULL PREMIUM FOR SUBSIDIZED LOW-INCOME INDIVIDUALS IF NO STANDARD (OR EQUIVALENT) COVERAGE IN AN AREA.—

''(1) IN GENERAL.—If there is no standard prescription drug coverage (as defined in paragraph (2)) offered in an area, in the case of an individual who is eligible for a premium subsidy under section 1860G and resides in the area, the PDP sponsor of any prescription drug plan offered in the area (and any Medicare+Choice organization that offers qualified prescription drug coverage in the area) shall accept the benchmark bid amount (under section 1860G(b)(2)) as payment in full for the premium charge for qualified prescription drug coverage.

''(2) STANDARD PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this subsection, the term 'standard prescription drug coverage' means qualified prescription drug coverage that is standard coverage or that has an actuarial value equivalent to the actuarial value for standard coverage.

''SEC. 1860G. PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS.

''(a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS WITH INCOME BELOW 175 PERCENT OF FEDERAL POVERTY LEVEL.—

''(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual (as defined in paragraph (4)) who is determined to have income that does not exceed 150 percent of the Federal poverty level, the individual is entitled under this section—

''(A) to an income-related premium subsidy equal to 100 percent of the amount described in subsection (b)(1); and

''(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860B(b) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that do not exceed $2 for a multiple source or generic drug (as described in section 1927(k)(7)(A)) and $5 for a non-preferred drug.

''(2) SLIDING SCALE PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME ABOVE 150, BUT BELOW 175 PERCENT, OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual who is determined to have income that exceeds 150

percent, but does not exceed 175 percent, of the Federal poverty level, the individual is entitled under this section to—

''(A) an income-related premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in subsection (b)(1) for individuals with incomes at 150 percent of such level to 0 percent of such amount for individuals with incomes at 175 percent of such level; and

''(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860B(b) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that do not exceed $2 for a multiple source or generic drug (as described in section 1927(k)(7)(A)) and $5 for a non-preferred drug.

''(3) CONSTRUCTION.—Nothing in this section shall be construed as preventing a PDP sponsor from reducing to 0 the cost-sharing otherwise applicable to generic drugs.

''(4) 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 eligible to elect, and has elected, to obtain qualified prescription drug coverage under this part;

''(ii) has income below 175 percent of the Federal poverty line; and

''(iii) meets the resources requirement described in section 1905(p)(1)(C).

''(B) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy eligible individual and the amount of such individual's income shall be determined under the State medicaid plan for the State under section 1935(a) or by the Social Security Administration. In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Administrator. 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.

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

''(i) income shall be determined in 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.

''(D) 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(e).

''(E) TREATMENT OF CONFORMING MEDIGAP POLICIES.—For purposes of this section, the term 'qualified prescription drug coverage' includes a medicare supplemental policy described in section 1860H(b)(4).

''(5) INDEXING DOLLAR AMOUNTS.—

''(A) FOR 2006.—The dollar amounts applied under paragraphs (1)(B) and (2)(B) for 2006 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2006.

''(B) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraphs (1)(B) and (2)(B) for a year after 2006 shall be the amounts (under this paragraph) applied under paragraph (1)(B) or (2)(B) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved.

''(b) PREMIUM SUBSIDY AMOUNT.—

''(1) IN GENERAL.—The premium subsidy amount described in this subsection for an individual residing in an area is the benchmark bid amount (as defined in paragraph (2)) for qualified prescription drug coverage offered by the prescription drug plan or the Medicare+Choice plan in which the individual is enrolled.

''(2) BENCHMARK BID AMOUNT DEFINED.—For purposes of this subsection, the term 'benchmark bid amount' means, with respect to qualified prescription drug coverage offered under—

''(A) a prescription drug plan that—

''(i) provides standard coverage (or alternative prescription drug coverage the actuarial value is equivalent to that of standard coverage), the bid amount for enrollment under the plan under this part (determined without regard to any subsidy under this section or any late enrollment penalty under section 1860A(c)(2)(B)); or

''(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the bid amount described in clause (i) multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage; or

''(B) a Medicare+Choice plan, the portion of the bid amount that is attributable to statutory drug benefits (described in section 1853(a)(1)(A)(ii)(II)).

''(c) RULES IN APPLYING COST-SHARING SUBSIDIES.—

''(1) IN GENERAL.—In applying subsections (a)(1)(B) and (a)(2)(B), nothing in this part shall be construed as preventing a plan or provider from waiving or reducing the amount of cost-sharing otherwise applicable.

''(2) LIMITATION ON CHARGES.—In the case of an individual receiving cost-sharing subsidies under subsection (a)(1)(B) or (a)(2)(B), the PDP sponsor may not charge more than $5 per prescription.

''(3) APPLICATION OF INDEXING RULES.—The provisions of subsection (a)(4) shall apply to the dollar amount specified in paragraph (2) in the same manner as they apply to the dollar amounts specified in subsections (a)(1)(B) and (a)(2)(B).

''(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator 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 prescription drug plan or is enrolled in a Medicare+Choice plan under which qualified prescription drug coverage is provided—

''(1) the Administrator provides for a notification of the PDP sponsor or Medicare+Choice organization involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

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

''(3) the Administrator periodically and on a timely basis reimburses the sponsor or organization for the amount of such reductions.

The reimbursement under paragraph (3) with respect to cost-sharing subsidies may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

''(e) RELATION TO MEDICAID PROGRAM.—

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

''(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for prescribed drugs provided under the medicaid program under title XIX.

''(3) COORDINATION.—The Administrator 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 Administrator shall involve the Secretary, the States, the data processing industry, pharmacists, and pharmaceutical manufacturers, and other experts.

''SEC. 1860H. SUBSIDIES FOR ALL MEDICARE BENEFICIARIES FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for all medicare beneficiaries consistent with an overall subsidy level of 67 percent, to reduce adverse selection among prescription drug plans and Medicare+Choice plans that provide qualified prescription drug coverage, and to promote the participation of PDP sponsors under this part, the Administrator shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the following subsidies:

''(1) DIRECT SUBSIDY.—In the case of an individual enrolled in a prescription drug plan, Medicare+Choice plan that provides qualified prescription drug coverage, or qualified retiree prescription drug plan, a direct subsidy equal to 37 percent of the total payments made by a qualifying entity for standard coverage under the respective plan.

''(2) SUBSIDY THROUGH REINSURANCE.—The reinsurance payment amount (as defined in subsection (c)), which in the aggregate is 30 percent of such total payments, for excess costs incurred in providing qualified prescription drug coverage—

''(A) for individuals enrolled with a prescription drug plan under this part;

''(B) for individuals enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage; and

''(C) for individuals who are enrolled in a qualified retiree prescription drug plan.

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

''(b) QUALIFYING ENTITY DEFINED.—For purposes of this section, the term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

''(1) A PDP sponsor offering a prescription drug plan under this part.

''(2) A Medicare+Choice organization that provides qualified prescription drug coverage under a Medicare+Choice plan under part C.

''(3) The sponsor of a qualified retiree prescription drug plan (as defined in subsection (f)).

''(c) REINSURANCE PAYMENT AMOUNT.—

''(1) IN GENERAL.—Subject to subsection (d)(1)(B) and paragraph (4), the reinsurance payment amount under this subsection for a qualifying covered individual (as defined in subsection (g)(1)) for a coverage year (as defined in subsection (g)(2)) is equal to the sum of the following:

''(A) For the portion of the individual's gross covered prescription drug costs (as defined in paragraph (3)) for the year that exceeds the initial copayment threshold specified in section 1860B(b)(2)(C), but does not exceed the initial coverage limit specified in section 1860B(b)(3), an amount equal to 30 percent of the allowable costs (as defined in paragraph (2)) attributable to such gross covered prescription drug costs.

''(B) For the portion of the individual's gross covered prescription drug costs for the year that exceeds the annual out-of-pocket threshold specified in 1860B(b)(4)(B), an amount equal to 80 percent of the allowable costs attributable to such gross covered prescription drug costs.

''(2) ALLOWABLE COSTS.—For purposes of this section, the term 'allowable costs' means, with respect to gross covered prescription drug costs under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid (net of average percentage rebates) under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

''(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term 'gross covered prescription drug costs' means, with respect to an enrollee with a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan (including costs attributable to administrative costs) for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

''(4) INDEXING DOLLAR AMOUNTS.—

''(A) AMOUNTS FOR 2005.—The dollar amounts applied under paragraph (1) for 2005 shall be the dollar amounts specified in such paragraph.

''(B) FOR 2006.—The dollar amounts applied under paragraph (1) for 2006 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860B(b)(5) for 2006.

''(C) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraph (1) for a year after 2006 shall be the amounts (under this paragraph) applied under paragraph (1) for the preceding year increased by the annual percentage increase described in section 1860B(b)(5) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved.

''(D) ROUNDING.—Any amount, determined under the preceding provisions of this paragraph for a year, which is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''(d) ADJUSTMENT OF PAYMENTS.—

''(1) ADJUSTMENT OF REINSURANCE PAYMENTS TO ASSURE 30 PERCENT LEVEL OF SUBSIDY THROUGH REINSURANCE.—

''(A) ESTIMATION OF PAYMENTS.—The Administrator shall estimate—

''(i) the total payments to be made (without regard to this subsection) during a year under subsections (a)(2) and (c); and

''(ii) the total payments to be made by qualifying entities for standard coverage under plans described in subsection (b) during the year.

''(B) ADJUSTMENT.—The Administrator shall proportionally adjust the payments made under subsections (a)(2) and (c) for a coverage year in such manner so that the total of the payments made under such subsections for the year is equal to 30 percent of the total payments described in subparagraph (A)(ii).

''(2) RISK ADJUSTMENT FOR DIRECT SUBSIDIES.—To the extent the Administrator determines it appropriate to avoid risk selection, the payments made for direct subsidies under subsection (a)(1) are subject to adjustment based upon risk factors specified by the Administrator. Any such risk adjustment shall be designed in a manner as to not result in a change in the aggregate payments made under such subsection.

''(e) PAYMENT METHODS.—

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

''(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Medicare Prescription Drug Trust Fund.

''(f) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN DEFINED.—

''(1) IN GENERAL.—For purposes of this section, the term 'qualified retiree prescription drug plan' means employment-based retiree health coverage (as defined in paragraph (3)(A)) if, with respect to an individual enrolled (or eligible to be enrolled) under this part who is covered under the plan, the following requirements are met:

''(A) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Administrator may require, that the coverage meets or exceeds the requirements for qualified prescription drug coverage.

''(B) AUDITS.—The sponsor (and the plan) shall maintain, and afford the Administrator access to, such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, and the accuracy of payments made.

''(C) PROVISION OF CERTIFICATION OF PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for issuance of certifications of the type described in section 1860A(c)(2)(D).

''(2) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to an individual who is enrolled under a qualified retiree prescription drug plan unless the individual is—

''(A) enrolled under this part;

''(B) is covered under the plan; and

''(C) is eligible to obtain qualified prescription drug coverage under section 1860A but did not elect such coverage under this part (either through a prescription drug plan or through a Medicare+Choice plan).

''(3) DEFINITIONS.—As used in this section:

''(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for individuals enrolled under this part (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

''(B) SPONSOR.—The term 'sponsor' means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

''(g) GENERAL DEFINITIONS.—For purposes of this section:

''(1) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

''(A) is enrolled with a prescription drug plan under this part;

''(B) is enrolled with a Medicare+Choice plan that provides qualified prescription drug coverage under part C; or

''(C) is enrolled for benefits under this title and is covered under a qualified retiree prescription drug plan.

''(2) COVERAGE YEAR.—The term 'coverage year' means a calendar year in which covered outpatient drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

"SEC. 1860I. MEDICARE PRESCRIPTION DRUG TRUST FUND.

''(a) IN GENERAL.—There is created on the books of the Treasury of the United States a trust fund to be known as the 'Medicare Prescription Drug Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. Except as otherwise provided in this section, the provisions of subsections (b) through (i) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund under such section.

''(b) PAYMENTS FROM TRUST FUND.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Administrator certifies are necessary to make—

''(A) payments under section 1860G (relating to low-income subsidy payments);

''(B) payments under section 1860H (relating to subsidy payments); and

''(C) payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Trust Fund to the Grants to States for Medicaid account amounts the Administrator certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

''(c) DEPOSITS INTO TRUST FUND.—

''(1) LOW-INCOME TRANSFER.—There is hereby transferred to the Trust Fund, from amounts appropriated for Grants to States for Medicaid, amounts equivalent to the aggregate amount of the reductions in payments under section 1903(a)(1) attributable to the application of section 1935(c).

''(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund, an amount equivalent to the amount of payments made from the Trust Fund under subsection (b), reduced by the amount transferred to the Trust Fund under paragraph (1).

''(d) RELATION TO SOLVENCY REQUIREMENTS.—Any provision of law that relates to the solvency of the Trust Fund under this part shall take into account the Trust Fund and amounts receivable by, or payable from, the Trust Fund.

"SEC. 1860J. DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C.

''(a) DEFINITIONS.—For purposes of this part:

''(1) COVERED OUTPATIENT DRUGS.—The term 'covered outpatient drugs' is defined in section 1860B(f).

''(2) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means such limit as established under section 1860B(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

''(3) MEDICARE PRESCRIPTION DRUG TRUST FUND.—The term 'Medicare Prescription Drug Trust Fund' means the Trust Fund created under section 1860I(a).

''(4) PDP SPONSOR.—The term 'PDP sponsor' means an entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

''(5) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' means health benefits coverage that—

''(A) is offered under a policy, contract, or plan by a PDP sponsor pursuant to, and in accordance with, a contract between the Administrator and the sponsor under section 1860D(b);

''(B) provides qualified prescription drug coverage; and

''(C) meets the applicable requirements of the section 1860C for a prescription drug plan.

''(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' is defined in section 1860B(a).

''(7) STANDARD COVERAGE.—The term 'standard coverage' is defined in section 1860B(b).

''(b) APPLICATION OF MEDICARE+CHOICE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a prescription drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

''(1) any reference to a Medicare+Choice plan included a reference to a prescription drug plan;

''(2) any reference to a provider-sponsored organization included a reference to a PDP sponsor;

''(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D(b); and

''(4) any reference to part C included a reference to this part.''.

(b) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS PART D.—Any reference in law (in effect before the date of the enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part E of such title (as in effect after such date).

(2) CONFORMING AMENDMENT PERMITTING WAIVER OF COST-SHARING.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

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

(B) by striking the period at the end of subparagraph (F) and inserting ''; and''; and

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

''(G) the waiver or reduction of any cost-sharing imposed under part D of title XVIII.''.

(3) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this subtitle.

(c) STUDY ON TRANSITIONING PART B PRESCRIPTION DRUG COVERAGE.—Not later than January 1, 2004, the Medicare Benefits Administrator shall submit a report to Congress that makes recommendations regarding methods for providing benefits under part D of title XVIII of the Social Security Act for outpatient prescription drugs for which benefits are provided under part B of such title.

SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE UNDER THE MEDICARE+CHOICE PROGRAM.

(a) IN GENERAL.—Section 1851 (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

''(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS.—

''(1) OFFER OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—A Medicare+Choice organization may not offer prescription drug coverage (other than that required under parts A and B) to an enrollee under a Medicare+Choice plan unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed as—

''(i) requiring a Medicare+Choice plan to include coverage of qualified prescription drug coverage; or

''(ii) permitting a Medicare+Choice organization from providing such coverage to an individual who has not elected such coverage under section 1860A(b).

For purposes of this part, an individual who has not elected qualified prescription drug coverage under section 1860A(b) shall be treated as being ineligible to enroll in a Medicare+Choice plan under this part that offers such coverage.

''(2) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a Medicare+Choice organization under a Medicare+Choice plan, the organization and plan shall meet the requirements of section 1860C, including requirements relating to information dissemination and grievance and appeals, in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D and shall submit to the Administrator the information described in section 1860F(a)(2). The Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

''(3) AVAILABILITY OF PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME ENROLLEES AND DIRECT AND REINSURANCE SUBSIDY PAYMENTS FOR ORGANIZATIONS.—For provisions—

''(A) providing premium and cost-sharing subsidies to low-income individuals receiving qualified prescription drug coverage through a Medicare+Choice plan, see section 1860G; and

''(B) providing a Medicare+Choice organization with direct and insurance subsidy payments for providing qualified prescription drug coverage under this part, see section 1860H.

''(4) TRANSITION IN INITIAL ENROLLMENT PERIOD.—Notwithstanding any other provision of this part, the annual, coordinated election period under subsection (e)(3)(B) for 2005 shall be the 6-month period beginning with November 2004.

''(5) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in section 1860B.''.

(b) CONFORMING AMENDMENTS.—Section 1851 (42 U.S.C. 1395w–21) is amended—

(1) in subsection (a)(1)—

(A) by inserting ''(other than qualified prescription drug benefits)'' after ''benefits'';

(B) by striking the period at the end of subparagraph (B) and inserting a comma; and

(C) by adding after and below subparagraph (B) the following:

''and may elect qualified prescription drug coverage in accordance with section 1860A.''; and

(2) in subsection (g)(1), by inserting ''and section 1860A(c)(2)(B)'' after ''in this subsection''.

(c) EFFECTIVE DATE.—The amendments made by this section apply to coverage provided on or after January 1, 2005.

SEC. 103. MEDICAID AMENDMENTS.

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

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

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

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

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

''(66) provide for making eligibility determinations under section 1935(a).''.

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

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

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

''SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

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

''(1) make determinations of eligibility for premium and cost-sharing subsidies under (and in accordance with) section 1860G;

''(2) inform the Administrator of the Medicare Benefits Administration of such determinations in cases in which such eligibility is established; and

''(3) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860G).

''(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 2005, 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 2006 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) 2006 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 Administrator 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.''.

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PREMIUM AND 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(c)(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:

''(c) 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 2005) the amount computed under this subsection is equal to the product of the following:

''(A) MEDICARE SUBSIDIES.—The total amount of payments made in the quarter under section 1860G (relating to premium and cost-sharing prescription drug subsidies for low-income medicare beneficiaries) that are attributable to individuals who are residents of the State and are entitled to benefits with respect to prescribed drugs under the State plan under this title (including such a plan operating under a waiver under section 1115).

''(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) 2005 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.''.

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

''(d) ADDITIONAL PROVISIONS.—

''(1) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to qualified prescription drug coverage under a prescription drug plan under part D of title XVIII (or under a Medicare+Choice plan under part C of such title) and medical assistance for 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 the prescription drug plan or the Medicare+Choice plan selected by the individual.

''(2) CONDITION.—A State may require, as a condition for the receipt of medical assistance under this title with respect to prescription drug benefits for an individual eligible to obtain qualified prescription drug coverage described in paragraph (1), that the individual elect qualified prescription drug coverage under section 1860A.''.

(d) TREATMENT OF TERRITORIES.—

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

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

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

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

''(e) 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), 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 with respect to the provision of covered outpatient drugs (as defined in section 1860B(f)) to low-income medicare beneficiaries; 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) 2005, is equal to $20,000,000; 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 1860B(b)(5) for the year involved.

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

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

(e) AMENDMENT TO BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended—

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

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

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

''(V) any prices charged which are negotiated by a prescription drug plan under part D of title XVIII, by a Medicare+Choice plan under part C of such title with respect to covered outpatient drugs, or by a qualified retiree prescription drug plan (as defined in section 1860H(f)(1)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B of such title.''.

SEC. 104. MEDIGAP TRANSITION.

(a) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) COVERAGE OF PRESCRIPTION DRUGS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, except as provided in paragraph (3) no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under this section on or after January 1, 2005, to an individual unless it replaces a medicare supplemental policy that was issued to that individual and that provided some coverage of expenses for prescription drugs.

''(2) ISSUANCE OF SUBSTITUTE POLICIES IF OBTAIN PRESCRIPTION DRUG COVERAGE UNDER PART D.—

''(A) IN GENERAL.—The issuer of a medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as 'A', 'B', 'C', 'D', 'E', 'F', or 'G' (under the standards established under subsection (p)(2)) and that is offered and is available for issuance to new enrollees by such issuer;

''(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

''(B) INDIVIDUAL COVERED.—An individual described in this subparagraph is an individual who—

''(i) enrolls in a prescription drug plan under part D; and

''(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as 'H', 'I', or 'J' under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

''(C) ENFORCEMENT.—The provisions of paragraph (4) of subsection (s) shall apply with respect to the requirements of this paragraph in the same manner as they apply to the requirements of such subsection.

''(3) NEW STANDARDS.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Medicare Modernization and Prescription Drug Act of 2002, with respect to policies issued to individuals who are enrolled under part D, the changes in standards shall only provide for substituting for the benefit packages that included coverage for prescription drugs two benefit packages that may provide for coverage of cost-sharing with respect to qualified prescription drug coverage under such part, except that such coverage may not cover the prescription drug deductible under such part. The two benefit packages shall be consistent with the following:

''(A) FIRST NEW POLICY.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

''(i) Coverage of 50 percent of the cost-sharing otherwise applicable, except coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

''(ii) No coverage of the part B deductible.

''(iii) Coverage for all hospital coinsurance for long stays (as in the current core benefit package).

''(iv) A limitation on annual out-of-pocket expenditures to $4,000 in 2005 (or, in a subsequent year, to such limitation for the previous year increased by an appropriate inflation adjustment specified by the Secretary).

''(B) SECOND NEW POLICY.—The policy described in this subparagraph has the same benefits as the policy described in subparagraph (A), except as follows:

''(i) Substitute '75 percent' for '50 percent' in clause (i) of such subparagraph.

''(ii) Substitute '$2,000' for '$4,000' in clause (iv) of such subparagraph.

''(4) CONSTRUCTION.—Any provision in this section or in a medicare supplemental policy relating to guaranteed renewability of coverage shall be deemed to have been met

through the offering of other coverage under this subsection.''.

SEC. 105. MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM.

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

''MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM

''SEC. 1807. (a) IN GENERAL.—The Secretary (or the Medicare Benefits Administrator pursuant to section 1808(c)(3)(C)) shall establish a program—

''(1) to endorse prescription drug discount card programs that meet the requirements of this section; and

''(2) to make available to medicare beneficiaries information regarding such endorsed programs.

''(b) REQUIREMENTS FOR ENDORSEMENT.—The Secretary may not endorse a prescription drug discount card program under this section unless the program meets the following requirements:

''(1) SAVINGS TO MEDICARE BENEFICIARIES.—The program passes on to medicare beneficiaries who enroll in the program discounts on prescription drugs, including discounts negotiated with manufacturers.

''(2) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The program applies to drugs that are available other than solely through mail order.

''(3) BENEFICIARY SERVICES.—The program provides pharmaceutical support services, such as education and counseling, and services to prevent adverse drug interactions.

''(4) INFORMATION.—The program makes available to medicare beneficiaries through the Internet and otherwise information, including information on enrollment fees, prices charged to beneficiaries, and services offered under the program, that the Secretary identifies as being necessary to provide for informed choice by beneficiaries among endorsed programs.

''(5) DEMONSTRATED EXPERIENCE.—The entity operating the program has demonstrated experience and expertise in operating such a program or a similar program.

''(6) QUALITY ASSURANCE.—The entity has in place adequate procedures for assuring quality service under the program.

''(7) OPERATION OF ASSISTANCE PROGRAM.—The entity meets such requirements relating to solvency, compliance with financial reporting requirements, audit compliance, and contractual guarantees as the Secretary finds necessary for the participation of the sponsor in the low-income assistance program under section 1807A.

''(8) ENROLLMENT FEES.—The program may charge an annual enrollment fee, but the amount of such annual fee may not exceed $25.

''(9) ADDITIONAL BENEFICIARY PROTECTIONS.—The program meets such additional requirements as the Secretary identifies to protect and promote the interest of medicare beneficiaries, including requirements that ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

The prices negotiated by a prescription drug discount card program endorsed under this section shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

''(c) PROGRAM OPERATION.—The Secretary shall operate the program under this section consistent with the following:

''(1) PROMOTION OF INFORMED CHOICE.—In order to promote informed choice among endorsed prescription drug discount card programs, the Secretary shall provide for the dissemination of information which compares the prices and services of such programs in a manner coordinated with the dissemination of educational information on Medicare+Choice plans under part C.

''(2) OVERSIGHT.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed programs with the requirements of this section, including verification of the discounts and services provided.

''(3) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the 1-800-medicare toll free telephone number for the receipt and response to inquiries and complaints concerning the program and programs endorsed under this section.

''(4) SANCTIONS FOR ABUSIVE PRACTICES.—The Secretary may implement intermediate sanctions or may revoke the endorsement of a program in the case of a program that the Secretary determines no longer meets the requirements of this section or that has engaged in false or misleading marketing practices.

''(5) ENROLLMENT PRACTICES.—A medicare beneficiary may not be enrolled in more than one endorsed program at any time. A medicare beneficiary may change the endorsed program in which the beneficiary is enrolled, but may not make such change until the beneficiary has been enrolled in a program for a minimum period of time specified by the Secretary.

''(d) TRANSITION.—The Secretary shall provide for an appropriate transition and discontinuation of the program under this section at the time prescription drug benefits first become available under part D.

''(e) ENDORSEMENT CONDITION.—The Secretary shall require, as condition of endorsement under of a prescription drug discount card program under this section that the program implement policies and procedures to safeguard the use and disclosure of program beneficiaries' individually identifiable health information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the program under this section and section 1807A.

''TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE PROGRAM FOR LOW-INCOME BENEFICIARIES

''SEC. 1807A. (a) PURPOSE.—The purpose of this section is to provide low-income medicare beneficiaries with immediate assistance in the purchase of covered outpatient prescription drugs during the period before the program under part D becomes effective.

''(b) FUNDS AVAILABLE; ALLOTMENTS.—

''(1) APPROPRIATIONS; TOTAL ALLOTMENTS.—

''(A) APPROPRIATIONS.—For the purpose of carrying out this section, there is appropriated, out of any money in the Treasury not otherwise appropriated—

''(i) for fiscal year 2003, $300,000,000;

''(ii) for fiscal year 2004, $2,100,000,000; and

''(iii) for fiscal year 2005, $500,000,000.

''(2) ALLOTMENTS.—

''(A) AMONG RESIDENTS OF 50 STATES AND THE DISTRICT OF COLUMBIA.—Subject to subparagraph (B), the amount appropriated under subparagraph (A) for each fiscal year shall be allotted among the 50 States and the District of Columbia based upon the Secretary's estimate of each State's or District's proportion of the total number of medicare beneficiaries with income below 175 percent of the Federal poverty line residing in all such States and the District. The Secretary shall determine the amount of the allotment for each such State and District not later than July 1, 2003.

''(B) AMONG RESIDENTS OF TERRITORIES.—Of the amount appropriated under subparagraph (A) for a fiscal year, the Secretary shall allot a percentage (determined consistent with the allotment provided to territories under the State children's health insurance program under section 2104(c)) among the commonwealths and territories described in section 2104(c)(3) in the same proportion as the allotment proportion under such program is allowed among such commonwealths and territories.

''(3) AVAILABILITY OF AMOUNTS ALLOTTED.—Amounts allotted with respect to a State pursuant to this subsection for a fiscal year shall remain available for expenditure through the end of the fiscal year in which benefits are first available under part D. Any funds allotted to States that are not obligated revert to the General Fund of the Treasury.

''(4) LIMITATION.—In no case shall the total amount of payments for assistance to eligible individuals (and administrative costs) in a State for a fiscal year (and previous fiscal years) under this section exceed the amount of the allotments with respect to that State in that year (and previous fiscal years). Nothing in this section shall be construed as preventing a State from providing, with its own funds, pharmaceutical assistance that is in addition to the assistance funded under this section.

''(c) ELIGIBILITY.—

''(1) IN GENERAL.—Taking into account the amounts allotted with respect to each State under subsection (b) and the minimum dollar value on assistance per eligible individual specified by the Secretary under subsection (d)(3), the Secretary shall establish guidelines for the establishment by each State of eligibility standards consistent with paragraph (2).

''(2) ELIGIBILITY RESTRICTIONS.—In no case shall an individual residing in a State be eligible for assistance under this section unless the individual—

''(A) is entitled to benefits under part A or enrolled under part B;

''(B) has income that is at or below a percentage (specified under the State eligibility plan under paragraph (1), but not to exceed 175 percent) of the Federal poverty line; and

''(C) meets the resources requirement described in section 1905(p)(1)(C);

''(D) is enrolled under a prescription drug discount card program (or under an alternative program authorized under subsection (d)(1)(B)); and

''(E) is not eligible for coverage of, or assistance for, outpatient prescription drugs under any of the following:

''(i) A medicaid plan under title XIX (including under any waiver approved under section 1115).

''(ii) Enrollment under a group health plan or health insurance coverage.

''(iii) Enrollment under a medicare supplemental insurance policy.

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

''(v) Chapter 17 of title 38, United States Code (relating to Veterans' medical care).

''(vi) Enrollment under a plan under chapter 89 of title 5, United States Code (relating to the Federal employees' health benefits program).

''(vii) The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(3) INCOME DETERMINATIONS.—The provisions of section 1860G(4)(C) shall apply for purposes of applying this subsection.

''(d) FORM OF ASSISTANCE AND AMOUNT OF BENEFITS.—

''(1) IN GENERAL.—

''(A) THROUGH PROGRAM SPONSOR.—Subject to subparagraph (B), the assistance under this section to an eligible individual shall be in the form of a discount (as identified by the sponsor to the Secretary) provided by the sponsor of a prescription drug discount card program to eligible individuals who are enrolled in such program.

''(B) THROUGH ALTERNATIVE STATE PROGRAM.—A State may apply to the Secretary for authorization to provide the assistance under this section to an eligible individual through a State pharmaceutical assistance program or private program of pharmaceutical assistance. The Secretary shall not authorize the use of such a program unless the Secretary finds that the program—

''(i) was in existence before the date of the enactment of this section; and

''(ii) is reasonably designed to provide for pharmaceutical assistance for a number of individuals, and in a scope, that is not less than the number of individuals, and minimum required amount, that would occur if the provisions of this subparagraph had not applied in the State.

''(2) GUIDANCE; MINIMUM LEVEL OF ASSISTANCE.—The Secretary shall establish guidelines for how the program under this section will operate. Based upon the aggregate amount appropriated in each fiscal year and other relevant factors, the Secretary shall establish a minimum amount of assistance that is available, subject to paragraph (4)(B), to each eligible individual for each calendar quarter (or other period specified by the Secretary) and provide guidance to sponsors regarding how assistance funds may be provided to eligible individuals consistent with such amount and funding limitations.

''(3) RELATIONSHIP TO DISCOUNTS.—The assistance provided under this section is in addition to the discount otherwise available to individuals enrolled in prescription drug discount card programs who are not eligible individuals.

''(4) LIMITATION ON ASSISTANCE.—

''(A) IN GENERAL.—The assistance under this section for an eligible individual shall be limited to assistance—

''(i) for covered outpatient drugs (as defined in section 1860B(f)) and for enrollment fees imposed under prescription drug discount card programs; and

''(ii) for expenses incurred—

''(I) on and after the date the individual is both enrolled in the prescription drug discount card program and determined to be an eligible individual under this section; and

''(II) before the date benefits are first available under the program under part D.

''(B) AUTHORITY.—The Secretary shall take such steps as may be necessary to assure compliance with the expenditure limitations described in subsection (b)(4).

''(e) PAYMENT OF FEDERAL SUBSIDY TO SPONSORS.—

''(1) IN GENERAL.—The Secretary shall make payment (within the allotments for each State, less the administrative payments made subsection (f)(2) to each State) to the sponsor of the prescription drug discount card program (or to a State or other entity operating a program under subsection (d)(1)(B)) in which an eligible individual is enrolled of the amount of the assistance provided by the sponsor pursuant to this section.

''(2) PERIODIC PAYMENTS.—Payments under this subsection (and subsection (f)(2)) shall be made on a monthly or other periodic installment basis, based upon estimates of the Secretary and shall be reduced or increased to the extent of any overpayment or underpayment which the Secretary determines was made under this section for any prior period and with respect to which adjustment has not already been made under this paragraph.

''(f) STATE RESPONSIBILITIES.—

''(1) ELIGIBILITY DETERMINATIONS.—As a condition for the payment of Federal financial participation to a State under section 1903(a) for periods during which assistance is available under this section, the State must submit to the Secretary an eligibility plan under which the State—

''(A) establishes eligibility standards consistent with the provisions of this section;

''(B) conducts determinations of eligibility and income in the same manner as the State is required to make eligibility and income determinations described in section 1860G(a)(4); and

''(C) communicates to the Secretary (or the Secretary's designee) determinations of eligibility or discontinuation of eligibility under this section.

The Secretary shall provide a method for communicating with sponsors concerning the identity of eligible individuals.

''(2) COVERAGE OF ADMINISTRATIVE COSTS.—Of the amount allotted with respect to a State under subsection (b), the Secretary shall pay to the State the amount of its administrative costs in carrying out this subsection, but not to exceed 10 percent of the amount of such allotment to the State. The provisions of subsection (e)(2) shall apply to such payments.

''(g) DEFINITIONS.—For purposes of this section:

''(1) ELIGIBLE INDIVIDUAL.—The term 'eligible individual' means an individual who is determined by a State to be eligible for assistance under this section.

''(2) PRESCRIPTION DRUG DISCOUNT CARD PROGRAM.—The term 'prescription drug discount card program' means such a program that is endorsed under section 1807.

''(3) SPONSOR.—The term 'sponsor' means the sponsor of a prescription drug discount card program, or, in the case of a program authorized under subsection (d)(1)(B), the State or other entity operating the program.

''(4) STATE.—The term 'State' has the meaning given such term for purposes of title XIX.''.

(b) CONFORMING AMENDMENT.—Section 1927(c)(1)(C)(i)(V) (42 U.S.C. 1396r–8(c)(1)(C)(i)(V)), as added by section 103(e), is amended by striking ''or by a qualified retiree prescription drug plan (as defined in section 1860H(f)(1))'' and inserting ''by a qualified retiree prescription drug plan (as defined in section 1860H(f)(1)), or by a prescription drug discount card program endorsed under section 1807''.

SEC. 106. GAO STUDY OF THE EFFECTIVENESS OF THE NEW PRESCRIPTION DRUG PROGRAM.

(a) STUDY.—The Comptroller General of the United States shall conduct a study on the effectiveness of the prescription drug program provided under part D of title XVIII of the Social Security Act. Such study shall—

(1) report—

(A) the percentage of eligible individuals who enrolled in the program;

(B) the demographic characteristics (including health status) of such enrollees;

(C) the number and type of qualified prescription drug coverage available to such individuals; and

(D) the premiums imposed for enrollment in different areas;

(2) evaluate the processes and methods developed by the Administrator and the decisions reached by outside actuaries to determine the actuarial valuation of prescription drug coverage; and

(3) assess whether the subsidy payments under such part accomplished its stated goals of reducing premium levels for all beneficiaries, reducing adverse selection, and promoting participation of PDP sponsors.

(b) REPORT.—Not later January 1, 2006, the Comptroller General shall submit a report to Congress on the study conducted under subsection (a).

TITLE II—MEDICARE+CHOICE REVITALIZATION AND MEDICARE+CHOICE COMPETITION PROGRAM

Subtitle A—Medicare+Choice Revitalization

SEC. 201. MEDICARE+CHOICE IMPROVEMENTS.

(a) EQUALIZING PAYMENTS BETWEEN FEE-FOR-SERVICE AND MEDICARE+CHOICE.—

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

''(D) BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

''(i) IN GENERAL.—For 2003 and 2004, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for the Medicare+Choice payment area for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare+Choice plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

''(ii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.''.

(2) CONFORMING AMENDMENT.—Such section is further amended, in the matter before subparagraph (A), by striking ''or (C)'' and inserting ''(C), or (D)''.

(b) REVISION OF BLEND.—

(1) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)) is amended by inserting ''who (with respect to determinations for 2003 and for 2004) are enrolled in a Medicare+Choice plan'' after ''the average number of medicare beneficiaries''.

(2) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(A) in paragraph (1)(A), by inserting ''(for a year before 2003)'' after ''multiplied''; and

(B) in paragraph (5), by inserting ''(before 2003)'' after ''for each year''.

(c) REVISION IN MINIMUM PERCENTAGE INCREASE FOR 2003 AND 2004.—Section 1853(c)(1)(C) (42 U.S.C. 1395w–23(c)(1)(C)) is amended by striking clause (iv) and inserting the following:

''(iv) For 2002, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2001.

''(v) For 2003 and 2004, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(vi) For 2005 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.''.

(d) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICARE+CHOICE PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is amended—

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

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

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2003), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(e) ANNOUNCEMENT OF REVISED MEDICARE+CHOICE PAYMENT RATES.—Within 4 weeks after the date of the enactment of this Act, the Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties) Medicare+Choice capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2003, revised in accordance with the provisions of this section.

(f) MEDPAC STUDY OF AAPCC.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that assesses the method used for determining the adjusted average per capita cost (AAPCC) under section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)). Such study shall examine—

(A) the bases for variation in such costs between different areas, including differences in input prices, utilization, and practice patterns;

(B) the appropriate geographic area for payment under the Medicare+Choice program under part C of title XVIII of such Act; and

(C) the accuracy of risk adjustment methods in reflecting differences in costs of providing care to different groups of beneficiaries served under such program.

(2) REPORT.—Not later than 9 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under paragraph (1). Such report shall include recommendations regarding changes in the methods for computing the adjusted average per capita cost among different areas.

(g) REPORT ON IMPACT OF INCREASED FINANCIAL ASSISTANCE TO MEDICARE+CHOICE PLANS.—Not later than July 1, 2003, the Secretary of Health and Human Services shall submit to Congress a report that describes the impact of additional financing provided under this Act and other Acts (including the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and BIPA) on the availability of Medicare+Choice plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

SEC. 202. MAKING PERMANENT CHANGE IN MEDICARE+CHOICE REPORTING DEADLINES AND ANNUAL, COORDINATED ELECTION PERIOD.

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

(b) DELAY IN ANNUAL, COORDINATED ELECTION PERIOD.—Section 1851(e)(3)(B) (42 U.S.C. 1395w–21(e)(3)(B)), as amended by section 532(c)(1)(A) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended by striking ''and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005'' and inserting '', the month of November before such year and with respect to 2003 and any subsequent year''.

(c) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—Section 1853(b)(1) (42 U.S.C. 1395w–23(b)(1)), as amended by section 532(d)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended by striking ''and after 2005 not later than March 1 before the calendar year concerned and for 2004 and 2005'' and inserting ''not later than March 1 before the calendar year concerned and for 2004 and each subsequent year''.

(d) REQUIRING PROVISION OF AVAILABLE INFORMATION COMPARING PLAN OPTIONS.—The first sentence of section 1851(d)(2)(A)(ii) (42 U.S.C. 1395w–21(d)(2)(A)(ii)) is amended by inserting before the period the following: ''to the extent such information is available at the time of preparation of materials for the mailing''.

SEC. 203. AVOIDING DUPLICATIVE STATE REGULATION.

(a) IN GENERAL.—Section 1856(b)(3) (42 U.S.C. 1395w–26(b)(3)) is amended to read as follows:

''(3) RELATION TO STATE LAWS.—The standards established under this subsection shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to Medicare+Choice plans which are offered by Medicare+Choice organizations under this part.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 204. SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.

(a) TREATMENT AS COORDINATED CARE PLAN.—Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is amended by adding at the end the following new sentence: ''Specialized Medicare+Choice plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.''.

(b) SPECIALIZED MEDICARE+CHOICE PLAN FOR SPECIAL NEEDS BENEFICIARIES DEFINED.—Section 1859(b) (42 U.S.C. 1395w–29(b)) is amended by adding at the end the following new paragraph:

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

''(A) IN GENERAL.—The term 'specialized Medicare+Choice plan for special needs beneficiaries' means a Medicare+Choice plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

''(B) SPECIAL NEEDS BENEFICIARY.—The term 'special needs beneficiary' means a Medicare+Choice eligible individual who—

''(i) is institutionalized (as defined by the Secretary);

''(ii) is entitled to medical assistance under a State plan under title XIX; or

''(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized Medicare+Choice plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.''.

(c) RESTRICTION ON ENROLLMENT PERMITTED.—Section 1859 (42 U.S.C. 1395w–29) is amended by adding at the end the following new subsection:

''(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2007, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs beneficiaries.''.

(d) REPORT TO CONGRESS.—Not later than December 31, 2005, the Medicare Benefits Administrator shall submit to Congress a report that assesses the impact of specialized Medicare+Choice plans for special needs beneficiaries on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the medicare program as a result of amendments made by subsections (a), (b), and (c).

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a), (b), and (c) shall take effect upon the date of the enactment of this Act.

(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.—No later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue final regulations to establish requirements for special needs beneficiaries under section 1859(b)(4)(B)(iii) of the Social Security Act, as added by subsection (b).

SEC. 205. MEDICARE MSAS.

(a) EXEMPTION FROM REPORTING ENROLLEE ENCOUNTER DATA.—

(1) IN GENERAL.—Section 1852(e)(1) (42 U.S.C. 1395w–22(e)(1)) is amended by inserting ''(other than MSA plans)'' after ''Medicare+Choice plans''.

(2) CONFORMING AMENDMENTS.—Section 1852 (42 U.S.C. 1395w–22) is amended—

(A) in subsection (c)(1)(I), by inserting before the period at the end the following: ''if required under such section''; and

(B) in subparagraphs (A) and (B) of subsection (e)(2), by striking '', a non-network MSA plan,'' and '', NON-NETWORK MSA PLANS,'' each place it appears.

(b) MAKING PROGRAM PERMANENT AND ELIMINATING CAP.—Section 1851(b)(4) (42 U.S.C. 1395w–21(b)(4)) is amended—

(1) in the heading, by striking ''ON A DEMONSTRATION BASIS'';

(2) by striking the first sentence of subparagraph (A); and

(3) by striking the second sentence of subparagraph (C).

(c) APPLYING LIMITATIONS ON BALANCE BILLING.—Section 1852(k)(1) (42 U.S.C. 1395w–22(k)(1)) is amended by inserting ''or with an organization offering a MSA plan'' after ''section 1851(a)(2)(A)''.

(d) ADDITIONAL AMENDMENT.—Section 1851(e)(5)(A) (42 U.S.C. 1395w–21(e)(5)(A)) is amended—

(1) by adding ''or'' at the end of clause (i);

(2) by striking '', or'' at the end of clause (ii) and inserting a semicolon; and

(3) by striking clause (iii).

SEC. 206. EXTENSION OF REASONABLE COST AND SHMO CONTRACTS.

(a) REASONABLE COST CONTRACTS.—

(1) IN GENERAL.—Section 1876(h)(5)(C) (42 U.S.C. 1395mm(h)(5)(C)) is amended—

(A) by inserting ''(i)'' after ''(C)'';

(B) by inserting before the period the following: '', except (subject to clause (ii)) in the case of a contract for an area which is not covered in the service area of 1 or more coordinated care Medicare+Choice plans under part C''; and

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

''(ii) In the case in which—

''(I) a reasonable cost reimbursement contract includes an area in its service area as of a date that is after December 31, 2003;

''(II) such area is no longer included in such service area after such date by reason of the operation of clause (i) because of the inclusion of such area within the service area of a Medicare+Choice plan; and

''(III) all Medicare+Choice plans subsequently terminate coverage in such area;

such reasonable cost reimbursement contract may be extended and renewed to cover such area (so long as it is not included in the service area of any Medicare+Choice plan).''.

(2) STUDY.—The Medicare Benefits Administrator shall conduct a study of an appropriate transition for plans offered under reasonable cost contracts under section 1876 of the Social Security Act on and after January 1, 2005. Such a transition may take into account whether there are one or more coordinated care Medicare+Choice plans being offered in the areas involved. Not later than February 1, 2004, the Administrator shall submit to Congress a report on such study and shall include recommendations regarding any changes in the amendment made by paragraph (1) as the Administrator determines to be appropriate.

(b) EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION (SHMO) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—Section 4018(b)(1) of the Omnibus Budget Reconciliation Act of 1987 is amended by striking ''the date that is 30 months after the date that the Secretary submits to Congress the report described in section 4014(c) of the Balanced Budget Act of 1997'' and inserting ''December 31, 2004''.

(2) SHMOS OFFERING MEDICARE+CHOICE PLANS.—Nothing in such section 4018 shall be construed as preventing a social health maintenance organization from offering a Medicare+Choice plan under part C of title XVIII of the Social Security Act.

Subtitle B—Medicare+Choice Competition Program

SEC. 211. MEDICARE+CHOICE COMPETITION PROGRAM.

(a) SUBMISSION OF BID AMOUNTS.—Section 1854 (42 U.S.C. 1395w–24) is amended—

(1) in the heading by inserting ''AND BID AMOUNTS'' after ''PREMIUMS'';

(2) in subsection (a)(1)(A)—

(A) by striking ''(A)'' and inserting ''(A)(i) if the following year is before 2005,''; and

(B) by inserting before the semicolon at the end the following: ''or (ii) if the following year is 2005 or later, the information described in paragraph (6)(A)''; and

(3) by adding at the end of subsection (a) the following:

''(6) SUBMISSION OF BID AMOUNTS BY MEDICARE+CHOICE ORGANIZATIONS.—

''(A) INFORMATION TO BE SUBMITTED.—The information described in this subparagraph is as follows:

''(i) The monthly aggregate bid amount for provision of all items and services under this part and the actuarial basis for determining such amount.

''(ii) The proportions of such bid amount that are attributable to—

''(I) the provision of statutory non-drug benefits (such portion referred to in this part as the 'unadjusted non-drug monthly bid amount');

''(II) the provision of statutory prescription drug benefits; and

''(III) the provision of non-statutory benefits;

and the actuarial basis for determining such proportions.

''(iii) Such additional information as the Administrator may require to verify the actuarial bases described in clauses (i) and (ii).

''(B) STATUTORY BENEFITS DEFINED.—For purposes of this part:

''(i) The term 'statutory non-drug benefits' means benefits under parts A and B.

''(ii) The term 'statutory prescription drug benefits' means benefits under part D.

''(iii) The term 'statutory benefits' means statutory prescription drug benefits and statutory non-drug benefits.

''(C) ACCEPTANCE AND NEGOTIATION OF BID AMOUNTS.—The Administrator has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportion described in subparagraph (A)(ii)). The Administrator may reject such a bid amount or proportion if the Administrator determines that such amount or proportion is not supported by the actuarial bases provided under subparagraph (A).''.

(b) PROVIDING FOR BENEFICIARY SAVINGS FOR CERTAIN PLANS.—

(1) IN GENERAL.—Section 1854(b) (42 U.S.C. 1395w–24(b)) is amended—

(A) by adding at the end of paragraph (1) the following new subparagraph:

''(C) BENEFICIARY REBATE RULE.—

''(i) REQUIREMENT.—The Medicare+Choice plan shall provide to the enrollee a monthly rebate equal to 75 percent of the average per capita savings (if any) described in paragraph (3) applicable to the plan and year involved.

''(iii) FORM OF REBATE.—A rebate required under this subparagraph shall be provided—

''(I) through the crediting of the amount of the rebate towards the Medicare+Choice monthly supplementary beneficiary premium or the premium imposed for prescription drug coverage under part D;

''(II) through a direct monthly payment (through electronic funds transfer or otherwise); or

''(III) through other means approved by the Medicare Benefits Administrator,

or any combination thereof.''; and

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

''(3) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for a Medicare+Choice plan and year is computed as follows:

''(A) DETERMINATION OF STATE-WIDE AVERAGE RISK ADJUSTMENT.—

''(i) IN GENERAL.—The Medicare Benefits Administrator shall determine, at the same time rates are promulgated under section 1853(b)(1) (beginning with 2005), for each State the average of the risk adjustment factors to be applied to enrollees under section 1853(a)(1)(A) in that State. In the case of a State in which a Medicare+Choice plan was offered in the previous year, the Administrator may compute such average based upon risk adjustment factors applied in that State in a previous year.

''(ii) TREATMENT OF NEW STATES.—In the case of a State in which no Medicare+Choice plan was offered in the previous year, the Administrator shall estimate such average. In making such estimate, the Administrator may use average risk adjustment factors applied to comparable States or applied on a national basis.

''(B) DETERMINATION OF RISK ADJUSTED BENCHMARK AND RISK-ADJUSTED BID.—For each Medicare+Choice plan offered in a State, the Administrator shall—

''(i) adjust the fee-for-service area-specific non-drug benchmark amount by the applicable average risk adjustment factor computed under subparagraph (A); and

''(ii) adjust the unadjusted non-drug monthly bid amount by such applicable average risk adjustment factor.

''(C) DETERMINATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—The average per capita monthly savings described in this subparagraph is equal to the amount (if any) by which—

''(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i), exceeds

''(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

''(D) AUTHORITY TO DETERMINE RISK ADJUSTMENT FOR AREAS OTHER THAN STATES.—The Administrator may provide for the determination and application of risk adjustment factors under this paragraph on the basis of areas other than States.''.

(2) COMPUTATION OF FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG BENCHMARK.—Section 1853 (42 U.S.C. 1395w–23) is amended by adding at the end the following new subsection:

''(j) COMPUTATION OF FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG BENCHMARK AMOUNT.—For purposes of this part, the term 'fee-for-service area-specific non-drug benchmark amount' means, with respect to a Medicare+Choice payment area for a month in a year, an amount equal to the greater of the following (but in no case less than 1/12 of the rate computed under subsection (c)(1), without regard to subparagraph (A), for the year):

''(1) BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS IN THE AREA.—An amount equal to 1/12 of 100 percent (for 2005 through 2007, or 95 percent for 2008 and years thereafter) of the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for the Medicare+Choice payment area, for the area and the year involved, for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare+Choice plan under this part for the year, and adjusted to exclude from such cost the amount the Medicare Benefits Administrator estimates is payable for costs described in subclauses (I) and (II) of subsection (c)(3)(C)(i) for the year involved and also adjusted in the manner described in subsection (c)(1)(D)(ii) (relating to inclusion of costs of VA and DOD military facility services to medicare-eligible beneficiaries).

''(2) MINIMUM MONTHLY AMOUNT.—The minimum amount specified in this paragraph is the amount specified in subsection (c)(1)(B)(iv) for the year involved.''.

(c) PAYMENT OF PLANS BASED ON BID AMOUNTS.—

(1) IN GENERAL.—Section 1853(a)(1)(A) (42 U.S.C. 1395w–23) is amended by striking ''in an amount'' and all that follows and inserting the following: ''in an amount determined as follows:

''(i) PAYMENT BEFORE 2005.—For years before 2005, the payment amount shall be equal to 1/12 of the annual Medicare+Choice capitation rate (as calculated under subsection (c)) with respect to that individual for that area, reduced by the amount of any reduction elected under section 1854(f)(1)(E) and adjusted under clause (iii).

''(ii) PAYMENT FOR STATUTORY NON-DRUG BENEFITS BEGINNING WITH 2005.—For years beginning with 2005—

''(I) PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C), the payment under this subsection is equal to the unadjusted non-drug monthly bid amount, adjusted under clause (iii), plus the amount of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year.

''(II) PLANS WITH BIDS AT OR ABOVE BENCHMARK.—In the case of a plan for which there are no average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the fee-for-service area-specific non-drug benchmark amount, adjusted under clause (iii).

''(iii) DEMOGRAPHIC ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—The Administrator shall adjust the payment amount under clause (i), the unadjusted non-drug monthly bid amount under clause (ii)(I), and the fee-for-service area-specific non-drug benchmark amount under clause (ii)(II) for such risk factors as age, disability status, gender, institutional status, and such

other factors as the Administrator determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Administrator may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

''(iv) REFERENCE TO SUBSIDY PAYMENT FOR STATUTORY DRUG BENEFITS.—In the case in which an enrollee is enrolled under part D, the Medicare+Choice organization also is entitled to a subsidy payment amount under section 1860H.''.

(d) CONFORMING AMENDMENTS.—

(1) PROTECTION AGAINST BENEFICIARY SELECTION.—Section 1852(b)(1)(A) (42 U.S.C. 1395w–22(b)(1)(A)) is amended by adding at the end the following: ''The Administrator shall not approve a plan of an organization if the Administrator determines that the benefits are designed to substantially discourage enrollment by certain Medicare+Choice eligible individuals with the organization.''.

(2) CONFORMING AMENDMENT TO PREMIUM TERMINOLOGY.—Subparagraphs (A) and (B) of section 1854(b)(2) (42 U.S.C. 1395w–24(b)(2)) are amended to read as follows:

''(A) MEDICARE+CHOICE MONTHLY BASIC BENEFICIARY PREMIUM.—The term 'Medicare+Choice monthly basic beneficiary premium' means, with respect to a Medicare+Choice plan—

''(i) described in section 1853(a)(1)(A)(ii)(I) (relating to plans providing rebates), zero; or

''(ii) described in section 1853(a)(1)(A)(ii)(II), the amount (if any) by which the unadjusted non-drug monthly bid amount exceeds the fee-for-service area-specific non-drug benchmark amount.

''(B) MEDICARE+CHOICE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term 'Medicare+Choice monthly supplemental beneficiary premium' means, with respect to a Medicare+Choice plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under such section to the provision of nonstatutory benefits.''.

(3) REQUIREMENT FOR UNIFORM BID AMOUNTS.—Section 1854(c) (42 U.S.C. 1395w–24(c)) is amended to read as follows:

''(c) UNIFORM BID AMOUNTS.—The Medicare+Choice monthly bid amount submitted under subsection (a)(6) of a Medicare+Choice organization under this part may not vary among individuals enrolled in the plan.''.

(4) PERMITTING BENEFICIARY REBATES.—

(A) Section 1851(h)(4)(A) (42 U.S.C. 1395w–21(h)(4)(A)) is amended by inserting ''except as provided under section 1854(b)(1)(C)'' after ''or otherwise''.

(B) Section 1854(d) (42 U.S.C. 1395w–24(d)) is amended by inserting '', except as provided under subsection (b)(1)(C),'' after ''and may not provide''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to payments and premiums for months beginning with January 2005.

SEC. 212. DEMONSTRATION PROGRAM FOR COMPETITIVE-DEMONSTRATION AREAS.

(a) IDENTIFICATION OF COMPETITIVE-DEMONSTRATION AREAS FOR DEMONSTRATION PROGRAM; COMPUTATION OF CHOICE NON-DRUG BENCHMARKS.—Section 1853, as amended by section 211(b)(2), is amended by adding at the end the following new subsection:

''(k) ESTABLISHMENT OF COMPETITIVE DEMONSTRATION PROGRAM.—

''(1) DESIGNATION OF COMPETITIVE-DEMONSTRATION AREAS AS PART OF PROGRAM.—

''(A) IN GENERAL.—For purposes of this part, the Administrator shall establish a demonstration program under which the Administrator designates Medicare+Choice areas as competitive-demonstration areas consistent with the following limitations:

''(i) LIMITATION ON NUMBER OF AREAS THAT MAY BE DESIGNATED.—The Administrator may not designate more than 4 areas as competitive-demonstration areas.

''(ii) LIMITATION ON PERIOD OF DESIGNATION OF ANY AREA.—The Administrator may not designate any area as a competitive-demonstration area for a period of more than 2 years.

The Administrator has the discretion to decide whether or not to designate as a competitive-demonstration area an area that qualifies for such designation.

''(B) QUALIFICATIONS FOR DESIGNATION.—For purposes of this title, a Medicare+Choice area (which is a metropolitan statistical area or other area with a substantial number of Medicare+Choice enrollees) may not be designated as a 'competitive-demonstration area' for a 2-year period beginning with a year unless the Administrator determines, by such date before the beginning of the year as the Administrator determines appropriate, that—

''(i) there will be offered during the open enrollment period under this part before the beginning of the year at least 2 Medicare+Choice plans (in addition to the fee-for-service program under parts A and B), each offered by a different Medicare+Choice organization; and

''(ii) during March of the previous year at least 50 percent of the number of Medicare+Choice eligible individuals who reside in the area were enrolled in a Medicare+Choice plan.

''(2) CHOICE NON-DRUG BENCHMARK AMOUNT.—For purposes of this part, the term 'choice non-drug benchmark amount' means, with respect to a Medicare+Choice payment area for a month in a year, the sum of the 2 components described in paragraph (3) for the area and year. The Administrator shall compute such benchmark amount for each competitive-demonstration area before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2005) in which it is designated as such an area.

''(3) 2 COMPONENTS.—For purposes of paragraph (2), the 2 components described in this paragraph for an area and a year are the following:

''(A) FEE-FOR-SERVICE COMPONENT WEIGHTED BY NATIONAL FEE-FOR-SERVICE MARKET SHARE.—The product of the following:

''(i) NATIONAL FEE-FOR-SERVICE MARKET SHARE.—The national fee-for-service market share percentage (determined under paragraph (5)) for the year.

''(ii) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG BID.—The fee-for-service area-specific non-drug bid (as defined in paragraph (6)) for the area and year.

''(B) M+C COMPONENT WEIGHTED BY NATIONAL MEDICARE+CHOICE MARKET SHARE.—The product of the following:

''(i) NATIONAL MEDICARE+CHOICE MARKET SHARE.—1 minus the national fee-for-service market share percentage for the year.

''(ii) WEIGHTED AVERAGE OF PLAN BIDS IN AREA.—The weighted average of the plan bids for the area and year (as determined under paragraph (4)(A)).

''(4) DETERMINATION OF WEIGHTED AVERAGE BIDS FOR AN AREA.—

''(A) IN GENERAL.—For purposes of paragraph (3)(B)(ii), the weighted average of plan bids for an area and a year is the sum of the following products for Medicare+Choice plans described in subparagraph (C) in the area and year:

''(i) PROPORTION OF EACH PLAN'S ENROLLEES IN THE AREA.—The number of individuals described in subparagraph (B), divided by the total number of such individuals for all Medicare+Choice plans described in subparagraph (C) for that area and year.

''(ii) MONTHLY NON-DRUG BID AMOUNT.—The unadjusted non-drug monthly bid amount.

''(B) COUNTING OF INDIVIDUALS.—The Administrator shall count, for each Medicare+Choice plan described in subparagraph (C) for an area and year, the number of individuals who reside in the area and who were enrolled under such plan under this part during March of the previous year.

''(C) EXCLUSION OF PLANS NOT OFFERED IN PREVIOUS YEAR.—For an area and year, the Medicare+Choice plans described in this subparagraph are plans that are offered in the area and year and were offered in the area in March of the previous year.

''(5) COMPUTATION OF NATIONAL FEE-FOR-SERVICE MARKET SHARE PERCENTAGE.—The Administrator shall determine, for a year, the proportion (in this subsection referred to as the 'national fee-for-service market share percentage') of Medicare+Choice eligible individuals who during March of the previous year were not enrolled in a Medicare+Choice plan.

''(6) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG BID.—For purposes of this part, the term 'fee-for-service area-specific non-drug bid' means, for an area and year, the amount described in section 1853(j)(1) for the area and year, except that any reference to a percent of less than 100 percent shall be deemed a reference to 100 percent.''.

(b) APPLICATION OF CHOICE NON-DRUG BENCHMARK IN COMPETITIVE-DEMONSTRATION AREAS.—

(1) IN GENERAL.—Section 1854 is amended—

(A) in subsection (b)(1)(C)(i), as added by section 211(b)(1)(A), by striking ''(i) REQUIREMENT.—The'' and inserting ''(i) REQUIREMENT FOR NON-COMPETITIVE-DEMONSTRATION AREAS.—In the case of a Medicare+Choice payment area that is not a competitive-demonstration area designated under section 1853(k)(1), the'';

(B) in subsection (b)(1)(C), as so added, by inserting after clause (i) the following new clause:

''(ii) REQUIREMENT FOR COMPETITIVE-DEMONSTRATION AREAS.—In the case of a Medicare+Choice payment area that is designated as a competitive-demonstration area under section 1853(k)(1), if there are average per capita monthly savings described in paragraph (4) for a Medicare+Choice plan and year, the Medicare+Choice plan shall provide to the enrollee a monthly rebate equal to 75 percent of such savings.'';

(C) by adding at the end of subsection (b), as amended by section 211(b)(1), the following new paragraph:

''(4) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS FOR COMPETITIVE-DEMONSTRATION AREAS.—For purposes of paragraph (1)(C)(ii), the average per capita monthly savings referred to in such paragraph for a Medicare+Choice plan and year shall be computed in the same manner as the average per capita monthly savings is computed under paragraph (3) except that the reference to the fee-for-service area-specific non-drug benchmark amount in paragraph (3)(B)(i) (or to the benchmark amount as adjusted under paragraph (3)(C)(i)) is deemed to be a reference to the choice non-drug benchmark amount (or such amount as adjusted in the manner described in paragraph (3)(B)(i)).''; and

(D) in subsection (d), as amended by section 211(d)(4), by inserting ''and subsection (b)(1)(D)'' after ''subsection (b)(1)(C)''.

(2) CONFORMING AMENDMENTS.—

(A) PAYMENT OF PLANS.—Section 1853(a)(1)(A)(ii), as amended by section 211(c)(1), is amended—

(i) in subclause (I), by inserting ''(or, in the case of a competitive-demonstration area, the choice non-drug benchmark amount)'' after ''unadjusted non-drug monthly bid amount''; and

(ii) in subclauses (I) and (II), by inserting ''(or, in the case of a competitive-demonstration area, described in section 1854(b)(4))'' after ''section 1854(b)(3)(C)''.

(B) DEFINITION OF MONTHLY BASIC PREMIUM.—Section 1854(b)(2)(A)(ii), as amended by section 211(d)(2), is amended by inserting ''(or, in the case of a competitive-demonstration area, the choice non-drug benchmark amount)'' after ''benchmark amount''.

(c) PREMIUM ADJUSTMENT.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

''(h)(1) In the case of an individual who resides in a competitive-demonstration area designated under section 1851(k)(1) and who is not enrolled in a Medicare+Choice plan under part C, the monthly premium otherwise applied under this part (determined without regard to subsections (b) and (f) or any adjustment under this subsection) shall be adjusted as follows: If the fee-for-service area-specific non-drug bid (as defined in section 1853(k)(6)) for the Medicare+Choice area in which the individual resides for a month—

''(A) does not exceed the choice non-drug benchmark (as determined under section 1853(k)(2)) for such area, the amount of the premium for the individual for the month shall be reduced by an amount equal to 75 percent of the amount by which such benchmark exceeds such fee-for-service bid; or

''(B) exceeds such choice non-drug benchmark, the amount of the premium for the individual for the month shall be adjusted to ensure that—

''(i) the sum of the amount of the adjusted premium and the choice non-drug benchmark for the area, is equal to

''(ii) the sum of the unadjusted premium plus amount of the fee-for-service area-specific non-drug bid for the area.

''(2) Nothing in this subsection shall be construed as preventing a reduction under paragraph (1)(A) in the premium otherwise applicable under this part to zero or from requiring the provision of a rebate to the extent such premium would otherwise be required to be less than zero.

''(3) The adjustment in the premium under this subsection shall be effected in such manner as the Medicare Benefits Administrator determines appropriate.

''(4) In order to carry out this subsection (insofar as it is effected through the manner of collection of premiums under 1840(a)), the Medicare Benefits Administrator shall transmit to the Commissioner of Social Security—

''(A) at the beginning of each year, the name, social security account number, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year; and

''(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.''.

(d) CONFORMING AMENDMENT.—Section 1844(c) (42 U.S.C. 1395w(c)) is amended by inserting ''and without regard to any premium adjustment effected under section 1839(h)'' before the period at the end.

(e) REPORT ON DEMONSTRATION PROGRAM.—Not later than 6 months after the date on which the designation of the 4th competitive-demonstration area under section 1851(k)(1) of the Social Security Act ends, the Medicare Payment Advisory Commission shall submit to Congress a report on the impact of the demonstration program under the amendments made by this section, including such impact on premiums of medicare beneficiaries, savings to the medicare program, and on adverse selection.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to payments and premiums for periods beginning on or after January 1, 2005.

SEC. 213. CONFORMING AMENDMENTS.

(a) CONFORMING AMENDMENTS RELATING TO BIDS.—

(1) Section 1854 (42 U.S.C. 1395w–24) is amended—

(A) in the heading of subsection (a), by inserting ''AND BID AMOUNTS'' after ''PREMIUMS''; and

(B) in subsection (a)(5)(A), by inserting ''paragraphs (2), (3), and (4) of'' after ''filed under''.

(b) ADDITIONAL CONFORMING AMENDMENTS.—

(1) ANNUAL DETERMINATION AND ANNOUNCEMENT OF CERTAIN FACTORS.—Section 1853(b) (42 U.S.C. 1395w–23(b)) is amended—

(A) in paragraph (1), by striking ''the respective calendar year'' and all that follows and inserting the following: ''the calendar year concerned with respect to each Medicare+Choice payment area, the following:

''(A) PRE-COMPETITION INFORMATION.—For years before 2005, the following:

''(i) MEDICARE+CHOICE CAPITATION RATES.—The annual Medicare+Choice capitation rate for each Medicare+Choice payment area for the year.

''(ii) ADJUSTMENT FACTORS.—The risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

''(B) COMPETITION INFORMATION.—For years beginning with 2005, the following:

''(i) BENCHMARKS.—The fee-for-service area-specific non-drug benchmark under section 1853(j) and, if applicable, the choice non-drug benchmark under section 1853(k)(2), for the year involved and, if applicable, the national fee-for-service market share percentage.

''(ii) ADJUSTMENT FACTORS.—The adjustment factors applied under section 1853(a)(1)(A)(iii) (relating to demographic adjustment), section 1853(a)(1)(B) (relating to adjustment for end-stage renal disease), and section 1853(a)(3) (relating to health status adjustment).

''(iii) PROJECTED FEE-FOR-SERVICE BID.—In the case of a competitive area, the projected fee-for-service area-specific non-drug bid (as determined under subsection (k)(6)) for the area.

''(iv) INDIVIDUALS.—The number of individuals counted under subsection (k)(4)(B) and enrolled in each Medicare+Choice plan in the area.''; and

(B) in paragraph (3), by striking ''in sufficient detail'' and all that follows up to the period at the end.

(2) REPEAL OF PROVISIONS RELATING TO ADJUSTED COMMUNITY RATE (ACR).—

(A) IN GENERAL.—Subsections (e) and (f) of section 1854 (42 U.S.C. 1395w–24) are repealed.

(B) CONFORMING AMENDMENT.—Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking '', and to reflect'' and all that follows and inserting a period.

(3) PROSPECTIVE IMPLEMENTATION OF NATIONAL COVERAGE DETERMINATIONS.—Section 1852(a)(5) (42 U.S.C. 1395w–22(a)(5)) is amended to read as follows:

''(5) PROSPECTIVE IMPLEMENTATION OF NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall only implement a national coverage determination that will result in a significant change in the costs to a Medicare+Choice organization in a prospective manner that applies to announcements made under section 1853(b) after the date of the implementation of the determination.''.

(4) PERMITTING GEOGRAPHIC ADJUSTMENT TO CONSOLIDATE MULTIPLE MEDICARE+CHOICE PAYMENT AREAS IN A STATE INTO A SINGLE STATEWIDE MEDICARE+CHOICE PAYMENT AREA.—Section 1853(d)(3) (42 U.S.C. 1395w–23(e)(3)) is amended—

(A) by amending clause (i) of subparagraph (A) to read as follows:

''(i) to a single statewide Medicare+Choice payment area,''; and

(B) by amending subparagraph (B) to read as follows:

''(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Medicare Benefits Administrator shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for Medicare+Choice payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for Medicare+Choice payment areas in the State in the absence of the adjustment under this paragraph.''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to payments and premiums for periods beginning on or after January 1, 2005.

TITLE III—RURAL HEALTH CARE IMPROVEMENTS

SEC. 301. REFERENCE TO FULL MARKET BASKET INCREASE FOR SOLE COMMUNITY HOSPITALS.

For provision eliminating any reduction from full market basket in the update for inpatient hospital services for sole community hospitals, see section 401.

SEC. 302. ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

(a) BLENDING OF PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by adding at the end the following new clause:

''(xiv)(I) In the case of discharges in a fiscal year beginning on or after October 1, 2002, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the old blend proportion (specified under subclause (III)) of the disproportionate share adjustment percentage otherwise determined under the respective clause and 100 percent minus such old blend proportion of the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

''(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 10 percent for a hospital that is not classified as a rural referral center under subparagraph (C).

''(III) For purposes of subclause (I), the old blend proportion for fiscal year 2003 is 80 percent, for each subsequent year (through 2006) is the old blend proportion under this subclause for the previous year minus 20 percentage points, and for each year beginning with 2007 is 0 percent.''.

(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in each of subclauses (II), (III), (IV), (V), and (VI) of clause (iv), by inserting ''subject to clause (xiv) and'' before ''for discharges occurring'';

(B) in clause (viii), by striking ''The formula'' and inserting ''Subject to clause (xiv), the formula''; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking ''For purposes'' and inserting ''Subject to clause (xiv), for purposes''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to discharges occurring on or after October 1, 2002.

SEC. 303. 2-YEAR PHASED-IN INCREASE IN THE STANDARDIZED AMOUNT IN RURAL AND SMALL URBAN AREAS TO ACHIEVE A SINGLE, UNIFORM STANDARDIZED AMOUNT.

Section 1886(d)(3)(A)(iv) (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking ''(iv) For discharges'' and inserting ''(iv)(I) Subject to the succeeding provisions of this clause, for discharges''; and

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

''(II) For discharges occurring during fiscal year 2003, the average standardized amount for hospitals located other than in a large urban area shall be increased by ½ of the difference between the average standardized amount determined under subclause (I) for hospitals located in large urban areas for such fiscal year and such amount determined (without regard to this subclause) for other hospitals for such fiscal year.

''(III) For discharges occurring in a fiscal year beginning with fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in any area within the United States and within each region equal to the average standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for hospitals located in any area) increased by the applicable percentage increase under subsection (b)(3)(B)(i).''.

SEC. 304. 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 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, 2003, 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. 305. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) REINSTATEMENT OF PERIODIC INTERIM PAYMENT (PIP).—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

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

(2) by adding ''and'' at the end of subparagraph (D); and

(3) by inserting after subparagraph (D) the following new subparagraph:

''(E) inpatient critical access hospital services;''.

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

(c) FLEXIBILITY IN BED LIMITATION FOR HOSPITALS.—Section 1820 (42 U.S.C. 1395i–4) is amended—

(1) in subsection (c)(2)(B)(iii), by inserting ''subject to paragraph (3)'' after ''(iii) provides'';

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

''(3) INCREASE IN MAXIMUM NUMBER OF BEDS FOR HOSPITALS WITH STRONG SEASONAL CENSUS FLUCTUATIONS.—

''(A) IN GENERAL.—Subject to subparagraph (C), in the case of a hospital that demonstrates that it meets the standards established under subparagraph (B) and has not made the election described in subsection (f)(2)(A), the bed limitations otherwise applicable under paragraph (2)(B)(iii) and subsection (f) shall be increased by 5 beds.

''(B) STANDARDS.—The Secretary shall specify standards for determining whether a critical access hospital has sufficiently strong seasonal variations in patient admissions to justify the increase in bed limitation provided under subparagraph (A).''; and

(3) in subsection (f)—

(A) by inserting ''(1)'' after ''(f)''; and

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

''(2)(A) A hospital may elect to treat the reference in paragraph (1) to '15 beds' as a reference to '25 beds', but only if no more than 10 beds in the hospital are at any time used for non-acute care services. A hospital that makes such an election is not eligible for the increase provided under subsection (c)(3)(A).

''(B) The limitations in numbers of beds under the first sentence of paragraph (1) are subject to adjustment under subsection (c)(3).''.

(d) 5-YEAR EXTENSION OF THE AUTHORIZATION FOR APPROPRIATIONS FOR GRANT PROGRAM.—Section 1820(j) (42 U.S.C. 1395i–4(j)) is amended by striking ''through 2002'' and inserting ''through 2007''.

(e) PROHIBITION OF RETROACTIVE RECOUPMENT.—The Secretary shall not recoup (or otherwise seek to recover) overpayments made for outpatient critical access hospital services under part B of title XVIII of the Social Security Act, for services furnished in cost reporting periods that began before October 1, 2002, insofar as such overpayments are attributable to payment being based on 80 percent of reasonable costs (instead of 100 percent of reasonable costs minus 20 percent of charges).

(f) EFFECTIVE DATES.—

(1) REINSTATEMENT OF PIP.—The amendments made by subsection (a) shall apply to payments made on or after January 1, 2003.

(2) PHYSICIAN PAYMENT ADJUSTMENT CONDITION.—The amendment made by subsection (b) 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).

(3) FLEXIBILITY IN BED LIMITATION.—The amendments made by subsection (c) shall apply to designations made on or after January 1, 2003, but shall not apply to critical access hospitals that were designated as of such date.

SEC. 306. EXTENSION OF TEMPORARY INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—Section 508(a) BIPA (114 Stat. 2763A–533) is amended—

(1) by striking ''24-MONTH INCREASE BEGINNING APRIL 1, 2001'' and inserting ''IN GENERAL''; and

(2) by striking ''April 1, 2003'' and inserting ''January 1, 2005''.

(b) CONFORMING AMENDMENT.—Section 547(c)(2) of BIPA (114 Stat. 2763A–553) is amended by striking ''the period beginning on April 1, 2001, and ending on September 30, 2002,'' and inserting ''a period under such section''.

SEC. 307. REFERENCE TO 10 PERCENT INCREASE IN PAYMENT FOR HOSPICE CARE FURNISHED IN A FRONTIER AREA AND RURAL HOSPICE DEMONSTRATION PROJECT.

For—

(1) provision of 10 percent increase in payment for hospice care furnished in a frontier area, see section 422; and

(2) provision of a rural hospice demonstration project, see section 423.

SEC. 308. REFERENCE TO PRIORITY FOR HOSPITALS LOCATED IN RURAL OR SMALL URBAN AREAS IN REDISTRIBUTION OF UNUSED GRADUATE MEDICAL EDUCATION RESIDENCIES.

For provision providing priority for hospitals located in rural or small urban areas in redistribution of unused graduate medical education residencies, see section 612.

SEC. 309. 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. 310. 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(1)(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. 311. RELIEF FOR CERTAIN NON-TEACHING HOSPITALS.

(a) IN GENERAL.—In the case of a non-teaching hospital that meets the condition of subsection (b), in each of fiscal years 2003, 2004, and 2005 the amount of payment made to the hospital under section 1886(d) of the Social Security Act for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during such fiscal year under section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)) had been increased by 5 percentage points. The previous sentence shall be applied for each such fiscal year separately without regard to its application in a previous fiscal year and shall not affect payment for discharges for any hospital occurring during a fiscal year after fiscal year 2005.

(b) CONDITION.—A non-teaching hospital meets the condition of this subsection if—

(1) it is located in a rural area and the amount of the aggregate payments under subsection (d) of section 1886 of the Social Security Act for hospitals located in rural areas in the State for their cost reporting periods beginning during fiscal year 1999 is less than the aggregate allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of such section) for all subsection (d) hospitals in such areas in such State with respect to such cost reporting periods; or

(2) it is located in an urban area and the amount of the aggregate payments under subsection (d) of such section for hospitals located in urban areas in the State for their cost reporting periods beginning during fiscal year 1999 is less than 103 percent of the aggregate allowable operating costs of inpatient hospital services (as defined in subsection (a)(4) of such section) for all subsection (d) hospitals in such areas in such State with respect to such cost reporting periods.

The amounts under paragraphs (1) and (2) shall be determined by the Secretary of Health and Human Services based on data of the Medicare Payment Advisory Commission.

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

(1) NON-TEACHING HOSPITAL.—The term ''non-teaching hospital'' means, for a cost reporting period, a subsection (d) hospital (as defined in subsection (d)(1)(B) of section 1886 of the Social Security Act, 42 U.S.C. 1395ww)) that is not receiving any additional payment under subsection (d)(5)(B) of such section or a payment under subsection (h) of such section for discharges occurring during the period. A subsection (d) hospital that receives additional payments under subsection (d)(5)(B) or (h) of such section shall, for purposes of this section, also be treated as a non-teaching hospital unless a chairman of a department in the medical school with which the hospital is affiliated is serving or has been appointed as a clinical chief of service in the hospital.

(2) RURAL; URBAN.—The terms ''rural'' and ''urban'' have the meanings given such terms for purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

TITLE IV—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

SEC. 401. REVISION OF ACUTE CARE HOSPITAL PAYMENT UPDATES.

Subclause (XVIII) of section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended to read as follows:

''(XVIII) for fiscal year 2003, the market basket percentage increase for sole community hospitals and such increase minus 0.25 percentage points for other hospitals, and''.

SEC. 402. 2-YEAR INCREASE IN LEVEL OF ADJUSTMENT FOR INDIRECT COSTS OF MEDICAL EDUCATION (IME).

Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI) by striking ''and'' at the end;

(2) by redesignating subclause (VII) as subclause (IX);

(3) in subclause (IX) as so redesignated, by striking ''2002'' and inserting ''2004''; and

(4) by inserting after subclause (VI) the following new subclause:

''(VII) during fiscal year 2003, 'c' is equal to 1.47;

''(VIII) during fiscal year 2004, 'c' is equal to 1.45; and''.

SEC. 403. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PPS.

(a) IMPROVING TIMELINESS OF DATA COLLECTION.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended by adding at the end the following new clause:

''(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.''.

(b) ELIGIBILITY STANDARD.—

(1) MINIMUM PERIOD FOR RECOGNITION OF NEW TECHNOLOGIES.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)) is amended—

(A) by inserting ''(I)'' after ''(vi)''; and

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

''(II) Under such criteria, a service or technology shall not be denied treatment as a new service or technology on the basis of the period of time in which the service or technology has been in use if such period ends before the end of the 2-to-3-year period that begins on the effective date of implementation of a code under ICD–9–CM (or a successor coding methodology) that enables the identification of a significant sample of specific discharges in which the service or technology has been used.''.

(2) ADJUSTMENT OF THRESHOLD.—Section 1886(d)(5)(K)(ii)(I) (42 U.S.C. 1395ww(d)(5)(K)(ii)(I)) is amended by inserting ''(applying a threshold specified by the Secretary that is the lesser of 50 percent of the national average standardized amount for operating costs of inpatient hospital services for all hospitals and all diagnosis-related groups or one standard deviation for the diagnosis-related group involved)'' after ''is inadequate''.

(3) CRITERION FOR SUBSTANTIAL IMPROVEMENT.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)), as amended by paragraph (1), is further amended by adding at the end the following subclause:

''(III) The Secretary shall by regulation provide for further clarification of the criteria applied to determine whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries. Under such criteria, in determining whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries, the Secretary shall deem a service or technology as meeting such requirement if the service or technology is a drug or biological that is designated under section 506 or 526 of the Federal Food, Drug, and Cosmetic Act, approved under section 314.510 or 601.41 of title 21, Code of Federal Regulations, or designated for priority review when the marketing application for such drug or biological was filed or is a medical device for which an exemption has been granted under section 520(m) of such Act, or for which priority review has been provided under section 515(d)(5) of such Act.''.

(4) PROCESS FOR PUBLIC INPUT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended by paragraph (1), is amended—

(A) in clause (i), by adding at the end the following: ''Such mechanism shall be modified to meet the requirements of clause (viii).''; and

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

''(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology not described in the second sentence of clause (vi)(III) represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries as follows:

''(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

''(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

''(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, medicare beneficiaries, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.''.

(c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is further amended by adding at the end the following new clause:

''(ix) Before establishing any add-on payment under this subparagraph with respect

to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. In such case, no add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).''.

(d) IMPROVEMENT IN PAYMENT FOR NEW TECHNOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after ''the estimated average cost of such service or technology'' the following: ''(based on the marginal rate applied to costs under subparagraph (A))''.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The Secretary shall implement the amendments made by this section so that they apply to classification for fiscal years beginning with fiscal year 2004.

(2) RECONSIDERATIONS OF APPLICATIONS FOR FISCAL YEAR 2003 THAT ARE DENIED.—In the case of an application for a classification of a medical service or technology as a new medical service or technology under section 1886(d)(5)(K) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was filed for fiscal year 2003 and that is denied—

(A) the Secretary shall automatically reconsider the application as an application for fiscal year 2004 under the amendments made by this section; and

(B) the maximum time period otherwise permitted for such classification of the service or technology shall be extended by 12 months.

SEC. 404. PHASE-IN OF FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)'' and inserting ''the applicable Puerto Rico percentage (specified in subparagraph (E))''; and

(B) in clause (ii), by striking ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)'' and inserting ''the applicable Federal percentage (specified in subparagraph (E))''; and

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

''(E) For purposes of subparagraph (A), for discharges occurring—

''(i) between October 1, 1987, and September 30, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

''(ii) on or after October 1, 1997, and before October 1, 2003, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

''(iii) during fiscal year 2004, the applicable Puerto Rico percentage is 45 percent and the applicable Federal percentage is 55 percent;

''(iv) during fiscal year 2005, the applicable Puerto Rico percentage is 40 percent and the applicable Federal percentage is 60 percent;

''(v) during fiscal year 2006, the applicable Puerto Rico percentage is 35 percent and the applicable Federal percentage is 65 percent;

''(vi) during fiscal year 2007, the applicable Puerto Rico percentage is 30 percent and the applicable Federal percentage is 70 percent; and

''(vii) on or after October 1, 2007, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.''.

SEC. 405. REFERENCE TO PROVISION RELATING TO ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

For provision enhancing disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds, see section 302.

SEC. 406. REFERENCE TO PROVISION RELATING TO 2-YEAR PHASED-IN INCREASE IN THE STANDARDIZED AMOUNT IN RURAL AND SMALL URBAN AREAS TO ACHIEVE A SINGLE, UNIFORM STANDARDIZED AMOUNT.

For provision phasing in over a 2-year period an increase in the standardized amount for rural and small urban areas to achieve a single, uniform, standardized amount, see section 303.

SEC. 407. REFERENCE TO PROVISION FOR MORE FREQUENT UPDATES IN THE WEIGHTS USED IN HOSPITAL MARKET BASKET.

For provision providing for more frequent updates in the weights used in hospital market basket, see section 304.

SEC. 408. REFERENCE TO PROVISION MAKING IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

For provision providing making improvements to critical access hospital program, see section 305.

SEC. 409. GAO STUDY ON IMPROVING THE HOSPITAL WAGE INDEX.

(a) STUDY.—

(1) IN GENERAL.—The Comptroller General of the United States shall conduct a study on the improvements that can be made in the measurement of regional differences in hospital wages reflected in the hospital wage index under section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

(2) EXAMINATION OF USE OF METROPOLITAN STATISTICAL AREAS (MSAS).—The study shall specifically examine the use of metropolitan statistical areas for purposes of computing and applying the wage index and whether the boundaries of such areas accurately reflect local labor markets. In addition, the study shall examine whether regional inequities are created as a result of infrequent updates of such boundaries and policies of the Bureau of the Census relating to commuting criteria.

(3) WAGE DATA.—The study shall specifically examine the portions of the hospital cost reports relating to wages, and methods for improving the accuracy of the wage data and for reducing inequities resulting from differences among hospitals in the reporting of wage data.

(b) CONSULTATION WITH OMB.—The Comptroller General shall consult with the Director of Office of Management and Budget in conducting the study under subsection (a)(2).

(c) REPORT.—Not later than May 1, 2003, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a) and shall include in the report such recommendations as may be appropriate on—

(1) changes in the definition of labor market areas used for purposes of the area wage index under section 1886 of the Social Security Act; and

(2) improvements in methods for the collection of wage data.

Subtitle B—Skilled Nursing Facility Services

SEC. 411. PAYMENT FOR COVERED SKILLED NURSING FACILITY SERVICES.

(a) TEMPORARY INCREASE IN NURSING COMPONENT OF PPS FEDERAL RATE.—Section 312(a) of BIPA is amended by adding at the end the following new sentence: ''The Secretary of Health and Human Services shall increase by 12, 10, and 8 percent the nursing component of the case-mix adjusted Federal prospective payment rate specified in Tables 3 and 4 of the final rule published in the Federal Register by the Health Care Financing Administration on July 31, 2000 (65 Fed. Reg. 46770) and as subsequently updated under section 1888(e)(4)(E)(ii) of the Social Security Act (42 U.S.C. 1395yy(e)(4)(E)(ii)), effective for services furnished during fiscal years 2003, 2004, and 2005, respectively.''.

(b) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—

(1) IN GENERAL.—Paragraph (12) of section 1888(e) (42 U.S.C. 1395yy(e)) is amended to read as follows:

''(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

''(A) IN GENERAL.—Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable shall be increased by 128 percent to reflect increased costs associated with such residents.

''(B) SUNSET.—Subparagraph (A) shall not apply on and after such date as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 2003.

Subtitle C—Hospice

SEC. 421. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking ''and'' at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting ''; and''; and

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

''(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician who is either the medical director or an employee of a hospice program and that consist of—

''(A) an evaluation of the individual's need for pain and symptom management;

''(B) counseling the individual with respect to end-of-life issues and care options; and

''(C) advising the individual regarding advanced care planning.''.

(b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this part shall be equal to an amount equivalent to the amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity under the fee schedule established under section 1848(b), other than the portion of such amount attributable to the practice expense component.''.

(c) CONFORMING AMENDMENT.—Section 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended by inserting before the comma at the end the following: ''and services described in section 1812(a)(5)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2004.

SEC. 422. 10 PERCENT INCREASE IN PAYMENT FOR HOSPICE CARE FURNISHED IN A FRONTIER AREA.

(a) IN GENERAL.—Section 1814(i)(1) (42 U.S.C. 1395f(i)(1)) is amended by adding at the end the following new subparagraph:

''(D) With respect to hospice care furnished in a frontier area on or after January 1, 2003, and before January 1, 2008, the payment rates otherwise established for such care shall be increased by 10 percent. For purposes of this subparagraph, the term 'frontier area' means a county in which the population density is less than 7 persons per square mile.''.

(b) REPORT ON COSTS.—Not later than January 1, 2007, the Comptroller General of the United States shall submit to Congress a report on the costs of furnishing hospice care in frontier areas. Such report shall include recommendations regarding the appropriateness of extending, and modifying, the payment increase provided under the amendment made by subsection (a).

SEC. 423. RURAL HOSPICE DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary shall conduct a demonstration project for the delivery of hospice care to medicare beneficiaries in rural areas. Under the project medicare beneficiaries who are unable to receive hospice care in the home for lack of an appropriate caregiver are provided such care in a facility of 20 or fewer beds which offers, within its walls, the full range of services provided by hospice programs under section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)).

(b) SCOPE OF PROJECT.—The Secretary shall conduct the project under this section with respect to no more than 3 hospice programs over a period of not longer than 5 years each.

(c) COMPLIANCE WITH CONDITIONS.—Under the demonstration project—

(1) the hospice program shall comply with otherwise applicable requirements, except that it shall not be required to offer services outside of the home or to meet the requirements of section 1861(dd)(2)(A)(iii) of the Social Security Act; and

(2) payments for hospice care shall be made at the rates otherwise applicable to such care under title XVIII of such Act.

The Secretary may require the program to comply with such additional quality assurance standards for its provision of services in its facility as the Secretary deems appropriate.

(d) REPORT.—Upon completion of the project, the Secretary shall submit a report to Congress on the project and shall include in the report recommendations regarding extension of such project to hospice programs serving rural areas.

Subtitle D—Other Provisions

SEC. 431. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under this section (in this section referred to as the ''project'') to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying underpayments and overpayments and recouping overpayments under the medicare program for services for which payment is made under part A of title XVIII of the Social Security Act. Under the project—

(1) payment may be made to such a contractor on a contingent basis;

(2) a percentage of the amount recovered may be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) the Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION.—The project shall cover at least 2 States and at least 3 contractors and shall last for not longer than 3 years.

(c) WAIVER.—The Secretary of Health and Human Services shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS.—

(1) IN GENERAL.—The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has knowledge of and experience with the payment rules and regulations under the medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) INELIGIBILITY OF CERTAIN CONTRACTORS.—The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY WITH PRIVATE INSURERS.—In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those entities that the Secretary determines have demonstrated proficiency in recovery audits with private insurers or under the medicaid program under title XIX of such Act.

(e) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the medicare program and recommendations on the cost-effectiveness of extending or expanding the project.

TITLE V—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

SEC. 501. REVISION OF UPDATES FOR PHYSICIANS' SERVICES.

(a) UPDATE FOR 2003 THROUGH 2005.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraphs:

''(5) UPDATE FOR 2003.—The update to the single conversion factor established in paragraph (1)(C) for 2003 is 2 percent.

''(6) SPECIAL RULES FOR UPDATE FOR 2004 AND 2005.—The following rules apply in determining the update adjustment factors under paragraph (4)(B) for 2004 and 2005:

''(A) USE OF 2002 DATA IN DETERMINING ALLOWABLE COSTS.—

''(i) The reference in clause (ii)(I) of such paragraph to April 1, 1996, is deemed to be a reference to January 1, 2002.

''(ii) The allowed expenditures for 2002 is deemed to be equal to the actual expenditures for physicians' services furnished during 2002, as estimated by the Secretary.

''(B) 1 PERCENTAGE POINT INCREASE IN GDP UNDER SGR.—The annual average percentage growth in real gross domestic product per capita under subsection (f)(2)(C) for each of 2003, 2004, and 2005 is deemed to be increased by 1 percentage point.''.

(2) CONFORMING AMENDMENT.—Paragraph (4)(B) of such section is amended, in the matter before clause (i), by inserting ''and paragraph (6)'' after ''subparagraph (D)''.

(3) NOT TREATED AS CHANGE IN LAW AND REGULATION IN SUSTAINABLE GROWTH RATE DETERMINATION.—The amendments made by this subsection shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)).

(b) USE OF 10-YEAR ROLLING AVERAGE IN COMPUTING GROSS DOMESTIC PRODUCT.—

(1) IN GENERAL.—Section 1848(f)(2)(C) (42 U.S.C. 1395w–4(f)(2)(C)) is amended—

(A) by striking ''projected'' and inserting ''annual average''; and

(B) by striking ''from the previous applicable period to the applicable period involved'' and inserting ''during the 10-year period ending with the applicable period involved''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to computations of the sustainable growth rate for years beginning with 2002.

(c) ELIMINATION OF TRANSITIONAL ADJUSTMENT.—Section 1848(d)(4)(F) (42 U.S.C. 1395w–4(d)(4)(F)) is amended by striking ''subparagraph (A)'' and all that follows and inserting ''subparagraph (A), for each of 2001 and 2002, of −0.2 percent.''

(d) GAO STUDY OF MEDICARE PAYMENT FOR INHALATION THERAPY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to examine the adequacy of current reimbursements for inhalation therapy under the medicare program.

(2) REPORT.—Not later than May 1, 2003, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 502. STUDIES ON ACCESS TO PHYSICIANS' SERVICES.

(a) GAO STUDY ON BENEFICIARY ACCESS TO PHYSICIANS' SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on access of medicare beneficiaries to physicians' services under the medicare program. The study shall include—

(A) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the medicare program;

(B) an examination of changes in the use by beneficiaries of physicians' services over time;

(C) an examination of the extent to which physicians are not accepting new medicare beneficiaries as patients.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include a determination whether—

(A) data from claims submitted by physicians under part B of the medicare program indicate potential access problems for medicare beneficiaries in certain geographic areas; and

(B) access by medicare beneficiaries to physicians' services may have improved, remained constant, or deteriorated over time.

(b) STUDY AND REPORT ON SUPPLY OF PHYSICIANS.—

(1) STUDY.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on the adequacy of the supply of physicians (including specialists) in the United States and the factors that affect such supply.

(2) REPORT TO CONGRESS.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the results of the study described in paragraph (1), including any recommendations for legislation.

SEC. 503. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS' SERVICES.

Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the effect of refinements to the practice expense component of payments for physicians' services, after the transition to a full resource-based payment system in 2002, under section 1848 of the Social Security Act (42 U.S.C. 1395w–4). Such report shall examine the following matters by physician specialty:

(1) The effect of such refinements on payment for physicians' services.

(2) The interaction of the practice expense component with other components of and adjustments to payment for physicians' services under such section.

(3) The appropriateness of the amount of compensation by reason of such refinements.

(4) The effect of such refinements on access to care by medicare beneficiaries to physicians' services.

(5) The effect of such refinements on physician participation under the medicare program.

SEC. 504. 1-YEAR EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of BIPA is amended by striking ''2-year period'' and inserting ''3-year period''.

SEC. 505. PHYSICIAN FEE SCHEDULE WAGE INDEX REVISION.

(a) INDEX REVISION.—

(1) IN GENERAL.—Subject to paragraph (2), notwithstanding any other provision of law, for purposes of payment under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services furnished during 2004, in no case may the work geographic index otherwise calculated under subsection (e)(1)(A)(iii) of such section be less than 0.985.

(2) SECRETARIAL DISCRETION.—Paragraph (1) shall not take effect or be in force if the Secretary determines, taking into account the report of the Comptroller General under subsection (b)(2), that there is no sound economic rationale for the implementation of such paragraph.

(3) EXEMPTION FROM LIMITATION ON ANNUAL ADJUSTMENTS.—Any increase in expenditures attributable to paragraph (1) during 2004 shall not be taken into account in applying section 1848(c)(2)(B)(ii)(II) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(B)(ii)(II)) for that year.

(b) GAO REPORT.—

(1) EVALUATION.—As part of the study on geographic differences in payments for physicians' services conducted under section 309, the Comptroller General shall evaluate the following:

(A) Whether there is a sound economic basis for the implementation of the adjustment under subsection (a)(1) in those areas in which the adjustment applies.

(B) The effect of such adjustment on physician location and retention in areas affected by such adjustment, taking into account—

(i) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

(ii) the mobility of physicians, including specialists, over the last decade.

(C) The appropriateness of establishing a floor of 1.0 for the work geographic index.

(2) REPORT.—By not later than September 1, 2003, the Comptroller General shall submit to Congress and to the Secretary a report on the evaluation conducted under paragraph (1).

Subtitle B—Other Services

SEC. 511. COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES.

(a) IN GENERAL.—Section 1847 (42 U.S.C. 1395w–3) is amended to read as follows:

''COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES

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

''(1) IMPLEMENTATION OF PROGRAMS.—

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

''(B) PHASED-IN IMPLEMENTATION.—The programs shall be phased-in among competitive acquisition areas over a period of not longer than 3 years in a manner so that the competition under the programs occurs in—

''(i) at least ⅓ of such areas in 2004; and

''(ii) at least ⅔ of such areas in 2005.

''(C) WAIVER OF CERTAIN PROVISIONS.—In carrying out the programs, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

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

''(A) DURABLE MEDICAL EQUIPMENT AND INHALATION DRUGS USED IN CONNECTION WITH DURABLE MEDICAL EQUIPMENT.—Covered items (as defined in section 1834(a)(13)) for which payment is otherwise made under section 1834(a), other than items used in infusion, and inhalation drugs used in conjunction with durable medical equipment.

''(B) OFF-THE-SHELF ORTHOTICS.—Orthotics (described in section 1861(s)(9)) for which payment is otherwise made under section 1834(h) which require minimal self-adjustment for appropriate use and does not require expertise in trimming, bending, molding, assembling, or customizing to fit to the patient.

''(3) EXEMPTION AUTHORITY.—In carrying out the programs under this section, the Secretary may exempt—

''(A) areas that are not competitive due to low population density; and

''(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

''(b) PROGRAM REQUIREMENTS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among entities supplying items and services described in subsection (a)(2) for each competitive acquisition area in which the program is implemented under subsection (a) with respect to such items and services.

''(2) CONDITIONS FOR AWARDING CONTRACT.—

''(A) IN GENERAL.—The Secretary may not award a contract to any entity under the competition conducted in an competitive acquisition area pursuant to paragraph (1) to furnish such items or services unless the Secretary finds all of the following:

''(i) The entity meets quality and financial standards specified by the Secretary or developed by accreditation entities or organizations recognized by the Secretary.

''(ii) The total amounts to be paid under the contract (including costs associated with the administration of the contract) are expected to be less than the total amounts that would otherwise be paid.

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

''(iv) Beneficiary liability is limited to the applicable percentage of contract award price.

''(B) QUALITY STANDARDS.—The quality standards specified under subparagraph (A)(i) shall not be less than the quality standards that would otherwise apply if this section did not apply and shall include consumer services standards. The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of physicians, practitioners, and suppliers to review (and advise the Secretary concerning) such quality standards.

''(3) CONTENTS OF CONTRACT.—

''(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

''(B) TERM OF CONTRACTS.—The Secretary shall rebid contracts under this section not less often than once every 3 years.

''(4) LIMIT ON NUMBER OF CONTRACTORS.—

''(A) IN GENERAL.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In awarding contracts, the Secretary shall take into account the ability of bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of beneficiaries for such items or services in the geographic area covered under the contract on a timely basis.

''(B) MULTIPLE WINNERS.—The Secretary shall award contracts to more than one entity submitting a bid in each area for an item or service.

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

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

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

''(6) AUTHORITY TO CONTRACT FOR EDUCATION, OUTREACH AND COMPLAINT SERVICES.—The Secretary may enter into a contract with an appropriate entity to address complaints from beneficiaries who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to such beneficiaries with respect to the program.

''(c) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual management report on the programs under this section. Each such report shall include information on savings, reductions in cost-sharing, access to items and services, and beneficiary satisfaction.

''(d) DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

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

''(A) for which payment is otherwise made under section 1833(h) or 1834(d)(1) (relating to colorectal cancer screening tests); and

''(B) which are furnished without a face-to-face encounter between the individual and the hospital or physician ordering the tests.

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

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

''(A) an initial report on the project not later than December 31, 2004; and

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

(b) CONTINUATION OF CERTAIN DEMONSTRATION PROJECTS.—Notwithstanding the amendment made by subsection (a), with respect to demonstration projects implemented by the Secretary under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) (relating to the establishment of competitive acquisition areas) that was in effect on the day before the date of the enactment of this Act, each such demonstration project may continue under the same terms and conditions applicable under that section as in effect on that date.

(c) REPORT ON DIFFERENCES IN PAYMENT FOR LABORATORY SERVICES.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that analyzes differences in reimbursement between public and private payors for clinical diagnostic laboratory services.

SEC. 512. PAYMENT FOR AMBULANCE SERVICES.

(a) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended—

(1) in paragraph (2)(E), by inserting ''consistent with paragraph (10)'' after ''in an efficient and fair manner'';

(2) by redesignating the paragraph (8) added by section 221(a) of BIPA as paragraph (9); and

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

''(10) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of service furnished in a year before January 1, 2007, the portion of the payment amount that is based on the fee schedule shall not be less than the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

''(A) For 2003, the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

''(B) For 2004, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

''(C) For 2005, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

''(D) For 2006, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the 9 Census divisions using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.''.

(b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—Section 1834(l), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

''(11) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after January 1, 2003, and before January 1, 2008, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the payment per mile otherwise applicable to such miles.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to ambulance services furnished on or after January 1, 2003.

SEC. 513. 2-YEAR EXTENSION OF MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO REPORTS.

(a) 2-YEAR EXTENSION OF MORATORIUM ON THERAPY CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking ''and 2002'' and inserting ''2002, 2003, and 2004''.

(b) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES.—Not later than December 31, 2002, the Secretary shall submit to Congress the reports required under section 4541(d)(2) of the Balanced Budget Act of 1997 (relating to alternatives to a single annual dollar cap on outpatient therapy) and under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (relating to utilization patterns for outpatient therapy).

(c) IDENTIFICATION OF CONDITIONS AND DISEASES JUSTIFYING WAIVER OF THERAPY CAP.—

(1) STUDY.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to identify conditions or diseases that should justify conducting an assessment of the need to waive the therapy caps under section 1833(g)(4) of the Social Security Act (42 U.S.C. 1395l(g)(4)).

(2) REPORTS TO CONGRESS.—Not later than September 1, 2003, the Secretary shall submit to Congress a preliminary report on the conditions and diseases identified under paragraph (1) and not later than December 31, 2003, a final report on the conditions and diseases so identified.

(d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL THERAPIST SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on access to physical therapist services in States authorizing such services without a physician referral and in States that require such a physician referral. The study shall—

(A) examine the use of and referral patterns for physical therapist services for patients age 50 and older in States that authorize such services without a physician referral and in States that require such a physician referral;

(B) examine the use of and referral patterns for physical therapist services for patients who are medicare beneficiaries;

(C) examine the potential effect of prohibiting a physician from referring patients to physical therapy services owned by the physician and provided in the physician's office;

(D) examine the delivery of physical therapists' services within the facilities of Department of Defense; and

(E) analyze the potential impact on medicare beneficiaries and on expenditures under the medicare program of eliminating the need for a physician referral and physician certification for physical therapist services under the medicare program.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than 1 year after the date of the enactment of this Act.

SEC. 514. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V), by inserting ''and'' at the end; and

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

''(W) an initial preventive physical examination (as defined in subsection (ww));''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Initial Preventive Physical Examination

''(ww) The term 'initial preventive physical examination' means physicians' services consisting of a physical examination with the goal of health promotion and disease detection and includes items and services (excluding clinical laboratory tests), as determined by the Secretary, consistent with the recommendations of the United States Preventive Services Task Force.''.

(c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

(1) DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(6)'', and

(B) by inserting before the period at the end the following: '', and (7) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1861(ww))''.

(2) COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) in clause (N), by inserting ''(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))'' after ''80 percent''; and

(B) in clause (O), by inserting ''(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))'' after ''80 percent''.

(d) PAYMENT AS PHYSICIANS' SERVICES.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(W),'' after ''(2)(S),''.

(e) OTHER CONFORMING AMENDMENTS.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

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

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

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

''(J) in the case of an initial preventive physical examination, which is performed not later than 6 months after the date the individual's first coverage period begins under part B;''; and

(2) in paragraph (7), by striking ''or (H)'' and inserting ''(H), or (J)''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004, but only for individuals whose coverage period begins on or after such date.

SEC. 515. RENAL DIALYSIS SERVICES.

(a) REPORT ON DIFFERENCES IN COSTS IN DIFFERENT SETTINGS.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report containing—

(1) an analysis of the differences in costs of providing renal dialysis services under the medicare program in home settings and in facility settings;

(2) an assessment of the percentage of overhead costs in home settings and in facility settings; and

(3) an evaluation of whether the charges for home dialysis supplies and equipment are reasonable and necessary.

(b) RESTORING COMPOSITE RATE EXCEPTIONS FOR PEDIATRIC FACILITIES.—

(1) IN GENERAL.—Section 422(a)(2) of BIPA is amended—

(A) in subparagraph (A), by striking ''and (C)'' and inserting '', (C), and (D)'';

(B) in subparagraph (B), by striking ''In the case'' and inserting ''Subject to subparagraph (D), in the case''; and

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

''(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term 'pediatric facility' means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.''.

(2) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by striking ''The Secretary'' and inserting ''Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary''.

(c) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES FURNISHED IN 2004.—Notwithstanding any other provision of law, with respect to payment under part B of title XVIII of the Social Security Act for renal dialysis services furnished in 2004, the composite payment rate otherwise established under section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)) shall be increased by 1.2 percent.

SEC. 516. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: ''and does not include screening mammography (as defined in section 1861(jj)) and unilateral and bilateral diagnostic mammography''.

(b) ADJUSTMENT TO TECHNICAL COMPONENT.—For diagnostic mammography performed on or after January 1, 2004, for which payment is made under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4), the Secretary, based on the most recent cost data available, shall provide for an appropriate adjustment in the payment amount for the technical component of the diagnostic mammography.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to mammography performed on or after January 1, 2004.

SEC. 517. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) WAIVER OF PENALTY.—

(1) IN GENERAL.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: ''No increase in the premium shall be effected for a month in the case of an individual who is 65 years of age or older, who enrolls under this part during 2001, 2002, or 2003, and who demonstrates to the Secretary before December 31, 2003, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to premiums for months beginning with January 2003. The Secretary of Health and Human Services shall establish a method for providing rebates of premium penalties paid for months on or after January 2003 for which a penalty does not apply under such amendment but for which a penalty was previously collected.

(b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—In the case of any individual who, as of the date of the enactment of this Act, is 65 years of age or older, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act, and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary of Health and Human Services shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin as soon as possible after the date of the enactment of this Act and shall end on December 31, 2003.

(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 518. COVERAGE OF CHOLESTEROL AND BLOOD LIPID SCREENING.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 514(a), is amended—

(1) in subparagraph (V), by striking ''and'' at the end;

(2) in subparagraph (W), by inserting ''and'' at the end; and

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

''(X) cholesterol and other blood lipid screening tests (as defined in subsection (XX));''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 514(b), is amended by adding at the end the following new subsection:

''Cholesterol and Other Blood Lipid Screening Test

''(xx)(1) The term 'cholesterol and other blood lipid screening test' means diagnostic testing of cholesterol and other lipid levels of the blood for the purpose of early detection of abnormal cholesterol and other lipid levels.

''(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cholesterol and other blood lipid screening tests, except that such frequency may not be more often than once every 2 years.''.

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 514(e), is amended

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

(2) by striking the semicolon at the end of subparagraph (J) and inserting ''; and''; and

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

''(K) in the case of a cholesterol and other blood lipid screening test (as defined in section 1861(xx)(1)), which is performed more frequently than is covered under section 1861(xx)(2).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2004.

TITLE VI—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 601. ELIMINATION OF 15 PERCENT REDUCTION IN PAYMENT RATES UNDER THE PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C. 1395fff(b)(3)(A)) is amended to read as follows:

''(A) INITIAL BASIS.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts) as follows:

''(i) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2001 shall be equal to the total amount that would have been made if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been enacted.

''(ii) For fiscal year 2002 and for the first quarter of fiscal year 2003, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for the previous fiscal year, updated under subparagraph (B).

''(iii) For 2003, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for fiscal year 2002, updated under subparagraph (B) for 2003.

''(iv) For 2004 and each subsequent year, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for the previous year, updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the amendments made by section 501 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554).

SEC. 602. UPDATE IN HOME HEALTH SERVICES.

(a) CHANGE TO CALENDAR YEAR UPDATE.—

(1) IN GENERAL.—Section 1895(b) (42 U.S.C. 1395fff(b)(3)) is amended—

(A) in paragraph (3)(B)(i)—

(i) by striking ''each fiscal year (beginning with fiscal year 2002)'' and inserting ''fiscal year 2002 and for each subsequent year (beginning with 2003)''; and

(ii) by inserting ''or year'' after ''the fiscal year'';

(B) in paragraph (3)(B)(ii)—

(i) in subclause (II), by striking ''fiscal year'' and inserting ''year'' and by redesignating such subclause as subclause (III); and

(ii) in subclause (I), by striking ''each of fiscal years 2002 and 2003'' and inserting the following: ''fiscal year 2002, the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points;

''(II) 2003'';

(C) in paragraph (3)(B)(iii), by inserting ''or year'' after ''fiscal year'' each place it appears;

(D) in paragraph (3)(B)(iv)—

(i) by inserting ''or year'' after ''fiscal year'' each place it appears; and

(ii) by inserting ''or years'' after ''fiscal years''; and

(E) in paragraph (5), by inserting ''or year'' after ''fiscal year''.

(2) TRANSITION RULE.—The standard prospective payment amount (or amounts) under section 1895(b)(3) of the Social Security Act for the calendar quarter beginning on October 1, 2002, shall be such amount (or amounts) for the previous calendar quarter.

(b) CHANGES IN UPDATES FOR 2003, 2004, AND 2005.—Section 1895(b)(3)(B)(ii) (42 U.S.C. 1395fff(b)(3)(B)(ii)), as amended by subsection (a)(1)(B), is amended—

(1) in subclause (II), by striking ''the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points'' and inserting ''2.0 percentage points'';

(2) by striking ''or'' at the end of subclause (II);

(3) by redesignating subclause (III) as subclause (V); and

(4) by inserting after subclause (II) the following new subclause:

''(III) 2004, 1.1 percentage points;

''(IV) 2005, 2.7 percentage points; or''.

(c) PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1895(b)(5) (42 U.S.C. 1395fff(b)(5)) is amended by striking ''5 percent'' and inserting ''3 percent''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to years beginning with 2003.

SEC. 603. OASIS TASK FORCE; SUSPENSION OF CERTAIN OASIS DATA COLLECTION REQUIREMENTS PENDING TASK FORCE SUBMITTAL OF REPORT.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish and appoint a task force (to be known as the ''OASIS Task Force'') to examine the data collection and reporting requirements under OASIS. For purposes of this section, the term ''OASIS'' means the Outcome and Assessment Information Set required by reason of section 4602(e) of Balanced Budget Act of 1997 (42 U.S.C. 1395fff note).

(b) COMPOSITION.—The OASIS Task Force shall be composed of the following:

(1) Staff of the Centers for Medicare & Medicaid Services with expertise in post-acute care.

(2) Representatives of home health agencies.

(3) Health care professionals and research and health care quality experts outside the Federal Government with expertise in post-acute care.

(4) Advocates for individuals requiring home health services.

(c) DUTIES.—

(1) REVIEW AND RECOMMENDATIONS.—The OASIS Task Force shall review and make recommendations to the Secretary regarding changes in OASIS to improve and simplify data collection for purposes of—

(A) assessing the quality of home health services; and

(B) providing consistency in classification of patients into home health resource groups (HHRGs) for payment under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(2) SPECIFIC ITEMS.—In conducting the review under paragraph (1), the OASIS Task Force shall specifically examine—

(A) the 41 outcome measures currently in use;

(B) the timing and frequency of data collection; and

(C) the collection of information on comorbidities and clinical indicators.

(3) REPORT.—The OASIS Task Force shall submit a report to the Secretary containing its findings and recommendations for changes in OASIS by not later than 18 months after the date of the enactment of this Act.

(d) SUNSET.—The OASIS Task Force shall terminate 60 days after the date on which the report is submitted under subsection (c)(2).

(e) NONAPPLICATION OF FACA.—The provisions of the Federal Advisory Committee Act shall not apply to the OASIS Task Force.

(f) SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS PENDING TASK FORCE REPORT.—

(1) IN GENERAL.—During the period described in paragraph (2), the Secretary of Health and Human Services may not require, under section 4602(e) of the Balanced Budget Act of 1997 or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act.

(2) PERIOD OF SUSPENSION.—The period described in this paragraph—

(A) begins on January 1, 2003, and

(B) ends on the last day of the 2nd month beginning after the date the report is submitted under subsection (c)(2).

SEC. 604. MEDPAC STUDY ON MEDICARE MARGINS OF HOME HEALTH AGENCIES.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of payment margins of home health agencies under the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Such study shall examine whether systematic differences in payment margins are related to differences in case mix (as measured by home health resource groups (HHRGs)) among such agencies. The study shall use the partial or full-year cost reports filed by home health agencies.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study under subsection (a).

SEC. 605. CLARIFICATION OF TREATMENT OF OCCASIONAL ABSENCES IN DETERMINING WHETHER AN INDIVIDUAL IS CONFINED TO THE HOME.

(a) IN GENERAL.—The penultimate sentence of section 1814(a) (42 U.S.C. 1395f(a) and the penultimate sentence of section 1835(a) (42 U.S.C. 1395n(a)) are each amended to read as follows: ''Any other absence of an individual from the home shall not so disqualify the individual if the absence is infrequent or of relatively short duration, such as an occasional trip to the barber or a walk around the block, and is not inconsistent with the assessment underlying the individual's plan of care for home health services.''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

Subtitle B—Direct Graduate Medical Education

SEC. 611. EXTENSION OF UPDATE LIMITATION ON HIGH COST PROGRAMS.

Section 1886(h)(2)(D)(iv) (42 U.S.C. 1395ww(h)(2)(D)(iv)) is amended—

(1) in subclause (I)—

(A) by striking ''AND 2002'' and inserting ''THROUGH 2012'';

(B) by striking ''during fiscal year 2001 or fiscal year 2002'' and inserting ''during the period beginning with fiscal year 2001 and ending with fiscal year 2012''; and

(C) by striking ''subject to subclause (III),'';

(2) by striking subclause (II); and

(3) in subclause (III)—

(A) by redesignating such subclause as subclause (II); and

(B) by striking ''or (II)''.

SEC. 612. 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, 2003, 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, 2001.

''(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, 2002.

''(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, 2003, 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, 2004.

''(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) NO APPLICATION OF INCREASE 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 clause (i) of subparagraph (I) of subsection (h)(4) shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subparagraph (F) of such subsection, but the provisions of clause (ii) of such subparagraph shall not apply.''.

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2004, 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)).

Subtitle C—Other Provisions

SEC. 621. MODIFICATIONS TO MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXAMINATION OF BUDGET CONSEQUENCES.—Section 1805(b) (42 U.S.C. 1395b–6(b)) is amended by adding at the end the following new paragraph:

''(8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.''.

(b) CONSIDERATION OF EFFICIENT PROVISION OF SERVICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–6(b)(2)(B)(i)) is amended by inserting ''the efficient provision of'' after ''expenditures for''.

(c) ADDITIONAL REPORTS.—

(1) DATA NEEDS AND SOURCES.—The Medicare Payment Advisory Commission shall conduct a study, and submit a report to Congress by not later than June 1, 2003, on the need for current data, and sources of current data available, to determine the solvency and financial circumstances of hospitals and other medicare providers of services. The Commission shall examine data on uncompensated care, as well as the share of uncompensated care accounted for by the expenses for treating illegal aliens.

(2) USE OF TAX-RELATED RETURNS.—Using return information provided under Form 990 of the Internal Revenue Service, the Commission shall submit to Congress, by not later than June 1, 2003, a report on the following:

(A) Investments and capital financing of hospitals participating under the medicare program and related foundations.

(B) Access to capital financing for private and for not-for-profit hospitals.

SEC. 622. DEMONSTRATION PROJECT FOR DISEASE MANAGEMENT FOR CERTAIN MEDICARE BENEFICIARIES WITH DIABETES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under this section (in this section referred to as the ''project'') to demonstrate the impact on costs and health outcomes of applying disease management to certain medicare beneficiaries with diagnosed diabetes. In no case may the number of participants in the project exceed 30,000 at any time.

(b) VOLUNTARY PARTICIPATION.—

(1) ELIGIBILITY.—Medicare beneficiaries are eligible to participate in the project only if—

(A) they are a member of a health disparity population (as defined in section 485E(d) of the Public Health Service Act), such as Hispanics;

(B) they meet specific medical criteria demonstrating the appropriate diagnosis and the advanced nature of their disease;

(C) their physicians approve of participation in the project; and

(D) they are not enrolled in a Medicare+Choice plan.

(2) BENEFITS.—A medicare beneficiary who is enrolled in the project shall be eligible—

(A) for disease management services related to their diabetes; and

(B) for payment for all costs for prescription drugs without regard to whether or not they relate to the diabetes, except that the project may provide for modest cost-sharing with respect to prescription drug coverage.

(c) CONTRACTS WITH DISEASE MANAGEMENT ORGANIZATIONS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall carry out the project through contracts with up to three disease management organizations. The Secretary shall not enter into such a contract with an organization unless the organization demonstrates that it can produce improved health outcomes and reduce aggregate medicare expenditures consistent with paragraph (2).

(2) CONTRACT PROVISIONS.—Under such contracts—

(A) such an organization shall be required to provide for prescription drug coverage described in subsection (b)(2)(B);

(B) such an organization shall be paid a fee negotiated and established by the Secretary in a manner so that (taking into account savings in expenditures under parts A and B of the medicare program under title XVIII of the Social Security Act) there will be no net increase, and to the extent practicable, there will be a net reduction in expenditures under the medicare program as a result of the project; and

(C) such an organization shall guarantee, through an appropriate arrangement with a reinsurance company or otherwise, the prohibition on net increases in expenditures described in subparagraph (B).

(3) PAYMENTS.—Payments to such organizations shall be made in appropriate proportion from the Trust Funds established under title XVIII of the Social Security Act.

(d) APPLICATION OF MEDIGAP PROTECTIONS TO DEMONSTRATION PROJECT ENROLLEES.—(1) Subject to paragraph (2), the provisions of section 1882(s)(3) (other than clauses (i) through (iv) of subparagraph (B)) and 1882(s)(4) of the Social Security Act shall apply to enrollment (and termination of enrollment) in the demonstration project under this section, in the same manner as they apply to enrollment (and termination of enrollment) with a Medicare+Choice organization in a Medicare+Choice plan.

(2) In applying paragraph (1)—

(A) any reference in clause (v) or (vi) of section 1882(s)(3)(B) of such Act to 12 months is deemed a reference to the period of the demonstration project; and

(B) the notification required under section 1882(s)(3)(D) of such Act shall be provided in a manner specified by the Secretary of Health and Human Services.

(e) DURATION.—The project shall last for not longer than 3 years.

(f) WAIVER.—The Secretary of Health and Human Services shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (c)(3).

(g) REPORT.—The Secretary of Health and Human Services shall submit to Congress an interim report on the project not later than 2 years after the date it is first implemented and a final report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on costs and health outcomes and recommendations on the cost-effectiveness of extending or expanding the project.

(h) WORKING GROUP ON MEDICARE DISEASE MANAGEMENT PROGRAMS.—The Secretary shall establish within the Department of Health and Human Services a working group consisting of employees of the Department to carry out the following:

(1) To oversee the project.

(2) To establish policy and criteria for medicare disease management programs within the Department, including the establishment of policy and criteria for such programs.

(3) To identify targeted medical conditions and targeted individuals.

(4) To select areas in which such programs are carried out.

(5) To monitor health outcomes under such programs.

(6) To measure the effectiveness of such programs in meeting any budget neutrality requirements.

(7) Otherwise to serve as a central focal point within the Department for dissemination of information on medicare disease management programs.

(i) GAO STUDY ON DISEASE MANAGEMENT PROGRAMS.—The Comptroller General of the United States shall conduct a study that compares disease management programs under title XVIII of the Social Security Act with such programs conducted in the private sector, including the prevalence of such programs and programs for case management. The study shall identify the cost-effectiveness of such programs and any savings achieved by such programs. The Comptroller General shall submit a report on such study to Congress by not later than 18 months after the date of the enactment of this Act.

SEC. 623. DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY CARE SERVICES.

(a) ESTABLISHMENT.—Subject to the succeeding provisions of this section, the Secretary of Health and Human Services shall establish a demonstration project (in this section referred to as the ''demonstration project'') under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day care facility, to provide medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

(b) PAYMENT.—

(1) IN GENERAL.—The amount of payment for an episode of care for home health services, a portion of which consists of substitute medical adult day care services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 u.s.c. 1395fff). In no case may a home health agency, or a medical adult day care facility under arrangements with a home health agency, separately charge a beneficiary for medical adult day care services furnished under the plan of care.

(2) BUDGET NEUTRALITY FOR DEMONSTRATION PROJECT.—Notwithstanding any other provision of law, the Secretary shall provide for an appropriate reduction in the aggregate amount of additional payments made under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to reflect any increase in amounts expended from the Trust Funds as a result of the demonstration project conducted under this section.

(c) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in not more than 5 States selected by the Secretary that license or certify providers of services that furnish medical adult day care services.

(d) DURATION.—The Secretary shall conduct the demonstration project for a period of 3 years.

(e) VOLUNTARY PARTICIPATION.—Participation of medicare beneficiaries in the demonstration project shall be voluntary. The total number of such beneficiaries that may participate in the project at any given time may not exceed 15,000.

(f) PREFERENCE IN SELECTING AGENCIES.—In selecting home health agencies to participate under the demonstration project, the Secretary shall give preference to those agencies that are currently licensed or certified through common ownership and control to furnish medical adult day care services.

(g) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act as may be necessary for the purposes of carrying out the demonstration project, other than waiving the requirement that an individual be homebound in order to be eligible for benefits for home health services.

(h) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the clinical and cost effectiveness of the demonstration project. Not later 30 months after the commencement of the project, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the project as compared to such outcomes and costs to beneficiaries receiving only home health services for the same health conditions.

(2) Such recommendations regarding the extension, expansion, or termination of the project as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

(1) HOME HEALTH AGENCY.—The term ''home health agency'' has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(2) MEDICAL ADULT DAY CARE FACILITY.—The term ''medical adult day care facility'' means a facility that—

(A) has been licensed or certified by a State to furnish medical adult day care services in the State for a continuous 2-year period;

(B) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(C) meets such standards established by the Secretary to assure quality of care and such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility; and

(D) provides medical adult day care services.

(3) MEDICAL ADULT DAY CARE SERVICES.—The term ''medical adult day care services'' means—

(A) home health service items and services described in paragraphs (1) through (7) of section 1861(m) furnished in a medical adult day care facility;

(B) a program of supervised activities furnished in a group setting in the facility that—

(i) meet such criteria as the Secretary determines appropriate; and

(ii) is designed to promote physical and mental health of the individuals; and

(C) such other services as the Secretary may specify.

(4) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means an individual entitled to benefits under part A of this title, enrolled under part B of this title, or both.

SEC. 624. PUBLICATION ON FINAL WRITTEN GUIDANCE CONCERNING PROHIBITIONS AGAINST DISCRIMINATION BY NATIONAL ORIGIN WITH RESPECT TO HEALTH CARE SERVICES.

Not later than January 1, 2003, the Secretary shall issue final written guidance concerning the application of the prohibition in title VI of the Civil Rights Act of 1964 against national origin discrimination as it affects persons with limited English proficiency with respect to access to health care services under the medicare program.

TITLE VII—MEDICARE BENEFITS ADMINISTRATION

SEC. 701. ESTABLISHMENT OF MEDICARE BENEFITS ADMINISTRATION.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 105, is amended by inserting after 1806 the following new section:

''MEDICARE BENEFITS ADMINISTRATION

''SEC. 1808. (a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an agency to be known as the Medicare Benefits Administration.

''(b) ADMINISTRATOR; DEPUTY ADMINISTRATOR; CHIEF ACTUARY.—

''(1) ADMINISTRATOR.—

''(A) IN GENERAL.—The Medicare Benefits Administration shall be headed by an administrator to be known as the 'Medicare Benefits Administrator' (in this section referred to as the 'Administrator') who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall be in direct line of authority to the Secretary.

''(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Administration, and shall have authority and control over all personnel and activities thereof.

''(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administration. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

''(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Administration as the Administrator considers necessary or appropriate, except as specified in this section.

''(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administration as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

''(2) DEPUTY ADMINISTRATOR.—

''(A) IN GENERAL.—There shall be a Deputy Administrator of the Medicare Benefits Administration who shall be appointed by the President, by and with the advice and consent of the Senate.

''(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be Acting Administrator of the Administration during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

''(3) CHIEF ACTUARY.—

''(A) IN GENERAL.—There is established in the Administration the position of Chief Actuary. The Chief Actuary shall be appointed by, and in direct line of authority to, the Administrator of such Administration. The Chief Actuary shall be appointed from among individuals who have demonstrated, by their education and experience, superior expertise in the actuarial sciences. The Chief Actuary may be removed only for cause.

''(B) COMPENSATION.—The Chief Actuary shall be compensated at the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

''(C) DUTIES.—The Chief Actuary shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence.

''(4) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

''(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

''(1) DUTIES.—

''(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

''(i) negotiating, entering into, and enforcing, contracts with plans for the offering of Medicare+Choice plans under part C, including the offering of qualified prescription drug coverage under such plans; and

''(ii) negotiating, entering into, and enforcing, contracts with PDP sponsors for the offering of prescription drug plans under part D.

''(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or part D, including demonstration projects carried out in part or in whole under such parts, the programs of all-inclusive care for the elderly (PACE program) under section 1894, the social health maintenance organization (SHMO) demonstration projects (referred to in section 4104(c) of the Balanced Budget Act of 1997), and through a Medicare+Choice project that demonstrates the application of capitation payment rates

for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved).

''(C) PRESCRIPTION DRUG CARD.—The Administrator shall carry out section 1807 (relating to the medicare prescription drug discount card endorsement program).

''(D) NONINTERFERENCE.—In carrying out its duties with respect to the provision of qualified prescription drug coverage to beneficiaries under this title, the Administrator may not—

''(i) require a particular formulary or institute a price structure for the reimbursement of covered outpatient drugs;

''(ii) interfere in any way with negotiations between PDP sponsors and Medicare+Choice organizations and drug manufacturers, wholesalers, or other suppliers of covered outpatient drugs; and

''(iii) otherwise interfere with the competitive nature of providing such coverage through such sponsors and organizations.

''(E) ANNUAL REPORTS.—Not later March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of parts C and D during the previous fiscal year.

''(2) STAFF.—

''(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, without regard to chapter 31 of title 5, United States Code, other than sections 3110 and 3112, such officers and employees as are necessary to administer the activities to be carried out through the Medicare Benefits Administration. The Administrator shall employ staff with appropriate and necessary expertise in negotiating contracts in the private sector.

''(B) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

''(i) IN GENERAL.—The staff of the Medicare Benefits Administration shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 (other than section 5101) and chapter 53 (other than section 5301) of such title (relating to classification and schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(C) LIMITATION ON FULL-TIME EQUIVALENT STAFFING FOR CURRENT CMS FUNCTIONS BEING TRANSFERRED.—The Administrator may not employ under this paragraph a number of full-time equivalent employees, to carry out functions that were previously conducted by the Centers for Medicare & Medicaid Services and that are conducted by the Administrator by reason of this section, that exceeds the number of such full-time equivalent employees authorized to be employed by the Centers for Medicare & Medicaid Services to conduct such functions as of the date of the enactment of this Act.

''(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

''(A) IN GENERAL.—The Secretary, the Administrator, and the Administrator of the Centers for Medicare & Medicaid Services shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare & Medicaid Services to the Administrator as is appropriate to carry out the purposes of this section.

''(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator of the Medicare Benefits Administration such information and data in the possession of the Administrator of the Centers for Medicare & Medicaid Services as the Administrator of the Medicare Benefits Administration requires to carry out the duties described in paragraph (1).

''(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Centers for Medicare & Medicaid Services is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Centers for Medicare & Medicaid Services in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

''(d) OFFICE OF BENEFICIARY ASSISTANCE.—

''(1) ESTABLISHMENT.—The Secretary shall establish within the Medicare Benefits Administration an Office of Beneficiary Assistance to coordinate functions relating to outreach and education of medicare beneficiaries under this title, including the functions described in paragraph (2). The Office shall be separate operating division within the Administration.

''(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

''(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate, directly or through contract, to medicare beneficiaries, by mail, by posting on the Internet site of the Medicare Benefits Administration and through a toll-free telephone number, information with respect to the following:

''(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

''(ii) Benefits, and limitations on payment under parts A and B, including information on medicare supplemental policies under section 1882.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, D, and medicare supplemental policies with benefits under Medicare+Choice plans under part C.

''(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the Medicare+Choice program under part C, and the Voluntary Prescription Drug Benefit Program under part D.

''(e) MEDICARE POLICY ADVISORY BOARD.—

''(1) ESTABLISHMENT.—There is established within the Medicare Benefits Administration the Medicare Policy Advisory Board (in this section referred to the 'Board'). The Board shall advise, consult with, and make recommendations to the Administrator of the Medicare Benefits Administration with respect to the administration of parts C and D, including the review of payment policies under such parts.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress and to the Administrator of the Medicare Benefits Administration such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

''(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

''(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C and D for services furnished to medicare beneficiaries.

''(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement to efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

''(iii) IMPLEMENTATION OF RISK-ADJUSTMENT.—Evaluation of the implementation under section 1853(a)(3)(C) of the risk adjustment methodology to payment rates under that section to Medicare+Choice organizations offering Medicare+Choice plans that accounts for variations in per capita costs based on health status and other demographic factors.

''(iv) DISEASE MANAGEMENT PROGRAMS.—Recommendations on the incorporation of disease management programs under parts C and D.

''(v) RURAL ACCESS.—Recommendations to improve competition and access to plans under parts C and D in rural areas.

''(C) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

''(3) DUTY OF ADMINISTRATOR OF MEDICARE BENEFITS ADMINISTRATION.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator of the Medicare Benefits Administration shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

''(4) MEMBERSHIP.—

''(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of seven members to be appointed as follows:

''(i) Three members shall be appointed by the President.

''(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairmen and the ranking minority members of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives.

''(iii) Two members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Senate Committee on Finance.

''(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

''(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

''(5) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(6) TERMS OF OFFICE.—

''(A) IN GENERAL.—The term of office of members of the Board shall be 3 years.

''(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

''(i) one shall be appointed for a term of 1 year;

''(ii) three shall be appointed for terms of 2 years; and

''(iii) three shall be appointed for terms of 3 years.

''(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

''(D) VACANCY.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

''(7) CHAIR.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

''(8) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than three times during each fiscal year.

''(9) DIRECTOR AND STAFF.—

''(A) APPOINTMENT OF DIRECTOR.—The Board shall have a Director who shall be appointed by the Chair.

''(B) IN GENERAL.—With the approval of the Board, the Director may appoint, without regard to chapter 31 of title 5, United States Code, such additional personnel as the Director considers appropriate.

''(C) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

''(i) IN GENERAL.—The Director and staff of the Board shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 and chapter 53 of such title (relating to classification and schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(D) ASSISTANCE FROM THE ADMINISTRATOR OF THE MEDICARE BENEFITS ADMINISTRATION.—The Administrator of the Medicare Benefits Administration shall make available to the Board such information and other assistance as it may require to carry out its functions.

''(10) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account), such sums as are necessary to carry out this section.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) TIMING OF INITIAL APPOINTMENTS.—The Administrator and Deputy Administrator of the Medicare Benefits Administration may not be appointed before March 1, 2003.

(3) DUTIES WITH RESPECT TO ELIGIBILITY DETERMINATIONS AND ENROLLMENT.—The Administrator of the Medicare Benefits Administration shall carry out enrollment under title XVIII of the Social Security Act, make eligibility determinations under such title, and carry out part C of such title for years beginning or after January 1, 2005.

(4) TRANSITION.—Before the date the Administrator of the Medicare Benefits Administration is appointed and assumes responsibilities under this section and section 1807 of the Social Security Act, the Secretary of Health and Human Services shall provide for the conduct of any responsibilities of such Administrator that are otherwise provided under law.

(c) MISCELLANEOUS ADMINISTRATIVE PROVISIONS.—

(1) ADMINISTRATOR AS MEMBER OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—Section 1817(b) and section 1841(b) (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking ''and the Secretary of Health and Human Services, all ex officio,'' and inserting ''the Secretary of Health and Human Services, and the Administrator of the Medicare Benefits Administration, all ex officio,''.

(2) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES; LEVEL FOR MEDICARE BENEFITS ADMINISTRATOR.—

(A) IN GENERAL.—Section 5314 of title 5, United States Code, by adding at the end the following:

''Administrator of the Centers for Medicare & Medicaid Services .

''Administrator of the Medicare Benefits Administration.''.

(B) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking ''Administrator of the Health Care Financing Administration.''.

(C) EFFECTIVE DATE.—The amendments made by this paragraph take effect on January 1, 2003.

TITLE VIII—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

SEC. 801. CONSTRUCTION; DEFINITION OF SUPPLIER.

(a) CONSTRUCTION.—Nothing in this title shall be construed—

(1) to compromise or affect existing legal remedies for addressing fraud or abuse, whether it be criminal prosecution, civil enforcement, or administrative remedies, including under sections 3729 through 3733 of title 31, United States Code (known as the False Claims Act); or

(2) to prevent or impede the Department of Health and Human Services in any way from its ongoing efforts to eliminate waste, fraud, and abuse in the medicare program.

Furthermore, the consolidation of medicare administrative contracting set forth in this Act does not constitute consolidation of the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund or reflect any position on that issue.

(b) DEFINITION OF SUPPLIER.—Section 1861 (42 U.S.C. 1395x) is amended by inserting after subsection (c) the following new subsection:

''Supplier

''(d) The term 'supplier' means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.''.

SEC. 802. ISSUANCE OF REGULATIONS.

(a) CONSOLIDATION OF PROMULGATION TO ONCE A MONTH.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

''(d)(1) Subject to paragraph (2), the Secretary shall issue proposed or final (including interim final) regulations to carry out this title only on one business day of every month.

''(2) The Secretary may issue a proposed or final regulation described in paragraph (1) on any other day than the day described in paragraph (1) if the Secretary—

''(A) finds that issuance of such regulation on another day is necessary to comply with requirements under law; or

''(B) finds that with respect to that regulation the limitation of issuance on the date described in paragraph (1) is contrary to the public interest.

If the Secretary makes a finding under this paragraph, the Secretary shall include such finding, and brief statement of the reasons for such finding, in the issuance of such regulation.

''(3) The Secretary shall coordinate issuance of new regulations described in paragraph (1) relating to a category of provider of services or suppliers based on an analysis of the collective impact of regulatory changes on that category of providers or suppliers.''.

(2) GAO REPORT ON PUBLICATION OF REGULATIONS ON A QUARTERLY BASIS.—Not later than 3 years after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the feasibility of requiring that regulations described in section 1871(d) of the Social Security Act be promulgated on a quarterly basis rather than on a monthly basis.

(3) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to regulations promulgated on or after the date that is 30 days after the date of the enactment of this Act.

(b) REGULAR TIMELINE FOR PUBLICATION OF FINAL RULES.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

''(3)(A) The Secretary, in consultation with the Director of the Office of Management and Budget, shall establish and publish a regular timeline for the publication of final regulations based on the previous publication of a proposed regulation or an interim final regulation.

''(B) Such timeline may vary among different regulations based on differences in the complexity of the regulation, the number and scope of comments received, and other relevant factors, but shall not be longer than 3 years except under exceptional circumstances. If the Secretary intends to vary such timeline with respect to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline by not later than the timeline previously established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

''(C) In the case of interim final regulations, upon the expiration of the regular timeline established under this paragraph for the publication of a final regulation after opportunity for public comment, the interim final regulation shall not continue in effect unless the Secretary publishes (at the end of the regular timeline and, if applicable, at the end of each succeeding 1-year period) a notice of continuation of the regulation that includes an explanation of why the regular timeline (and any subsequent 1-year extension) was not complied with. If such a notice is published, the regular timeline (or such timeline as previously extended under this paragraph) for publication of the final regulation shall be treated as having been extended for 1 additional year.

''(D) The Secretary shall annually submit to Congress a report that describes the instances in which the Secretary failed to publish a final regulation within the applicable regular timeline under this paragraph and that provides an explanation for such failures.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on

the date of the enactment of this Act. The Secretary shall provide for an appropriate transition to take into account the backlog of previously published interim final regulations.

(c) LIMITATIONS ON NEW MATTER IN FINAL REGULATIONS.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)), as amended by subsection (b), is further amended by adding at the end the following new paragraph:

''(4) If the Secretary publishes notice of proposed rulemaking relating to a regulation (including an interim final regulation), insofar as such final regulation includes a provision that is not a logical outgrowth of such notice of proposed rulemaking, that provision shall be treated as a proposed regulation and shall not take effect until there is the further opportunity for public comment and a publication of the provision again as a final regulation.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to final regulations published on or after the date of the enactment of this Act.

SEC. 803. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh), as amended by section 802(a), is amended by adding at the end the following new subsection:

''(e)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

''(i) such retroactive application is necessary to comply with statutory requirements; or

''(ii) failure to apply the change retroactively would be contrary to the public interest.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of the enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(e)(1), as added by subsection (a), is amended by adding at the end the following:

''(B)(i) Except as provided in clause (ii), a substantive change referred to in subparagraph (A) shall not become effective before the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

''(ii) The Secretary may provide for such a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.

''(C) No action shall be taken against a provider of services or supplier with respect to noncompliance with such a substantive change for items and services furnished before the effective date of such a change.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of the enactment of this Act.

(c) RELIANCE ON GUIDANCE.—

(1) IN GENERAL.—Section 1871(e), as added by subsection (a), is further amended by adding at the end the following new paragraph:

''(2)(A) If—

''(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a medicare contractor (as defined in section 1889(g)) acting within the scope of the contractor's contract authority, with respect to the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

''(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in writing; and

''(iii) the guidance was in error;

the provider of services or supplier shall not be subject to any sanction (including any penalty or requirement for repayment of any amount) if the provider of services or supplier reasonably relied on such guidance.

''(B) Subparagraph (A) shall not be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment insofar as the overpayment was solely the result of a clerical or technical operational error.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act but shall not apply to any sanction for which notice was provided on or before the date of the enactment of this Act.

SEC. 804. REPORTS AND STUDIES RELATING TO REGULATORY REFORM.

(a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine the feasibility and appropriateness of establishing in the Secretary authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the medicare program under title XVIII of the Social Security Act. Such study shall examine the appropriate timeframe for issuing such advisory opinions, as well as the need for additional staff and funding to provide such opinions.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than January 1, 2004.

(b) REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by section 803(a), is amended by adding at the end the following new subsection:

''(f)(1) Not later than 2 years after the date of the enactment of this subsection, and every 2 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

''(2) In preparing a report under paragraph (1), the Secretary shall collect—

''(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, providers of services, and suppliers and from the Medicare Beneficiary Ombudsman and the Medicare Provider Ombudsman with respect to such areas of inconsistency and conflict; and

''(B) information from medicare contractors that tracks the nature of written and telephone inquiries.

''(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.''.

Subtitle B—Contracting Reform

SEC. 811. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

''CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

''SEC. 1874A. (a) AUTHORITY.—

''(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

''(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

''(A) the entity has demonstrated capability to carry out such function;

''(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

''(C) the entity has sufficient assets to financially support the performance of such function; and

''(D) the entity meets such other requirements as the Secretary may impose.

''(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

''(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

''(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services or supplier (or class of such providers of services or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services or supplier or class of provider of services or supplier.

''(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions, provider services functions, and functions relating to services furnished to individuals entitled to benefits under part A or enrolled under part B, or both, as follows:

''(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, suppliers and individuals.

''(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

''(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Providing education and outreach to individuals entitled to benefits under part A or enrolled under part B, or both, and providing assistance to those individuals with specific issues, concerns or problems.

''(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable

them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services or suppliers.

''(E) COMMUNICATION WITH PROVIDERS.—Communicating to providers of services and suppliers any information or instructions furnished to the medicare administrative contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

''(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions relating to provider education, training, and technical assistance.

''(G) ADDITIONAL FUNCTIONS.—Performing such other functions as are necessary to carry out the purposes of this title.

''(5) RELATIONSHIP TO MIP CONTRACTS.—

''(A) NONDUPLICATION OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of medicare administrative contractors in carrying out activities under parts A and B do not duplicate activities carried out under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

''(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

''(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

''(b) CONTRACTING REQUIREMENTS.—

''(1) USE OF COMPETITIVE PROCEDURES.—

''(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section, taking into account performance quality as well as price and other factors.

''(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every five years.

''(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the providers of services and suppliers affected by such transfer, and contact information for the contractors involved).

''(D) INCENTIVES FOR QUALITY.—The Secretary shall provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

''(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, quality of services provided, and other matters as the Secretary finds pertinent.

''(3) PERFORMANCE REQUIREMENTS.—

''(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—In developing contract performance requirements, the Secretary shall develop performance requirements applicable to functions described in subsection (a)(4).

''(B) CONSULTATION.— In developing such requirements, the Secretary may consult with providers of services and suppliers, organizations representing individuals entitled to benefits under part A or enrolled under part B, or both, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

''(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

''(i) shall reflect the performance requirements developed under subparagraph (A), but may include additional performance requirements;

''(ii) shall be used for evaluating contractor performance under the contract; and

''(iii) shall be consistent with the written statement of work provided under the contract.

''(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

''(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

''(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

''(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

''(c) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—A contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

''(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of identifying situations in which the provisions of section 1862(b) may apply.

''(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

''(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payments certified by the individual under this section.

''(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of gross negligence or intent to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

''(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless in connection with such payment or in the supervision of or selection of such officer the medicare administrative contractor acted with gross negligence.

''(4) INDEMNIFICATION BY SECRETARY.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (D), in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from or relating directly to the claims administration process under this title, the Secretary may, to the extent the Secretary determines to be appropriate and as specified in the contract with the contractor, indemnify the contractor and such persons.

''(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the judicial proceeding or by the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to a contractor before a determination that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

''(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

''(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate such settlement or compromise. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement or compromise of a proceeding described in such subparagraph are conditioned upon prior written approval by the Secretary of the final settlement or compromise.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

''(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.''.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act, as inserted by paragraph (1), the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of

such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART A''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking ''agreement under this section'' and inserting ''contract under section 1874A that provides for making payments under this part''.

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking ''An agreement with an agency or organization under this section'' and inserting ''A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part''; and

(B) by striking ''such agency or organization'' and inserting ''such medicare administrative contractor'' each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART B''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking ''carriers'' and inserting ''medicare administrative contractors''; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking ''Each such contract shall provide that the carrier'' and inserting ''The Secretary'';

(ii) by striking ''will'' the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting ''shall'';

(iii) in subparagraph (B), in the matter before clause (i), by striking ''to the policyholders and subscribers of the carrier'' and inserting ''to the policyholders and subscribers of the medicare administrative contractor'';

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking ''if it makes determinations or payments with respect to physicians' services,'' in the matter preceding clause (i); and

(II) by striking ''carrier'' and inserting ''medicare administrative contractor'' in clause (i);

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking ''and shall contain'' and all that follows through the period; and

(ix) in the seventh sentence, by inserting ''medicare administrative contractor,'' after ''carrier,''; and

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(F) in paragraph (7), by striking ''the carrier'' and inserting ''the Secretary'' each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)(A), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B),'' and inserting ''contract under section 1874A that provides for making payments under this part'';

(C) in paragraph (3)(A), by striking ''subsection (a)(1)(B)'' and inserting ''section 1874A(a)(3)(B)'';

(D) in paragraph (4), in the matter preceding subparagraph (A), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(E) by striking paragraphs (5) and (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking ''carrier or carriers'' and inserting ''medicare administrative contractor or contractors''.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking ''Each carrier having an agreement with the Secretary under subsection (a)'' and inserting ''The Secretary''; and

(ii) by striking ''Each such carrier'' and inserting ''The Secretary'';

(B) in paragraph (3)(A)—

(i) by striking ''a carrier having an agreement with the Secretary under subsection (a)'' and inserting ''medicare administrative contractor having a contract under section 1874A that provides for making payments under this part''; and

(ii) by striking ''such carrier'' and inserting ''such contractor'';

(C) in paragraph (3)(B)—

(i) by striking ''a carrier'' and inserting ''a medicare administrative contractor'' each place it appears; and

(ii) by striking ''the carrier'' and inserting ''the contractor'' each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking ''carriers'' and inserting ''medicare administrative contractors'' each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(B) in paragraph (2), by striking ''carrier'' and inserting ''medicare administrative contractor''.

(9) Subsection (p)(3)(A) is amended by striking ''carrier'' and inserting ''medicare administrative contractor''.

(10) Subsection (q)(1)(A) is amended by striking ''carrier''.

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2004, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this Act, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2009.

(D) WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—During the period beginning on the date of the enactment of this Act and before the date specified under subparagraph (A), the Secretary may enter into new agreements under section 1816 of the Social Security Act (42 U.S.C. 1395h) without regard to any of the provider nomination provisions of such section.

(2) GENERAL TRANSITION RULES.—The Secretary shall take such steps, consistent with paragraph (1)(B) and (1)(C), as are necessary to provide for an appropriate transition from contracts under section 1816 and section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONS UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER ROLLOVER CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include a contract under section 1874A of such Act, as inserted by subsection (a)(1), that continues the activities referred to in such provisions.

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to an appropriate medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) REPORTS ON IMPLEMENTATION.—

(1) PLAN FOR IMPLEMENTATION.—By not later than October 1, 2003, the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2007, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

SEC. 812. REQUIREMENTS FOR INFORMATION SECURITY FOR MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 811(a)(1), is amended by adding at the end the following new subsection:

''(e) REQUIREMENTS FOR INFORMATION SECURITY.—

''(1) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement a contractor-wide information security program to provide information security for the operation and assets of the contractor with respect to such functions under this title. An information security program under this paragraph shall meet the requirements for information security programs imposed on Federal agencies under section 3534(b)(2) of title 44, United States Code (other than requirements under subparagraphs (B)(ii), (F)(iii), and (F)(iv) of such section).

''(2) INDEPENDENT AUDITS.—

''(A) PERFORMANCE OF ANNUAL EVALUATIONS.—Each year a medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall undergo an evaluation of the information security of the contractor with respect to such functions under this title. The evaluation shall—

''(i) be performed by an entity that meets such requirements for independence as the Inspector General of the Department of Health and Human Services may establish; and

''(ii) test the effectiveness of information security control techniques for an appropriate subset of the contractor's information systems (as defined in section 3502(8) of title 44, United States Code) relating to such functions under this title and an assessment of compliance with the requirements of this subsection and related information security policies, procedures, standards and guidelines.

''(B) DEADLINE FOR INITIAL EVALUATION.—

''(i) NEW CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant subparagraph (A) shall be completed prior to commencing such functions.

''(ii) OTHER CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that is not described in clause (i), the first independent evaluation conducted pursuant subparagraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

''(C) REPORTS ON EVALUATIONS.—

''(i) TO THE INSPECTOR GENERAL.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services.

''(ii) TO CONGRESS.—The Inspector General of Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations.''.

(b) APPLICATION OF REQUIREMENTS TO FISCAL INTERMEDIARIES AND CARRIERS.—

(1) IN GENERAL.—The provisions of section 1874A(e)(2) of the Social Security Act (other than subparagraph (B)), as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(2) DEADLINE FOR INITIAL EVALUATION.—In the case of such a fiscal intermediary or carrier with an agreement or contract under such respective section in effect as of the date of the enactment of this Act, the first evaluation under section 1874A(e)(2)(A) of the Social Security Act (as added by subsection (a)), pursuant to paragraph (1), shall be completed (and a report on the evaluation submitted to the Secretary) by not later than 1 year after such date.

Subtitle C—Education and Outreach

SEC. 821. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—The Social Security Act is amended by inserting after section 1888 the following new section:

''PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

''SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (g), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services and suppliers.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(3) REPORT.—Not later than October 1, 2003, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 811(a)(1) and as amended by section 812(a), is amended by adding at the end the following new subsection:

''(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—In order to give medicare administrative contractors an incentive to implement effective education and outreach programs for providers of services and suppliers, the Secretary shall develop and implement a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.''.

(2) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(f) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(3) GAO REPORT ON ADEQUACY OF METHODOLOGY.—Not later than October 1, 2003, the Comptroller General of the United States shall submit to Congress and to the Secretary a report on the adequacy of the methodology under section 1874A(f) of the Social Security Act, as added by paragraph (1), and shall include in the report such recommendations as the Comptroller General determines appropriate with respect to the methodology.

(4) REPORT ON USE OF METHODOLOGY IN ASSESSING CONTRACTOR PERFORMANCE.—Not later than October 1, 2003, the Secretary shall submit to Congress a report that describes how the Secretary intends to use such methodology in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses. The report shall include an analysis of the sources of identified errors and potential changes in systems of contractors and rules of the Secretary that could reduce claims error rates.

(c) PROVISION OF ACCESS TO AND PROMPT RESPONSES FROM MEDICARE ADMINISTRATIVE CONTRACTORS.—

(1) IN GENERAL.—Section 1874A, as added by section 811(a)(1) and as amended by section 812(a) and subsection (b), is further amended by adding at the end the following new subsection:

''(g) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS OF SERVICES AND SUPPLIERS.—

''(1) COMMUNICATION STRATEGY.—The Secretary shall develop a strategy for communications with individuals entitled to benefits under part A or enrolled under part B, or both, and with providers of services and suppliers under this title.

''(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare administrative contractor shall, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

''(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims to the contractor for claims processing and for those individuals entitled to benefits under part A or enrolled under part B, or both, with respect to whom claims are submitted for claims processing, a toll-free telephone number at which such individuals, providers of services and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

''(4) MONITORING OF CONTRACTOR RESPONSES.—

''(A) IN GENERAL.—Each medicare administrative contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

''(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

''(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

''(B) DEVELOPMENT OF STANDARDS.—

''(i) IN GENERAL.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

''(ii) EVALUATION.—In conducting evaluations of individual medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or

both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

''(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect October 1, 2003.

(3) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(g) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

(d) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsections:

''(b) ENHANCED EDUCATION AND TRAINING.—

''(1) ADDITIONAL RESOURCES.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) $25,000,000 for each of fiscal years 2004 and 2005 and such sums as may be necessary for succeeding fiscal years.

''(2) USE.—The funds made available under paragraph (1) shall be used to increase the conduct by medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

''(c) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

''(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)).

''(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

''(A) a provider of services with fewer than 25 full-time-equivalent employees; or

''(B) a supplier with fewer than 10 full-time-equivalent employees.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2003.

(e) REQUIREMENT TO MAINTAIN INTERNET SITES.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (d), is further amended by adding at the end the following new subsection:

''(d) INTERNET SITES; FAQS.—The Secretary, and each medicare contractor insofar as it provides services (including claims processing) for providers of services or suppliers, shall maintain an Internet site which—

''(1) provides answers in an easily accessible format to frequently asked questions, and

''(2) includes other published materials of the contractor,

that relate to providers of services and suppliers under the programs under this title (and title XI insofar as it relates to such programs).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2003.

(f) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (d) and (e), is further amended by adding at the end the following new subsections:

''(e) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

''(f) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

''(g) DEFINITIONS.—For purposes of this section, the term 'medicare contractor' includes the following:

''(1) A medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1816 and a carrier with a contract under section 1842.

''(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this title or title IX with respect to such activities and such provider of services or supplier.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 822. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under medicare program under title XVIII of the Social Security Act (including provisions of title XI of such Act insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

(2) FORMS OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph is—

(A) evaluation and recommendations regarding billing and related systems; and

(B) information and assistance regarding policies and procedures under the medicare program, including coding and reimbursement.

(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, the term ''small providers of services or suppliers'' means—

(A) a provider of services with fewer than 25 full-time-equivalent employees; or

(B) a supplier with fewer than 10 full-time-equivalent employees.

(b) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary shall enter into contracts with qualified organizations (such as peer review organizations or entities described in section 1889(g)(2) of the Social Security Act, as inserted by section 5(f)(1)) with appropriate expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

(c) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a direct and in-person examination of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more efficient or effective means of achieving such compliance.

(d) AVOIDANCE OF RECOVERY ACTIONS FOR PROBLEMS IDENTIFIED AS CORRECTED.—The Secretary shall provide that, absent evidence of fraud and notwithstanding any other provision of law, any errors found in a compliance review for a small provider of services or supplier that participates in the demonstration program shall not be subject to recovery action if the technical assistance personnel under the program determine that—

(1) the problem that is the subject of the compliance review has been corrected to their satisfaction within 30 days of the date of the visit by such personnel to the small provider of services or supplier; and

(2) such problem remains corrected for such period as is appropriate.

The previous sentence applies only to claims filed as part of the demonstration program and lasts only for the duration of such program and only as long as the small provider of services or supplier is a participant in such program.

(e) GAO EVALUATION.—Not later than 2 years after the date of the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether claims error rates are reduced for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

(f) FINANCIAL PARTICIPATION BY PROVIDERS.—The provision of technical assistance to a small provider of services or supplier under the demonstration program is conditioned upon the small provider of services or supplier paying an amount estimated (and disclosed in advance of a provider's or supplier's participation in the program) to be equal to 25 percent of the cost of the technical assistance.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the demonstration program—

(1) for fiscal year 2004, $1,000,000, and

(2) for fiscal year 2005, $6,000,000.

SEC. 823. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: ''; MEDICARE PROVIDER OMBUDSMAN'';

(2) by inserting ''PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)'' after ''(a)'';

(3) in paragraph (1), as so redesignated under paragraph (2), by striking ''in this section'' and inserting ''in this subsection'';

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

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

''(b) MEDICARE PROVIDER OMBUDSMAN.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Provider Ombudsman. The Ombudsman shall—

''(1) provide assistance, on a confidential basis, to providers of services and suppliers with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

''(2) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

''(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

''(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.''.

(b) MEDICARE BENEFICIARY OMBUDSMAN.—Title XVIII, as amended by sections 105 and 701, is amended by inserting after section 1808 the following new section:

''MEDICARE BENEFICIARY OMBUDSMAN

''SEC. 1809. (a) IN GENERAL.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

''(b) DUTIES.—The Medicare Beneficiary Ombudsman shall—

''(1) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any aspect of the medicare program;

''(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including—

''(A) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary; and

''(B) assistance to such individuals with any problems arising from disenrollment from a Medicare+Choice plan under part C; and

''(3) submit annual reports to Congress and the Secretary that describe the activities of the Office and that include such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

''(c) WORKING WITH HEALTH INSURANCE COUNSELING PROGRAMS.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funding under section 4360 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding Medicare+Choice plans and changes to those plans. Nothing in this subsection shall preclude further collaboration between the Ombudsman and such programs.''.

(c) DEADLINE FOR APPOINTMENT.—The Secretary shall appoint the Medicare Provider Ombudsman and the Medicare Beneficiary Ombudsman, under the amendments made by subsections (a) and (b), respectively, by not later than 1 year after the date of the enactment of this Act.

(d) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5) and section 1809 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2003 and each succeeding fiscal year.

(e) USE OF CENTRAL, TOLL-FREE NUMBER (1-800-MEDICARE).—

(1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: ''The Secretary shall provide, through the toll-free number 1-800-MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.''.

(2) MONITORING ACCURACY.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study to monitor the accuracy and consistency of information provided to individuals entitled to benefits under part A or enrolled under part B, or both, through the toll-free number 1-800-MEDICARE, including an assessment of whether the information provided is sufficient to answer questions of such individuals. In conducting the study, the Comptroller General shall examine the education and training of the individuals providing information through such number.

(B) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subparagraph (A).

SEC. 824. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both, regarding the medicare program at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by individuals referred to in subsection (a).

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) DURATION.—The demonstration program shall be conducted over a 3-year period.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(A) utilization of, and satisfaction of those individuals referred to in subsection (a) with, the assistance provided under the program; and

(B) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local offices of the Social Security Administration.

(2) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing medicare specialists at local offices of the Social Security Administration.

Subtitle D—Appeals and Recovery

SEC. 831. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) TRANSITION PLAN.—

(1) IN GENERAL.—Not later than October 1, 2003, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) GAO EVALUATION.—The Comptroller General of the United States shall evaluate the plan and, not later than the date that is 6 months after the date on which the plan is received by the Comptroller General, shall submit to Congress a report on such evaluation.

(b) TRANSFER OF ADJUDICATION AUTHORITY.—

(1) IN GENERAL.—Not earlier than July 1, 2004, and not later than October 1, 2004, the Commissioner of Social Security and the Secretary shall implement the transition plan under subsection (a) and transfer the administrative law judge functions described in such subsection from the Social Security Administration to the Secretary.

(2) ASSURING INDEPENDENCE OF JUDGES.—The Secretary shall assure the independence of administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Centers for Medicare & Medicaid Services and its contractors.

(3) GEOGRAPHIC DISTRIBUTION.—The Secretary shall provide for an appropriate geographic distribution of administrative law judges performing the administrative law judge functions transferred under paragraph (1) throughout the United States to ensure timely access to such judges.

(4) HIRING AUTHORITY.—Subject to the amounts provided in advance in appropriations Act, the Secretary shall have authority to hire administrative law judges to hear such cases, giving priority to those judges with prior experience in handling medicare

appeals and in a manner consistent with paragraph (3), and to hire support staff for such judges.

(5) FINANCING.—Amounts payable under law to the Commissioner for administrative law judges performing the administrative law judge functions transferred under paragraph (1) from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund shall become payable to the Secretary for the functions so transferred.

(6) SHARED RESOURCES.—The Secretary shall enter into such arrangements with the Commissioner as may be appropriate with respect to transferred functions of administrative law judges to share office space, support staff, and other resources, with appropriate reimbursement from the Trust Funds described in paragraph (5).

(c) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to ensure timely action on appeals before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (as amended by section 521 of BIPA, 114 Stat. 2763A–534), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums as are necessary for fiscal year 2004 and each subsequent fiscal year to—

(1) increase the number of administrative law judges (and their staffs) under subsection (b)(4);

(2) improve education and training opportunities for administrative law judges (and their staffs); and

(3) increase the staff of the Departmental Appeals Board.

(d) CONFORMING AMENDMENT.—Section 1869(f)(2)(A)(i) (42 U.S.C. 1395ff(f)(2)(A)(i)), as added by section 522(a) of BIPA (114 Stat. 2763A–543), is amended by striking ''of the Social Security Administration''.

SEC. 832. PROCESS FOR EXPEDITED ACCESS TO REVIEW.

(a) EXPEDITED ACCESS TO JUDICIAL REVIEW.—Section 1869(b) (42 U.S.C. 1395ff(b)) as amended by BIPA, is amended—

(1) in paragraph (1)(A), by inserting '', subject to paragraph (2),'' before ''to judicial review of the Secretary's final decision'';

(2) in paragraph (1)(F)—

(A) by striking clause (ii);

(B) by striking ''PROCEEDING'' and all that follows through ''DETERMINATION'' and inserting ''DETERMINATIONS AND RECONSIDERATIONS''; and

(C) by redesignating subclauses (I) and (II) as clauses (i) and (ii) and by moving the indentation of such subclauses (and the matter that follows) 2 ems to the left; and

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

''(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

''(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or an individual entitled to benefits under part A or enrolled under part B, or both, who has filed an appeal under paragraph (1) may obtain access to judicial review when a review panel (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that no entity in the administrative appeals process has the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation in a case of an appeal.

''(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review panel that no review panel has the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute and if such request is accompanied by the documents and materials as the appropriate review panel shall require for purposes of making such determination, such review panel shall make a determination on the request in writing within 60 days after the date such review panel receives the request and such accompanying documents and materials. Such a determination by such review panel shall be considered a final decision and not subject to review by the Secretary.

''(C) ACCESS TO JUDICIAL REVIEW.—

''(i) IN GENERAL.—If the appropriate review panel—

''(I) determines that there are no material issues of fact in dispute and that the only issue is one of law or regulation that no review panel has the authority to decide; or

''(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

''(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

''(I) clause (i)(I), within 60 days of date of the determination described in such subparagraph; or

''(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

''(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

''(iv) INTEREST ON AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier seeks judicial review pursuant to this paragraph, the amount in controversy shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Hospital Insurance Trust Fund and by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services or suppliers under this Act.

''(D) REVIEW PANELS.—For purposes of this subsection, a 'review panel' is a panel consisting of 3 members (who shall be administrative law judges, members of the Departmental Appeals Board, or qualified individuals associated with a qualified independent contractor (as defined in subsection (c)(2)) or with another independent entity) designated by the Secretary for purposes of making determinations under this paragraph.''.

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting ''(A)'' after ''(h)(1)''; and

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

''(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2003.

(d) EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.—

(1) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which the remedy of termination of participation, or a remedy described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) which is applied on an immediate basis, has been imposed. Under such process priority shall be provided in cases of termination.

(2) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such additional sums for fiscal year 2004 and each subsequent fiscal year as may be necessary. The purposes for which such amounts are available include increasing the number of administrative law judges (and their staffs) and the appellate level staff at the Departmental Appeals Board of the Department of Health and Human Services and educating such judges and staffs on long-term care issues.

SEC. 833. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by BIPA and as amended by section 832(a), is further amended by adding at the end the following new paragraph:

''(3) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE BY PROVIDERS.—A provider of services or supplier may not introduce evidence in any appeal under this section that was not presented at the reconsideration conducted by the qualified independent contractor under subsection (c), unless there is good cause which precluded the introduction of such evidence at or before that reconsideration.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2003.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended by BIPA, is amended by inserting ''(including the medical records of the individual involved)'' after ''clinical experience''.

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)), as amended by BIPA, is amended by adding at the end the following new paragraph:

''(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial

determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall include—

''(A) the specific reasons for the determination, including—

''(i) upon request, the provision of the policy, manual, or regulation used in making the determination; and

''(ii) as appropriate in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination;

''(B) the procedures for obtaining additional information concerning the determination or redetermination; and

''(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.

The written notice on a redetermination shall be provided in printed form and written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both.''.

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)), as amended by BIPA, is amended—

(A) by inserting ''be written in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include (to the extent appropriate)'' after ''in writing, ''; and

(B) by inserting ''and a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section'' after ''such decision, ''.

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)), as amended by BIPA, is amended—

(A) in the heading, by inserting ''; NOTICE'' after ''SECRETARY''; and

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

''(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner calculated to be understood by the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

''(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

''(B) the procedures for obtaining additional information concerning the decision; and

''(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.''.

(4) SUBMISSION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by striking ''prepare'' and inserting ''submit'' and by striking ''with respect to'' and all that follows through ''and relevant policies''.

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(3) (42 U.S.C. 1395ff(c)(3)), as amended by BIPA, is amended—

(A) in subparagraph (A), by striking ''sufficient training and expertise in medical science and legal matters'' and inserting ''sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing''; and

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

''(K) INDEPENDENCE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

''(I) is not a related party (as defined in subsection (g)(5));

''(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

''(III) does not otherwise have a conflict of interest with such a party.

''(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

''(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.''.

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff), as amended by BIPA, is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

''(D) QUALIFICATIONS FOR REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).''; and

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

''(g) QUALIFICATIONS OF REVIEWERS.—

''(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

''(A) each individual conducting a review shall meet the qualifications of paragraph (2);

''(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

''(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), each reviewing professional meets the qualifications described in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), each reviewing professional shall be a physician (allopathic or osteopathic).

''(2) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

''(i) not be a related party (as defined in paragraph (5));

''(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

''(iii) not otherwise have a conflict of interest with such a party.

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of a participation agreement with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

''(I) the individual is not involved in the provision of items or services in the case under review;

''(II) the fact of such an agreement is disclosed to the Secretary and the individual entitled to benefits under part A or enrolled under part B, or both, (or authorized representative) and neither party objects; and

''(III) the individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of having such staff privileges if the existence of such privileges is disclosed to the Secretary and such individual (or authorized representative), and neither party objects; or

''(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

For purposes of this paragraph, the term 'participation agreement' means an agreement relating to the provision of health care services by the individual and does not include the provision of services as a reviewer under this subsection.

''(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

''(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be—

''(A) a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services and has medical expertise in the field of practice that is appropriate for the items or services at issue; or

''(B) a health care professional who is legally authorized in one or more States (in accordance with State law or the State regulatory mechanism provided by State law) to furnish the health care items or services at issue and has medical expertise in the field of practice that is appropriate for such items or services.

''(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving a specific individual entitled to benefits under part A or enrolled under part B, or both, any of the following:

''(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

''(B) The individual (or authorized representative).

''(C) The health care professional that provides the items or services involved in the case.

''(D) The institution at which the items or services (or treatment) involved in the case are provided.

''(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

''(F) Any other party determined under any regulations to have a substantial interest in the case involved.''.

(3) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, (114 Stat. 2763A–534).

(4) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by paragraph (2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 834. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 811(a)(1) and as amended by sections 812(b), 821(b)(1), and 821(c)(1), is further amended by adding at the end the following new subsection:

''(h) CONDUCT OF PREPAYMENT REVIEW.—

''(1) CONDUCT OF RANDOM PREPAYMENT REVIEW.—

''(A) IN GENERAL.—A medicare administrative contractor may conduct random prepayment review only to develop a contractor-wide or program-wide claims payment error

rates or under such additional circumstances as may be provided under regulations, developed in consultation with providers of services and suppliers.

''(B) USE OF STANDARD PROTOCOLS WHEN CONDUCTING PREPAYMENT REVIEWS.—When a medicare administrative contractor conducts a random prepayment review, the contractor may conduct such review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

''(C) CONSTRUCTION.—Nothing in this paragraph shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review.

''(D) RANDOM PREPAYMENT REVIEW.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.

''(2) LIMITATIONS ON NON-RANDOM PREPAYMENT REVIEW.—

''(A) LIMITATIONS ON INITIATION OF NON-RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate non-random prepayment review of a provider of services or supplier based on the initial identification by that provider of services or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined in subsection (i)(3)(A)).

''(B) TERMINATION OF NON-RANDOM PREPAYMENT REVIEW.—The Secretary shall issue regulations relating to the termination, including termination dates, of non-random prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect 1 year after the date of the enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(h) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of the enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary shall specify.

(c) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(h) of the Social Security Act, as added by subsection (a), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395u) in the same manner as they apply to medicare administrative contractors under such provisions.

SEC. 835. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1893 (42 U.S.C. 1395ddd) is amended by adding at the end the following new subsection:

''(f) RECOVERY OF OVERPAYMENTS.—

''(1) USE OF REPAYMENT PLANS.—

''(A) IN GENERAL.—If the repayment, within 30 days by a provider of services or supplier, of an overpayment under this title would constitute a hardship (as defined in subparagraph (B)), subject to subparagraph (C), upon request of the provider of services or supplier the Secretary shall enter into a plan with the provider of services or supplier for the repayment (through offset or otherwise) of such overpayment over a period of at least 6 months but not longer than 3 years (or not longer than 5 years in the case of extreme hardship, as determined by the Secretary). Interest shall accrue on the balance through the period of repayment. Such plan shall meet terms and conditions determined to be appropriate by the Secretary.

''(B) HARDSHIP.—

''(i) IN GENERAL.—For purposes of subparagraph (A), the repayment of an overpayment (or overpayments) within 30 days is deemed to constitute a hardship if—

''(I) in the case of a provider of services that files cost reports, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services for the cost reporting period covered by the most recently submitted cost report; or

''(II) in the case of another provider of services or supplier, the aggregate amount of the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the previous calendar year.

''(ii) RULE OF APPLICATION.—The Secretary shall establish rules for the application of this subparagraph in the case of a provider of services or supplier that was not paid under this title during the previous year or was paid under this title only during a portion of that year.

''(iii) TREATMENT OF PREVIOUS OVERPAYMENTS.—If a provider of services or supplier has entered into a repayment plan under subparagraph (A) with respect to a specific overpayment amount, such payment amount under the repayment plan shall not be taken into account under clause (i) with respect to subsequent overpayment amounts.

''(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

''(i) the Secretary has reason to suspect that the provider of services or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

''(ii) there is an indication of fraud or abuse committed against the program.

''(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

''(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

''(2) LIMITATION ON RECOUPMENT.—

''(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination under section 1869(b)(1), the Secretary may not take any action (or authorize any other person, including any medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered. If the provisions of section 1869(b)(1) (providing for such a reconsideration by a qualified independent contractor) are not in effect, in applying the previous sentence any reference to such a reconsideration shall be treated as a reference to a redetermination by the fiscal intermediary or carrier involved.

''(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is against the provider of services or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination against the provider of services or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest at the same rate as would apply under the previous sentence for the period in which the amount was recouped.

''(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(g).

''(3) LIMITATION ON USE OF EXTRAPOLATION.—A medicare contractor may not use extrapolation to determine overpayment amounts to be recovered by recoupment, offset, or otherwise unless—

''(A) there is a sustained or high level of payment error (as defined by the Secretary by regulation); or

''(B) documented educational intervention has failed to correct the payment error (as determined by the Secretary).

''(4) PROVISION OF SUPPORTING DOCUMENTATION.—In the case of a provider of services or supplier with respect to which amounts were previously overpaid, a medicare contractor may request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

''(5) CONSENT SETTLEMENT REFORMS.—

''(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

''(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services or supplier a consent settlement, the Secretary shall—

''(i) communicate to the provider of services or supplier—

''(I) that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment;

''(II) the nature of the problems identified in such evaluation; and

''(III) the steps that the provider of services or supplier should take to address the problems; and

''(ii) provide for a 45-day period during which the provider of services or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

''(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

''(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

''(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

''(I) the opportunity for a statistically valid random sample; or

''(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

''(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

''(6) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing

the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers served by the contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

''(7) PAYMENT AUDITS.—

''(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services or supplier under this title, the contractor shall provide the provider of services or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

''(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services or supplier under this title, the contractor shall—

''(i) give the provider of services or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services or supplier and permits the development of an appropriate corrective action plan;

''(ii) inform the provider of services or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary);

''(iii) give the provider of services or supplier an opportunity to provide additional information to the contractor; and

''(iv) take into account information provided, on a timely basis, by the provider of services or supplier under clause (iii).

''(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

''(8) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.''.

(b) EFFECTIVE DATES AND DEADLINES.—

(1) USE OF REPAYMENT PLANS.—Section 1893(f)(1) of the Social Security Act, as added by subsection (a), shall apply to requests for repayment plans made after the date of the enactment of this Act.

(2) LIMITATION ON RECOUPMENT.—Section 1893(f)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date of the enactment of this Act.

(3) USE OF EXTRAPOLATION.—Section 1893(f)(3) of the Social Security Act, as added by subsection (a), shall apply to statistically valid random samples initiated after the date that is 1 year after the date of the enactment of this Act.

(4) PROVISION OF SUPPORTING DOCUMENTATION.—Section 1893(f)(4) of the Social Security Act, as added by subsection (a), shall take effect on the date of the enactment of this Act.

(5) CONSENT SETTLEMENT.—Section 1893(f)(5) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of the enactment of this Act.

(6) NOTICE OF OVERUTILIZATION.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish the process for notice of overutilization of billing codes under section 1893A(f)(6) of the Social Security Act, as added by subsection (a).

(7) PAYMENT AUDITS.—Section 1893A(f)(7) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of the enactment of this Act.

(8) STANDARD FOR ABNORMAL BILLING PATTERNS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act, as added by subsection (a).

SEC. 836. PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) by adding at the end of the heading the following: ''; ENROLLMENT PROCESSES''; and

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

''(j) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

''(1) ENROLLMENT PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title.

''(B) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment). The Secretary shall monitor the performance of medicare administrative contractors in meeting the deadlines established under this subparagraph.

''(C) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the provider enrollment forms required of such providers and suppliers to be eligible to submit claims for which payment may be made under this title.

''(2) HEARING RIGHTS IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a hearing and judicial review of such denial under the procedures that apply under subsection (h)(1)(A) to a provider of services that is dissatisfied with a determination by the Secretary.''.

(b) EFFECTIVE DATES.—

(1) ENROLLMENT PROCESS.—The Secretary shall provide for the establishment of the enrollment process under section 1866(j)(1) of the Social Security Act, as added by subsection (a)(2), within 6 months after the date of the enactment of this Act.

(2) CONSULTATION.—Section 1866(j)(1)(C) of the Social Security Act, as added by subsection (a)(2), shall apply with respect to changes in provider enrollment forms made on or after January 1, 2003.

(3) HEARING RIGHTS.—Section 1866(j)(2) of the Social Security Act, as added by subsection (a)(2), shall apply to denials occurring on or after such date (not later than 1 year after the date of the enactment of this Act) as the Secretary specifies.

SEC. 837. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(g) of the Social Security Act, as inserted by section 821(a)(1)) and representatives of providers of services and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

SEC. 838. PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES; ADVANCE BENEFICIARY NOTICES.

(a) IN GENERAL.—Section 1869 (42 U.S.C. 1395ff(b)), as amended by sections 521 and 522 of BIPA and section 833(d)(2)(B), is further amended by adding at the end the following new subsection:

''(h) PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.—

''(1) ESTABLISHMENT OF PROCESS.—

''(A) IN GENERAL.—With respect to a medicare administrative contractor that has a contract under section 1874A that provides for making payments under this title with respect to eligible items and services described in subparagraph (C), the Secretary shall establish a prior determination process that meets the requirements of this subsection and that shall be applied by such contractor in the case of eligible requesters.

''(B) ELIGIBLE REQUESTER.—For purposes of this subsection, each of the following shall be an eligible requester:

''(i) A physician, but only with respect to eligible items and services for which the physician may be paid directly.

''(ii) An individual entitled to benefits under this title, but only with respect to an item or service for which the individual receives, from the physician who may be paid directly for the item or service, an advance beneficiary notice under section 1879(a) that payment may not be made (or may no longer be made) for the item or service under this title.

''(C) ELIGIBLE ITEMS AND SERVICES.—For purposes of this subsection and subject to paragraph (2), eligible items and services are items and services which are physicians' services (as defined in paragraph (4)(A) of section 1848(f) for purposes of calculating the sustainable growth rate under such section).

''(2) SECRETARIAL FLEXIBILITY.—The Secretary shall establish by regulation reasonable limits on the categories of eligible items and services for which a prior determination of coverage may be requested under this subsection. In establishing such limits, the Secretary may consider the dollar amount involved with respect to the item or service, administrative costs and burdens, and other relevant factors.

''(3) REQUEST FOR PRIOR DETERMINATION.—

''(A) IN GENERAL.—Subject to paragraph (2), under the process established under this subsection an eligible requester may submit to the contractor a request for a determination, before the furnishing of an eligible item or service involved as to whether the item or service is covered under this title consistent with the applicable requirements of section 1862(a)(1)(A) (relating to medical necessity).

''(B) ACCOMPANYING DOCUMENTATION.—The Secretary may require that the request be accompanied by a description of the item or service, supporting documentation relating to the medical necessity for the item or service, and any other appropriate documentation. In the case of a request submitted by an eligible requester who is described in paragraph (1)(B)(ii), the Secretary may require that the request also be accompanied by a copy of the advance beneficiary notice involved.

''(4) RESPONSE TO REQUEST.—

''(A) IN GENERAL.—Under such process, the contractor shall provide the eligible requester with written notice of a determination as to whether—

''(i) the item or service is so covered;

''(ii) the item or service is not so covered; or

''(iii) the contractor lacks sufficient information to make a coverage determination.

If the contractor makes the determination described in clause (iii), the contractor shall

include in the notice a description of the additional information required to make the coverage determination.

''(B) DEADLINE TO RESPOND.—Such notice shall be provided within the same time period as the time period applicable to the contractor providing notice of initial determinations on a claim for benefits under subsection (a)(2)(A).

''(C) INFORMING BENEFICIARY IN CASE OF PHYSICIAN REQUEST.—In the case of a request in which an eligible requester is not the individual described in paragraph (1)(B)(ii), the process shall provide that the individual to whom the item or service is proposed to be furnished shall be informed of any determination described in clause (ii) (relating to a determination of non-coverage) and the right (referred to in paragraph (6)(B)) to obtain the item or service and have a claim submitted for the item or service.

''(5) EFFECT OF DETERMINATIONS.—

''(A) BINDING NATURE OF POSITIVE DETERMINATION.—If the contractor makes the determination described in paragraph (4)(A)(i), such determination shall be binding on the contractor in the absence of fraud or evidence of misrepresentation of facts presented to the contractor.

''(B) NOTICE AND RIGHT TO REDETERMINATION IN CASE OF A DENIAL.—

''(i) IN GENERAL.—If the contractor makes the determination described in paragraph (4)(A)(ii)—

''(I) the eligible requester has the right to a redetermination by the contractor on the determination that the item or service is not so covered; and

''(II) the contractor shall include in notice under paragraph (4)(A) a brief explanation of the basis for the determination, including on what national or local coverage or noncoverage determination (if any) the determination is based, and the right to such a redetermination.

''(ii) DEADLINE FOR REDETERMINATIONS.—The contractor shall complete and provide notice of such redetermination within the same time period as the time period applicable to the contractor providing notice of redeterminations relating to a claim for benefits under subsection (a)(3)(C)(ii).

''(6) LIMITATION ON FURTHER REVIEW.—

''(A) IN GENERAL.—Contractor determinations described in paragraph (4)(A)(ii) or (4)(A)(iii) (and redeterminations made under paragraph (5)(B)), relating to pre-service claims are not subject to further administrative appeal or judicial review under this section or otherwise.

''(B) DECISION NOT TO SEEK PRIOR DETERMINATION OR NEGATIVE DETERMINATION DOES NOT IMPACT RIGHT TO OBTAIN SERVICES, SEEK REIMBURSEMENT, OR APPEAL RIGHTS.—Nothing in this subsection shall be construed as affecting the right of an individual who—

''(i) decides not to seek a prior determination under this subsection with respect to items or services; or

''(ii) seeks such a determination and has received a determination described in paragraph (4)(A)(ii),

from receiving (and submitting a claim for) such items services and from obtaining administrative or judicial review respecting such claim under the other applicable provisions of this section. Failure to seek a prior determination under this subsection with respect to items and services shall not be taken into account in such administrative or judicial review.

''(C) NO PRIOR DETERMINATION AFTER RECEIPT OF SERVICES.—Once an individual is provided items and services, there shall be no prior determination under this subsection with respect to such items or services.''.

(b) EFFECTIVE DATE; TRANSITION.—

(1) EFFECTIVE DATE.—The Secretary shall establish the prior determination process under the amendment made by subsection (a) in such a manner as to provide for the acceptance of requests for determinations under such process filed not later than 18 months after the date of the enactment of this Act.

(2) TRANSITION.—During the period in which the amendment made by subsection (a) has become effective but contracts are not provided under section 1874A of the Social Security Act with medicare administrative contractors, any reference in section 1869(g) of such Act (as added by such amendment) to such a contractor is deemed a reference to a fiscal intermediary or carrier with an agreement under section 1816, or contract under section 1842, respectively, of such Act.

(3) LIMITATION ON APPLICATION TO SGR.—For purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)), the amendment made by subsection (a) shall not be considered to be a change in law or regulation.

(c) PROVISIONS RELATING TO ADVANCE BENEFICIARY NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—

(1) DATA COLLECTION.—The Secretary shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (4)) has been provided and on instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

(2) OUTREACH AND EDUCATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the medicare program.

(3) GAO REPORT REPORT ON USE OF ADVANCE BENEFICIARY NOTICES.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act. Such report shall include information concerning the providers of services and other persons that have provided such notices and the response of beneficiaries to such notices.

(4) GAO REPORT ON USE OF PRIOR DETERMINATION PROCESS.—Not later than 18 months after the date on which section 1869(g) of the Social Security Act (as added by subsection (a)) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

(A) information concerning the types of procedures for which a prior determination has been sought, determinations made under the process, and changes in receipt of services resulting from the application of such process; and

(B) an evaluation of whether the process was useful for physicians (and other suppliers) and beneficiaries, whether it was timely, and whether the amount of information required was burdensome to physicians and beneficiaries.

(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term ''advance beneficiary notice'' means a written notice provided under section 1879(a) of the Social Security Act (42 U.S.C. 1395pp(a)) to an individual entitled to benefits under part A or B of title XVIII of such Act before items or services are furnished under such part in cases where a provider of services or other person that would furnish the item or service believes that payment will not be made for some or all of such items or services under such title.

Subtitle E—Miscellaneous Provisions

SEC. 841. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES.

(a) IN GENERAL.—The Secretary may not implement any new documentation guidelines for evaluation and management physician services under the title XVIII of the Social Security Act on or after the date of the enactment of this Act unless the Secretary—

(1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;

(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

(3) has conducted appropriate and representative pilot projects under subsection (b) to test modifications to the evaluation and management documentation guidelines;

(4) finds that the objectives described in subsection (c) will be met in the implementation of such guidelines; and

(5) has established, and is implementing, a program to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

(b) PILOT PROJECTS TO TEST EVALUATION AND MANAGEMENT DOCUMENTATION GUIDELINES.—

(1) IN GENERAL.—The Secretary shall conduct under this subsection appropriate and representative pilot projects to test new evaluation and management documentation guidelines referred to in subsection (a).

(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—

(A) be voluntary;

(B) be of sufficient length as determined by the Secretary to allow for preparatory physician and medicare contractor education, analysis, and use and assessment of potential evaluation and management guidelines; and

(C) be conducted, in development and throughout the planning and operational stages of the project, in consultation with practicing physicians (including both generalists and specialists).

(3) RANGE OF PILOT PROJECTS.—Of the pilot projects conducted under this subsection—

(A) at least one shall focus on a peer review method by physicians (not employed by a medicare contractor) which evaluates medical record information for claims submitted by physicians identified as statistical outliers relative to definitions published in the Current Procedures Terminology (CPT) code book of the American Medical Association;

(B) at least one shall focus on an alternative method to detailed guidelines based on physician documentation of face to face encounter time with a patient;

(C) at least one shall be conducted for services furnished in a rural area and at least one for services furnished outside such an area; and

(D) at least one shall be conducted in a setting where physicians bill under physicians' services in teaching settings and at least one shall be conducted in a setting other than a teaching setting.

(4) BANNING OF TARGETING OF PILOT PROJECT PARTICIPANTS.—Data collected under this subsection shall not be used as the basis for overpayment demands or post-payment audits. Such limitation applies only to claims

filed as part of the pilot project and lasts only for the duration of the pilot project and only as long as the provider is a participant in the pilot project.

(5) STUDY OF IMPACT.—Each pilot project shall examine the effect of the new evaluation and management documentation guidelines on—

(A) different types of physician practices, including those with fewer than 10 full-time-equivalent employees (including physicians); and

(B) the costs of physician compliance, including education, implementation, auditing, and monitoring.

(6) PERIODIC REPORTS.—The Secretary shall submit to Congress periodic reports on the pilot projects under this subsection.

(c) OBJECTIVES FOR EVALUATION AND MANAGEMENT GUIDELINES.—The objectives for modified evaluation and management documentation guidelines developed by the Secretary shall be to—

(1) identify clinically relevant documentation needed to code accurately and assess coding levels accurately;

(2) decrease the level of non-clinically pertinent and burdensome documentation time and content in the physician's medical record;

(3) increase accuracy by reviewers; and

(4) educate both physicians and reviewers.

(d) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOCUMENTATION FOR PHYSICIAN CLAIMS.—

(1) STUDY.—The Secretary shall carry out a study of the matters described in paragraph (2).

(2) MATTERS DESCRIBED.—The matters referred to in paragraph (1) are—

(A) the development of a simpler, alternative system of requirements for documentation accompanying claims for evaluation and management physician services for which payment is made under title XVIII of the Social Security Act; and

(B) consideration of systems other than current coding and documentation requirements for payment for such physician services.

(3) CONSULTATION WITH PRACTICING PHYSICIANS.—In designing and carrying out the study under paragraph (1), the Secretary shall consult with practicing physicians, including physicians who are part of group practices and including both generalists and specialists.

(4) APPLICATION OF HIPAA UNIFORM CODING REQUIREMENTS.—In developing an alternative system under paragraph (2), the Secretary shall consider requirements of administrative simplification under part C of title XI of the Social Security Act.

(5) REPORT TO CONGRESS.—(A) Not later than October 1, 2004, the Secretary shall submit to Congress a report on the results of the study conducted under paragraph (1).

(B) The Medicare Payment Advisory Commission shall conduct an analysis of the results of the study included in the report under subparagraph (A) and shall submit a report on such analysis to Congress.

(e) STUDY ON APPROPRIATE CODING OF CERTAIN EXTENDED OFFICE VISITS.—The Secretary shall conduct a study of the appropriateness of coding in cases of extended office visits in which there is no diagnosis made. Not later than October 1, 2004, the Secretary shall submit a report to Congress on such study and shall include recommendations on how to code appropriately for such visits in a manner that takes into account the amount of time the physician spent with the patient.

(f) DEFINITIONS.—In this section—

(1) the term ''rural area'' has the meaning given that term in section 1886(d)(2)(D) of the Social Security Act, 42 U.S.C. 1395ww(d)(2)(D); and

(2) the term ''teaching settings'' are those settings described in section 415.150 of title 42, Code of Federal Regulations.

SEC. 842. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) IMPROVED COORDINATION BETWEEN FDA AND CMS ON COVERAGE OF BREAKTHROUGH MEDICAL DEVICES.—

(1) IN GENERAL.—Upon request by an applicant and to the extent feasible (as determined by the Secretary), the Secretary shall, in the case of a class III medical device that is subject to premarket approval under section 515 of the Federal Food, Drug, and Cosmetic Act, ensure the sharing of appropriate information from the review for application for premarket approval conducted by the Food and Drug Administration for coverage decisions under title XVIII of the Social Security Act.

(2) PUBLICATION OF PLAN.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to appropriate Committees of Congress a report that contains the plan for improving such coordination and for shortening the time lag between the premarket approval by the Food and Drug Administration and coding and coverage decisions by the Centers for Medicare & Medicaid Services.

(3) CONSTRUCTION.—Nothing in this subsection shall be construed as changing the criteria for coverage of a medical device under title XVIII of the Social Security Act nor premarket approval by the Food and Drug Administration and nothing in this subsection shall be construed to increase premarket approval application requirements under the Federal Food, Drug, and Cosmetic Act.

(b) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Section 1868 (42 U.S.C. 1395ee), as amended by section 823(a), is amended by adding at the end the following new subsection:

''(c) COUNCIL FOR TECHNOLOGY AND INNOVATION.—

''(1) ESTABLISHMENT.—The Secretary shall establish a Council for Technology and Innovation within the Centers for Medicare & Medicaid Services (in this section referred to as 'CMS').

''(2) COMPOSITION.—The Council shall be composed of senior CMS staff and clinicians and shall be chaired by the Executive Coordinator for Technology and Innovation (appointed or designated under paragraph (4)).

''(3) DUTIES.—The Council shall coordinate the activities of coverage, coding, and payment processes under this title with respect to new technologies and procedures, including new drug therapies, and shall coordinate the exchange of information on new technologies between CMS and other entities that make similar decisions.

''(4) EXECUTIVE COORDINATOR FOR TECHNOLOGY AND INNOVATION.—The Secretary shall appoint (or designate) a noncareer appointee (as defined in section 3132(a)(7) of title 5, United States Code) who shall serve as the Executive Coordinator for Technology and Innovation. Such executive coordinator shall report to the Administrator of CMS, shall chair the Council, shall oversee the execution of its duties, and shall serve as a single point of contact for outside groups and entities regarding the coverage, coding, and payment processes under this title.''.

(c) GAO STUDY ON IMPROVEMENTS IN EXTERNAL DATA COLLECTION FOR USE IN THE MEDICARE INPATIENT PAYMENT SYSTEM.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study that analyzes which external data can be collected in a shorter time frame by the Centers for Medicare & Medicaid Services for use in computing payments for inpatient hospital services. The study may include an evaluation of the feasibility and appropriateness of using of quarterly samples or special surveys or any other methods. The study shall include an analysis of whether other executive agencies, such as the Bureau of Labor Statistics in the Department of Commerce, are best suited to collect this information.

(2) REPORT.—By not later than October 1, 2003, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

(d) IOM STUDY ON LOCAL COVERAGE DETERMINATIONS.—

(1) STUDY.—The Secretary shall enter into an arrangement with the Institute of Medicine of the National Academy of Sciences under which the Institute shall conduct a study on local coverage determinations (including the application of local medical review policies) under the medicare program under title XVIII of the Social Security Act. Such study shall examine—

(A) the consistency of the definitions used in such determinations;

(B) the types of evidence on which such determinations are based, including medical and scientific evidence;

(C) the advantages and disadvantages of local coverage decisionmaking, including the flexibility it offers for ensuring timely patient access to new medical technology for which data are still be collected;

(D) the manner in which the local coverage determination process is used to develop data needed for a national coverage determination, including the need for collection of such data within a protocol and informed consent by individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both; and

(E) the advantages and disadvantages of maintaining local medicare contractor advisory committees that can advise on local coverage decisions based on an open, collaborative public process.

(2) REPORT.—Such arrangement shall provide that the Institute shall submit to the Secretary a report on such study by not later than 3 years after the date of the enactment of this Act. The Secretary shall promptly transmit a copy of such report to Congress.

(e) METHODS FOR DETERMINING PAYMENT BASIS FOR NEW LAB TESTS.—Section 1833(h) (42 U.S.C. 1395l(h)) is amended by adding at the end the following:

''(8)(A) The Secretary shall establish by regulation procedures for determining the basis for, and amount of, payment under this subsection for any clinical diagnostic laboratory test with respect to which a new or substantially revised HCPCS code is assigned on or after January 1, 2004 (in this paragraph referred to as 'new tests').

''(B) Determinations under subparagraph (A) shall be made only after the Secretary—

''(i) makes available to the public (through an Internet site and other appropriate mechanisms) a list that includes any such test for which establishment of a payment amount under this subsection is being considered for a year;

''(ii) on the same day such list is made available, causes to have published in the Federal Register notice of a meeting to receive comments and recommendations (and data on which recommendations are based) from the public on the appropriate basis under this subsection for establishing payment amounts for the tests on such list;

''(iii) not less than 30 days after publication of such notice convenes a meeting, that includes representatives of officials of the Centers for Medicare & Medicaid Services involved in determining payment amounts, to

receive such comments and recommendations (and data on which the recommendations are based);

''(iv) taking into account the comments and recommendations (and accompanying data) received at such meeting, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of proposed determinations with respect to the appropriate basis for establishing a payment amount under this subsection for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and a request for public written comments on the proposed determination; and

''(v) taking into account the comments received during the public comment period, develops and makes available to the public (through an Internet site and other appropriate mechanisms) a list of final determinations of the payment amounts for such tests under this subsection, together with the rationale for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

''(C) Under the procedures established pursuant to subparagraph (A), the Secretary shall—

''(i) set forth the criteria for making determinations under subparagraph (A); and

''(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

''(D) The Secretary may convene such further public meetings to receive public comments on payment amounts for new tests under this subsection as the Secretary deems appropriate.

''(E) For purposes of this paragraph:

''(i) The term 'HCPCS' refers to the Health Care Procedure Coding System.

''(ii) A code shall be considered to be 'substantially revised' if there is a substantive change to the definition of the test or procedure to which the code applies (such as a new analyte or a new methodology for measuring an existing analyte-specific test).''.

SEC. 843. TREATMENT OF HOSPITALS FOR CERTAIN SERVICES UNDER MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) IN GENERAL.—The Secretary shall not require a hospital (including a critical access hospital) to ask questions (or obtain information) relating to the application of section 1862(b) of the Social Security Act (relating to medicare secondary payor provisions) in the case of reference laboratory services described in subsection (b), if the Secretary does not impose such requirement in the case of such services furnished by an independent laboratory.

(b) REFERENCE LABORATORY SERVICES DESCRIBED.—Reference laboratory services described in this subsection are clinical laboratory diagnostic tests (or the interpretation of such tests, or both) furnished without a face-to-face encounter between the individual entitled to benefits under part A or enrolled under part B, or both, and the hospital involved and in which the hospital submits a claim only for such test or interpretation.

SEC. 844. EMTALA IMPROVEMENTS.

(a) PAYMENT FOR EMTALA-MANDATED SCREENING AND STABILIZATION SERVICES.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by inserting after subsection (c) the following new subsection:

''(d) For purposes of subsection (a)(1)(A), in the case of any item or service that is required to be provided pursuant to section 1867 to an individual who is entitled to benefits under this title, determinations as to whether the item or service is reasonable and necessary shall be made on the basis of the information available to the treating physician or practitioner (including the patient's presenting symptoms or complaint) at the time the item or service was ordered or furnished by the physician or practitioner (and not on the patient's principal diagnosis). When making such determinations with respect to such an item or service, the Secretary shall not consider the frequency with which the item or service was provided to the patient before or after the time of the admission or visit.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to items and services furnished on or after January 1, 2003.

(b) NOTIFICATION OF PROVIDERS WHEN EMTALA INVESTIGATION CLOSED.—Section 1867(d) (42 U.S.C. 42 U.S.C. 1395dd(d)) is amended by adding at the end the following new paragraph:

''(4) NOTICE UPON CLOSING AN INVESTIGATION.—The Secretary shall establish a procedure to notify hospitals and physicians when an investigation under this section is closed.''.

(c) PRIOR REVIEW BY PEER REVIEW ORGANIZATIONS IN EMTALA CASES INVOLVING TERMINATION OF PARTICIPATION.—

(1) IN GENERAL.—Section 1867(d)(3) (42 U.S.C. 1395dd(d)(3)) is amended—

(A) in the first sentence, by inserting ''or in terminating a hospital's participation under this title'' after ''in imposing sanctions under paragraph (1)''; and

(B) by adding at the end the following new sentences: ''Except in the case in which a delay would jeopardize the health or safety of individuals, the Secretary shall also request such a review before making a compliance determination as part of the process of terminating a hospital's participation under this title for violations related to the appropriateness of a medical screening examination, stabilizing treatment, or an appropriate transfer as required by this section, and shall provide a period of 5 days for such review. The Secretary shall provide a copy of the organization's report to the hospital or physician consistent with confidentiality requirements imposed on the organization under such part B.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to terminations of participation initiated on or after the date of the enactment of this Act.

SEC. 845. EMERGENCY MEDICAL TREATMENT AND LABOR ACT (EMTALA) TECHNICAL ADVISORY GROUP.

(a) ESTABLISHMENT.—The Secretary shall establish a Technical Advisory Group (in this section referred to as the ''Advisory Group'') to review issues related to the Emergency Medical Treatment and Labor Act (EMTALA) and its implementation. In this section, the term ''EMTALA'' refers to the provisions of section 1867 of the Social Security Act (42 U.S.C. 1395dd).

(b) MEMBERSHIP.—The Advisory Group shall be composed of 19 members, including the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and of which—

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least 2 of which have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology or cardiothoracic surgery, orthopedic surgery, neurosurgery, obstetrics-gynecology, and psychiatry, with not more than one physician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investigations from different regional offices of the Centers for Medicare & Medicaid Services; and

(5) 1 shall be from a State survey office involved in EMTALA investigations and 1 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

In selecting members described in paragraphs (1) through (3), the Secretary shall consider qualified individuals nominated by organizations representing providers and patients.

(c) GENERAL RESPONSIBILITIES.—The Advisory Group—

(1) shall review EMTALA regulations;

(2) may provide advice and recommendations to the Secretary with respect to those regulations and their application to hospitals and physicians;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations; and

(4) may disseminate information on the application of such regulations to hospitals, physicians, and the public.

(d) ADMINISTRATIVE MATTERS.—

(1) CHAIRPERSON.—The members of the Advisory Group shall elect a member to serve as chairperson of the Advisory Group for the life of the Advisory Group.

(2) MEETINGS.—The Advisory Group shall first meet at the direction of the Secretary. The Advisory Group shall then meet twice per year and at such other times as the Advisory Group may provide.

(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 846. AUTHORIZING USE OF ARRANGEMENTS WITH OTHER HOSPICE PROGRAMS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following new subparagraph:

''(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.''.

(b) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)), as amended by section 421(b), is amended by adding at the end the following new paragraph:

''(5) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care provided on or after the date of the enactment of this Act.

SEC. 847. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (R), by striking ''and'' at the end;

(B) in subparagraph (S), by striking the period at the end and inserting ''; and''; and

(C) by inserting after subparagraph (S) the following new subparagraph:

''(T) in the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970, to comply with the Bloodborne Pathogens standard under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated).''; and

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

''(4)(A) A hospital that fails to comply with the requirement of subsection (a)(1)(T) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to termination of an agreement under this section.

''(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under section 17 of the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(1)(T) by a hospital that is subject to the provisions of such Act.

''(C) A civil money penalty under this paragraph shall be imposed and collected in the same manner as civil money penalties under subsection (a) of section 1128A are imposed and collected under that section.''.

(b) EFFECTIVE DATE.—The amendments made by this subsection (a) shall apply to hospitals as of July 1, 2003.

SEC. 848. BIPA-RELATED TECHNICAL AMENDMENTS AND CORRECTIONS.

(a) TECHNICAL AMENDMENTS RELATING TO ADVISORY COMMITTEE UNDER BIPA SECTION 522.—(1) Subsection (i) of section 1114 (42 U.S.C. 1314)—

(A) is transferred to section 1862 and added at the end of such section; and

(B) is redesignated as subsection (j).

(2) Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the last sentence of subsection (a), by striking ''established under section 1114(f)''; and

(B) in subsection (j), as so transferred and redesignated—

(i) by striking ''under subsection (f)''; and

(ii) by striking ''section 1862(a)(1)'' and inserting ''subsection (a)(1)''.

(b) TERMINOLOGY CORRECTIONS.—(1) Section 1869(c)(3)(I)(ii) (42 U.S.C. 1395ff(c)(3)(I)(ii)), as amended by section 521 of BIPA, is amended—

(A) in subclause (III), by striking ''policy'' and inserting ''determination''; and

(B) in subclause (IV), by striking ''medical review policies'' and inserting ''coverage determinations''.

(2) Section 1852(a)(2)(C) (42 U.S.C. 1395w–22(a)(2)(C)) is amended by striking ''policy'' and ''POLICY'' and inserting ''determination'' each place it appears and ''DETERMINATION'', respectively.

(c) REFERENCE CORRECTIONS.—Section 1869(f)(4) (42 U.S.C. 1395ff(f)(4)), as added by section 522 of BIPA, is amended—

(1) in subparagraph (A)(iv), by striking ''subclause (I), (II), or (III)'' and inserting ''clause (i), (ii), or (iii)'';

(2) in subparagraph (B), by striking ''clause (i)(IV)'' and ''clause (i)(III)'' and inserting ''subparagraph (A)(iv)'' and ''subparagraph (A)(iii)'', respectively; and

(3) in subparagraph (C), by striking ''clause (i)'', ''subclause (IV)'' and ''subparagraph (A)'' and inserting ''subparagraph (A)'', ''clause (iv)'' and ''paragraph (1)(A)'', respectively each place it appears.

(d) OTHER CORRECTIONS.—Effective as if included in the enactment of section 521(c) of BIPA, section 1154(e) (42 U.S.C. 1320c–3(e)) is amended by striking paragraph (5).

(e) EFFECTIVE DATE.—Except as otherwise provided, the amendments made by this section shall be effective as if included in the enactment of BIPA.

SEC. 849. CONFORMING AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: ''Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than five years, except that, upon the request of the administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on individuals entitled to benefits under part A of title XVIII or enrolled under part B of such title, or both, the Secretary may waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.''.

SEC. 850. TREATMENT OF CERTAIN DENTAL CLAIMS.

(a) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended by adding after subsection (g) the following new subsection:

''(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(v)) providing supplemental or secondary coverage to individuals also entitled to services under this title shall not require a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making a claims determination for such benefits under the group health plan.

''(2) A group health plan may require a claims determination under this title in cases involving or appearing to involve inpatient dental hospital services or dental services expressly covered under this title pursuant to actions taken by the Secretary.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date that is 60 days after the date of the enactment of this Act.

SEC. 851. ANNUAL PUBLICATION OF LIST OF NATIONAL COVERAGE DETERMINATIONS.

The Secretary shall provide, in an appropriate annual publication available to the public, a list of national coverage determinations made under title XVIII of the Social Security Act in the previous year and information on how to get more information with respect to such determinations.

TITLE IX—MEDICAID PROVISIONS

SEC. 901. NATIONAL BIPARTISAN COMMISSION ON THE FUTURE OF MEDICAID.

(a) ESTABLISHMENT.—There is established a commission to be known as the National Bipartisan Commission on the Future of Medicaid (in this section referred to as the ''Commission'').

(b) DUTIES OF THE COMMISSION.—The Commission shall—

(1) review and analyze the long-term financial condition of the medicaid program under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.);

(2) identify the factors that are causing, and the consequences of, increases in costs under the medicaid program, including—

(A) the impact of these cost increases upon State budgets, funding for other State programs, and levels of State taxes necessary to fund growing expenditures under the medicaid program;

(B) the financial obligations of the Federal government arising from the Federal matching requirement for expenditures under the medicaid program; and

(C) the size and scope of the current program and how the program has evolved over time;

(3) analyze potential policies that will ensure both the financial integrity of the medicaid program and the provision of appropriate benefits under such program;

(4) make recommendations for establishing incentives and structures to promote enhanced efficiencies and ways of encouraging innovative State policies under the medicaid program;

(5) make recommendations for establishing the appropriate balance between benefits covered, payments to providers, State and Federal contributions and, where appropriate, recipient cost-sharing obligations;

(6) make recommendations on the impact of promoting increased utilization of competitive, private enterprise models to contain program cost growth, through enhanced utilization of private plans, pharmacy benefit managers, and other methods currently being used to contain private sector healthcare costs;

(7) make recommendations on the financing of prescription drug benefits currently covered under medicaid programs, including analysis of the current Federal manufacturer rebate program, its impact upon both private market prices as well as those paid by other government purchasers, recent State efforts to negotiate additional supplemental manufacturer rebates and the ability of pharmacy benefit managers to lower drug costs;

(8) review and analyze such other matters relating to the medicaid program as the Commission deems appropriate; and

(9) analyze the impact of impending demographic changes upon medicaid benefits, including long term care services, and make recommendations for how best to appropriately divide State and Federal responsibilities for funding these benefits.

(c) MEMBERSHIP.—

(1) NUMBER AND APPOINTMENT.—The Commission shall be composed of 17 members, of whom—

(A) four shall be appointed by the President;

(B) six shall be appointed by the Majority Leader of the Senate, in consultation with the Minority Leader of the Senate, of whom not more than 4 shall be of the same political party;

(C) six shall be appointed by the Speaker of the House of Representatives, in consultation with the Minority Leader of the House of Representatives, of whom not more than 4 shall be of the same political party; and

(D) one, who shall serve as Chairman of the Commission, appointed jointly by the President, Majority Leader of the Senate, and the Speaker of the House of Representatives.

(2) DEADLINE FOR APPOINTMENT.—Members of the Commission shall be appointed by not later than December 1, 2002.

(3) TERMS OF APPOINTMENT.—The term of any appointment under paragraph (1) to the Commission shall be for the life of the Commission.

(4) MEETINGS.—The Commission shall meet at the call of its Chairman or a majority of its members.

(5) QUORUM.—A quorum shall consist of 8 members of the Commission, except that 4 members may conduct a hearing under subsection (e).

(6) VACANCIES.—A vacancy on the Commission shall be filled in the same manner in which the original appointment was made not later than 30 days after the Commission is given notice of the vacancy and shall not affect the power of the remaining members to execute the duties of the Commission.

(7) COMPENSATION.—Members of the Commission shall receive no additional pay, allowances, or benefits by reason of their service on the Commission.

(8) EXPENSES.—Each member of the Commission shall receive travel expenses and per

diem in lieu of subsistence in accordance with sections 5702 and 5703 of title 5, United States Code.

(d) STAFF AND SUPPORT SERVICES.—

(1) EXECUTIVE DIRECTOR.—

(A) APPOINTMENT.—The Chairman shall appoint an executive director of the Commission.

(B) COMPENSATION.—The executive director shall be paid the rate of basic pay for level V of the Executive Schedule.

(2) STAFF.—With the approval of the Commission, the executive director may appoint such personnel as the executive director considers appropriate.

(3) APPLICABILITY OF CIVIL SERVICE LAWS.—The staff of the Commission shall be appointed without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and shall be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of such title (relating to classification and General Schedule pay rates).

(4) EXPERTS AND CONSULTANTS.—With the approval of the Commission, the executive director may procure temporary and intermittent services under section 3109(b) of title 5, United States Code.

(5) PHYSICAL FACILITIES.—The Administrator of the General Services Administration shall locate suitable office space for the operation of the Commission. The facilities shall serve as the headquarters of the Commission and shall include all necessary equipment and incidentals required for the proper functioning of the Commission.

(e) POWERS OF COMMISSION.—

(1) HEARINGS AND OTHER ACTIVITIES.—For the purpose of carrying out its duties, the Commission may hold such hearings and undertake such other activities as the Commission determines to be necessary to carry out its duties.

(2) STUDIES BY GAO.—Upon the request of the Commission, the Comptroller General shall conduct such studies or investigations as the Commission determines to be necessary to carry out its duties.

(3) COST ESTIMATES BY CONGRESSIONAL BUDGET OFFICE AND OFFICE OF THE CHIEF ACTUARY OF CMS.—

(A) The Director of the Congressional Budget Office or the Chief Actuary of the Centers for Medicare & Medicaid Services, or both, shall provide to the Commission, upon the request of the Commission, such cost estimates as the Commission determines to be necessary to carry out its duties.

(B) The Commission shall reimburse the Director of the Congressional Budget Office for expenses relating to the employment in the office of the Director of such additional staff as may be necessary for the Director to comply with requests by the Commission under subparagraph (A).

(4) DETAIL OF FEDERAL EMPLOYEES.—Upon the request of the Commission, the head of any Federal agency is authorized to detail, without reimbursement, any of the personnel of such agency to the Commission to assist the Commission in carrying out its duties. Any such detail shall not interrupt or otherwise affect the civil service status or privileges of the Federal employee.

(5) TECHNICAL ASSISTANCE.—Upon the request of the Commission, the head of a Federal agency shall provide such technical assistance to the Commission as the Commission determines to be necessary to carry out its duties.

(6) USE OF MAILS.—The Commission may use the United States mails in the same manner and under the same conditions as Federal agencies and shall, for purposes of the frank, be considered a commission of Congress as described in section 3215 of title 39, United States Code.

(7) OBTAINING INFORMATION.—The Commission may secure directly from any Federal agency information necessary to enable it to carry out its duties, if the information may be disclosed under section 552 of title 5, United States Code. Upon request of the Chairman of the Commission, the head of such agency shall furnish such information to the Commission.

(8) ADMINISTRATIVE SUPPORT SERVICES.—Upon the request of the Commission, the Administrator of General Services shall provide to the Commission on a reimbursable basis such administrative support services as the Commission may request.

(9) PRINTING.—For purposes of costs relating to printing and binding, including the cost of personnel detailed from the Government Printing Office, the Commission shall be deemed to be a committee of the Congress.

(f) REPORT.—Not later than March 1, 2004, the Commission shall submit a report to the President and Congress which shall contain a detailed statement of the recommendations, findings, and conclusions of the Commission.

(g) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report required in subsection (f).

(h) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,500,000 to carry out this section.

SEC. 902. DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

Section 1923(f)(3) (42 U.S.C. 1396r–4(f)(3)) is amended—

(1) in subparagraph (A), by amending subparagraph (A) to read as follows:

''(A) IN GENERAL.—The DSH allotment for any State—

''(i) for fiscal year 2003 is equal to the DSH allotment for the State for fiscal year 2001 under the table in paragraph (2), without regard to paragraph (4), increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for fiscal year 2001; and

''(ii) for each succeeding fiscal year is equal to the DSH allotment for the State for the previous fiscal year under this subparagraph increased, subject to subparagraph (B) and paragraph (5), by 1.7 percent or, in the case of fiscal years beginning with the fiscal year specified in subparagraph (C) for that State, the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.''; and

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

''(C) FISCAL YEAR SPECIFIED.—For purposes of subparagraph (A)(ii), the fiscal year specified in this subparagraph for a State is the first fiscal year for which the Secretary estimates that the DSH allotment for that State will equal (or no longer exceed) the DSH allotment for that State under the law as in effect before the date of the enactment of this subparagraph.''.

SEC. 903. MEDICAID PHARMACY ASSISTANCE PROGRAM.

Title XIX is amended—

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

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

''PHARMACY ASSISTANCE PROGRAM

''SEC. 1936. (a) IN GENERAL.—A State plan under this title may provide assistance, consistent with this section, to pharmacies in implementing the new prescription drug benefit under part D of title XVIII.

''(b) USE OF FUNDS.—Such grants may be provided to assist pharmacies—

''(1) in complying with requirements relating to electronic prescribing;

''(2) in prospective drug utilization review; and

''(3) in developing innovative medication therapy management programs using information technology.

''(c) CONDITION FOR RECEIPT.—A pharmacy is not eligible for a grant under this section unless the pharmacy demonstrates how it will operate a program that will work effectively with patients to reduce adverse drug reactions and medical errors. No grant shall be awarded under this section before January 1, 2004.

(d) PRIORITIES.—In awarding grants under this section, a State shall take into account and give priority to the needs of small or rural pharmacies and to pharmacies which service underserved areas.

''(e) FUNDING.—

''(1) TREATMENT AS MEDICAL ASSISTANCE.—Subject to paragraph (2), amounts provided under grants by a State under this section (and the reasonable administrative expenses of a State in carrying out this section, not to exceed 10 percent of the total amount awarded as grants by a State) shall be treated as the provision of medical assistance for purposes of section 1903. In applying section 1903(a)(1) with respect to such assistance, the Federal medical assistance percentage is deemed to be 100 percent.

''(2) LIMITATION AND ALLOTMENT.—

''(A) LIMITATION.—The total amount for which Federal financial participation is available under section 1903(a) for grants and administrative expenses under this section in calendar quarters in any fiscal year is limited to $150,000,000 in each of fiscal years 2004 through 2007.

''(B) ALLOCATION.—The Secretary shall provide a method for the allocation of the amount of funds described in subparagraph (A) in each fiscal year among the States. Such method shall take into account the distribution among States of priority pharmacies specified in subsection (d).

''(3) REQUIREMENT FOR APPLICATION.—The preceding provisions of this section shall only apply to a State if the State has filed with the Secretary an amendment to its State plan that provides for the awarding of grants under this section that is consistent with the requirements of this section.''.

The SPEAKER pro tempore. The gentlewoman from Connecticut (Mrs. JOHNSON), the gentleman from California (Mr. STARK), the gentleman from Louisiana (Mr. TAUZIN), and the gentleman from Michigan (Mr. DINGELL) each will control 30 minutes of debate on the bill.

The Chair recognizes the gentlewoman from Connecticut (Mrs. JOHNSON).

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, I rise in strong support of H.R. 4954 because it provides prescription drugs to all seniors as an entitlement under Medicare.

Mr. Speaker, I am honored to bring this bill to the floor of this great House. Everywhere I go, seniors look at me with worry in their eyes, concern that they will not be able to buy the prescription drugs needed to get well, worry that they will not be able to afford the many prescriptions needed to enable them to enjoy their lives and keep on with their daily activities.

Mr. Speaker, nothing is more important than assuring that our seniors have access to prescription drugs as part of Medicare, within Medicare as

part of that entitlement to health services, because indeed, Medicare without prescription drugs is a mere shadow of the promise of health care security that Medicare has always represented to the seniors of our great country.

Mr. Speaker, I am very proud that this bill provides the deepest discounts on drug prices that any bill has ever brought to this floor. It is a 30 percent discount, compared to every other plan that provides a 10 percent discount.

On top of that 30 percent discount are powerful subsidies, 80 percent subsidies, up to $1,000 in drug costs, and 50% after that. This is powerful help. For those living under 150 percent of poverty income, it will provide 100 percent of their drug cost needs up to $2,000. For over that, States will have freed-up resources to help those that cannot afford their prescriptions.

This is a powerful benefit for our seniors right up through catastrophic coverage, which provides the peace of mind that they so deserve in their senior years.

But that is not all this bill does. It goes on to provide better preventive care for our seniors and to provide those plans that are able to provide disease management, which is the only way that seniors with chronic illness are going to enjoy health in their elder years. Also, it reduces the cost of medication errors, provides safety for our seniors, compensates our providers more realistically, and in general, would strengthen our Medicare program.

I am going to go into the details of the bill later, Mr. Speaker. I will reserve my time for a discussion of this powerful new expansion of Medicare to improve the lives of the seniors of our country.

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

Mr. STARK. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, I would explain, when one sells out to the insurance industry, we get the Republican bill. They free up any resources that go to the Hartford Insurance Companies.

The truth is that the average senior in this country spends $3,059 on drugs. Under the Republican plan, they will have to spend $1,959 out of pocket to get that $3,000 worth of drugs. Under the bill that we would suggest, they would spend only $691.80.

So Members can see that the Democratic plan, had we been allowed to offer it, is better. It does something for the seniors that the Republican bill does not do: it gives them the wherewithal to afford drugs. It gives them an entitlement that they are entitled to.

The Republican bill is an entitlement for the pharmaceutical industry and the insurance industry. They are the only ones who get any money under the Republican bill. Under our alternative, the seniors are entitled.

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

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 3½ minutes to the gentleman from California (Mr. THOMAS), the chairman of the Committee on Ways and Means and an expert on health policy and prescription drugs.

Mr. THOMAS. Mr. Speaker, I thank the gentlewoman for yielding time to me.

Mr. Speaker, at some point, somebody needs to talk about reality. What we have heard from the other side of the aisle is that they want to operate under democracy, that democracy does not operate here.

There is a difference between democracy and chaos. Democracy means majority rules, but it also means rights of the minority. What are some of those rights? The rights are the minority gets to participate if they play by the rules. What are the rules? That under the budget, and they want democracy, under the budget they have the right to offer a plan which costs no more than the amount the budget provides: $350 billion. What they presented was a plan that costs $974 billion.

Guess what? They do not play by the rules; they do not get to offer their substitute. What they want to do is do whatever they want to do without following the rules. That is not democracy.

Secondly, what I heard from the gentleman from Florida while we were arguing the rules was, our bill does not do a pay-back to the providers. What does that mean? They are going to spend $1 trillion, and they do not take any of it to address the fact that our physicians serving seniors have a payment system that is broken. Why is it broken? Because it is not automatic. If it were automatic, it would adjust to the market. Instead, it is an arbitrary, fixed price. But they do not even want to fix that in their bill.

Now, we have also heard several times, the latest argument was that we are in the pocket of somebody; that Republicans can only write a bill if they are in the pocket of somebody. Oftentimes we have heard that we are in the pocket of the pharmaceutical manufacturers.

Mr. Speaker, let me explain what is in this bill. The Democrats put into effect a payment called ''best price.'' Whenever someone says, we are going to give you the best price, you had better beware. What is ''best price''? It is an arbitrary, bureaucratic, green eye shade determination of a floor of what we are going to pay.

When the Democrats ran this place and when the Democrats wrote legislation, they put in best price. Do Members know what we suggest? In this bill, we get rid of best price. What in the world would we pay if we got rid of best price? Guess what.

Do Members know that in that pocket of the pharmaceutical manufacturers that we are in there is going to be a whole lot more room for us, because the pharmaceutical manufacturers get taken out of their bottom line $18 billion in this bill. They are denied $18 billion by going from best price.

They have to help us solve this problem by the tune of $18 billion, because instead of best price, guess what we ask them to do? We ask them to compete. We have all kinds of laws to produce pure drugs. Who will give it to us at the cheapest price? A modest competition produces a savings of $18 billion applied to the benefits to seniors paid for by pharmaceutical manufacturers.

They have nothing in their bill. They have rhetoric. They have hot air. We have $18 billion paid out of the pockets of the pharmaceutical manufacturers to help seniors.

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

Mr. Speaker, I would remind the distinguished chair of the Committee on Ways and Means that I suggested that the Republicans were in the pocket of the insurance companies, and I was about to say that when they go to bed with the pharmaceutical industry, they get a bill like this.

Mr. Speaker, I yield 2½ minutes to the gentleman from Michigan (Mr. LEVIN).

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

Mr. LEVIN. Mr. Speaker, I say to the gentleman from California (Mr. THOMAS), democracy means give the minority a substitute bill, period. That is what it means. Under the rules? Look, we go by the American rules, not the rules of the gentleman from California (Mr. THOMAS).

It is a disgrace that they do not give us the chance for a substitute. They did it on the trade bill, a motion to recommit. Now they are doing it on this.

Mr. Speaker, we will never yield to the gentleman's demeaning democracy. The gentlewoman from Connecticut (Mrs. JOHNSON) talks about ''this great House.'' I want to talk substance, that she is demeaning this great House. She is changing this from the people's House to something else.

Mr. Speaker, this bill is a shell. It is worse than empty in the sense that it is filled with deceptions. Ten words: no set premiums, no assured benefits, and use private insurance.

The gentlewoman from Connecticut (Mrs. JOHNSON) said, let us not get into the details. I can understand why. She likes to say that 44 percent of women will be covered without cost. What she does not say is that those women are especially vulnerable to paying more than $2,000 bucks; and after that, they fall into a deep hole of noncoverage.

This bill is not part of Medicare like hospital and physician bills, and we say, why not? They just do not like Medicare.

□ 2300

Now, the gentleman from California (Mr. THOMAS) does not like us to talk about Medicare+Choice. I can understand. That has not worked. Under Medicare+Choice if there is not enough money then you have to come to Congress. Under your bill if there is not

enough money, I would call this no prescription choice, except you can run to the Secretary to get some more money.

This bill, as I said, is worse than an empty shell; and what makes it worse is you are playing the shell game with democracy.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2 minutes and 15 seconds to the gentleman from Illinois (Mr. CRANE).

Mr. CRANE. Mr. Speaker, I rise in strong support of H.R. 4954, the Medicare Modernization and Prescription Drug Act.

When it comes to Medicare, Congress must consistently balance accessibility of services from qualified providers, cost and financial stability of the Medicare program. This legislation does just that.

H.R. 4954 provides a long-overdue prescription drug benefit that is voluntary and available to all Medicare beneficiaries in a fiscally responsible way. Our House-passed budget provides for $350 billion for a Medicare prescription drug benefit and modernizations to the program.

According to CBO estimates our proposed drug benefit is estimated to cost $310 billion over 10 years and also achieves a 30 percent savings on drug costs. It is projected that in 2004 the median out-of-pocket drug costs for Medicare beneficiaries will be $1,453. Under our proposal, $827 of that, more than 50 percent, of the beneficiary's drug expenditures will be covered.

The Medicare Modernization and Prescription Drug Act also provides a number of reasonable and necessary adjustments to provider payments. Most importantly, this legislation includes $21.3 billion for physicians to reverse the negative and irrational payment updates they received this year and are expected to receive next year.

The physician payment provision helps us to ensure that physicians will continue to participate in the Medicare program and provide quality health service to beneficiaries. If we do not ensure that providers are adequately reimbursed, all the new benefits that we have passed and will pass for Medicare beneficiaries will be for naught because providers will close their doors to beneficiaries.

My colleagues on the other side of the aisle argue that this legislation is an empty promise to seniors. I cannot disagree more. This package provides a prescription drug benefit that covers more than 95 percent of Medicare beneficiaries and helps to improve access to quality health care services.

Let us give our seniors access to quality health services that they deserve. Let us pass a meaningful prescription drug benefit that is voluntary and available to all Medicare beneficiaries. Let us make sure that our seniors have a choice in Medicare. Let us not play politics with America's seniors.

I urge my colleagues to support the Medicare Modernization and Prescription Drug Act.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Maryland (Mr. CARDIN).

Mr. CARDIN. Mr. Speaker, let me thank the gentleman from California (Mr. STARK) for yielding me time.

Mr. Speaker, this bill is fundamentally flawed. It does not use the Medicare model for providing benefits; and with Medicare, when we provide benefits for physicians or hospitals, our seniors are guaranteed those benefits. In this bill for prescription drugs, they are guaranteed nothing.

It reminds me of what we told our seniors with HMOs. Join HMOs and you will get prescription drug coverage. What happened as soon as they joined? The deductible, the co-pays went up, and the amount of coverage went down.

There is no protection in this bill on premiums like under Medicare. In Medicare, our seniors know that their Part B premium is tied to 25 percent of the cost. They know how much it will be. There is no protection in this bill as to what the premium will be set at or how much it will increase. No protections to our seniors.

In Medicare, we know that there will be a reimbursement system in our communities. You can always rely on Medicare. The underlying bill relies on private insurance. Mr. Speaker, there is no protection in this bill for those private insurance companies leaving our community.

Look what happened with the HMOs. They enrolled seniors. They brought them in, and then they left town.

Ask the people in Maryland. In 1996, we had eight HMOs writing seniors business, private insurance. Today, we have one with a capped enrollment. The private insurance companies will be there as long as they can make money; and as soon as they cannot make money, they will be gone.

There is no protection in this bill to provide prescription drugs to our seniors. It is fundamentally flawed, and we should correct it. We will have an opportunity to do it with the motion to recommit.

I urge my colleagues, if we are serious about providing prescription drug coverage for seniors, let us use the model that has worked. Let us use the Medicare model. Let us not use private insurance, solely private insurance. It has not worked in the past, and it will not work under this bill.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2 minutes to the gentleman from Louisiana (Mr. MCCRERY), an esteemed member of the Subcommittee on Health of the Committee on Ways and Means.

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

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

Mr. Speaker, to those who say the benefit in this bill is not rich enough, Mr. Speaker, I would ask them to remember that Medicare spending, despite the bipartisan Balanced Budget Act of 1997, is still growing at an unsustainable rate. As a share of our gross domestic product, Medicare has grown from 1.3 percent in 1980 to more than 2.2 percent today and will hit 5 percent by the year 2030. By 2075, Medicare will be just under 10 percent of our gross domestic product.

10 percent of GDP may not seem like much until you consider that over the last four decades Federal tax revenues have averaged between 18 and 19 percent of GDP. In other words, Mr. Speaker, under current projections, unless the Federal tax burden is raised to new and potentially economically destructive levels, Medicare, together with Social Security and Medicaid, will quickly crowd out spending on other important initiatives, including defense, homeland security, education, transportation and others.

These long-term trends will only be exacerbated by the addition of a prescription drug benefit which is not coupled with meaningful structural reform of the Medicare program.

I am pleased, therefore, that the legislation before us this evening includes the first steps towards the long-term structural reforms needed to bend the growth curve. Just as it would be irresponsible for the Congress, Mr. Speaker, not to try to help seniors with the cost of prescription drugs, it would be irresponsible to add a prescription drug benefit to Medicare without tackling these long-term trends in the growth of Medicare spending.

I hope, Mr. Speaker, that next year we will come back here on this floor and continue the kind of reforms that we started in this bill tonight so that those who are under 65 in our society will not be burdened with a tax that just cannot be sustained and continue the kind of society, the kind of economy that we enjoy in this country.

Mr. Speaker, I urge my colleagues to adopt this bill along with the minor reforms that we have this evening.

Mr. STARK. Mr. Speaker, pending recognizing the gentleman from Washington (Mr. MCDERMOTT) for 2 minutes, I would just like to remind the Members that the gentleman from Louisiana (Mr. MCCRERY) recalls that it was the gentlewoman from Connecticut (Mrs. JOHNSON) who voted in committee not to increase money for nursing homes. She voted against eliminating co-pays for home health care. She voted against limiting the premiums to seniors, and she voted against giving seniors a choice of going to any pharmacy. So much for her concern for the seniors.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I assume my colleague was speaking on his own time.

The SPEAKER pro tempore (Mr. THORNBERRY). The gentlewoman is correct. The gentleman was speaking on his time.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the gentleman from Washington (Mr. MCDERMOTT).

Mr. MCDERMOTT. Mr. Speaker, this is a bad bill because there is no assured

benefits and there is no set premiums because the Republicans are privatizing Medicare. They are giving this whole benefit to the private insurance companies.

Now you have to remember that the chairman of the committee chaired the Medicare Commission and spent an entire year trying to get a voucher system for senior citizens in Medicare. This is his second try. Buried in this bill is the creation of a new private benefit management company or management authority that will handle the HMOs and will handle the private drug plans.

Now you think I am making this up, but if you take the bill, and I will bet you there is not a person on this floor that has read page 157, line 16, which prevents the Secretary of HHS from ''interfering in any way with the negotiations between the private drug plans and the Medicare+Choice organizations and drug manufacturers.''

Now what this is saying is that the Secretary of Health and Human Services, whoever that may be, has no ability to stand up for the people of this country, the senior citizens, the 40 million people that count on this program, and negotiate for them. She has to stand back and let the private drug programs and the pharmaceutical companies negotiate.

Now, we all saw what happened with Medicare+Choice. Hundreds of thousands of people were lured into HMOs and then were dumped out in the street; 500,000 in my State; and I do not know how many across this country. And you say, well, we did not learn anything from that. We know the private industry will take care of them. So let us give them the drug benefit. You are going to get the same thing, and it is rotten.

Everyone should vote ''no'' and vote ''yes'' on the Democratic alternative.

Mr. STARK. Mr. Speaker, I yield myself 15 seconds to remind the Members that both the gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from Florida (Mr. SHAW) voted against increasing payments to hospitals, voting against filling the Republican gap in the drug coverage, and voted against requiring drug companies to offer real discounts. So much that they care for the senior citizens of this country.

Mr. Speaker, I yield 2 minutes to the gentleman from Wisconsin (Mr. KLECZKA).

Mr. KLECZKA. Mr. Speaker, we are told by my Republican colleagues that this is a powerful benefit, that this is an historic opportunity. Well, nothing could be further from the truth. For you see, Mr. Speaker, 2 years ago to the day an identical bill passed this House of Representatives. And why did it pass 2 years ago at this time and why is this bill on the floor here today? Because 4 months from now we will have the November congressional elections.

And you see, the American public wants a drug benefit. And they do not want to give one, but they keep bringing up this fig leaf 4 months, every 2 years before the Congressional elections.

But what is their bill all about? This is not a Medicare benefit like hospitals and physicians. This is a subsidy to insurance companies. We were told 2 years ago when this same bill was up that no insurance companies are going to sell these policies. For everyone who buys a policy will have a claim against the policy, and it is going to be identical to the failed experiment that the gentleman from California (Mr. THOMAS) called Medicare Choice.

Two million people have been canceled by insurance companies from that plan, and the same is going to happen here. But for a senior with drug costs of $3,800 a year, the Republican plan will give them almost nothing. After they are charged a premium, a deductible, they pay $150 for the first $1,000 of costs. They pay one-half or $500 for the next thousand. Then they have no coverage at all for any and all drug costs from $2,000 to $3,800. So for $3,800 in drug costs per year the senior gets $3,100 of extra payments out of the pocket. The benefit is $680.

Is that what they want to give their mothers and their aging fathers? They should be ashamed of themselves.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 1 minute to the gentleman from Iowa (Mr. NUSSLE).

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

Mr. NUSSLE. Mr. Speaker, I rise in support of H.R. 4954, the Medicare Modernization Prescription Drug Act. It is a good bill. It fits within a budget. It fits within a budget plan. We have got a budget. We have got a plan. It meets the needs of seniors. It meets the needs of health care providers. It meets the needs for the future.

In 1965, Medicare should have included a prescription drug benefit.

□ 2315

For many years after 1965, Democrats had the opportunity to propose legislation for a prescription drug benefit. In fact as early as 1993, they controlled the House, the other body and the House down the road here, and did not do a thing for seniors on prescription drugs; and now tonight they rush in, claim that we will not let them have the substitute when in fact their substitute costs almost a trillion dollars; and that is the reason they cannot have it, because it does not fit within a budget, and it does not fit within a plan.

Mr. Speaker, just 3 hours ago they were screaming that we had to raise the debt ceiling because we were spending too much. Tonight they are claiming we are not spending enough. Vote for this bill.

I rise in support of H.R. 4954, the Medicare Modernization and Prescription Drug act of 2002. I'd like to congratulate the Committees on Ways and Means and Energy and Commerce for producing a bill that provides a much-needed Medicare prescription drug benefit within a fiscally responsible framework.

No senior should be forced to choose between the basic necessities of life and purchasing prescription drugs. This bill provides prescription drug coverage that is affordable, accessible, and completely voluntary.

Because the Medicare program has not been significantly modernized since its inception in 1965 to include a prescription drug benefit, it is not meeting the needs of Iowa seniors.

While the drug benefit is indeed important, Iowans recognize that the critical inequities in today's current Medicare program must also be addressed. While Iowa boasts the 8th highest quality of heathcare in the Nation, it is 50th in Medicare reimbursement.

Actions that affect Medicare affect Iowa's entire health care system. If health care providers leave rural areas, who will write prescriptions under the new drug benefit? Who will provide the care that cannot be provided by drugs alone? If local hospitals close, where will we take our children for emergency care?

Many of these problems have compounded since 1965, but rural health care, particularly in Iowa, is on the verge of a crisis. This bill offers significant progress toward bridging the gap between urban providers and those in rural States such as Iowa.

As a member of the House Committee on Ways and Means, I successfully amended this important legislation with Medicare's antiquated reimbursement policies in the current system in mind. My amendment is directed at the hospitals that need help the most, especially those in Iowa. It has been estimated that my amendment will provide $123 million over the years in much-needed relief for Iowa hospitals such as Covenant in Waterloo, Mercy in Dubuque, and Regional Medical Center in my hometown of Manchester.

I am also pleased that this legislation includes an important provision recognizing the unique cost of physician work in rural areas. This provision would give the Secretary of Health and Human Services discretion to raise the minimum level of physician wages providing an increase of roughly $7 million to physicians in Iowa.

After years of working to correct these inequities, I'm glad to see that the House of Representatives is following my lead in addressing these disparities in the current system. While this legislation is an important step forward, I will not stop working on this important issue.

Today we are adding an unquestionably important prescription drug benefit to Medicare as well as beginning to reverse the years of unjust reimbursement formulas that have burdened Iowa's hospitals and physicians. We have listened to both seniors and health care professionals.

The budgetary parameters for this bill were established in the Concurrent Resolution on the budget for Fiscal Year 2003 (H. Con. Res 353), the budget resolution that the House passed in March and then deemed enforceable in the House last month.

That budget made modernizing Medicare with, among other things, a prescription drug benefit and reforming Medicare among the highest priorities for the Congress—along with fighting the war on terrorism and encouraging economic recovery.

The budget provides $5 billion in fiscal year 2003 and $350 billion over 10 years to strengthen Medicare and include a prescription drug benefit. That money was specifically fenced off from the rest of a budget in a reserve fund.

This bill meets the requirements in the budget resolution and therefore I am releasing amounts in the reserve fund provided in the budget resolution to enable the House to consider the bill.

Some have said that $350 billion is inadequate. The bottom line is that we made the maximum amount available for Medicare, given the state of the economy and the costs we face in the war against terrorism.

Indeed, the bill provides almost twice the resources for Medicare reform as the President proposed in his budget for fiscal year 2003. Unfortunately, critics of the bill failed to offer an alternative when the budget resolution was considered on the floor. And the other body has yet to even consider a budget resolution, despite the fact that they are required by law to do so by April 15.

As modified by the rule, this bill is ''on budget'' and within the reserve fund level of $350 billion over 10 years. About $310 billion of the total is for the drug benefit, around $40 billion of additional assistance is provided to struggling medicare providers, and the rest is for various miscellaneous but important provisions such as regulatory reform.

The modernization provisions in the bill include a Medicare+Choice competition program, regulatory reform, and the President's prescription drug discount card.

I believe that modernization efforts like the Medicare Plus Choice competition program are necessary to help address Medicare's long-term financial liabilities. I would encourage future conferees on this bill to make further reforms to address Medicare's financial liabilities, should the other body act on this legislation and allow us to have a conference.

In conclusion, this bill fulfills our commitment to enact a prescription drug benefit within Medicare that is affordable, and that is part of the overall effort to reform Medicare to make the program sustainable over the long term.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the gentleman from Tennessee (Mr. TANNER), who realizes that the National Community Pharmacists Association states that the Republican bill penalizes beneficiaries desiring to continue their trusted relationship with their pharmacists and access to valuable pharmacist services.

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

Mr. TANNER. Mr. Speaker, I thank the gentleman from California (Mr. STARK) for yielding me this time.

Mr. Speaker, my problem with the bill that is under consideration tonight is in the theory behind it. My family has been in the insurance business in Tennessee for over a hundred years, and the reason we have Medicare in this country is because in the private world of insurance, there is no way that a senior citizen 80 years old with heart trouble and diabetes can buy health insurance. That is why Medicare came into being. They still could not buy it if we did not have Medicare. So what we are trying to do here is put a square peg in a round hole in that this bill tries to make an insurable product out of a benefit for which there is no risk pool for the concept, the theory of insurance to work.

Insurance does not work when every policyholder is also making a claim against their policy. By the very inception of this kind of protocol, every policyholder will be making a claim. It is simply not an insurable product. What we are going to wind up with, I am afraid, and we will be back here in a year if this passes and passes the Senate, is we are going to have a patchwork across the country of differing coverages, differing plans, differing copays, differing premiums, differing in every respect. Nobody will know for sure what they have got.

What is one to do? One will figure what one's drug payment is a year; and if it is less than what they would get if there is a plan offered and knowing they cannot go to their neighborhood pharmacy even if the pharmacy is willing to abide by the plan, if their drug benefit is more than what they are spending, they will take it. If it is less than that, they will not. So everybody that the insurance company signed up will be making a claim and will be getting more than their premium copayments. The whole structure of this thing is flawed, and that is why I cannot support it.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2 minutes to the gentlewoman from Washington (Ms. DUNN), a member of the Committee on Ways and Means.

Ms. DUNN. Mr. Speaker, one of the most important values to all seniors is that they be financially independent in their retirement, and that means they do not want to be a burden on their children and that means access to affordable health care. The high cost of prescription drugs and the lack of prescription drug coverage has caused many seniors, and especially senior women, to be very worried about their independence.

I was sorry to have witnessed early this evening my women colleagues in the opposition claiming that older women will not be helped by this bill because I have seen how older women are being forced to make tough decisions about whether to spend their limited dollars on necessary prescription drugs or other of life's necessities. Our mothers and grandmothers are outliving our fathers and our grandfathers. They are living on fewer dollars for more years, and they are far more likely to develop chronic medical conditions.

This bill does benefit women. This bill helps seniors on fixed incomes and those with high drug costs. A woman living on an income of less than $15,000 a year will receive total assistance from this Federal Government Medicare program for prescription drugs. While all seniors will benefit because any senior can opt to buy this coverage, nearly 17 million or 44 percent of Medicare beneficiaries will qualify for additional assistance when this bill is fully implemented.

Perhaps the most important part of this bill, Mr. Speaker, is the fact that no senior under this coverage will ever have to pay more than $3,700 a year for their total of drugs. Improving Medicare, though, is not only about providing drug benefits. It is about giving seniors access to doctors and hospitals and Medicare HMOs and other services they need. So we put some additional benefits in this bill to ensure that doctors will continue to serve seniors. We increase the reimbursements those doctors receive. We also help rural, urban, and teaching hospitals care for seniors and low-income individuals.

For Medicare HMOs this bill requires Medicare to account for military retirees in the future, which means higher Medicare+Choice reimbursements in every county in this country with military facilities.

I urge my colleagues to support this fine bill.

Mr. STARK. Mr. Speaker, I yield 15 seconds to the gentlewoman from Florida (Mrs. THURMAN).

Mrs. THURMAN. Mr. Speaker, I thank the gentleman from California (Mr. STARK) for yielding me this time.

I want to point out something here that continues to be talked about in the low-income seniors being given total prescription drugs. The problem is in the bill that we are talking about, it does not waive the asset test that beneficiaries would have to meet in order to get their benefits. So in fact the number of people who would qualify for the low-income benefit would actually be much less.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. HOLDEN).

Mr. HOLDEN. Mr. Speaker, I rise in opposition to the bill. Those of us from rural districts and those of us from central and northeastern Pennsylvania know that the idea that we are going to turn over the administration of a prescription drug program for our senior citizens to the insurance industry, to the HMOs, and have it be fair and universal is ridiculous. In fact it is a joke.

Number one, the insurance industry wants no part of it. As the gentleman from Tennessee (Mr. TANNER) mentioned before, why would they when every policyholder is also going to file a claim? They are going to lose their shirt in this proposal. Medicare+Choice has failed across the country, but it has failed miserably in rural America. My constituents had to look at commercials coming out of the Philadelphia media market, Cadillac plan for prescription drug coverage and low premiums, and they were not able to participate. The reason they were not able to participate is because they had lower participation and lower reimbursement from Medicare.

As a result of it, we did not have universal coverage as Medicare+Choice.

We cannot make the same mistake. We need to have a divine benefit. We need to have a divine premium, and we need to have universal coverage for all our senior citizens.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 20 seconds. I want to make a correction of the record.

Over and over again my colleagues say we do not have a defined benefit. We have a very clearly defined benefit. Do we have a defined premium? Of course not. The part B premium is not defined. That is a percentage of costs and it varies every year. Federal health employee benefit plans do not define the premium in law. It varies every year.

In our plan we do not want to set the premium in law because if we can provide a more efficient plan, we want to be able to pass on that savings through a lower premium to seniors. We are proud of our core benefit.

Mr. Speaker, I yield 2 minutes to the gentleman from Ohio (Mr. PORTMAN).

Mr. PORTMAN. Mr. Speaker, I thank the chairwoman for yielding me the time. I am glad that she was able to correct the record on a few misstatements that have been made this evening.

I would like to correct the record again. My friend from Pennsylvania just stood up and talked about Medicare+Choice and how this is the same. It is not. In fact, in this bill, we are helping to make Medicare+Choice work. Just because we have choked off the funding to Medicare+Choice so it does not work for our seniors, including a bunch of mine, who were not getting the right reimbursement has nothing to do with this plan. This is an entirely different plan, but it does help on Medicare+Choice, and I hope people are happy to hear that who are so concerned about it.

This is a great plan. This is exactly what our seniors need. One would never design the Medicare program today without adding prescription drugs. The other side wants to add $1 trillion of prescription drugs. After just voting not to raise the debt limit they want to add another $1 trillion.

We are doing this within $350 billion, which is responsible, which is, unlike what my friend from Wisconsin said earlier, a lot different than the bill 2 years ago. It is more money, yes, because we believe it is necessary to be able to provide seniors with the coverage they need.

CBO has scored this. CBO has said that this will lower prescription drug prices more than any other bill that has been introduced in this House that has been scored by CBO. Our bill lowers drug prices more. There is a discount for all seniors. In fact, for the average senior there will be a 44 percent reduction in the drug costs. Average drug costs $2,150, they only pay $1,200 out of pocket. That is a savings of 44 percent.

There is another 44 percent number we ought to hear about tonight and that is for low-income seniors, which is 44 percent of seniors. They will pay no deductible. They will pay no percentage, 20 percent or 50 percent. They only have a nominal copay. They get this for free. That is 44 percent of the seniors. The very people the other side has said tonight repeatedly they are worried about, that they are not going to get a benefit, they get a total benefit.

This is precisely the kind of plan that the Republican Party has been talking about for the last couple of years, but it is even better than the one from 2 years ago. It meets the principles. It lowers the cost of prescription drugs and does that now. It guarantees all seniors drug coverage. It gives seniors more choices including Medicare+Choice.

It is a good plan. It is affordable. It is voluntary. It preserves the right to choose. I strongly urge its adoption.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from North Dakota (Mr. POMEROY), pending which I would point out to my distinguished colleagues that the gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from Florida (Mr. SHAW) both voted against protecting low-income seniors from higher copayments and the gaping gap in the Republican plan. So much they care for the senior citizens.

Mr. POMEROY. Mr. Speaker, I thank the gentleman for yielding me the time.

At the heart of what this debate is all about is a clear choice, whether we should provide a prescription drug benefit for seniors through the Medicare program or whether we should send money to insurance companies to induce them to provide a coverage that at the present time they have said they do not want to write, prescription drug coverage for seniors.

I used to be an insurance commissioner. For 8 years it was my responsibility to protect the seniors from insurance companies in the State of North Dakota. There has not been a Member of this body that spent more time talking to seniors about insurance than me, and directions that I have received from seniors on this issue are absolutely consistent and absolutely clear. They want Medicare coverage for prescription drugs.

Not a single senior has said to me, please, I want to go buy another insurance policy; please send me more agents, I want to hear what they have to say; please give me that fine print, it is fascinating and I want to read some more of it; and by the way, I want to deal with insurance companies because I so enjoy wondering whether they are going to pay that claim or whether they will not; I so enjoy wondering whether they are going to be there when I need them or whether they will be gone and out of business.

No senior has said that. It is ludicrous on its face. They know Medicare. Medicare covers their hospital bills. Medicare covers their doctor bills. Medicare has been the program that has been so vital to preserving and promoting the health of seniors in this country for the last nearly 4 decades. We do not have to invent some new hocus pocus private sector, gosh-I-hope-it-works kind of deal. We have got Medicare and the seniors know it and they like it; and they would have preferred that plan tonight, which is why we were not allowed our substitute to have a Medicare delivery of a prescription drug benefit as opposed to the alternative the majority has advanced.

Nobody wants prescription drug coverage for seniors more than the minority in this body, and they will be opposing this version because it simply will not work. It does not get the job done. Vote it ''no.''

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 10 seconds.

Under Medicare we have part A. We have part B. We have part C, and this will be part D under Medicare, providing prescription drugs to seniors to any plan sponsor, and plan sponsors may be a group of any sort, preferably companies skilled and experienced in managing drug benefits.

Mr. Speaker, I yield 1 minute to the gentleman from Michigan (Mr. CAMP).

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

Mr. CAMP. Mr. Speaker, today we have the opportunity to help seniors improve their quality of life by providing a prescription drug benefit in Medicare. On a daily basis it is reported that the cost of cutting-edge, life-saving medicines have skyrocketed, forcing those on fixed incomes to make difficult choices.

One constituent in my district had drug costs of over $15,000 a year for him and his wife, and their Social Security check was $21,000 a year, and there are countless other heartbreaking stories just like that one.

□ 2330

These seniors have worked hard all their lives to provide for their families, but now they can barely make ends meet.

We can all agree if Medicare were created today it would contain a prescription drug component. In Michigan alone, this bill would benefit over 1.2 million seniors. This proposal provides affordable coverage for every senior without gimmicks, without sunsets, without pie-in-the-sky proposals that cost over $1 trillion.

Regrettably, some have sought to politicize this issue and hold other seniors and the disabled hostage to a cruel game of brinksmanship. We must strengthen and modernize Medicare. Vote for this bill.

Mr. STARK. Mr. Speaker, I yield myself 15 seconds to point out that every Republican, including the gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from Florida (Mr. SHAW), voted against assuring seniors that they could get the drugs that

their doctor prescribes, because there is nothing in the Republican bill that guaranties the drugs that a doctor might prescribe.

Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. BECERRA).

Mr. BECERRA. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, my colleagues on the Republican side have never truly embraced Medicare. They opposed it in 1965, they have talked about letting it die on the vine, and they have described it as a Soviet-style program. In fact, what we have in this bill from my Republican colleagues and friends is a bill that moves us much closer to privatizing Medicare all together.

To privatize Medicare is to ignore the lessons of the Enron scandal and the pension abuse that occurred as a result. To privatize Medicare is to turn back the clock to those bad old days before 1965 when the health care for our seniors was not guaranteed and left to the private sector.

Under this Republican plan, a senior who is paying $250 a month in prescription drugs, and that is a lot of our seniors, would lose coverage, total coverage under this plan after August. So that, come September, come October, come November, come December, that senior would have to, out of his or her own pocket, pay for the remaining cost of all those drugs.

Under this plan, a senior who has $5,000 in annual prescription drug costs, and there are a lot of them who do, would have to pay $4,200 out-of-pocket out of that $5,000 cost. Compare that to the Democratic plan, where the total cost to that senior for the $5,000 would be $1,380, a savings of $2,800 between the Republican plan and the Democratic plan.

Those are the facts, and that is the difference. But we do not have a chance to put our Democratic plan for a vote here. Mr. Speaker, today, today as we speak, seniors are having to make a choice, do I buy my groceries, or do I buy my prescription drugs? Do I pay my rent, or do I buy the medication I need? We should not have them make that choice.

Give seniors what they want. They want an affordable and guaranteed benefit. The Democratic plan does that; the Republican plan does not. Let us defeat this plan.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself such time as I may consume to note that it is curious the gentleman from California keeps citing the votes that we cast against his unfunded amendments, the unfunded amendments from the other side, when he is about to cast a vote against funding 43 percent of the seniors in California with everything, drug costs, copayments, deductibles, premiums, the whole business, 43 percent, and saving California $5 billion under Medicaid with which they can then expand drug benefits for many other folks in their State. Too bad.

Mr. Speaker, I yield 2 minutes to the gentleman from Pennsylvania (Mr. ENGLISH).

Mr. ENGLISH. Mr. Speaker, as a member of the Subcommittee on Health of the Committee on Ways and Means, I particularly want to pay tribute to the gentlewoman from Connecticut (Mrs. JOHNSON), who has been on the receiving end of many barbs tonight. The fact is that no one has fought harder to bring a prescription drug benefit to the Medicare program; and if we are successful in that, she, perhaps more than any other Member of this body, will deserve substantial credit.

I am here tonight because I represent a district which consists of working families for whom the abstractions of this debate do not mean much but who desperately need help on their prescriptions. This program that is being proposed in this landmark legislation would give them a flexible and affordable benefit, one that would be voluntary, a program that would give them real choices, allowing them to customize their benefits. It would provide a benefit that would be very substantial, more generous in fact than the one that had been previously proposed by the Clinton administration that folks on the other side of the aisle once embraced.

This is a program that represents a $350 billion investment in the Medicare program and one that would provide substantial benefits to seniors that would be available for a premium of about $1 a day. At the same time, for those seniors, including many in my district who cannot afford that premium, this program would provide full coverage for low-income seniors.

What is particularly striking about this legislation is that it establishes a firm ceiling, a limit, catastrophic coverage for people who participate in this program, an ultimate limit on the amount of prescription drugs they would be liable for in a given year, a limit of $3,700. That is extraordinarily generous, and it positions people who participate in this program to be able to have affordable drugs when they need it.

The 30 percent discount that is built into this program has been much mentioned. Let me say it also allows CMS to negotiate with the drug companies to get the best possible discount and to sharpen their pencils.

This is a great program, and I hope the House will pass it tonight.

Mr. STARK. Mr. Speaker, I recognize the gentlewoman from Florida (Mrs. THURMAN) for 15 seconds.

Mrs. THURMAN. Mr. Speaker, we keep hearing this 30 percent. Actually, there has been a letter dated by the CBO on July 26 that says that they are confused, that there has been some confusion about the meaning of the 30 percent cost management factor that CBO applied in analyzing H.R. 4954. It goes on to say, the savings are stated as a proportion of total spending and do not represent a per-prescription discount.

Mr. STARK. Mr. Speaker, I am privileged to yield 2 minutes to the gentleman from Arkansas (Mr. ROSS), who understands why the National Association of Chain Drug Stores and the National Retail Federation and other pharmacy groups have said they consider a vote for the Republican bill to be a vote against the professional pharmacy and pharmacists.

Mr. ROSS. Mr. Speaker, I do rise in opposition, strong opposition, to this bill.

Just a few months ago, I was in Glenwood, Arkansas, a small town in my district, and ran into an elderly woman who is a retired pharmacist and who just happened to be a relief pharmacist in my hometown when I was a small child growing up.

She related the story to me about how when I was a child and she was a pharmacist, if she had a prescription that cost over $5, she would go on and fill the next one while she built up enough confidence to let the patient know it was going to cost $5. I think that really demonstrates, more than life itself, that today's Medicare, if we think about it, was really designed for yesterday's medical care.

Health insurance companies, which are very greedy, in my opinion, make huge profits and even they cover the cost of medicine. Why? Because they know it helps patients to get well and live healthier lifestyles.

As a small town family pharmacy owner, I am sick and tired of seeing seniors leave the doors of our pharmacy without their medicine. And living in a small town, I learn a week or 10 days later where they are in the hospital running up a $10,000 or $20,000 Medicare bill simply because they could not afford their medicine or could not afford to take it properly. So I came to Congress to try to do something about it.

This should not be a partisan issue. I wrote a bipartisan bill alongside the gentlewoman from Missouri (Mrs. EMERSON), a Republican; and the Republican national leadership would not give us a hearing on our bill. They would not give us a vote on our bill.

Now, less than 5 months before, yes, another election, they are coming to us with this plan, this so-called Medicare plan, which has nothing to do with Medicare other than attempting to privatize it, written by the drug manufacturers for the drug manufacturers.

I know my colleagues have heard a lot from both sides tonight and that very few seniors are still awake listening because it is midnight, and that is the reason they are bringing it up now, but let me say this: Do not listen to them and do not listen to us. Go to the family pharmacist and ask them which plan is right for America.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 30 seconds to the gentleman from California (Mr. THOMAS).

Mr. THUNE. Mr. Speaker, will the gentleman yield?

Mr. THOMAS. I yield to the gentleman from South Dakota.

Mr. THUNE. Mr. Speaker, I thank the gentleman for yielding to me; and I want to commend the chairman, because I know he has worked hard, along with the gentlewoman from Connecticut, to fashion a bill that addresses these concerns.

Mr. Speaker, we have seniors in South Dakota who need prescription drug relief. We have rural providers who need relief. I also share some of the concerns the gentleman just voiced about the pharmacist, and I would inquire of the chairman whether, as this process moves forward, he would be willing to work with me to provide assurances to pharmacists, particularly those in rural areas, that their concerns will be addressed?

Mr. THOMAS. Reclaiming my time, Mr. Speaker, I appreciate the gentleman's concerns. We have moved in the direction. There are still some concerns, and I assure him that, as we move forward in Congress, we will address the concerns of pharmacists.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 15 seconds.

I would like to point out to the gentleman from South Dakota that, while on page 18 of the other party's bill they say they require any willing provider, on page 8 of the other party's bill they say that there has to be pharmacy networks and the networks can determine cost sharing for beneficiaries outside the network.

So their bill does not provide any willing providers; and ours, at a later time, provides a lot of recognition to pharmacists.

Mr. Speaker, I yield 2 minutes to the gentleman from Arizona (Mr. HAYWORTH).

Mr. HAYWORTH. Mr. Speaker, I thank the gentlewoman from Connecticut for yielding me this time and who has worked so hard on this legislation.

It is important for citizens of my home State, Arizona, the seniors there who are still awake at what is 20 until 9, prime time in the State of Arizona, to understand exactly what we are doing in this legislation.

Despite the wailing and gnashing of teeth about process, we ought to focus on results. Here are the simple facts, Mr. Speaker: Under our plan, prescription drug coverage under Medicare is available to every senior who wants it. Every senior who wants this plan will be eligible for coverage. We will leave no senior behind.

That is especially important when we look at the people who need the most help. The 44 percent of seniors nationwide below 175 percent of poverty, their benefit is paid for. Over $40 billion in savings to Medicaid. Real money for real people with a real prescription drug benefit.

And this is the most compelling argument, Mr. Speaker. When we cut through all the smoke and mirrors and all the rhetoric, what seniors want, what I heard at the Mesa Senior Center a couple of weeks ago, was that seniors want prescription drug savings now. When we pass this, when the other body takes its action, our plan begins covering seniors and lowering costs as soon as 50 days after the President signs the bill into law.

Mr. Speaker, the time is now to act. If this can be moved, if this bill can become law, seniors can start realizing savings before Christmas. The perfect present to give our mothers and fathers and grandmothers and grandfathers. Support this legislation.

Mr. STARK. Mr. Speaker, I yield myself 25 seconds to remind the gentleman from Arizona that he should tell the seniors in Mesa that he has lined his own pockets with a benefit for Members of Congress which is 50 percent more generous than what he is willing to give the seniors in his home State, and that he and the gentlewoman from Connecticut (Mrs. JOHNSON) and the gentleman from Florida (Mr. SHAW) voted against eliminating cost sharing for preventive benefits for seniors.

Now that again shows us how much they care for the seniors in Hartford or in Florida or in Arizona.

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Mr. Speaker, I yield 1 minute to the gentlewoman from Indiana (Ms. CARSON).

Ms. CARSON of Indiana. Mr. Speaker, there is an old adage that says those that pay the piper name the tune. We are here tonight on a tune that was written by a $30 million dinner a few nights ago. As I understand it, the senior citizens were not allowed to even win door prizes for prescription drugs at that event. And $30 million would have undergirded the cost of prescription drugs for millions of seniors who need them across this country. Those that pay the piper name the tune.

When the nonpartisan Congressional Research Service did a comparison of the drug benefit under the Blue Cross/Blue Shield standard option available to Federal employees to the Democrat and Republican prescription drug plans, they found that the Republican plan would give about 40 percent of the coverage Members of Congress receive, but the Democratic would give comparable coverage. But those that pay the piper name the tune and obviously have now begun to get their thrill on Capitol Hill.

Mr. Speaker, the senior citizens still suffer with a headache or heartache from this incredible sham that the Republicans have offered.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. WELLER).

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

Mr. WELLER. Mr. Speaker, I am proud to say tonight we have an opportunity to provide prescription drug coverage under Medicare for our senior citizens. Tonight we are seeing an example of two different kinds of debate. Some people want to offer partisan rhetoric for political purposes. Others want to offer policy, policy which gives a solution to the challenge we have. The bottom line is we want to provide prescription drug coverage for our seniors.

It was quoted earlier this year, one of the advisers to the Democratic leadership said, ''One of the biggest worries that our policy people had was that they would actually write a good bill.''

We have a good bill before us. This is a bill that increases funding for Medicare by $350 billion, provides prescription drug coverage under Medicare, lowers the cost of prescription drugs now, guarantees all senior citizens prescription drug coverage, improves Medicare with more choices and more savings, and strengthens Medicare for the future.

The question is: What does that mean for the average senior citizen? The bottom line is under the plan that the gentlewoman from Connecticut (Mrs. JOHNSON) is managing before the House of Representatives, we have an opportunity to save for senior citizens real money. The overall out-of-pocket drug costs would fall by as much as 70 percent according to the Department of Human Services with the plan we have before us today.

According to a Health and Human Services study released this week, the House Republican plan would provide real relief for seniors and disabled Americans. Those who now pay full retail prices would typically see the cost of each prescription cut by 60 to 85 percent. Their overall out-of-pocket drug costs would fall as much as 70 percent, all in exchange for an affordable premium of $34 a month.

It is projected that the average senior would save $940 a year as a result of this plan. We have a plan that takes $18 billion out of the pockets of the pharmaceutical companies and saves the average senior $940. It deserves bipartisan support.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. DOGGETT).

Mr. DOGGETT. Mr. Speaker, this is one of those proposals that is perhaps best considered very late in the evening when the cover of darkness can attempt to hide the shame of the proposal. This bill is about creating the appearance of doing something when it does nothing to improve the lot of our seniors. When we get right down to it, despite the charts, the Republicans have no plan. All they offer is a placebo based on privatization. I suppose we can call it a Swiss cheese plan, but seniors get all of the holes and no cheese. There is no guaranteed deductible, no guaranteed premium, no guaranteed benefit, and there is no insurance company that has ever offered a plan of this type; and most have said that they will not be able to provide a plan of this type.

It all centers on the Republican ideological insistence that we must privatize Medicare, and that is not a prescription for reform; it is a prescription for disaster.

This very day, one of their top leaders called the plan that Lyndon Johnson signed into law and upon which millions of Americans have relied, had the audacity to call it a Soviet-style plan. They did not like Medicare then. They have never accepted it, and they are determined to use this device to privatize it.

Further, we find in the fine print of the plan in the paragraph called noninterference, a specific command that the administrator of this program cannot act to reduce costs. This figure of $18 billion has been pulled out of the air by a Republican Health and Human Services administrator. It has no basis in fact.

Rather, with this bill, the Republican leadership has once again pledged its allegiance to the pharmaceutical manufacturers whose price gouging forces our seniors to pay the highest prices of anyone in the world. Little wonder that those same manufacturers are continuing to pay for ads all over the country telling people that the Republican partners are great people for obstructing the help that our seniors so desperately need.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. BRADY).

Mr. BRADY of Texas. Mr. Speaker, this is an important night for the seniors in my community. I am proud the House is standing up for seniors who desperately need an affordable, permanent prescription drug plan under Medicare, and who need it right now.

The House plan gives America's seniors the right to choose the Medicare prescription plan that is best for them with catastrophic protection for the very costly illnesses, extra help for the poor who need it the most, and lower drug prices for all seniors using group buying power so drug companies will compete for our business and not the other way around.

That means for nearly half up Texas' seniors on Medicare, they will receive up to $2,000 of essentially free medicine each year that they need, and that is real help.

Thankfully, tonight we are rejecting the alternatives, alluringly irresponsible schemes that are simply too good to be true, schemes that would bankrupt Medicare within 10 years and leave our vulnerable seniors to face grim choices. I support the Republican plan, and my seniors do as well.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from California (Mr. BACA), who understands that the AARP opposes the Republican drug bill in its present form and says that it needs vast improvement before their members can support it.

Mr. BACA. Mr. Speaker, I stand in opposition to this shameful decoy that creates the illusion that it covers all seniors, when we know that it does not cover all seniors. It only covers someone as long as it only reaches a certain limit.

We have to make sure that all seniors are guaranteed coverage, make sure that they are able to get the kind of services that they need. Currently right now, they cannot even buy or put food on the table, and they have to decide between buying prescription drugs or not.

This is like an insurance plan in California, telling drivers they have the coverage, when in fact they have the coverage as long as there is no accident. The minute there is an accident, the premiums go up, and you lose the coverage. They are afraid. They are afraid to file a claim. This is the same situation that we are going to have here. We are going to have seniors that are afraid to buy drug prescriptions because their coverage will go up. They will continue to go to Tijuana and buy it cheaper because they do not have the coverage. This is shameful and a decoy. We should support the Democratic plan that covers all seniors and all individuals.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 1 minute to the gentleman from Wisconsin (Mr. RYAN), but in the course of doing that I want to mention that the Congressional Budget Office in their letter to us made clear that exempting Medicare prescription drug plans from Medicaid's best price drives down drug prices $18 billion for our seniors.

Mr. RYAN of Wisconsin. Mr. Speaker, I would like to put one thing straight. The AARP does not oppose this bill.

But for the benefit of Members who are truly listening to this debate and trying to make up their minds, let me point out three distinct differences. The Democratic bill will have the consequence of pushing out private-sector-provided prescription drug coverage. The Republican bill supplements that. What the Democratic bill will do, will have the consequence of making sure that all those employers who are providing prescription drug benefits for their employees do not do so any more so the government will pick it up so we are needlessly forcing taxpayers to pay for a benefit that the private sector is already providing.

The Republican bill includes deeper discounts on prescription drugs than the Democrat bill does. The Democrat bill is a $1 trillion-plus bill that will do nothing more than make Medicare go broke faster. We have a problem. We have two problems. We need prescription drug coverage for our seniors. We need to give them access to deep discounts on their price of drugs, and we need to make Medicare solvent for the baby boomer generation. The Democrat bill fails in that area. The Republican bill delivers.

Mr. STARK. Mr. Speaker, I yield 15 seconds to myself to apologize to the Republicans and quote the actual words that I misspoke. The AARP does not oppose their bill, they just say that it requires improvements before our members would support their bill. I want the record to make it perfectly clear, while they do not oppose it, they do not support it.

Mr. Speaker, I yield 1 minute to the gentleman from Tennessee (Mr. CLEMENT).

Mr. CLEMENT. Mr. Speaker, I could not support the Republican bill because we have to have fairness. It does not offer fairness. As a matter of fact, I just completed a survey in Tennessee, and the fact is that prescription drugs are twice what they are in Canada and Europe and Asia. But that is not true just in Tennessee; it is true all over the country.

There are a lot of things we could do. The Bush administration could reimport those drugs from Canada right now, and we would get a break. We have a lot of people on the border that can go across the border and get prescription drugs, a 90-day supply. There are a lot of things that we can do that are not being done.

The United States Senate Democrats have a very good plan, and we ought to look at the Senate Democrat plan because we are not going to get any justice here.

I suggest to Members, vote ''no.'' The fact is we are subsidizing other countries. We have got price gouging going on by the pharmaceutical companies at present. We need to give relief now, and prescription drugs should be part of the Medicare package.

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Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 1 minute to the gentleman from Louisiana (Mr. VITTER).

Mr. VITTER. Mr. Speaker, I rise in proud support of this Republican prescription drug plan. Prescription drug coverage is absolutely critical for seniors today, and no senior should have to choose between paying for prescription drugs and paying for food or rent. So we are acting and we are producing a plan and we are passing a plan to give seniors choice. They can choose the plan that works best for their needs. It reduces their out-of-pocket costs for prescription drugs, gives them a lifetime benefit, and the plan is voluntary.

So if seniors have a plan already that they are happy with, they can stay with it. They are not going to get kicked out. But for those without coverage, this bill will help them get that coverage and cover those escalating costs of prescription drugs.

Seniors deserve a prescription drug benefit, not just talk, not just debate, and they deserve it today, and that is why we are going to act today, not talk, not debate but act, act responsibly and act within a budget that we can sustain over time.

Mr. STARK. Mr. Speaker, I am honored to yield the balance of my time to the distinguished gentlewoman from California (Ms. PELOSI), pending which I would just like to remind all the seniors in the country to review all the

votes that the Republicans took against their interests in coming to this useless bill which they have brought to the floor.

The SPEAKER pro tempore (Mr. THORNBERRY). The gentlewoman from California is recognized for 3 minutes.

Ms. PELOSI. Mr. Speaker, I thank the gentleman for yielding me this time and thank him for his leadership and that of so many other members on the Committee on Commerce and the Committee on Ways and Means for their leadership in making the distinction between what the Democrats would have proposed had the Republicans not been afraid of seeing a real prescription drug benefit plan on the floor tonight and their sham, their cruel hoax, on America's seniors that they have presented.

Why is it a cruel hoax? It is a cruel hoax because it helps pharmaceutical companies and HMOs and it does not help seniors pay for needed medication. It is a cruel hoax because there is no guaranteed coverage because insurance companies just will not offer plans. Our plan would have guaranteed coverage for all seniors through Medicare. Their plan does nothing to lower prices and ours would have lowered prices by enabling Medicare to negotiate on behalf of seniors. It goes on and on.

What is very important for me to note is that we spend annually $70 billion on doctors under Medicare, $140 billion on hospitals. It would be necessary to spend $90 billion on pharmaceuticals. It sounds like a lot of money, and it is. But it is a tremendous investment in the health of the American people.

The committee on which I serve that funds the National Institutes of Health, we have seen the progress in science since the inception of Medicare. It is miraculous what these drugs can do. Would it not be great if seniors could have the opportunity to have funding for self-administered drugs that is prevented so far and that the Republican bill does nothing to improve?

It would save seniors money. It would save the taxpayers money. Because these drugs are not only an adjunct to care and to hospitalization, they are a substitute for it. It would improve the quality of life, it would save the taxpayers money, and it would go a long way to restoring the dignity to our seniors which we owe them.

Every family in America, Mr. Speaker, is just one accident or one diagnosis away from sadness not only in terms of what it means to physical health but in terms of economic security. We have an agreement with the American people that their health is part of the strength of our country. Access and affordability are linked. Access to affordable prescription drugs is central to the health of our senior population. We owe them better than a debate on a sham bill that has no guarantee. It is a suggestion but not a guarantee. It is not a prescription drug entitlement under Medicare as what is promised and should be promised to our seniors. Again, it does nothing to address the issue of cost.

Every senior in America deserves the respect and dignity of economic and health security. The Republican bill is a cruel hoax on them. I urge a ''no'' vote.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 5 seconds.

Respectfully, how could a sham bill accelerate the pace at which technology will come into Medicare for the first time ever? And I am proud of it.

Mr. Speaker, I yield 1 minute to the gentleman from New York (Mr. GRUCCI).

Mr. GRUCCI. Mr. Speaker, I thank the gentlewoman for yielding me this time. When I went back to my district and I started talking about this program and this plan for senior citizens, I was wondering what kind of reception I was going to get, what they were going to say to me, the things that they would tell me.

One of the things I saw that really lit the fire of passion in my heart on this issue and on this particular bill was when I saw the hope in the eyes of the senior citizens when they recognized for the first time ever they were going to get help on their prescription drugs, that the cost of their prescription drugs was going to come down, that they were going to be able to put hundreds of dollars back into their pockets and they were going to be able to use that for the rhetoric that we keep talking about, to buy their food, to be able to put heat in their homes, so that instead of having to stretch their medicine, they could take it as prescribed.

I sat across the table from these senior citizens and they were not just telling me rhetoric, they were telling me how they have to live their lives. When they saw the benefits of this program coming in front of them, when they saw the opportunity to get their money back into their pockets, they had hope.

For that, Mr. Speaker, I encourage my colleagues here tonight to have a ''yes'' vote on this particular bill.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield the balance of my time to the gentleman from Missouri (Mr. BLUNT).

The SPEAKER pro tempore. The gentleman from Missouri (Mr. BLUNT) is recognized for 1 minute and 40 seconds.

Mr. BLUNT. Mr. Speaker, I thank the gentleman for yielding time, the great job she has done on the floor tonight and the great job that she and the committee have done with this bill.

This is a tremendous step forward. It provides so many things that seniors need. The amount of money allocated to this bill is possible. It is within budget. Health care providers and hospitals support this bill.

The AARP in a letter to the chairman of the Committee on Ways and Means said, ''We are pleased that your bill makes the voluntary prescription drug benefit permanent and maintains the entitlement nature of the Medicare program.''

This is something that can actually be done. It is within a real budget. It is an amount of money that can be spent for this purpose and can start immediately. It makes a difference in the lives of seniors.

Certainly health care delivery has changed dramatically since Medicare was created. This benefit needs to be added to Medicare. It needs to be an entitlement, not an experiment. It needs to be something that we do now, not come up with an amount of money that is impossible to do for years to come.

The amount of money allocated to this bill far exceeds the amount of money that our friends on the other side of the aisle said was necessary just 2 years ago. New drugs and devices would not be a result of a government-run health care program. They will be a result of a program that maintains incentives but guarantees lower cost, guarantees access, makes this an entitlement. It is supported by health care providers for a reason. The AARP says it has great merit for a reason.

We need to do this. We need to do it now. We need to make this a reality this year.

The SPEAKER pro tempore. Pursuant to House Resolution 465, the gentleman from Louisiana (Mr. TAUZIN) and the gentleman from Michigan (Mr. DINGELL) each will control 30 additional minutes of debate.

The Chair recognizes the gentleman from Louisiana (Mr. TAUZIN).

Mr. TAUZIN. Mr. Speaker, I yield myself 3½ minutes.

Mr. Speaker, I rise in strong support of H.R. 4954.

I first want to thank the gentleman from Michigan (Mr. DINGELL) and all the members of the Committee on Energy and Commerce who spent over 30 hours of markup in producing this bill. I particularly want to thank my colleagues on the other side for the spirited but I think agreeably friendly debate we had that stretched over 3 days and ended up on Thursday when we started at 9:30 and completed at 8:30 the next morning.

This is a complex piece of legislation. I have heard people describe it on the other side as a hollow bill that contains no benefits. Let me make it clear, this is a bill that spends 350 billion of American taxpayer dollars that will create a valuable new entitlement for Medicare beneficiaries, that will finally provide them with prescription drug coverage, and it will do so in a comprehensive way, ensuring that the benefit will work within a stronger Medicare system for decades to come.

I do not speak just for myself. Let me quote a letter from the AARP. The letter from the AARP says our members and virtually all older Americans need this coverage now. They are tired of excuses. They are tired of politics. They want us to pass this benefit bill now.

Here is what they said about our bill. ''We are pleased that your bill makes

the voluntary prescription drug benefit permanent and maintains the entitlement nature of the Medicare program.''

They went on further to say, ''The bill contains other favorable components as well.'' They talk about the coverage of the first $2,000 in the bill and particularly the financial assistance for low-income beneficiaries with drug costs under $2,000 as being vitally important. They also mention, and I quote, we appreciate your efforts to contain drug costs because a Medicare drug benefit bill alone without effective cost controls will be difficult to sustain. They understand we cannot bankrupt Medicare. We have got to make this system work within our budget.

But they went on to say, ''You can improve this. We don't like this home health copay.'' It is now gone. Our committee voted it out, and it is not in the bill.

They asked us to do what we could to close the gap, the $4,500 gap that existed between the first $2,000 of coverage and the catastrophic coverage. We found $18 billion by forcing the pharmaceutical companies to negotiate discounts below the so-called best price, $18 billion from pharmaceutical companies, and we lowered that loss from $4,500 of out-of-pocket expenses down to $3,700. We paid $800 more of drug cost in the bill now, exactly what AARP asked us to do.

Finally, they said, it is important, because our research indicates that Americans are looking for stability and dependability, to ensure that private sector entities will be willing to offer coverage.

We have a letter, too, from the Health Insurance Association of America and this is what their letter says:

''The improvements contained in the proposal should make the benefit more attractive to beneficiaries. Consequently, there is now a much better chance our members will offer the benefit.''

We have a comprehensive plan, a permanent plan, a voluntary entitlement within Medicare that is within budget, that insurance companies say they will be able to work under it and provide plans and what CBO says as high as 97 percent of the seniors in America will find drug coverage and participate in.

This is a great bill. Seniors want it now. They are tired of politics. Let us pass it tonight.

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

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, I listened to the chairman of our committee from Louisiana, and it bothers me because he is not looking at the bill. He is not talking about the Republican bill that is on the floor of this House. This is not a Medicare bill. This is not a Medicare program. There is nothing in this bill that is going to help the average American senior.

If you look at it, first of all, we know that it does not provide Medicare coverage, no guarantees. What it does is to give some money and throw some money to private insurance companies in the hope that somehow they are going to provide a Medicare benefit. The insurance companies have said they are not going to provide the benefit. If they were providing the benefit, we would not need a Federal program.

Let us imagine that somewhere, somehow, I do not believe it, but somewhere, somehow some private insurance company is willing to provide the plan the way the chairman describes. Why in the world would anybody buy into such a plan? Look at some of the figures that we have.

First of all, if I could use this chart, it shows very dramatically that the senior citizen is only going to get about 22 percent of their coverage paid for by the Federal Government, compared to the Democratic plan which was significantly more. Look at this so-called doughnut hole in coverage. In the beginning you are going to get, if it is even available, you will get some money in the very beginning, up to $1,000 and then up to $2,000 out of pocket. But then after that there is no coverage. For 40 percent of the beneficiaries, the average senior citizen, they are going to get no coverage during this interim period.

If you are going to be in a situation, either there is no plan at all, you do not have the advantage of a plan because the private insurance companies do not provide it, or, secondly, the premium is so high, the deductible is so high or it costs so much over the course of the year that it is not even worth buying.

Who in the world would want to buy the coverage even if it was available? The answer is nobody. That is the reality of this bill.

The other thing that really bothers me here is I have heard some of my colleagues on the Republican side tonight talk about how there is going to be a 30 percent discount. I asked the gentlewoman from Connecticut (Mrs. JOHNSON), where is this in the bill? There is nothing in the bill that provides any discount here. She is assuming that there is going to be some competition to provide it, but they put a noninterference clause in the bill that prevents any price reduction. They do not want price reduction.

□ 0015

Mr. TAUZIN. Mr. Speaker, I note that New Jersey is going to receive $1.5 billion in Medicaid savings directly from this bill, and 40 percent of their seniors will receive subsidized coverage of their insurance premium.

Mr. Speaker, I yield 5 minutes to the gentleman from Florida (Mr. BILIRAKIS), the chairman of the Subcommittee on Health of the Committee on Energy and Commerce.

Mr. BILIRAKIS. Mr. Speaker, I thank the gentleman for yielding me this time.

Before I get into my remarks, I would say that the gentleman from New Jersey, as usual, does not listen. When the chairman read from the AARP letter, when they said, ''We are pleased that your bill makes the voluntary prescription drug benefit permanent and maintains the entitlement nature of the Medicare program,'' that means it is under Medicare.

Mr. Speaker, obviously, I rise in support of the bill. I believe that today's vote is another example of our commitment to getting something done for seniors this year, not just talk about it this year.

The bill creates a new entitlement under Medicare. Senior citizens and persons with disabilities will now have access to a voluntary, comprehensive prescription drug benefit. Our bill creates this benefit without jeopardizing the financial health of the overall program, which would certainly happen under the plan offered by our friends on the other side of the aisle.

During the Committee on Energy and Commerce's consideration of the bill last week, committee Democrats offered an amendment in the nature of a substitute that, while not scored, would likely cost over $900 billion over 10 years. I was disappointed that they would offer such an irresponsible plan during such a serious debate, especially since, just last year, House Democrats included $330 billion for a new prescription drug benefit in their proposed budget resolution.

A benefit without explanations is, of course, no benefit at all. The counterproposal offered by my colleagues does not explain how they would fund this enormous program since they did not even offer a budget resolution this year. I repeat, they did not even offer a budget resolution this year.

The fact that they have now tripled the amount they say is necessary for a prescription drug benefit tells me that, instead of being serious about a solution, they care only about outbidding Republicans in an attempt to score a political point for the November elections. After all, as has been said before, they controlled this House for 40 consecutive years and at no time did they attempt to address this problem.

We are addressing it. We want to help seniors now, not just use political rhetoric.

Our plan provides Medicare beneficiaries with meaningful, comprehensive coverage. It does not force beneficiaries into a one-size-fits-all program where bureaucrats pick their medicines. Instead, seniors will have a choice of at least two prescription drug plans which will provide the best price discounts available. The bill also puts into effect an idea presented to me some time ago by Dr. William Hale of Dunedin, Florida, to offer at government expense an initial medical physical for all beneficiaries going into the Medicare program. It is easy to envision, I think, that many diseases will be picked up at that time in their early

stages and, thus, result in more healthful retirement years and ultimate health cost savings.

Mr. Speaker, H.R. 4954 places an appropriate focus on two populations that have long been, as many know, a priority of mine: the low-income senior without prescription drug coverage and the very ill senior who is in danger of impoverishing him or herself in order to pay for their medications.

The bill we are considering today includes strong protections for these vulnerable beneficiaries. It fully subsidizes cost-sharing, except for nominal copayments for Medicare beneficiaries with incomes up to 75 percent of poverty. This feature means that 44 percent of our Nation's seniors, those with incomes less than $15,505 for singles and $20,895 for married couples, could be eligible for full cost-sharing assistance. Mr. Speaker, $20,895 for married couples, could be eligible for full cost-sharing assistance.

Our bill makes needed changes to the program by raising reimbursement rates. That has been talked about.

Mr. Speaker, I hope that the Senate follows our lead and passes a bill soon so that we can begin the process of reconciling our two packages later this year. This is a good bill, a responsible plan, not a perfect plan by any means, but intended to help our seniors now, and we need to support it.

Mr. DINGELL. Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from Ohio (Mr. BROWN), the ranking member of the subcommittee.

Mr. BROWN of Ohio. Mr. Speaker, I thank the gentleman for yielding me this time.

The Republican HMO drug plan does several things.

First of all, it begins the process of privatizing Medicare. The Republican HMO drug plan gives 30 percent less choice, 30 percent less choice for seniors' prescription drugs. The Republican HMO drug plan is an entitlement for insurance companies, not for America's seniors. It does nothing to bring drug prices down. In fact, prices in the United States will continue to be, under the Republican plan, the highest, two, three, four times what they are in other countries, the highest prices in the world. And the Republican HMO drug plan gives benefits almost twice as good to Members of Congress as it does to America's seniors. As we can see on this chart, Members of Congress have a plan worth about $2,100. The Republican plan provides for America's seniors a plan worth about $1,300.

Now, why would our friends on the other side of the aisle come up with a plan like this that privatizes Medicare, that gives seniors 30 percent less choices, an entitlement for insurance companies, that most outrageously gives a much better plan to Members of Congress than it does to America's seniors? Why would they do that?

I think the answer to that, Mr. Speaker, came last Wednesday afternoon when our committee, the Committee on Energy and Commerce, adjourned early at 5 o'clock so that all of the Republican Members could troop off to a $30 million, that is $30 million fund-raiser underwritten by the American drug and the prescription drug industry where the money went to feed the coffers of Republican Party candidates. This fund-raiser was chaired by the CEO of one of the world's largest drug companies, the CEO of Glaxo, a drug company located in England, a foreign drug company. His company gave $250,000 to this Republican event. He was joined by $250,000 contributions from the trade association representing the drug companies and many others.

The question, Mr. Speaker, is of voting for a plan that is written by and for the drug companies or a plan for America's seniors.

So, the next day, when Members of Congress from our committee returned to vote on legislation, to vote on this prescription drug bill, surprise: every vote cast by my Republican friends, whether it was to make the seniors' plan the same as Members of Congress, whether it was to bring prices down, whether it was to reduce out-of-pocket expenses, every time these Republican Members of Congress voted with the drug companies.

It is a question of, do we vote for legislation written by and for America's drug companies, or do we vote for legislation written for America's seniors?

Mr. TAUZIN. Mr. Speaker, Ohio, under our bill, will earn $1.8 billion in Medicaid savings, and 38 percent of their seniors will get free premiums under our bill.

Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Kentucky (Mr. WHITFIELD), a distinguished member of our committee.

Mr. WHITFIELD. Mr. Speaker, I have been somewhat shocked, really, at the animosity expressed against our plan this evening. Medicare as it exists today uses private companies to administer the Medicare program. Under the Democratic plan, private companies will be used to administer their drug program, just as ours is.

I was looking, and in Kentucky we have 615,000 citizens under Medicare. Under this plan, the plan that we will be voting on and passing tonight, 315,000, or 50 percent of them, will basically receive free prescription drugs with a very small copay of like $2 for generics and $5 for name-brand drugs. So how could we possibly oppose helping seniors with this kind of a meaningful program?

We have heard a lot of discussion tonight about how horrible the drug companies are in America. I think they have the best research and development, and we are fortunate to live in a country where drugs are being discovered every day to cure serious diseases.

Mr. Speaker, I urge the support and passage of this legislation.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. Mr. Speaker, I thank the distinguished ranking member for yielding me this time.

Mr. Speaker, I rise tonight to speak about an issue that calls to a need of the American people. This is really a solemn moment in this Chamber, and I regret enormously that my friends on the other side of the aisle did not have enough confidence in themselves to debate here tonight two plans, not just their plan. So since it is just their plan, that is what I am going to direct my comments to.

I know you all love your mothers and fathers. So do we. We all love our families. We are talking about the American family. We are talking about senior citizens.

Now when the American people go shopping for coverage for something, what do they want? They want something that is comprehensive, they want something that is affordable, they want something that is guaranteed, and they want something that is understandable. They have come to trust the gold standard that Medicare represents.

Now my friends on the other side keep using the word ''Medicare.'' Do we know why? It is the best marketing word in the country. But look at the fine print. What they do is they put the language down for Medicare, but they take the taxpayers' money and shift to private insurance companies, with no guarantee that there is any insurance company that is going to bring them these benefits.

So American people: Beware. Beware of false advertising. This is no more a Medicare prescription drug plan than I am a redhead.

Mr. TAUZIN. Mr. Speaker, the State of California will get $5.1 billion in Medicaid savings under this bill, and 1.5 million California seniors, including redheads, will get free premium insurance coverage.

Mr. Speaker, I yield 2 minutes to the gentleman from Iowa (Mr. GANSKE).

Mr. GANSKE. Mr. Speaker, this is a $350 billion bill. Since when has $350 billion been pencil dust, I ask my colleagues. That is a third of a trillion dollars.

Mr. Speaker, 37 percent of Iowan senior citizens will have no copayment, deductible, or premium. They will get this benefit free. That is not pencil dust.

We have another problem that we have not addressed, and that is that in rural States like my State, rural hospitals and other providers, the rural hospitals are going broke and other providers are not taking care of, cannot take any more Medicare patients into their practices, and this bill addresses that. This bill addresses that.

Without this bill, we would have a 15 percent cut in physician payments. Without this bill, rural hospitals in Iowa will go bankrupt. This bill provides Iowa with $330 million in additional payments for Medicaid, and this is at a time when my State is struggling to meet its payments.

This bill helps seniors. U.S. Seniors endorses it, and Sixty Plus. It helps the providers like physicians to keep taking Medicare patients into their practices.

□ 0030

It helps keep the rural hospitals open. That is why it is endorsed by the AMA and the American Hospital Association. Ninety-five percent of seniors would find this a good deal and sign up for this bill.

This bill basically is a bird in the hand. That is worth more than two or three in the bush. Senior citizens in Iowa are telling me that $350 billion now will help a lot, and that is a lot better than an empty promise for two or three times more than that.

Mr. Speaker, a few winters ago, when Iowa was experiencing skyrocketing home heating bills, I received numerous letters from Iowa seniors who were forced to choose between paying their monthly heating bills or paying for their prescription drugs.

I don't believe that's a choice Iowans should have to make.

That is why this week, I have been working with my Energy and Commerce committee to pass the Medicare Modernization and Prescription Drug Act of 2002, which would provide a prescription-drug benefit for needy Iowa seniors through Medicare.

Although many members of the other party continue to treat Medicare as a political football, we are moving forward to provide immediate help to those who need it most.

Specifically, the bill includes an affordable and permanent prescription drug benefit with an average premium of $35 per month. The bill also includes a standard benefit that would begin with a $250 deductible and pay 80% of spending up to the first $1,000 and 50% up to the second $1,000. Seniors who meet the low-income criteria (50% of seniors currently without coverage) would pay less than $5 per prescription, up to coverage limits. All participants are protected against catastrophic costs, with out-of-pocket expenditures capped at $3,800 per year. An estimated 94% of eligible seniors in this country would participate in this plan in the first year, according to the nonpartisan Congressional Budget Office.

In addition to the drug benefit, our legislation also provides a boost to rural Iowa hospitals that, for too long, have ranked last in the country in Medicare reimbursements. The bill provides increased equity for all hospitals in rural areas, as well as increasing payments to sole community hospitals, rural home health agencies, and rural ambulance services.

Congressman NUSSLE and I also have worked to amend the legislation to provide an increase of up to $40 million per year to Iowa's non-teaching hospitals.

These provisions are significant because the vitality of Iowa's rural hospitals is central to the economy of our state. Our bill would help ensure that Iowans living and working in rural areas have access to reliable and affordable health care.

Our prescription drug legislation contains significant provisions for lower-income Iowans. Benefit premiums for Medicare beneficiaries below 150% of poverty level would be fully subsidized, as would cost-sharing expenditures for beneficiaries under 175% of poverty. Premiums for individuals between 150% and 175% of poverty would be subsidized on a sliding-scale basis.

The Medicaid provisions would mean savings of $337 million dollars to Iowa's state budget—needed help to our state legislators who are struggling to balance the state budget.

Has the other party proposed, a prescription drug bill of their own? Yes—a bill that irresponsibly busts the budget and risks bankrupting the entire Medicare system.

Our legislation, on the other hand, provides an immediate $350 billion drug benefit and fits into the budget.

So, do Iowa's seniors want our prescription-drug benefit now, or the other party's empty promises of a drug benefit at some undetermined point in the future?

The answer is that Iowa seniors want help now—because they realize that a bird in the hand is better than two in the bush.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Florida (Mr. DEUTSCH).

Mr. DEUTSCH. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, this bill and the two proposals, one is in front of us and one was not allowed to be in front of us, really are fundamental policy differences. What the American people want is to have prescription drugs as part of Medicare.

When Medicare was created in 1965, there are two interesting statistics. One is that the average age of Americans was 65 in 1965. It has gone up by more than 10 years. I think we consider that a high-class problem.

The second interesting statistic is that the out-of-pocket payments by seniors in America, the percentage of their income has actually gone up, even with Medicare.

One of the main reasons for both of those statistics is because of prescription drugs. We cannot conceive of a Medicare program, which is an insurance program, it is a forced insurance program, and that has been Medicare's success, we cannot conceive of that being set up today without prescription drugs.

What my colleagues on the other side of the aisle are proposing, and I do not doubt the chairman of the full committee will cite a statistic about Florida saving Medicaid dollars after I finish speaking, but that is not Medicare, Mr. Speaker. That is not Medicare.

That is not what American seniors want. It is a sham. It is misadvertising for American seniors, and they get it. They get it, and they do not want it. They do not want what Members are proposing. What they want is simple. They want an expansion of Medicare coverage for prescription drugs, because they understand on a day-to-day basis that prescription drugs are a necessary component of Medicare, and eventually the American seniors are going to get what they want, regardless of the action that we take today.

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

Mr. Speaker, Floridians, seniors under Medicare, over 1 million will have free premiums under this bill, and the State of Florida will receive $3.1 billion in Medicaid savings.

Mr. Speaker, I yield 1 minute to the gentleman from North Carolina (Mr. BURR), distinguished vice chairman of the Committee on Energy and Commerce.

Mr. BURR of North Carolina. Mr. Speaker, I have listened to the debate tonight for over an hour. I have heard the word ''sham'' and I have heard other words used. Those words are in fact about a benefit that we are going to extend to Medicare, a benefit that had not been extended since 1965, when Medicare was created.

Mr. Speaker, tonight we have a great opportunity. We have a great opportunity to pass a bill that is not perfect, but few things in this House are. We have the opportunity to extend for seniors for the first time coverage that the majority of Americans eligible for Medicare want and need. I do not think that is a sham; I think it is a tremendous opportunity for the Congress of the United States to pass for those individuals.

Some will get up and say that ''GOP'' is ''get old people.'' Maybe they ought to change the words tonight to ''GOPD, Get Old People Drugs.'' That is what we are here to do. If we can put aside partisanship, we can pass a bill that for the first time brings drugs to the American people.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from California (Mr. WAXMAN).

Mr. WAXMAN. Mr. Speaker, I cannot tell Members how disappointed I am that we are not discussing a Medicare bill that will really meet the needs of the American people.

We are not doing it on a bipartisan basis. Who would have thought this is a partisan issue? Both parties promised prescription drugs for seniors under the Medicare program in the last election, but the Republican plan that is before us today does not provide an adequate benefit. It does not help bring down the cost of drugs or stop excessive pharmaceutical company profits. It does not establish what the premium will be, or if it will be affordable.

Our Republican colleagues claim that the premium is set the same way the Medicare premium is now established; but that is wrong, and they know it. Medicare's premium is not set by a private insurance company that is interested first and foremost in its own profits. These premiums will be set just that way.

The Republican plan does not guarantee help with the cost of the drugs the physicians prescribe for us, and it does not ensure that we get our drugs at the local pharmacy. The fact is, this plan does not guarantee anything except subsidies for private insurance companies.

Let us put a real benefit in Medicare. Let us defeat this bill and give people the help they need. If they want to compare, for those seniors who are

watching this, if they want to compare what they will get from the Republican bill and what they would have received from the Democratic bill if we had even had a chance to debate and pass it, go to the Web site. Go to www.House.gov/reform/min, and Members will be able to compare easily on that Web site what the reality is compared to all the promises we have heard from the Republicans.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. THORNBERRY). The Chair would remind all Members to address their remarks to the Chair.

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

Mr. Speaker, not only will 43 percent of the seniors in California get subsidized premiums under this bill, but the State of California safety net hospitals receive over $63 million new dollars of help to provide health care.

Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Georgia (Mr. NORWOOD).

Mr. NORWOOD. Mr. Speaker, I thank the gentleman for yielding time to me.

Mr. Speaker, I heard comments earlier tonight saying that we should not be debating so late, that nobody would be awake. My contention is it does not matter whether one is awake or asleep. We cannot get anything out of this kind of debate at all.

I do not believe I have ever heard more misrepresentations or mistruths or demagoguery on a subject in a long, long time. I could spend the night discounting some of the things, but some of the statements are just absolutely ludicrous, like people lining up over here saying that $320 billion going into prescription drugs is going to harm people. Who in the world thinks we are going to spend $320 billion of the taxpayers' money to harm somebody?

There are statements saying in 1964, Republicans hated Medicare; they voted against it. That is not true. That is not true at all. Republicans, in fact, the majority voted for Medicare, and not all the Democrats voted for Medicare in 1965. It was a discussion worth having back then.

But do not stand up here and say all Republicans hate Medicare. Those who continue to say that Republicans say Medicare is going to wither on the vine, I saw that speech. I have a copy of that speech. Newt Gingrich made the speech. He said that HCFA was going to wither on the vine, and that outdated organization needs to have some rework, because it is interfering with the care of patients, for pity's sakes.

There have been a lot of complaints about the rules, and not a lot of truths about the bill. This is not a perfect bill. I know that; Members know that. All of us could do better. Any one of us could write a perfect bill if we did not have to worry about a budget. We could write a perfect bill, all of us could, if we did not care about bankrupting the trust fund, but we do.

But I will tell Members what this bill will do. They can call it, say it, do any way they want to, but what this bill will do is it will help the poorest and help the sickest seniors. We need to do it now, because this is the only game in town.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to my good friend, the gentleman from Michigan (Mr. STUPAK).

Mr. STUPAK. Mr. Speaker, I thank the gentleman for yielding time to me.

With all due respect to the last speaker, this is not a perfect bill; this is not even a good bill. Through all this debate, I went back to my office tonight and listened to all this.

I pulled two letters from my district, one from Vanderbilt, Michigan. A couple there has $6,288 per year in drug costs. Under the Democratic plan, if we would ever get a chance to vote on it, they would pay $1,637 and they would save $4,650, or 74 percent of their drug savings.

Underneath their plan, their bill here tonight, they would have to pay $4,096. They would only save $2,192, or 35 percent of their drug costs.

The other couple I pulled was from Travers City, Michigan. They have $3,240 per year on drug costs. Under the Democratic plan, they would pay $1,028 and save $2,212 or 68 percent. Under the Republican plan, they would pay $2,536 and save only $704, or 22 percent.

Do the math. The Republican plan just does not add up.

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

Mr. Speaker, Michigan will get one and one-tenth billion dollars in this plan of Medicaid savings, and nearly 40 percent of their seniors will get subsidized premiums for their Medicare prescription drug coverage.

Mr. Speaker, I yield 1 minute to the distinguished gentleman from Oregon (Mr. WALDEN) from our committee.

Mr. WALDEN of Oregon. Mr. Speaker, if we think about this, nobody has fought harder for Patients' Bill of Rights in this country than the gentleman from Georgia (Mr. NORWOOD), the gentleman from Iowa (Mr. GANSKE), and the gentleman from Kentucky (Mr. FLETCHER). They are unanimously in support of this bill.

These are careful legislators who have evaluated this bill carefully. They unanimously support it because they know it is within the budget. It will give care to those who need it the most. From the people that I represent, that is what is most important, that we put together a plan that will fit within the budget framework we have been given to operate under that will get them care, because they need help now. They need help now. They do not want partisan rhetoric. We are sick and tired of that in America.

This winter and spring, I went around and met with hospitals, doctors, patients, and seniors all across my district. The clear message was: get us help now; do what you can for us now. This bill does that. That is why organizations representing these doctors and hospitals and seniors and others support it.

It will help home health care; it will help Medicare patients. This is a good plan that will make a real difference for patients. It provides prescription drugs at no cost to those who make $15,000 or less a year in our senior community.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to my distinguished friend, the gentleman from Massachusetts (Mr. MARKEY).

Mr. MARKEY. Mr. Speaker, watch out, Grandma. Watch out, Grandpa. The GOP doctors are on their way, and boy, do they have a prescription for you. Every senior citizen gets three bitter pills to swallow:

Pill number one is a half-dose of dollars. The Republicans provide less than half the money that Democrats provide to seniors in their plan so that they will not be burdened by the soaring cost of prescription drugs, but the Republicans will not allow a vote on that plan.

Pill number two is a poison pill for Medicare. The Republicans are diverting Medicare funds into risky private drug plans with no maximum premiums and no guaranteed coverage in a cynical drive to privatize the Medicare program. But they will not allow a vote to prevent the privatization of Medicare.

Pill number three is a privacy piracy. The Republicans allow the pharmaceutical fat cats to exploit Grandma and Grandpa's sensitive medical secrets in marketing schemes without their knowledge or consent, and they will not allow a vote to protect that privacy, which is inside of the Democratic bill.

''GOP,'' it used to stand for ''Grand Old Party.'' ''GOP'' now stands for ''get old people.'' Vote ''no'' on the Republican plan tonight.

Mr. TAUZIN. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, how dare any of the Members suggest they love their mothers and fathers more than we love our mothers and fathers. How dare they suggest that we dislike our grandparents and would feed them bitter pills, and get them. How dare they make that suggestion.

My mother is alive because of Medicare. Medicare saved her life not once but three times. We are here to fight for Medicare and to improve it tonight, Republicans and Democrats alike. They have a different plan than us, but we all love our mothers and fathers. We all love our grandparents. How dare they suggest otherwise.

Mr. Speaker, I yield 1 minute to my friend, the gentleman from Michigan (Mr. UPTON).

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

Mr. UPTON. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, I am pleased that we are moving forward tonight with a very important bill for our Nation's seniors,

our moms and dads and health professionals who care for them.

□ 0045

No senior should be forced to forego needed medications, take less than the prescribed dose or go without necessities in order to afford life-saving medication.

The bill before us tonight will provide much-needed comprehensive Medicare, prescriptive care for all seniors who elect to participate. For those who can least afford their prescriptions, Medicare will cover a hundred percent of these premium deductibles.

In addition to modernizing Medicare by adding a prescription drug benefit, the bill before us tonight will also help to ensure that Medicare beneficiaries continue to have ready access to high-quality community-based health care services.

The bill fixes flaws in the Medicare prescription fee schedules that are resulting in significant unintended cuts in physician payments. It also improves hospitals and skilled nursing homing reimbursement, eliminates a scheduled 15 percent cut in home health payments, puts a moratorium on the cap on physical therapy reimbursement, and takes a good first step in improving reimbursement for ambulance services.

It is a good bill. I urge my colleagues to votes yes.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Mr. Speaker, I thank my ranking member from Michigan for yielding me time.

It is hard to say in one and a half minutes how much is wrong with this piece of legislation. We should have the opportunity to debate alternatives to correct the problems, but the tyranny of the majority makes that mockery of democracy.

There is one major glaring problem that should be mentioned: the gaping hole in the coverage of the drug costs that exceed $2,000. If a senior has a $300 monthly drug bill, they can expect to lose their drug coverage halfway through the year. But they will have to keep paying month after month for the rest of the year until they reach that catastrophic limit.

Another problem is, if seniors have other coverage from an employer or maybe some help from their church or a charitable organization, these contribution will not count as out-of-pocket expenses for that senior. So that is wrong with the bill.

There is another major disincentive for employers to provide retiree health care. It will further erode what little health care coverage we have left in our country.

Diabetes is a major illness for seniors. This bill, granted, covers insulin, but it does not pay for the syringes. So those seniors have to pay to inject the insulin we will give them. What kind of sense does this make?

Mr. Speaker, there are so many problems with this legislation we should be allowed our alternative, providing a meaningful prescription drug benefit, but the Republican majority again is afraid to allow amendments to pass.

My Republican colleague from Iowa said that their bill is a bird in the hand, but seniors, when they find out what this bill does, will be left with only bird droppings in their hands.

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

Mr. Speaker, the seniors of Texas will receive $1.9 billion in Medicaid savings under this bill; and 55 percent of them will have subsidized premium coverage. That is not bird droppings.

Mr. Speaker, I yield 1 minute to my friend, the gentleman from Pennsylvania (Mr. GEKAS).

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

Mr. GEKAS. Mr. Speaker, I thank the gentleman for yielding me time.

There is an extra benefit that is being conferred by passage of this bill and that is to our veterans. Veterans are experiencing two phenomena that we can help remove here tonight. One is the higher cost of medications that they are experiencing, of course. All seniors will benefit from that. But there is another idea that we have to shake away from the existing scene about our veterans and that is the long waiting lines that they are experiencing at the VA hospitals.

In our central Pennsylvania area, some 6,000 are waiting to see a doctor in waiting lines, and their medications that will be prescribed are not waiting for them because of the long lines and because of the high costs of medication. Strike a blow here for your veterans as well as the other seniors by passing this legislation, reducing the cost of prescriptions to our veterans and reducing the long lines that they are now facing in and even waiting to see a doctor at VA hospitals for the purpose of medication.

Waiting lists at veterans hospitals across the country are growing. In central Pennsylvania alone there are over 6,000 veterans waiting to be seen. Nearly 70 percent of these veterans are rated as category seven by the VA, meaning that they have no service connected disability. In fact, the vast majority of them are seeking a meeting with a VA doctor solely in order to receive assistance with their medications. They are seeking help because of the high cost of their medications or because their health plan discontinued their pharmacy benefits.

Our new Medicare prescription drug benefit will reduce out-of-pocket drug expenses for Americans by 25–30 percent. That savings may help veterans in central Pennsylvania opt out of the long waiting lines at the veterans health care facilities in Lebanon, Camp Hill, Berks, Pottsville, and others. Veterans will be able to switch from their veterans plans to the plan we vote on today without penalty.

I have visited with VA officials in my district to discuss the problem of lengthening waiting lists. At the Lebanon VA hospital, I was told that nearly 1,800 veterans still wait to be seen by a doctor. Of those waiting, 65 percent are category seven and most likely waiting to get assistance with medication. I commended the caring individuals who run that acclaimed facility for providing outstanding healthcare. The Lebanon VA hospital has, in fact, received the highest patient satisfaction scores of all VA medical centers across the Nation. But I had to agree with them that we do not want to see these quality institutions simply turned into pharmacies. Furthermore, we do not want to see long lines of patients waiting to see a VA doctor when a drug plan that reduces their drug expenditures would work just as well.

One of the great benefits to come from passage of this prescription drug coverage bill will be the relief provided to veterans and VA hospitals. Vets will be able to choose this new drug coverage plan and opt out of the long lines at VA hospitals. Veterans who need help purchasing their medication will get real relief. Those who are waiting inordinate lengths of time on waiting lists to see a doctor at there local VA hospital may look forward to shorter waits and prompter services. Our veterans deserve no less.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Ohio (Mr. STRICKLAND).

Mr. STRICKLAND. Mr. Speaker, we need to tell the full truth about veterans and prescription drugs. This administration has raised the co-pay for medications that veterans get at our VA facilities from $2 to $7 per prescription, a $250 increase. That is the fact.

Mr. Speaker, the assets test provided under the Republican plan makes a mockery of one of the key objectives of the Medicare prescription drug benefit, to prevent senior citizens from having to pauperize themselves to get the drugs they need. Think what this means.

It means that a frail elderly woman who qualifies for a handicapped sticker on her car because she cannot walk a short distance cannot keep a car that she cannot be confident will not break down on the highway if she wants to qualify for the assistance she needs to get the drugs her doctor prescribes.

It means that a spouse who has managed to buy a burial plot, a burial plot so that they can lie for eternity next to a husband or wife may have to sell that plot to get the prescription drugs they need to survive. For shame.

Those of you who want to give a death tax elimination for the multi-millionaires in this country have no problem with requiring grandma to give up her burial plot in order to qualify for the assistance under this plan. You ought to be ashamed of yourselves.

Mr. TAUZIN. Mr. Speaker, I yield myself 15 seconds.

That claim is disingenuous. Section 1902 allows the States to waive that means test. There is an additional section, 1115 waivers are also allowed for the States, and they can waive that means test any time they want to.

Mr. Speaker, I yield 1 minute to the gentleman from Pennsylvania (Mr. GREENWOOD), the distinguished chairman of the Subcommittee on Oversight

and Investigations of the Committee of Energy and Commerce.

Mr. GREENWOOD. Mr. Speaker, I do not have a single new thing to say about this issue because it has all been said over and over again. But as I have been sitting listening to the debate for these last 2 hours and looking at it and listening to the howling and the shrieking and the bellowing and the clattering of pans, I could think of nothing more than the ancient times when there was an eclipse; and as the sun was eclipsed the ancients ran out and made some noise.

For decades, the Democrats claimed to be the party that represented and cared for the seniors. They did nothing for the prescription drug benefit. Finally, our plan is eclipsing their stature; and they cannot stand it; and they are bellowing and howling. When the sun comes up tomorrow morning, we will have passed the first prescription drug plan in the history of this program. The howling will silence, and the seniors will have something to be proud of. And I am proud of you, Mr. Speaker.

The SPEAKER pro tempore. The gentleman from Louisiana (Mr. TAUZIN) has 10 minutes remaining. The gentleman from Michigan (Mr. DINGELL) has 15 minutes remaining.

Mr. DINGELL. Mr. Speaker, I yield 30 seconds to the distinguished gentleman from Ohio (Mr. STRICKLAND).

Mr. STRICKLAND. Mr. Speaker, I would like to speak to the chairman of the committee. He says that the States can waive this requirement. In fact, they can not. The asset test was placed under title 18. The States are not able to waive this requirement under this bill.

Mr. TAUZIN. Mr. Speaker, I will yield myself 15 seconds to indicate again that our information is the States have the power to exercise the waivers under this bill.

Mr. Speaker, how much time is remaining on each side?

The SPEAKER pro tempore. The gentleman from Michigan (Mr. DINGELL) has 14¾ minutes remaining. The gentleman from Louisiana (Mr. TAUZIN) has 9¾ minutes remaining.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentlewoman from Colorado (Ms. DEGETTE).

Ms. DEGETTE. Mr. Speaker, with this bill Congress should be keeping a solemn promise to our seniors. But what the Republicans are doing is giving simply a fig leaf instead.

This proposal covers only about 20 percent of the expenses that seniors will incur for prescription drugs in the next 10 years. Well, the Republicans say we are operating under budget constraints. We cannot afford to pay the 80 percent of the costs that the Democratic alternative would have offered had we been able to offer it. Why? Why do we have these budget constraints? Because their priority is not to give relief to the 40 million Americans who need the relief but to give it to the 500,000 of the very wealthiest Americans who want estate tax relief.

Take a look at this chart. Here is the number of seniors who need this prescription drug plan and need a thorough plan, 35 million. Here is the number of people who will benefit from the Republican estate tax cut that they passed a few weeks ago and that caused the budget constraints which are preventing us from passing a real benefit.

The seniors of America need to know this is why we cannot give grandma and grandpa their drugs. It is not because God came down and gave us these constraints. It is because the Republican caucus gave them to us.

Let me answer one more thing. Mr. STRICKLAND says that grandma and grandpa will not be able to buy their burial plots because of the assets test. That is under Medicare. That cannot be waived under title 18 by the State. It is nonwaivable.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from New York (Mr. ENGEL.)

Mr. ENGEL. Mr. Speaker, I thank the ranking member for yielding me time.

The fact of the matter is that the bill that we are debating today is inadequate because there is inadequate funding for the bill; and the reason there is inadequate funding for the bill is, as the previous speaker pointed out, all the money has been used up with tax relief for the very wealthy in this country, $1.6 trillion worth of tax relief for the very wealthy people in the country. So, of course, when it comes to a prescription drug benefit we do not have enough money to provide a real meaningful plan.

We would like to debate the Democratic bill along with the Republican bill here, but we were denied the opportunity. So we do not have the ability to show why our plan is better.

The fact of the matter is, our plan is better. It will cover more seniors. It will give an entitlement under the Medicare program which is really what seniors want.

The bill we are debating today does not provide any real guaranteed benefit and simply, in my opinion, lays the groundwork to eventually privatize Medicare. The bill does not contain the entitlement to a defined benefits package as provided in the rest of the Medicare program. It only promises that seniors can shop for some kind of coverage undefined either through private insurance plans or Medicare HMOs. The bill does not contain, again, any defined premium or assurances that prescription drugs will be affordable; and it will cover less, and listen to this, it will cover less than one-fifth of the estimated drug costs of Medicare beneficiaries over the next 10 years. There is a large gap in the coverage.

Seniors who needs more than $2,000 worth of the drugs in the calendar year must pay for 100 percent of their drugs until they reach $3,700. So what we are seeing here is a woefully inadequate bill, and it is an indication where sometimes when you have something it is worse than having nothing.

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

Mr. Speaker, this bill that has been described as so terrible will give to the State of New York $4.5 billion of Medicaid savings. It will cover 51 percent of New York seniors with subsidized premiums paid for by the government and will provide safety net hospitals in New York with nearly 90 million new dollars. What a terrible bill.

Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. BARTON), the distinguished chairman of the Subcommittee on Energy and Air Quality of the Committee on Energy and Commerce.

Mr. BARTON of Texas. Mr. Speaker, I want to thank my distinguished chairman and simply tell him I am glad to be on the floor backing him up, and I look forward to tomorrow delivering one of his famous cookbooks to one of my dearest friends down in Texas who has indicated to me you need to be backed up tonight with great, great enthusiasm.

I would like to tell my good Democratic friends that I agree with them on one point, and that is the fact that the rule should have allowed you to offer your substitute. I think it would have been a neat trick to have almost to a person voted against an increase in the debt ceiling of $450 billion and then turn right around and voted for a $1 trillion expansion of a brand new entitlement program 2 hours later.

□ 0100

I think this is a good bill. The provider part of it is almost universally supported. I think the prescription drug benefit is a good start. I think it could be improved.

I would like at some point in time to have the ability to offer the additional option of a prescription drug savings account. Many in my district, over two-thirds of the seniors that I have talked to, have said that they would probably opt for some sort of a drug savings account if they were given that option, and I hope that later this year we could do that.

This bill that is before us for over half of the seniors in this country would pay nothing for prescription drugs except a small copayment for the specific drug that they had to use, and I would point out that prescription drugs for most of our seniors are not of a catastrophic nature. They are of a chronic nature. They are to treat heart disease or to treat high blood pressure or cholesterol. They are something they have to take to have a lifestyle that we want them to have.

So I think my idea of a prescription drug savings account would give them a lot of options to do that, and again, I hope that we have the opportunity to offer that at some point in time.

To start the ball rolling, I agree that this bill is a good start and hope we will vote for it later this evening.

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

Mrs. CAPPS. Mr. Speaker, I thank the ranking member for yielding time to me; and, Mr. Speaker, for seniors in my district, there is no issue more important than prescription drug coverage, but the bill before us will not offer my seniors what they need.

First, it entices insurance companies to offer the drug coverage plans. In fact, it gives them the money without any guarantee of a benefit for seniors. Medicare+Choice has shown us that just relying on private insurance companies does not work.

Second, under the majority's proposal, as a senior's drug costs increase, their benefits decrease. In fact, once a senior's costs exceed $2,000, a senior has to spend another $2,900 on their medications before they will get any help.

This chart here, the GOP plan, shows a calendar for seniors. Many seniors in my district pay $400 a month. This senior paying $400 a month will get no benefit during the first month while he is paying his deductible; but then he will get a benefit, February, March, April and May. Unfortunately, then he reaches that $2,000. No more benefit for this senior for the entire rest of the month, and we call this is a drug benefit for our seniors? This is the plan we are voting on tonight because we have no alternative.

We are not allowed to bring a plan that our side has developed that would offer affordable, reliable prescription drug coverage for all under Medicare. For our $25 premium, $100 deductible, seniors would get 80 percent coverage of all their medications. This person during this time of having no coverage is not allowed to rely on a church who wants to step to their aid or family members or if they have a pension plan because of their services, they cannot use that.

This plan is the one that we must vote ''yes'' or ''no'' on tonight. We do have many alternatives. The one we wanted to put up would be a good and fair plan. No opportunity to do that because the majority is so afraid that they will lose the opportunity to do the things that they know in their hearts they should do for this Greatest Generation. We owe our seniors a better plan than this one.

Mr. TAUZIN. Mr. Speaker, would the Chair again advise us how much time remains on each side?

The SPEAKER pro tempore (Mr. THORNBERRY). The gentleman from Louisiana (Mr. TAUZIN) has 7½ minutes remaining. The gentleman from Michigan (Mr. DINGELL) has 9¾ minutes remaining.

Mr. TAUZIN. Mr. Speaker, I am pleased to yield 1 minute to the distinguished gentleman from New Jersey (Mr. FERGUSON).

Mr. FERGUSON. Mr. Speaker, I thank the chairman for yielding me the time.

We have heard a lot tonight about facts and figures and partisan rhetoric and attacks and misrepresentations. Some of our colleagues on the other side of the aisle earlier tonight suggested that we talk about or focus on senior women. I would like to do that for a second, one in particular, my mother.

My mother, Roberta, was diagnosed almost 5 years ago with cancer, deadly form of cancer, should have been dead by now. She is alive today, thank God, because she has had access to good medical care and prescription drugs that have saved her life. Why is that so important? Because without it, she never would have met her grandkids. Our kids, 3 and 2 years old, she never would have met them. Thank God she had access to these life-changing, life-saving products, because of scientists and researchers and companies who invest hundreds of millions of dollars, indeed billions of dollars, to find the miracle cures of tomorrow.

We have to make these miracle products affordable and accessible to everyone because our seniors are too important to let this opportunity sneak by. Our grandmothers want to meet their grandkids. Let us make it happen. Pass this plan tonight.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Maine (Mr. ALLEN).

Mr. ALLEN. Mr. Speaker, I thank the gentleman for yielding me the time.

Mr. Speaker, anyone who has been half awake for the last 2 years knows that for Republicans tax cuts for the wealthy are far more important than prescription drugs for seniors. In the room upstairs, Republicans can call Medicare a Soviet-style program; but down here on television, they say they are providing a Medicare benefit.

The Republican plan relies on private, stand-alone prescription drug insurance plans. They do not even exist now, and they probably never will. No guaranteed benefits, no guaranteed premium, no guaranteed reduction in price. Their plan is an empty promise.

We have been asked where is our plan. The truth is my colleagues will not let us vote on it. Why? Because they know that a real Medicare benefit would reduce prescription drug prices. That is not acceptable to the pharmaceutical companies, so it is not part of the Republican bill.

Many Americans may be confused by this debate. All these numbers, estimates, projections. Just remember that Republicans get most of the money from HMOs and pharmaceutical companies. This bill is great for them, but it is a fraud on America's seniors.

Mr. TAUZIN. Mr. Speaker, I am pleased to advise the great citizen of Maine that their citizens, their seniors, 40 percent of them will get subsidized and mostly fully subsidized premium coverage under this bill.

Mr. Speaker, I am pleased to yield 1 minute to the distinguished gentleman from Tennessee (Mr. BRYANT), a member of the Committee on Energy and Commerce.

Mr. BRYANT. Mr. Speaker, I thank the chairman for yielding me the time, and I thank the chairman for making a priority of our committee to bring forth this first prescription drug benefit that is going to be available to people eligible for Medicare.

I think it is a good bill. It offers low-cost drugs. I think it guarantees insurance coverage, and it is all done in a fiscally responsible way. It fits within our budget, and I thank again the chairman for doing this.

I know our folks in Tennessee, we have about 700,000 senior citizens, and about 45 percent of those senior citizens will be eligible for virtually cost-free drugs under this plan; and I know those citizens in Tennessee that are dual eligible, that are covered, are qualified both in Medicare and Medicaid, that would result in, when this program picks up those people from the State, in a savings of about $565 million over the years 2005 to 2012.

So, Mr. Speaker, again I commend the gentleman from Louisiana (Mr. TAUZIN) for bringing forth this very good bill and making it a priority of this Republican Congress to give us our first-ever prescription drug benefit in the Medicare system outside the hospital.

Mr. DINGELL. Mr. Speaker, I yield 1½ minutes to the distinguished gentleman from Illinois (Mr. PHELPS).

Mr. PHELPS. Mr. Speaker, I want to thank the gentleman for what he has done in the leadership in this particular subject that has brought us here tonight.

I rise in opposition to this plan and sadly because the rhetoric I guess tonight comes to an end. After promises from both sides of the aisle and those who have run an election for the last several years who promised to do something on this particular subject, we fall short and it is sad because I wanted to come to this body to have a true, fair debate on subjects of great priority like this, not to debate at 1:00 a.m. in the morning where we hide things from people, to say just one plan is the best plan, it is the only plan. That is not what we are about.

I am not here to promote adversity. I do not want conflicts. I want us to come together in a bipartisan manner to try to solve the very best of all plans, not just say one plan is the only plan, and say, Illinois, that I know that the gentleman is about to quote how many millions of dollars we are going to receive and help, but what could we have received? That is the question. Those people out there, constituents that I represent, will never know until the true light of day is shed on my colleagues' plan, and that is what we intend to do.

They have limited us to debate here tonight, trying to get one side of our plan more clear, under handicap conditions. That is not what we are about.

That is not why we were elected, to have one party or a majority party have the only plan to make it deceptively look like it is a positive plan.

That is why we are here tonight, to debate the best, the most priority issue in the Nation, not in the wee hours in the morning just one plan, but a fair plan for all the best of all plans.

Mr. TAUZIN. Mr. Speaker, I am pleased to let my friend know that the great State of Illinois will get a great fair share of this bill, about $2 billion in Medicaid savings, and about half a million of his senior citizens will get totally free premiums for their Medicare premium drug insurance coverage. That is a pretty good deal, pretty fair.

Mr. Speaker, I am pleased to yield 1 minute to the gentleman from Indiana (Mr. BUYER), a distinguished member of the Committee on Energy and Commerce.

Mr. BUYER. Mr. Speaker, it took me 3 years to redesign the pharmacy benefit of military health delivery system. As the only Member of this body in this Congress to offer a prescription drug bill that has been passed and signed into law, I want to share a few observations.

Number one, I want to thank the gentleman from Hawaii (Mr. ABERCROMBIE) because we worked in a bipartisan fashion, something that has not occurred here.

Secondly, we were able to modernize a program without dulling the cutting edge of new prescription drugs.

Missing from this debate is the celebration of capitalization, a free enterprise system that avails the great minds of the world, the incentives to form at-risk entities to push the bounds of modern medicine and pharmacology to the benefit of our people and the improvements in their quality of life.

Please do not demonize these scientists and those in the medical community. Americans are living longer with many chronic illnesses. Why? Because modern medicine and the best health care system in the world is giving them that chance. Access to these drugs is what is important. That is what the Republican drug plan is going to do.

Please vote for this bill.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1 minute to the gentlewoman from Florida (Mrs. MEEK).

Mrs. MEEK of Florida. Mr. Speaker, first of all, this bill tonight, I have listened very carefully. It is a relief act for the insurance industry. That is what it is.

Also, the Republican plan is not a fair plan. It is not going to help all seniors. Think about that. That is the fact. It does not cover them. There is no real guarantee at all, and many of them keep getting up and saying this is the first plan. That is all they want to go out and say, this is the first plan. It does not mean anything except it is the first ever, and it is not worth doodley squat. So they run with that.

So we have got to think of three things. It will not cover all the seniors. Imagine this, seniors having to run around, trying to shop around and find a plan. That is a big hassle for older Americans. They cannot contend with all these various insurance plans that come and go. We do not know how the model is going to work. Those of us who have been around, we know it did not work in 1965; and this is just another part of it. It is not going to work now.

We should be sure tonight to vote against this relief act for the insurance agencies.

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

I am pleased to let my dear friend, the gentlewoman from Florida (Mrs. MEEK), know that the poor seniors in her State, over 1 million of them, will get free insurance drug coverage under this bill. That is 42 percent of her seniors and the State will get $3.1 billion of Medicaid assistance.

Mrs. MEEK of Florida. Mr. Speaker, will the gentleman yield?

Mr. TAUZIN. I yield to the gentlewoman from Florida for 15 seconds only.

Mrs. MEEK of Florida. Mr. Speaker, I did not say poor seniors. I said all seniors.

Mr. TAUZIN. Mr. Speaker, I am saying all seniors are going to get helped, but the poorest will get totally free insurance coverage.

Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Kentucky (Mr. FLETCHER), a new member of the Committee on Energy and Commerce.

Mr. FLETCHER. Mr. Speaker, again, prescription drugs for our seniors is probably the most pressing health care issue that we face, and I want to thank the chairman of the Committee on Energy and Commerce for his leadership in bringing this to the floor, a plan that is reasonable, responsible and doable, unlike a plan that was brought up in our committee and will be brought up in the recommit motion. That is a plan that scores out at $973 billion with absolutely no way to pay for it.

□ 0115

That means you are either going to have to increase taxes on our children, grandchildren or you are going to have to take it from education, national security, homeland security, or Social Security. Those are the only choices you have.

Let me talk just briefly. Two years ago there was a $303 billion prescription bill plan. Who supported that? Virtually every single Democrat supported that. What happened this year? I think they have had an election year epiphany. All of a sudden, it is an election year; and we need three times as much money for it to be a reasonable plan. Is it not amazing that when we offer a plan that is reasonable, doable, it will be a plan that will provide benefits for every senior?

Let me talk about Kentucky. There are 615,000 Medicare beneficiaries that will receive help with this. Fifty percent of those in Kentucky are at 175 percent of the poverty level or below, which means they will be subsidized. It means $459 million for Kentucky. We are a small State, but $459 million for Kentucky, and those dual eligible for Medicare and Medicaid will get help. We are having trouble meeting our budgetary needs, so this bill is the right kind of a bill. It is a responsible bill, it is a reasonable bill, it is a doable bill, and they thought it was 2 years ago, but now in an election year, no, it is not enough.

I think we need to lay aside election-year politics, pass this thing on a bipartisan basis, and let us do what our seniors need, provide them a prescription drug bill and help for our States.

Mr. BROWN of Ohio. Mr. Speaker, I notice that my friends on the other side of the aisle talk about giving free coverage to poor seniors except for the $2,700 out of pocket they would have to pay under the Republican private insurance plan.

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

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

Ms. MCCARTHY of Missouri. Mr. Speaker, I am in opposition to the measure before us and in support of the Democrat alternative that was denied.

I rise today in opposition to H.R. 4954, the Medicare Modernization and Prescription Drug Act of 2002. This "Insurance Company Protection Act" will not provide an affordable and dependable benefit for seniors. The Democratic substitute, which is being denied consideration by Republican leadership, provides comprehensive prescription drug coverage and savings to employers.

The "Insurance Company Protection Act" is an effort to privatize Medicare. This bill shifts $68 billion in health care costs onto employers, by designing the benefit so that private plans are required to cover prescription drug costs. As a result of this increase in costs for employers, the Congressional Budget Office (CBO) estimates that one third of seniors in employer sponsored retiree plans will be dropped, leaving three million seniors who currently have employee based retiree coverage owing more for prescription drugs after this law is enacted.

The "Insurance Company Protection Act" threatens our local pharmacies. With myriad medications, seniors rely on their local pharmacists for advice and help in the management of their prescriptions. This legislation does not allow any pharmacy to be applicable for the prescription drug program, breaking many long standing relationships between pharmacist and patient.

Instead of shifting costs onto employers and seniors losing their coverage, the Democratic proposal offers a universal benefit with a $25 a month premium, $100 a year deductible, 80 percent of costs paid by Medicare, and a $2,000 out of pocket limit per beneficiary per year. It provides low income subsidies to ensure that every senior can afford to participate

in the Medicare Prescription Drug Plan. In addition, physicians would have received a true solution to the Medicare payment problems that threaten the program today.

The Rules Committee had an opportunity to produce a bill that provides sufficient drug coverage for our seniors by allowing a vote on the Democratic substitute. Instead, the House will vote on a plan set by industry, the ''Insurance Company Protection Act,'' that provides no entitlement under Medicare, an inadequate and ill defined benefit, and no equality for seniors in different parts of the country. Seniors cannot even be assured that the drugs they are prescribed will be covered, or that they will be able to continue their trusted relationship with their pharmacist. With these provisions, it is not difficult to understand why every senior group opposes the bill before us. I urge my colleagues to vote against the Medicare Modernization and Prescription Drug Act.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1 minute to my friend, the gentleman from Washington State (Mr. INSLEE).

Mr. INSLEE. Mr. Speaker, why should the senior citizens of America have to settle with a big gamble about whether they are going to get prescription drugs? Why should they have to gamble that maybe, maybe an insurance company will show up when no insurance companies exist on the face of this planet today to provide this service?

When one thinks about this, the Republican plan does not provide drugs. It provides a pair of dice to roll, and that is not good enough for senior citizens. Now, you do provide them a chance maybe some of them will get prescription drugs, but this generation has taken enough chances. It took chances on Omaha Beach, it took chances on Iwo Jima, and it should not have to have a crapshoot to see whether or not they are going to be able to get prescription drugs, and one would think after the abject failure of Medicare+Choice that you would not place your bets on a horse that has gone lame all over this country time and time again.

Mr. Speaker, we ought to reject this pathetic excuse and pass a real meaningful Medicare plan.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. TURNER).

Mr. TURNER. Mr. Speaker, we have had a lot said on this floor tonight, but what really is going to count is what is said when we get out there talking to those seniors that we are trying to help here tonight.

I traveled all over my district and collected pill bottles from those seniors, and I know how they feel, and they are going to ask some tough questions of us. If this plan passes, they are going to want to know and they are going to hand me that list of medicines they have been prescribed by their doctor and they are going to ask, are these medicines going to be covered under this plan? And if you give them an honest answer, you are going to have to say, I do not know, because you do not know.

They are going to say, how much is the premium going to be for this plan? If you give them an honest answer, you are going to say, I do not know. That is going to depend on what the insurance company that is going to carry this plan is going to charge you.

Then they may look at you and say, well, can I get this plan at my local pharmacy? You know the answer to that one. The answer is no. You are going to have to get it through mail order.

And if you look at them again and they say, this does not sound like too good a program, how do I know that this program is going to be there? The answer is you do not know because those Medicare HMOs have not been there for our seniors.

So I think what we have got to do tonight is be honest with our seniors and tell them we are passing a sham tonight, a sham that means nothing to these seniors, and what we have got to do is pass a real plan, a real Medicare plan for our seniors.

Mr. BROWN of Ohio. Mr. Speaker, I yield 1½ minutes to the gentlewoman from New York (Mrs. LOWEY).

Mrs. LOWEY. Mr. Speaker, I rise in strong opposition to this bill. The skyrocketing cost of prescription drugs is a bitter pill to swallow, and the Republican leadership's refusal to let us consider the Democratic proposal is simply bad medicine for America's seniors.

My colleagues, last year, I conducted a study which showed that seniors in Westchester County are paying from 57 percent to 128 percent more than their counterparts in six foreign countries for the five drugs most commonly used by seniors in the United States. It also revealed that three medications frequently prescribed to seniors increased in price by at least twice the rate of inflation.

These statistics reveal to us over and over again the depth of the problem, which is growing worse by the day. Clearly, America's seniors deserve more than a hope and a prayer when it comes to ensuring their health and well-being.

The bill under consideration would, unfortunately, not guarantee benefits for seniors. Instead, it would pay subsidies to insurance companies in the hopes that they will establish drug-only insurance plans for Medicare beneficiaries. Under the Democratic plan, which we were not able to really debate this evening, Medicare would provide voluntary prescription drug coverage for all Medicare beneficiaries.

It is simply unconscionable that the Republicans are denying us a vote on the Democratic bill because perhaps they feel their Members will join us in voting for a real prescription drug benefit.

I also note that congressional action on provider payment increase and protections for Medicare-Plus Choice is long overdue.

Let us vote for a real plan. Let us have a real debate. Let us vote down this bill.

Mr. BROWN of Ohio. Mr. Speaker, I yield the balance of my time to the gentleman from Michigan (Mr. DINGELL), who will explain why the Democratic plan is written for America's seniors and the Republican plan is written by and for America's drug companies.

The SPEAKER pro tempore (Mr. THORNBERRY). The gentleman from Michigan (Mr. DINGELL) is recognized for 2½ minutes.

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

Mr. DINGELL. Mr. Speaker, I am Mr. JOHN DINGELL. My dad was the original author of Medicare. He wrote it for and under Harry Truman's guidance and tutelage. It was a great piece of legislation. It took us 10 years to get it enacted into law. I sat in the Chair when we passed it. The Republicans, after years of fighting it, finally came along and supported it because they saw the handwriting on the wall.

I know Medicare, and this fraudulent proposal that is before the House is not Medicare. What it is is a subsidy for the insurance companies. We give a pile of money to the insurance companies that they can spend any way they want.

The counsel of the committee was inquired of by me for about 20 minutes. He could not tell us of any constraints on the insurance companies or any rights of the insured that would be protected under this Republican legislation.

That is why this is bad legislation. The insurance companies can take this money and spend it any doggone way they want, dividends, or they can give it in corporate executive salaries and bonuses. That is why it is a bad bill.

The Democratic bill is a very simple bill. What it does is it says, you pay $25 a month, you get 80 percent of your prescription pharmaceuticals paid for by the government, and you pay 20 percent of the cost yourself. Very simple, very understandable, very plain. No great big donut hole, no disqualifications for having your expenditures counted, and you get your benefits all year round. Not like this sorry mess that my Republican colleagues would foist upon our senior citizens.

This is a bad proposal. This is a bad process. This is a situation where we do not get an honest chance to either offer an amendment or see to it it is properly explained.

But I would note one thing. Every honest senior citizen organization in the United States says this Republican bill is a bad bill, and AARP says it needs significant improvement before they can support it.

We want to give the American senior citizens Social Security in good form, Medicare in proper form, and a Medicare benefit which will take care of their needs for prescription pharmaceuticals when they come. No longer should we have a situation where American senior citizens have to decide whether they are going to pay

their rent or whether they are going to eat or whether they are going to get their prescription pharmaceuticals. That is wrong.

Our bill corrects that. The Republican bill does not. Vote against their bill. Vote for the motion to recommit and my colleagues will serve their constituents well, especially their seniors.

Mr. Speaker, I include for the RECORD a letter written to the gentleman from Louisiana (Mr. TAUZIN) from AARP, which was referred to earlier.

AARP,
June 18, 2002.

Hon. W.J. TAUZIN,
Chairman, Committee on Energy and Commerce, U.S. House of Representatives, Washington, DC.

DEAR CHAIRMAN TAUZIN: Thank you for your initiative to move legislation through the House this year that will address the important need for prescription drug coverage in Medicare. As you know, AARP's top priority is available and affordable prescription drug coverage for all Medicare beneficiaries.

Our members, and virtually all older Americans, need this coverage now. They cannot wait any longer for protection against the increasing costs of prescription drugs.

We are pleased that your bill makes the voluntary prescription drug benefit permanent and maintains the entitlement nature of the Medicare program.

The bill contains other favorable components as well. For the approximately 50 percent of beneficiaries who are estimated to have annual prescription drug costs of $2,000 or less in 2005, the initial level of coinsurance in the bill should be attractive. Likewise, the financial assistance for low-income beneficiaries with drug costs under $2,000 is vitally important.

We also appreciate your efforts to contain drug costs because a Medicare drug benefit alone, without effective cost controls will be difficult to sustain as our growing population of older Americans increases its drug utilization. While we want to ensure that cost containment mechanisms result in meaningful savings, it is critical that these mechanisms do not impede access to needed medications.

More needs to be done to ensure that a final bill provides a benefit of value to our members and a program in which Medicare beneficiaries will enroll. As the process moves forward, the issues of funding adequacy, structure, benefit viability, and other Medicare changes like the home health copay, need to be addressed.

A voluntary drug benefit must attract broad enough participation to avoid the dangers of risk selection. Our research show that beneficiaries assess the value of the benefit by adding up the premium, coinsurance, and deductible to determine if it is a good buy. The existence of a large coverage gap is a strong disincentive to enrollment. More funds are needed to close this gap and protect the viability of the program.

Unfortunately, a substantial amount of the already limited funds allocated for a prescription drug benefit have been diverted to pay for provider reimbursement increases. We believe that providers should be paid fairly for treating Medicare patients, but Medicare beneficiaries have waited long enough for relief from high prescription drug costs. Every dollar allocated to ''givebacks'' package means one dollar less for a Medicare drug benefit. We firmly believe that agreement on an affordable Medicare prescription drug benefit should be reached before Congress considers additional provider reimbursement increases.

Our research also indicates that older Americans are looking for stability and dependability in coverage. Therefore, it is important to ensure that private sector entities will be willing to offer coverage.

AARP's goal is enactment this year of an affordable Medicare drug benefit that is available to all beneficiaries. This bill requires improvements before our members will provide their support. We want to work with you to assure adequate funding and resolve other issues as the process moves forward and before any legislation is enacted into law.

Sincerely,

WILLIAM D. NOVELLI,
Executive Director and CEO.

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

Mr. Speaker, this debate tonight should not be about politics. American seniors have heard all the politics they can stomach. And the AARP said it best in their letter. They said, ''Our members, virtually all older Americans, need this coverage now.'' What coverage were they talking about? They were talking about the coverage in this bill.

Here is a quote from the AARP, and I am sorry my colleagues are in such disagreement with the AARP, but here is their quote. ''We are pleased that your bill makes the voluntary prescription drug benefit permanent and maintains the entitlement nature of the Medicare program.''

Now this is not also about who loves their mother or father the most or their grandparents the most or who is willing to step up to the plate and do what they can to make sure that American citizens in their senior years have prescription drug benefits. This is about whether or not we have a plan that works. We think it does, and the AARP agrees with us.

Now let me make another point. We have heard a lot about the drug companies. I want to give my colleagues a Clinton administration statistic. The Clinton administration estimated that seniors without drug coverage pay 20 percent more for their drugs than anybody else in America with drug coverage. This bill will give seniors drug coverage. It will reduce the cost of their drugs at the expense of the pharmaceuticals.

We had the courage in the Committee on Energy and Commerce to do something our friends on the other side would not do. We got rid of the floor that pharmaceuticals will not negotiate below, and we forced the pharmaceuticals to spend $18 billion more, lowering the cost of drugs by eliminating that floor.

This is a great bill for Americans. This makes for a great savings on the drug bills of moms and dads and grandparents. We ought to vote for it tonight.

Mr. HOYER. Mr. Speaker, This GOP drug bill is nothing but a candy-coated placebo that fails to cure the problems faces by million and millions of senior citizens who are struggling every single month to pay for life-saving prescription drugs.

The American people are just not going to swallow it.

If the FDA approved a drug that was this untested and unreliable, there would be an outcry across this great Nation for immediate congressional investigations.

Three words say it all: It won't work.

This ideological plan—which depends on private insurance drug only policies—even has insurers scratching their heads.

As Bill Gradison, our former Republican colleague in this House and the former head of the Health Insurance Association of America, recently said: ''I'm very skeptical that 'drug only' private plans would work.''

There's no guarantee insurers will offer drug only policies.

There's no guaranteed monthly premium. There's no defined benefit for seniors. There's no guaranteed access to the drugs you need.

The only guarantee in this bill is that it would provide inadequate coverage.

Everyone of us knows that the Republican party really wants to privatize Medicare.

This bill is the first step. A few years ago, the majority leader even told the Chicago Tribune that he ''deeply resents the fact that when I'm 65, I must enroll in Medicare.''

In sharp contrast, Democrats want to create a plan under Medicare that's affordable, guaranteed, universal, and voluntary.

The only argument that our Republican friends can muster against the Democratic plan is cost.

But these are the same folks who voted to give Enron $250 Million, who voted to give a handful of other corporations billions more, who voted to eliminate the estate tax on the wealthiest estates in the country.

Vote against this shameless drug bill.

Let's adopt a plan that gives seniors the drugs they need and deserve.

Mr. UDALL of New Mexico. Mr. Speaker, I rise today in opposition to H.R. 4954, the Medicare Modernization and Prescription Drug Act. It's a sad day for seniors all across this country and especially in my congressional district in New Mexico. It is sad because the Republican leadership has decided that the House will only consider their pharmaceutical company-backed Medicare prescription drug benefit program.

The majority does not seem to care about making affordable prescription drugs available to all of our seniors. Instead, they only care about making political capital at the expense, literally, of our low income-seniors. For Congress after Congress, Democrats have called for making affordable prescription drugs available to seniors. And now that the Republicans fear losing their majority, they have brought a bill forward that has been industry-bought and industry-paid for.

The Democrat alternative that we have proposed, and that the majority refuses to allow us to debate, has been bought and paid for by the American people, many who are seniors that have sent us here to represent their interests and not the interests of America's pharmaceutical companies. Our bill which has been endorsed by most senior advocacy groups would charge a $25 monthly premium and a $100 deductible and require co-payments of 20 percent up to $2,000. After that amount, the government would pay all costs. The Democratic plan has no gaps in coverage and low-income seniors are protected under our plan. The majority says it is too expensive.

Why? Because all the money was spent last year on the $1.3 trillion Bush tax cut for the wealthy few.

The Republican proposal is a ridiculous sham that has been introduced to fool our senior citizens into believing that they will finally have a prescription drug plan under Medicare that works. Republican strategists believe that their passage of any drug bill will inoculate their candidates against criticism. Even the spokesman for House Republicans' campaign committee has been quoted in the Washington Post as saying, ''The fact that the House will have passed a prescription-drug bill will take away the Democrats' ammunition, and will make Senate Democrats look worse for failing to pass it.''

Ar you kidding me? This shouldn't be about politics. It should be about policy. Prescription drugs are nothing more than a political game to the majority. Frankly, this is slap in the face to every American senior and not to mention insulting.

My poor constituency in New Mexico cannot afford the outrageous prices of prescription drugs. Many of them drive hundreds of miles across the U.S./Mexico border to buy affordable prescription drugs. Many of them have to go without paying their bills in order to afford prescription drugs. Many of them have to forgo buying groceries, clothes, and other basic necessities to afford prescription drugs.

We owe it to America's seniors to do the right thing and propose a plan that offers a real prescription drug benefit. We owe it to America's seniors to be able to debate a plan that offers real prescription drug benefits. We owe it to American's seniors to debate our bill.

Our seniors deserve a prescription drug plan that works with a defined benefit plan, guaranteed premium and access, and protection for low-income seniors. The democratic alternative is the real prescription drug plan and not hoax on low-income seniors.

I urge my colleagues to vote ''no'' on H.R. 4954. Send this back and give us a fair vote on a real prescription drug plan.

Mr. OWENS. Mr. Speaker, H.R. 4954, the Republican Pharmaceutical Industry Protection Act, is a cruel and unusual joke perpetrated against the senior citizens of America. The Republicans are preoccupied with the goal of the prescription drug manufacturers which is to maintain the highest possible prices and profits in America. Without operating at a loss in foreign markets, these drug companies sell their products at much lower prices. They sell at lower prices because foreign government negotiators refuse to pay exorbitant prices. Insults are added to injuries when Americans are forced to pay the highest prices for drugs which our Government often play a major role in research and development. A workable and simple plan offering the necessary benefits to seniors in need can be set in motion immediately. First, lower the cost of prescription drugs by following the principles and procedures set forth in my bill, H.R. 4772, the Pharmaceutical Products Price Equity Act which I first introduced on September 25, 2000. This bill ensures that pharmaceutical companies cannot charge more the 6 percent above the average retail price of prescription drugs sold in the 5 most industrialized, free-market countries. This will ensure that pharmaceutical companies charge consumers within the U.S. prescription drug prices that are comparable to other nations.

The second simple step is to follow the program of implementation as stated in the Democratic Plan. No new HMO and insurance bureaucracy is necessary. Let the Prescription Drug Benefit Plan be an extension of the of the Medicare program. Instead of offering a cruel and unusual joke, this Congress should unite behind a plan which relieves the very desperate needs of many of our senior citizens.

Mr. FILNER. Mr. Speaker and colleagues, I rise today to protest the half-baked drug scheme that the GOP has jammed down Congress' throat. I find it a particular affront to our system of democracy that the Republicans blocked consideration of a plan that would easily cover all seniors.

I join hundreds of my colleagues in opposing a GOP scheme that would force America's seniors and future seniors to rely on private insurance companies or HMOs for prescription drug coverage. GOP supporters of the scheme received hundreds of thousands of dollars in campaign contributions from pharmaceutical companies and HMOs.

America's seniors deserve affordable prescription drug coverage. They should not have to make the preposterous choice between prescription drugs and paying their rent.

The Democratic bill—on which GOP leaders refused to allow a vote—would have guaranteed voluntary prescription coverage for all Medicare beneficiaries. Medicare is available to the vast majority of people over 65. It would have a $25 monthly premium and a deductible of $100 per year. After that, beneficiaries would be responsible for just 20 percent of drug costs, with Medicare covering the remaining 80 percent. All costs would be covered after a beneficiary spent $2,000 out-of-pocket.

The Republican bill guarantees no specific benefit and subsidizes insurance companies in the hope they will create private insurance plans. Many HMOs and private insurance would not want to offer coverage under the plan. Those that did would be able devise the coverage and set the premium.

We should not be playing a shell game with something as important as our seniors' health and well-being. The Republican bill leaves our seniors out in the cold.

Mr. DAVIS of Illinois. Mr. Speaker, I rise today to urge my colleagues to support a fair and equal prescription drug plan.

Mr. Speaker, as you know, Adam Smith's economic theory of competition over monopoly has worked for our country's economy for nearly 200 years. While competition works for material items, it does not work for social services and human needs such as health care and prescription drugs. If we allow private companies to set their own premiums and encourage competition among the prescription drug plan providers we will not cut costs, nor will we provide seniors with low premiums and co-pays.

As we have seen from health insurance providers, the most affordable insurance plans offer the least amount of coverage, while the most comprehensive plans are the most expensive. This leaves a senior, on a tight monthly budget, with the option of enrolling in a low-cost plan, or no plan at all. Therefore, by voting for this legislation, and allowing these companies to set their own premiums and deductibles, we are not guaranteeing anything to our seniors, and will be leaving the sickest ones, on the tightest budgets behind.

The Democratic plan is simply stated. There will be a $25 premium, $100 deductible, and 20 percent co-pay, and an out-of-pocket limit at $2,000. However, the Republican plan is extremely complicated. Different people will pay different co-pays depending on their total prescription drug costs. And let us not forget the gap in coverage for those who exceed $2,000 in total costs, but do not exceed their out-of-pocket cost of $3,800, all the while continuing to pay their high premiums of $35 per month.

In order to maintain all these different co-pays and to assure that competition is available, this bill would create a new agency called the Medicare Benefits Administration. This would only create more bureaucracy and red tape that is currently driving up the cost of health care in America. Almost 25 percent of the cost of health care is to cover the administrative overhead. We cannot add to this current horrible problem.

Not only is the Republican plan more confusing, but it will cost our seniors more. Let us look at two examples. The first is of individuals with $100 per month in prescription drug costs. Under the Republican plan they would pay $892 a year, but under the Democratic plan they would pay only $620 a year. How about those that have $300 per month in prescription drug costs? Under the Republican plan they would pay $2,892 a year, but under the Democratic plan they would only have to pay $1,100; that is a difference of $1,796 a year.

Mr. Speaker, let me close by saying that the issue of adding prescription drug coverage for Medicare recipients is long over due. But H.R. 4954 is not the answer.

Mr. RAMSTAD. Mr. Speaker, I rise today in strong support of H.R. 4954, the Medicare Modernization and Prescription Drug Act of 2002.

This is truly a monumental day for millions of seniors in America. Congress is finally addressing our greatest generation's need for a prescription drug benefit under Medicare.

Prescription drug coverage is one of the most critical issues facing our Nation. This issue has moral, medical, and economic implications for every single American.

Under this bill, seniors will no longer have to become insolvent just to pay for the prescription drugs they need. We are rescuing seniors from the terrible dilemma of paying for food or life-saving medicines.

The problem is that when the majority of people need prescription drugs most, in the later years of life, the largest insurer of the elderly does not provide prescription drug coverage. As a result, many seniors go without the drugs they need, dilute their prescriptions or forego other basic necessities to purchase vital prescription drugs. This is wrong, Mr. Speaker.

H.R. 4954 not only provides affordable prescription drug coverage, but also strengthens the Medicare system to ensure that doctors are available to treat Medicare patients and hospitals can keep their doors open to Medicare beneficiaries.

Mr. Speaker, our seniors need and deserve a Medicare system that reflects the advances in medicine that have occurred in the past 37 years since Medicare began in 1965. They also deserve prescription drug coverage under Medicare.

The Medicare Modernization and Prescription Drug Act provides a prescription drug

benefit to all seniors and reforms irrational payments to doctors, hospitals, and nursing homes. The bill also strengthens the long-term financial condition of the Medicare program.

All Medicare beneficiaries are eligible for this prescription drug coverage, and seniors will save nearly 30 percent, according to the Congressional Budget Office.

Mr. Speaker, I urge my colleagues to pass this critical legislation because the seniors of America deserve a prescription drug benefit and a modernized Medicare system.

Ms. HARMAN. Mr. Speaker, tonight we are engaged in a partisan debate on what should be a bipartisan issue.

Reforming Medicare to ensure access to prescription drugs is one of the most important things we could do this year. Seniors have been promised this benefit by both parties during the past two Congresses.

Rather than engage in constructive debate, the Republican leadership has introduced a bill that does not get the job done under a rule for debate designed to prevent the consideration of any alternatives.

I intend to vote against the Republican bill because it fails to provide genuine, reliable drug coverage for seniors.

The Republican bill is confusing and unworkable. It requires seniors pay different amount in co-payments depending on how much they spend on prescription drugs overall. In fact, its benefits are likely so meager that only the sickest seniors would want to enroll—a recipe for bankruptcy of the system.

The Republican bill does not ensure discounts on all the drugs seniors need. Not only does it offer no guarantee that private plans will cover all the prescriptions seniors need, but because of high cost-sharing and premiums, it will cover only 20 percent of the average senior's drug costs in a year.

The Republican bill has a large gap in coverage. It offers seniors no assistance on drug costs between $2,000 and $3,700. That means that nearly half of all seniors will receive no coverage of their prescriptions for part of the year, even though they continue to pay premiums.

A Medicare prescription drug benefit must be affordable for both senior citizens and the federal government. A plan with high premiums and deductibles—or large gaps in coverage—won't help the seniors who need it most.

I believe that a Medicare drug benefit should achieve the following goals, and I am eager to work with my colleagues to achieve them:

(1) Help those who need it most first. We need to provide genuine and immediate assistance to low-income seniors and seniors who do not currently have drug coverage.

(2) Provide relief from the high and escalating cost of prescription drugs. Prescription drugs cost more in the United States than in any other nation in the world. Medicare should have the ability to negotiate lower prices for senior citizens as part of a drug benefit.

(3) Encourage new disease management techniques and innovation in the delivery of care. Medicare needs to catch up with the private sector in focusing on preventive care and the treatment of chronic conditions. Improving Medicare's coverage on these fronts will improve seniors' lives—and reduce their health care costs as well.

I hope we will be able to work in a bipartisan manner in the coming months to keep our promises to seniors and enact a fiscally responsible, meaningful law to include prescription drugs under Medicare.

Mr. WATTS of Oklahoma. Mr. Speaker, this House stepped up to the plate in March and set aside three hundred and fifty billion dollars in our budget for prescription drug coverage. What was in the Democrat budget proposal for senior citizens? Well, nothing. They didn't bother to offer a budget.

But the absence of action did not prevent the other party from criticism and condemnation. It's always easy to yell and scream when you have nothing to offer.

The plan before the House today is one that will lower the cost of prescription drugs and help seniors get the life-saving medicine they need. It is practical, realistic, and supported by the President.

The Medicare Modernization and Prescription Drug Act of 2002 is the right remedy for a national problem. In fact, the Department of Health and Human Services recently released a report that stated: ''The House Republican plan would provide real relief for seniors and disabled Americans: those who now pay full retail prices would typically see the costs of each prescription cut by 60 to 85 percent, and their overall out-of-pocket drug costs would fall by as much as 70 percent—in exchange for a stable and affordable premium starting at thirty-four dollars per month.''

The Democrat plan is a prescription for higher drug costs, enriching drug companies and fiscal disaster. It is an election year gimmick that will cost over eight hundred billion dollars over ten years and lead to higher drug prices and government price controls.

The Republican plan lowers drug costs, guarantees coverage and gives seniors choices. Seniors would be able to pick the plan of their choice—because one size does not fit all. Competition will drive down costs.

Mr. Speaker, no senior should have to decide between buying food and buying medicine. I urge my colleagues to support this legislation to give seniors the life-saving drugs they need and the peace of mind they deserve.

Mr. BLUMENAUER. Mr. Speaker, the pattern denying opportunity for full debate and reasonable alternatives continues as we deal with prescription drug benefits for our Nation's seniors. The House will not be permitted to vote on the Democratic prescription alternative. Instead, we will only be allowed to consider the Republican bill, which does not provide a guaranteed drug benefit, instead offering only an HMO-style managed-drugs plan for some. Medicare was created in 1965 because most elderly people could not afford to buy expensive health insurance on the private market. Most still cannot, and we as a Congress should not in fairness impose this flawed plan on seniors.

Especially important to Oregon seniors are the regional inequities that already exist in Medicare, and that the Republican bill would allow to grow. Medicare already punishes Oregon for its size and efficiency with a Medicare reimbursement rate that is 66 percent of the national average rate per enrollee. As a result, Oregon seniors lose more than ¾ of a billion dollars every year. That represents approximately $1,660 per enrollee that ought to be going to medical care and services. We cannot tell how much we will lose under the bill before us today.

Their bill allows many different insurance companies to deal with seniors differently from city to city, and state to state. A senior in Oregon might pay significantly more than someone in Louisiana for the same, or even a reduced benefit. All seniors paid their taxes, and they all deserve an equal benefit. Rural areas and western states have had enough of this regional healthcare discrimination!

Choice is illusory in the Republican bill because the plans they propose do not exist and there is no assurance that insurance companies will ever offer these plans.

The Democratic bill, by comparison, is simple and fair. All beneficiaries will receive the same benefits, the same low $25 a month premiums, a lower $2,000 out-of-pocket limit, with any pharmacy they choose—wherever they live.

Furthermore, the Democratic alternative allows the Secretary to use collective purchasing powers on behalf of 40 million beneficiaries to negotiate lower prices, as he did getting Cipro, the antibiotic used for Anthrax, in the Fall of 2001. The Republican bill has no such provision. I support the plan that helps seniors, Medicare contractors, and is fair to the taxpayers.

Mr. STRICKLAND. Mr. Speaker, the Republican prescription drug bill is a sham, and the unfair rule that brings it to the floor exposed this partisan and shameful process for what it is—a political masquerade designed to convince Americans that we have answered the plea to add a prescription drug benefit to Medicare. Make no mistake, we fall far short of that goal today. I am appalled that the Republican leadership is not willing to allow the American people the decency of comparing the bill before us to a substitute that would provide a real drug benefit for Medicare beneficiaries. This limited debate available to us speaks volumes about the quality of the proposal before us today and its lack of a meaningful prescription drug benefit for the seniors.

The Republican sham prescription drug plan would not provide a guaranteed adequate prescription drug benefit for seniors. The coverage outlined in the bill isn't the kind of coverage most Americans think of when the need for prescription drug coverage for seniors. Coverage if 80/20 only through the first $1,000, when coverage drops to 50/50. And then there is a huge gap in coverage between $2,000, when the initial benefits run out, and $3,700, when catastrophic coverage finally begins. A beneficiary will receive zero benefits between $2,000 and $3,800 in spending, even though she will continue to pay the $35 monthly premium.

Perhaps even worse, the bill take the first step toward privitizing Medicare by contracting this new drug benefit out to private insurance plans. In so doing, premiums, deductibles, and copayments will vary across the country—so a senior who lives in Florida will likely pay a different premium than one of my constituents in Ohio. In addition, coverage under the bill we are considering today will be unstable because plans will be able to pull out from an area when they decide it doesn't fit their business plan. Where, then do our seniors turn for prescription drug coverage? The experience of Medicare+Choice illustrates this concern: there were Medicare+Choice HMOs in my district, but every single one left. Thankfully, those seniors who did switch to an M+C plan had traditional Medicare to fall back on. This

won't be the case for prescription drugs if we pass the Republican drug plan. Instead, seniors will be left without any drug plan at all if and when the private insurers leave the area.

The Democrats' prescription drug plan would provide quality, guaranteed help for seniors. Unlike the Republican plan, the Democrats' proposal would create a prescription drug benefit that *is* part of Medicare, thus avoiding instability or variation in premiums that occur depending on where the beneficiary happens to live. In addition, the Democrats' plan provides much more help for seniors: there is no gap in coverage, catastrophic coverage would begin at $2,000 rather than 3,800, and the monthly premium would be $25. The unfair rule under which we debate this incredibly important issue means that Americans won't get to hear this comparison in detail or see how it fares in a vote. This is exactly what the Republicans want because they know their proposal can't compete with the Democrats' concrete plan, which has been endorsed by a litany of groups, including the Alliance of Retired Persons, the AARP, the AFL–CIO, AFSCME, The American Federation of Teachers, the Center for Medicare Advocacy, Families USA, the National Committee to Preserve Social Security, and Medicare, the National Council on the Aging, the National Partnership for Women and Families, and the National Senior Citizens Law Center.

Some of my colleagues will contend that the difference between our plan and theirs is the cost. They will say that the Democrats' are fiscally irresponsible and that our plan breaks the bank. On this point, I stand firm. It is a fact that this Congress has chosen to give huge tax breaks to the wealthy. The President told us we could do both: he said we could enact nearly $2 trillion in tax cuts as well as a prescription drug benefit for America's seniors. But Congress chose to pass tax cuts for the wealthy, and we have chosen not to enact a real prescription drug benefit for seniors. If the choice is between enacting a real prescription drug benefit and giving tax breaks to the wealthy and corporations, then I am proud to choose to stand on the side of America's seniors.

The rule also means that I won't be able to vote for a bill including many commendable provisions that have clear bipartisan support. This year, doctors were hit with a 5.4 percent cut in their Medicare reimbursement, hospitals are struggling with decreases in Medicaid disproportionate share hospital (DSH) funding and shortages in other payments, home health agencies are facing a 15 percent cut in reimbursement, and most Medicare providers are struggling with an increasingly difficult regulatory burden.

Doctors and hospitals in my district provide invaluable care to Medicare and Medicaid recipients, and I hope they know that I support fixing all of these problems. I hope they do not interpret my no vote on this bill as a vote against the compromises that have been reached to address these problems. I recognize that our failure to fix these could seriously threaten the quality of care seniors and the disabled receive, and I cannot overstate my determination to continue working with my colleagues on both sides of the aisle to enact these important solutions. We have, in some cases, already done this. For example, last year, the House passed a Medicare regulatory reform package that is now also included in this bill. And even though I support a permanent fix to the formula used to calculate the physician update in Medicare, I have worked with my colleagues to reach a temporary compromise that is included in this bill. I support these and other provisions that will go a long way to ensuring providers have the resources they need to continue to offer quality care for seniors. Therefore, it is with regret that I cannot support the bill that includes many of these solutions, and I will continue to work for their enactment this year.

I would like for all Americans to understand that the rule bringing this bill to the floor today undermines their ability to hear a full and open debate about developing a prescription drug plan for our seniors. It is shameful that politics is getting in the way of a healthy debate on the addition of a prescription drug benefit to Medicare. And it is also shameful that politics is interfering in the needed changes in Medicare reimbursements that will ensure beneficiaries continue to receive quality care. This is no way to develop thoughtful, reasonable, balanced legislation that will best serve the nation. Our seniors deserve much better.

Mr. WICKER. Mr. Speaker, I rise in support of this comprehensive package which will provide needed improvements to the Medicare system. Much of the debate on this legislation has centered on the need to add a prescription drug component to Medicare. I agree with this goal, and I support the responsible proposal put forth by the Ways and Means and Commerce Committees. The practice of medicine has significantly changed since the Medicare program was created in the 1960s, and the role of prescription drugs has dramatically increased. It is time we reform the Medicare program to reflect changing times.

However, I want to focus on other, very important parts of this legislation related to reimbursements for providers, especially those in rural America. This legislation provides a lifeline for rural America.

In my conversations with doctors, hospital administrators, and community leaders throughout Mississippi, a common concern is the decreasing ability to provide access to quality care in rural areas. The jobs of rural health care professionals are made harder by inequities in Medicare reimbursement rates between rural and urban areas. This bill goes a long way in correcting this problem by increasing the standardized amount for hospital reimbursement in small cities and rural areas to the level of urban areas in a two step process over the next 2 fiscal years. This is in addition to an increase in the market basket adjustment that all hospitals—urban, suburban, and rural—will receive.

The level of the standardized amount is especially important because this is the base with which Medicare starts when establishing reimbursement rates for specific services. Equalizing the standardized amount reduces the difference in payments caused by other parts of the Medicare reimbursement formula. But by putting urban and rural hospitals on the same footing at the beginning of the reimbursement formula, rural hospitals will benefit for years to come as changes are made to any part of the reimbursement system. This major improvement for rural hospitals will be fully implemented in just 2 years.

Other aspects of this bill provide additional benefits for home health agencies and critical access hospitals in rural America. The threat of a 15 percent reduction for home health services has been eased in recent years as Congress has continually delayed the planned reduction. This bill will eliminate the threat by permanently repealing the 15 percent cut, allowing home health agencies to adequately prepare their financial future. Critical access hospitals are increasingly an attractive option for rural communities that would otherwise be without health care service. By improving the rules and regulations for critical access hospitals, this legislation provides more flexibility in operations and in attracting physicians to medically underserved areas.

I am also pleased this legislation includes a three site hospice pilot project which is based upon H.R. 3270, a bill which I introduced in an effort to improve options for hospice care in rural areas. I believe the current 80 percent out-patient requirement makes it economically difficult to provide inpatient hospice care in rural areas because of smaller patient populations. It is my hope that this pilot project will validate the worth of our proposal and lead to an expansion of this specialized care to rural areas across the Nation.

Mr. Speaker, this is a good bill which will improve access to quality health care, be it for prescription drugs, or care in a hospital, home health agency, or hospice. I urge support for this legislation.

Mr. SIMMONS. Mr. Speaker, in my 18 months in Congress, through the many town hall meetings, letters, e-mails and phone calls, I consistently hear the same concern from people of eastern Connecticut—the rising cost of prescription drugs.

We all heard about seniors who have cut their medication in half because they can't afford to take their entire prescription or a senior who has to choose between buying food and buying their medication. We see seniors who are confronted with this choice at supermarkets everyday. We need to lower the cost of prescription drugs for our seniors now.

This concern is not perceived, but very real. The non-partisan Congressional Budget Office estimated that in 1999, nearly 90 percent of Medicare beneficiaries filled at least one prescription. In 2001, the average Medicare beneficiary pay $1,756 on prescription drugs annually, filling approximately 22 prescriptions in that year.

Next month, Medicare will turn 37 years old. The delivery of health care today is very different from the system of our parents and grandparents and very different from the way we cared for our seniors back in 1965.

I believe Medicare needs to be improved to better reflect these changes and strengthened for the future. If Medicare were being designed today, it would include a prescription drug benefit. Because of the remarkable advances made in prescription drugs, seniors are living longer, with a better quality of life. Unfortunately, the promise of prescription drugs is very hollow for those who cannot afford them.

Twenty-six states—including Connecticut—have already enacted some form of prescription drug assistance program and they are to be prescription drug assistance program and they are to be commended. I have long felt that the Federal Government should partner with states to help provide prescription drug relief to seniors, particularly to low-income seniors who have the greatest need.

Earlier this year, in an effort to provide immediate relief for Connecticut's seniors who

were feeling the financial pinch over paying for their medicine, I introduced ''Immediate Helping Hand'' legislation, which provides more than $48 billion to states to give those who can't afford prescription drugs a ''helping hand.''

My bill would provide Connecticut's ConnPACE program with more than $91 million per year and expand prescription drug coverage to thousands of seniors. My plan was a solid first step—a bridge to provide seniors with immediate assistance until Congress passed a more comprehensive prescription drug benefit through Medicare.

But as of tonight, only 51 or so legislative days remain until Congress adjourns. I've come to realize with the short window of time left, its time to roll up our sleeves and work together on this issue. If Congress really wants to give seniors a prescription drug benefit, then we would need to do it now.

The Ways and Means and the Energy and Commerce Committees have introduced a plan to provide a prescription drug benefit under Medicare that is voluntary and affordable and guarantees prescription drug coverage for all seniors. Our plan gives seniors immediate relief from the rising costs of prescription medications by providing a 30 percent discount off the top of their overall drug bill. While seniors would pay a $35 monthly premium and A $250 annual deductible, our bill provides 80 percent coverage for drug bills between $251 and $1,000 of out of pocket drug expenses and 50 percent coverage for the next $1,000. Finally, our plan provides 100 percent catastrophic coverage for out of pocket drug expenses over $4,500 a year, ensuring that no senior will be forced into bankruptcy because of their prescription medication bill during a long-term, serious illness.

Our plan will lower the cost of prescription drugs now by providing a discount so that seniors can better afford their medications. Our plan will guarantee all senior citizens prescription drug coverage and provide additional assistance to low-income seniors. Our plan will improve Medicare with more choices and more savings and will strengthen Medicare for the future. Our plan is a reasonable solution that provides seniors with upfront savings on the high costs of drugs now as well as guarantee them a drug benefit under Medicare that doesn't sunset and can't be taken away.

Our seniors have worked hard to save for their ''Golden Years.'' Yet the cost of prescription drugs is depleting their savings and jeopardizing their retirement security. Under our plan, seniors will be protected from run-away drug costs.

Our plan is also of particular importance to women. Women have a higher life expectancy than men; yet often have lower incomes in their retirement and face additional costs after their husbands pass on.

Speaker HASTERT asked me to participate in a special Prescription Drug Action Team and I thank him for this opportunity. In this role, I have tried to advance the cause of providing a prescription drug benefit under Medicare by meeting with the President and members of his cabinet; hold outreach meetings with groups such as senior citizen advocates and representatives of pharmacies and drug companies; attend listening sessions at local senior centers, such as Rose City Senior Center in Norwich and the Colchester Seniors Center, and pharmacies; and participate in bipartisan discussions with other Members of Congress to find lawmakers with the same goals who will work with me to produce a plan that will help provide real relief to seniors in Connecticut as well as the rest of the country.

Our seniors should not be forced to scrimp on food and shelter just to be able to afford their medicine. Older Americans deserve more savings and more choice when they fill their prescriptions, and I hope Democrats and Republicans will join together now to see that they receive meaningful prescription drug coverage.

To delay is to deny. Lets get a prescription drug benefit signed into law now.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today to speak out against H.R. 4954, what should have been called the Republican Insurance Protection Act.

When medical students become doctors, they take an oath written by Hippocrates, a great Greek philosopher and naturalist, in the year 400 BC. The underlying spirit of the Hippocratic Oath, is that when someone needs your help, when they trust you to do the right thing to improve their health, the number one priority is to do not harm.

As we design a system to get the much-needed medications to our Nation's seniors and disabled citizens on Medicare, we must keep the spirit of the Hippocratic oath in mind. These folks need our help, we have promised them that we would help them get the health care they need, and they trust us to keep that promise.

The Republican plan to privatize and compromise Medicare would be a step in the wrong direction. It is a gift to insurance companies and the pharmaceuticals industry, but does nothing for most of our seniors. If it passes, Hippocrates will probably be turning over in his grave.

Let's look at some numbers:

Let's consider one senior, she could be your mother or grandmother. She could be on a fixed income, and her doctor has decided she needs $500 per month in prescription medications to live comfortably. Not only is she carrying a huge financial burden, but she is sick, and from talking to our constituents at home, we all know the frustration and even depression that can accompany long-term illness.

She is a member of the greatest generation, as they have been called, that generation that worked hard to give us the unprecedented prosperity and security we all have enjoyed over the past decades, and now she needs our help.

And what does the Insurance Protection Act offer her?

As the year starts, so do her bills. Her out of pocket costs rise rapidly throughout the year—$1,000, $2,000, $3,000, about $4,000, because even if she hits the catastrophic limit, she is still paying premiums that add to her burden.

And what about her benefits? They are almost non-existent for most of the year. She gets a little help at first, but it falls off rapidly. Then, for a big chunk of the year—she gets nothing, as she falls into the Republican gap.

Finally, when she hits catastrophe, her bills get covered. But, most seniors don't ever get there—they just end up stuck in the Republican gap.

These numbers are the best we could calculate last week with the vague plan that we had been presented with. These numbers look bad, but they may be even worse. H.R. 4954 does not guarantee even this low level of benefit. It only offers subsidies to private insurance companies in hopes that they might take care of our seniors even though we don't. Associations of insurance companies have already gone on record stating they probably will not offer the drug-only plans necessary for the Republican plan to function.

The Republican plan puts this sick senior on a roller coaster. Her premiums are not guaranteed. Her deductible is high. She is not assured that she will be able to buy the drugs her doctor prescribes at the pharmacy she trusts. She gets nothing for a big part of the year, even though she keeps paying her premiums.

She gets all of the paperwork and premiums of a big government program—with none of the benefits. This is a gimmick. It is a step in the wrong direction, and it violates the principle of do no harm.

We do not have to take this step backward because, there is a choice. The Democratic alternative provides a continuous stream of aid to all of those who need it. It offers low premiums and guaranteed benefits. Yes it costs more, but it could actually be a bargain. Unlike the Republican plan which does nothing for the vast majority of seniors, the Democratic plan helps all seniors. By harnessing the bargaining power of those 40 million seniors, the Democratic plan will drive down the cost of prescription drugs. Also, new medications, especially preventive medications can save us money in the long run. By keeping people out of hospitals and emergency rooms and off of the surgeon's table, a good prescription drug bill could actually start saving us money.

But most importantly, it is what our seniors deserve. I urge my colleagues to wait for a better alternative, and vote ''no'' today on H.R. 4539, the Insurance Protection Plan.

Mr. SERRANO. Mr. Speaker, I rise in opposition to the bill before us and in strong support of the Democratic alternative, of which I am an original cosponsor.

The Republicans know that the American people demand prescription drug coverage for seniors. But instead of passing a bill to help our seniors, they've chosen to give $350 billion to insurance companies, trusting them to do what's right for seniors.

This bill is a cruel joke. Republicans broke their word—they promised to help seniors and the disabled with a real Medicare prescription drug benefit, and instead passed a pathetic gimmick that will leave seniors holding the bag. This bill isn't a Medicare benefit plan for seniors, it's a Republican benefit plan for corporations.

I am an original cosponsor of a alternative bill that would provide real coverage for our seniors through Medicare. The Democratic plan fulfills our responsibility to provide for those who made this country what it is today. No senior should be forced into poverty to pay for life-saving drugs—and no senior living in poverty should be denied necessary medications.

Our plan would not only provide a meaningful prescription drug benefit, it would allow seniors and individuals with disabilities to go on making the choices that matter. The Republican bill would take choices away, offering coverage through private plans that may not allow seniors to choose their pharmacy, or

their doctor. The only choice left for many seniors would be between purchasing food and purchasing drugs.

The Democratic plan is so good, in fact, that Republicans would not even let it come to a vote. They did not want to admit that their trillion dollar tax cuts for the super-rich don't leave enough money for a real benefit for seniors. But the American people are not so easily fooled. They know that Republicans put the interests of the rich ahead of the interests of seniors.

Our plan would help all Americans. It would bring down the skyrocketing price of prescription drugs, so that giant pharmaceutical companies can't inflate their profits at public expense. Medicare contractors would obtain guaranteed reductions in price, and the Secretary of Health and Human Services would be able to fight back against price gouging, using the collective bargaining power of Medicare's 40-million beneficiaries. It would stop patent abuses, bringing down drug prices for all Americans. The Secretary would also be able to encourage the use of generic drugs, set lower coinsurance for preferred drugs, enhance disease management, and strengthen beneficiary and provider education. The Republican plan would do nothing to reduce the price of prescription drugs. Tax dollars would be used to pay the same inflated prices that seniors pay today.

I urge my colleagues to make good on their promises, to defeat H.R. 4954, and to pass meaningful prescription drug coverage in Medicare for seniors and the disabled.

Mr. HINOJOSA. Mr. Speaker, I rise today in opposition to the Republican prescription drug bill. For years, our seniors have been begging for help to obtain affordable prescription drugs. The bill before us today gives relief to the large drug companies, not our vulnerable seniors.

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

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

But we will not have the opportunity to vote on this sensible plan that is supported by the majority of Americans because the Republican leadership is afraid it would pass.

I urge my colleagues to oppose the sham Republican proposal and say no to the big drug companies. I yield back the balance of my time.

Mr. WEXLER. Mr. Speaker, prescription drug coverage has long been a top priority for a majority of Americans, and as a result, both George Bush and Al Gore pledged during the 2000 Presidential campaign to provide seniors with a comprehensive prescription drug plan and finally put an end to the prescription drug crisis in America. The House Republican leadership avoided this issue for as long as they could, but the day of reckoning arrived, and when it was time for both sides to ante up, the Republicans offered nothing but a sham. Now here we are, preparing to vote on what the Republicans say is a plan that will help seniors pay for prescription drugs. But before we do, I want all my colleagues to know what is really on the table.

Quite simply, the Republican prescription drug plan is a disgrace; it is nothing more than a half-hearted attempt to deliver on an empty promise and provide themselves with election year cover. This will not bring the rising costs of prescription drugs down, it has significant gaps in coverage, and where it does provide coverage, it relies completely on unreliable HMOs and insurance companies to provide it. The Republican plan will get us nowhere and will leave too many seniors with nothing at all. As we look at the Republican proposal, it is clear that while the needs of so many are being neglected, the wants of an influential few are being met.

The Democratic prescription drug bill we have offered will provide real, meaningful, affordable, prescription drug coverage under Medicare. It will allocate $800 billion to ensure that all seniors can afford coverage. There will be no gaps in coverage, and nobody will be force to join an HMO. But regrettably, we can't even debate this bill today. While that is a shame in and of itself, the real tragedy is that we must choose between a horrible bill or no bill at all. But maybe that is what Republicans—who have been raking in campaign contributions from the insurance industry and the pharmaceutical companies who are the only true beneficiaries of the Republican bill—wanted all along.

The bill that I am sponsoring will be affordable for all seniors, will cover any prescription regardless of the brand, and not just cover those on the insurance companies' formularies. Our prescription drug plan will provide seniors substantial savings by using the government's bargaining power to obtain the best prices for Medicare, as currently done for Medicaid and the Veterans Administration. The Republican plan, in contrast, relies on the insurance industry and HMOs to provide the already scant coverage that it offers. The Republicans have disguised their shallow attempt to pay back the pharmaceutical companies and insurance industry for millions in campaign contributions under the title of Medicare Modernization. The real name for this bill should be the Insurance and Pharmaceutical Industry Payback Act.

The criticism that has been offered by Republicans regarding the Democratic bill is that it is unrealistic. That is their argument, simply because they know that the Democratic bill interferes with their $1.3 trillion tax cut. And to add insult to injury, Republicans continue to push for additional billions in tax cuts for the wealthiest Americans, which is more than enough to pay for the more generous Democratic plan. It is shameful that while Republicans pander to the narrow interests they serve, seniors continue to wait for a real solution to the prescription drug crisis.

Mr. KNOLLENBERG. Mr. Speaker, it is simply unacceptable that 13 million seniors do not have prescription drug coverage. Seniors need prescription drug coverage and they need it now.

The legislation before us today provides a real, timely drug benefit while helping ensure the future solvency of the Medicare program. Although much more reform is necessary, the Medicare modernization provisions contained in the bill are a significant step forward in providing long overdue Medicare improvements. If the Medicare system is to remain viable in the future, it is essential that we bring the Medicare program in line with 21st century healthcare advances and expectations.

I support the Medicare Modernization and Prescription Drug Act of 2002 because it creates a prescription drug benefit in Medicare that is affordable, available, and voluntary. It gives people the power to choose the plan that best fits their needs, including protection against high out-of-pocket drug costs that threaten their health and financial security.

This bill guarantees a choice of at least two drug plans in every area of the country, without endangering existing drug coverage that seniors might already have through a former employer. We avoid giving the Federal Government too heavy a hand in controlling drug benefits, ensuring that seniors will not be denied the right to select the coverage that best fits their needs.

Furthermore, the bill will bring the increased competition among health plans that is necessary to reduce drug prices. According to the Department of Health and Human Services, this plan is the only proposal before Congress that would lower drug prices and provide an immediate drug discount of up to 15 percent.

Mr. Speaker, seniors must not have to choose between their medicine and other basics like food and housing. We have a chance to strengthen the Medicare program to guarantee that our children and their children have access to quality health services and prescription drugs when they become eligible for Medicare. Let us take this monumental step and improve Medicare for the future.

Mr. COSTELLO. Mr. Speaker, I rise today in opposition to H.R. 4954 and in support of the Democratic substitute. It is imperative that we provide senior citizens with quality, affordable, and reliable health care. H.R. 4954 does not accomplish these important goals.

I am committed to strengthening and improving Medicare. As the nationwide health insurance program for the elderly, Medicare has provided important protections for millions of Americans over its 37-year history. However, the program continues to face increasing problems. Like so many Americans, I am concerned that the program's structure has failed to keep pace with the changes in the health care system as a whole. When Medicare was created, prescription drug use was limited, with most beneficiaries being treated in hospitals. Today, advances in pharmaceutical research allow doctors to treat seniors on an outpatient basis. Unfortunately, Medicare has not keep up with this change.

As a result, Congress has been actively working to craft a prescription drug benefit for Medicare that is affordable and reliable. Yet, under the Republican bill, the government would pay subsidies to insurance companies to induce them to offer drug coverage. These ''drug only'' insurance plans do not currently exist, and may never exist, and therefore do not offer a guaranteed benefit to our seniors. Beneficiaries would be forced to choose between HMOs and risky private drug-only insurance plans. Further, this legislation merely provides suggestions for standard coverage; private insurers have the freedom to alter premiums which can be much higher, varying from county to county, and year to year. Seniors would not know what to expect from their drug benefit from year to year or how much it would cost.

In addition, H.R. 4954 provides inadequate coverage to Medicare beneficiaries. It would cover less than a quarter of beneficiaries' estimated drug costs over the next 10 years.

Nearly half of all seniors spend over $2,000 annually. This bill would not pay for drug costs between $2,000 and $3,700. Further, this legislation would do nothing to assist low-income beneficiaries. Low-income beneficiaries may have to pay $2 to $5 co-pays and 100 percent of the costs in the coverage gap.

In contrast, the Democratic substitute, had we been able to offer it, offers seniors a real Medicare prescription drug benefit for with relief from the high cost of prescription drug prices. This legislation would lower the costs of drugs for all seniors, would offer an affordable, guaranteed Medicare drug benefit, would ensure seniors coverage of the drugs their doctors prescribe, and would not force seniors into HMOs or private insurance. Beneficiaries would pay a $25 premium per month, a $100 deductible per year, and would receive full coverage after paying $2,000 in out of pocket expenses. In addition, this substitute would help low-income beneficiaries with premium and co-insurance payments. Finally, it would guarantee Medicare beneficiaries the choices that matter: choice of prescription drug, choice of pharmacy, and choice of doctor and hospital.

I support the provider payment adjustments made to hospitals, physicians, and rural communities represented in both H.R. 4954 and the Democratic substitute; however, I cannot in good faith support H.R. 4954 with its unacceptable prescription drug plan.

Mr. Speaker, I am committed to providing a comprehensive benefit that is affordable and dependable for all beneficiaries with no gaps or gimmicks in its coverage. What Congress offers to senior citizens and individuals with disabilities should be no less generous than what Members of Congress and other Federal employees receive. For these reasons, I oppose H.R. 4954. I urge my colleagues to do the same.

Mr. BONILLA. Mr. Speaker, while I support this bill because it provides meaningful prescription drug coverage for America's seniors and implements measures needed to modernize the Medicare system, I rise out of concern for the effects of this bill on pharmacy services. Pharmacists are on the front lines of health care for millions of Americans. Seniors count on their pharmacist for quality medications and medication therapy services. Coverage of prescription drugs should go hand-in-hand with access to quality pharmacy services.

This bill would inhibit the ability of America's seniors to select the pharmacy that best meets their needs. In many of the smaller towns in my district, seniors have established long-standing relationships of trust with their community pharmacists. This bill would force many of these seniors to turn elsewhere for prescription drug services.

Furthermore, this bill allows Pharmacy Benefit Managers to establish restrictive pharmacy networks, preferred formularies, mail order services and inadequate reimbursement rates, severely undermining the future viability of community pharmacies. Prescription drug plan sponsors, not pharmacists or doctors, would determine the selection of medications to be included on formularies. Cost would supercede the medication that is in the best interest of the patient, and community pharmacies would be left struggling to stay in business.

This bill also compromises seniors' access to medication-therapy services. Pharmacists play an important role in reducing medication-related problems. They routinely resolve complex drug interaction problems for seniors who take multiple medications. These problems cost billions of dollars annually and kill hundreds-of-thousands of persons. Medication-therapy services decrease long-term health care costs while increasing safety.

As a conservative, I recognize the need to be fiscally responsible, however we should not allow our efforts to rein in the high cost of prescription drugs to jeopardize the health of our seniors. Taken together, the provisions of this legislation would impose economic hardships that would severely damage pharmacy infrastructure and compromise the health of America's precious seniors.

Thousands of pharmacists have diligently served America's seniors with dedication and excellence. We should not inhibit their ability to continue providing the drugs and services our seniors desperately need.

Mr. PAUL. Mr. Speaker, while there is little debate about the need to update and modernize the Medicare system to allow seniors to use Medicare funds for prescription drugs, there is much debate about the proper means to achieve this end. However, much of that debate is phony, since neither H.R. 4954 or the alternative allow seniors the ability to control their own health care. Instead both plans give a large bureaucracy the power to determine what prescription drugs senior citizens can receive. The only difference is that alternative puts seniors under the control of the federal bureaucy, while H.R. 4954 gives this power to ''private'' health maintenance organizations and insurance companies.

I am pleased that the drafters of H.R. 4954 incorporate regulatory relief legislation, which I have supported in the past, into the bill. This will help relieve some of the tremendous regulatory burden imposed on health care providers by the Federal Government. I am also pleased that H.R. 4954 contains several good provisions addressing the Congressionally-created crisis in rural health and attempting to ensure that physicians are fairly reimbursed by the Medicare system.

However, Mr. Speaker, at the heart of this legislation is a fatally flawed plan that will fail to provide seniors access to the pharmaceuticals of their choice. H.R. 4954 requires seniors to enroll in a prescription benefit management company (PBM), which is the equivalent of an HMO. Under this plan, the PBM will have the authority to determine which pharmaceuticals are available to seniors. Thus, in order to get any help with their prescription drug costs, seniors have to relinquish their ability to choose the type of prescriptions that meet their own individual needs! The inevitable result of this process will be rationing, as PBM bureaucrats attempt to control costs by reducing the reimbursements paid to pharmacists to below-market levels (thus causing pharmacists to refuse to participate in PBM plans), and restricting the type of pharmacies seniors may use in the name of ''cost effectiveness.'' PBM bureaucrats may even go so far as to forbid seniors from using their own money to purchase Medicare-covered pharmaceuticals. I remind my colleagues that today the federal government prohibits seniors from using their own money to obtain health care services which differ from those ''approved'' of by the Medicare bureaucracy!

Since H.R. 4954 extends federal subsidies (and federal regulations) to private insurers, the effects of this program will be felt even by those seniors with private insurance. Thus, H.R. 4954 will in actuality reduce the access of many seniors to the prescription drugs of their choice!

I must express my disappointment that this legislation does nothing to reform the government policies responsible for the skyrocketing costs of prescription drugs. Congress should help all Americans by reforming federal patent laws and FDA policies which provide certain large pharmaceutical companies a government-granted monopoly over pharmaceutical products. Perhaps the most important thing Congress could do to reduce pharmaceutical policies is liberalize the regulations surrounding the reimportation of FDA-approved pharmaceuticals.

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

The alternative suffers from the same flaws, and will have the same (if not worse) negative consequences for seniors as will H.R. 4954. The only difference between the two is that under the alternative, seniors will be denied the choice for pharmaceuticals by bureaucrats at the Center for Medicare and Medicaid Services (CMS) rather than by a federally subsidized PMB bureaucrat.

Mr. Speaker, our seniors deserve better than a ''choice'' between whether a private-or-public sector bureaucrat will control their health care. Meaningful prescription drug legislation should be based on the principles of maximum choice and flexibility for senior citizens. For example, my H.R. 2268 provides seniors the ability to use Medicare dollars to cover the costs of prescription drugs in a manner that increases seniors' control over their own health care.

H.R. 2268 removes the numerical limitations and sunset provisions in the Medicare Medical Savings Accounts (MSA) program. Medicare MSAs consist of a special saving account containing Medicare funds for seniors to use for their routine medical expenses, including prescription drug costs. Unlike the plans contained in H.R. 4504, and the Democratic alternative, Medicare MSAs allow seniors to use Medicare funds to obtain the prescription drugs that fit their unique needs. Medicare MSAs also allow seniors to use Medicare funds for other services not available under traditional Medicare, such as mammograms.

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

Mr. Speaker, seniors should not be treated like children by the federal government and told what health care services they can and

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

In conclusion, Mr. Speaker, both H.R. 4954 and the alternative force seniors to cede control over what prescription medicines they may receive. The only difference between them is that H.R. 4954 gives federally funded HMO bureaucrats control over seniors prescription drugs, while the alternative gives government functionaries the power to tell seniors what prescription drug they can (and can't) have. Congress can, and must, do better for our Nation's seniors, by rejecting this command-and-control approach. Instead, Congress should give seniors the ability to use Medicare funds to pay for the prescription drugs of their choice by passing my legislation giving all seniors access to Medicare Medicaid Savings Accounts.

Ms. ROYBAL-ALLARD. Mr. Speaker, I rise in opposition to the Republican Party's sham prescription drug benefit proposal. Prescription drugs, especially for our elderly population, are not a luxury but a matter of life or death. Prescripton drug costs in our country are rising nearly 20 percent each year, forcing more and more of our country's parents and grandparents to choose between their medication and other necessities of life such as food. Our Nation's seniors worked hard to make this country strong, many fighting in far-off places to keep us free. They deserve to have health care security.

Unfortunately, the Republican prescription drug plan falls short in providing this security to our seniors. First, the Republican plan covers less than a quarter of the costs seniors will pay for their medication over the next 10 years. Second, under the Republican plan, the premiums and the deductible are so high that most seniors won't be able to afford the plan and as a result will receive no benefits at all. Finally, the Republicans have no universal prescription drug plan. Instead, they leave it to individual insurance companies to develop their own plans. This means seniors will be left on their own to do the research on each plan that will vary in price, benefits, and availability across the country.

This complicated, time-consuming, and expensive process is unfair and unnecessary, and it represents just another step in the Republican Party's effort to privatize Medicare. That is why Democrats have offered a simple, affordable prescription drug plan with a standard benefit and a low deductible. Through the use of collective buying power, the Democratic prescription drug plan actually lowers drug prices for all of Medicare's 40 million beneficiaries. Unfortunately, Republicans did not allow this alternative plan to be presented to the House for a vote. The Republican bill before us is a sham that does little to help our Nation's seniors.

The House must defeat the Republican bill and take the necessary steps to pass the Democratic prescription drug bill that will give all America's seniors the benefits they need and the health care security they deserve.

Ms. BROWN of Florida. Mr. Speakers, it matters who is in charge. This Republican leadership must think the American people are stupid. Last week they raised $30 million dollars in a fund raiser with the drug companies, and this week we have a prescription drug bill on the floor. Now who do you think they wrote this bill for: The seniors they've been promising relief to for 2 years, or the big drug companies that will be funding their elections this fall?

While on a trip back home to Jacksonville in March, I went to the drug store for my grandmother to pick up just one of her prescriptions. I was expecting maybe a $15 co-payment because I knew her insurance plan had drug coverage. The bill was $91 dollars. She had a limit on her coverage, and it had run out. We were 3 months into the year, and she no longer has a drug plan.

My grandmother, and all grandmothers deserve better than this. If the Republicans can take a break from their million dollar drug company fund raisers and constant tax cut bills for their country club friends, maybe we can work on a compromise that will provide our seniors with the relief we have been promising them. My Republican colleagues talk the talk, but they don't walk the walk. The Republican leadership has come up with a privatized drug plan that has been rejected by both the insurance industry and the drug stores as unworkable, and fails to truly help seniors.

This is one more perfect example of why it matters who is in charge.

Mrs. BONO. Mr. Speaker, I rise today to support comprehensive health care improvements for our country. The Medicare Modernization and Prescription Drug Act of 2002 offers a real and immediate benefit to our seniors, while also offering substantive improvements to a Medicare system that will collapse in on itself without out reforms.

Currently the seniors in my district, which represent over one in five of all individuals in California's 44th District, are without prescription drug coverage that is essential to their quality of health. With this legislation, these individuals will receive an affordable option that will become a permanent facet of Medicare for generations to come.

I have had the honor of serving on the Speaker's Prescription Drug Action team, and we have worked hard to address both prescription drug coverage and improvements to the Medicare system. These include helping our doctors continue to better serve Medicare beneficiaries and helping our hospitals to keep their doors open to those who can't afford to meet even basic health care needs. In particular, the Medicaid Disproportionate Share Hospital monies included in this bill are a serious start to helping our public hospitals, including two in my district.

There is still work to be done in properly funding these hospitals that offer such essential services, but this comprehensive legislation is taking a step in the right direction.

One of my constituents recently wrote to me and spoke of the urgency with which we need to provide our seniors with affordable prescription drug coverage. Her message is echoed by thousands of others, and she is correct that we can no longer ignore the urgent need to improve our health care system.

It is urgent because our seniors cannot continue to keep up with rising prescription drug costs. It is urgent because our doctors and hospitals must have the tools to continue to offer quality care. And it is urgent because we can no longer afford to make patchwork fixes to a program that has not received needed improvements since its inception in 1965. It is for these reasons that I rise today in support of The Medicare Modernization and Prescription Drug Act of 2002.

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

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

> My medication is $135.00 per month. Fortunately my husband is not on any medication. If we both were not working part-time, I guess that we would have to make a choice between food and Medication—does one eat to survive or take the medication for a ''long and happy life''?

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

Seniors without prescription drug coverage often pay the highest prices for their medication. Pharmaceutical companies negotiate prices with their most favored customers, such as HMOs, but seniors without drug coverage do not benefit from these negotiations. Not only do my seniors face price discrimination in their hometowns, but also they can go to Canada and get the same medicine for a substantially cheaper price. On average my constituents would pay about 80 percent less for their drugs in Canada than they do at home in western Wisconsin. That is wrong.

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

Unfortunately, today's debate is a sham. We will not have the opportunity to discuss this issue in a fair and open process. The majority decided to railroad the debate and silence the minority by not allowing an alternative to be debated and voted upon. Our nation's seniors deserve better. They deserve an open process, but the Republican leadership has failed to deliver this.

The leadership has also failed seniors with their prescription drug proposal. The Republican plan is doomed to fail because the plan relies on health insurance companies to offer drug only polices which they have said they won't offer. If insurance companies won't offer these policies, how will seniors actually obtain prescription drug coverage under the leadership plan?

Every insurance company with whom I have spoken has said that they will not offer a drug-only insurance policy. In fact, during our last debate on this issue, the Health Insurance Association of America, which consists of nearly 300 insurance companies, released a statement claiming, ''These 'drug only' policies represent an empty promise to America's seniors. They are not workable or realistic.''

Why should the insurance companies provide these drug only policies? They are in the business of insuring risk and there is no risk associated with a drug only policy. This single benefit policy will result in adverse risk seleciton—only people with predictably high prescription medicine costs will purchase the plan. This will increase the cost to the insurance companies who in turn will pass the costs on to the beneficiaries through higher premiums.

In addition, providing a drug benefit through private plans could be problematic, specifically for folks living in rural and small communities. There are no requirements as to what has to be covered and the coverage may vary from area to area depending on the plan. Wisconsin may end up on the short end of the stick like we have in the past under Medicare. Another problem is the huge hole in coverage. Once a senior hits $2,000 in drug costs there is no coverage until they spend $3,700 in out-of-pocket expenses. Nearly half of all seniors have drug expenditures over $2,000 and will receive no drug coverage for part of the year. Further, there is no help for low-income seniors to cover their drug costs over $2,000 and before they hit the stop-loss.

We must provide a real solution to the problem of prescription drug coverage for our seniors. The Republican plan falls woefully short. The Democratic proposal, however, heads in the right direction and builds on the current Medicare program. The benefit would include: a $25/month premium; a $100 annual deductible; 20 percent cost-sharing for drug costs; and $2,000 out-of-pocket annual stop-loss. Low-income individuals up to 150 percent of poverty will pay no premium or cost-sharing. The Democratic plan would guarantee a minimum benefit and ensure that those who live in Wisconsin would receive the same benefit as those who live in California or Florida.

This plan is expensive but it would work because of its simplicity. The question about its affordability depends on whether the American people want a meaningful prescription drug program or if they would rather see large tax cuts in the future for the wealthiest Americans.

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

Mr. BEREUTER. Mr. Speaker, this Member will vote for H.R. 4954, the Medicare Modernization and Prescription Drug Act of 2002. There are elements in this Medicare reform legislation which improve the access of health care services in rural areas.

For example, not only does this legislation continue an effort to address some of this Member's concerns regarding the significant difference in reimbursement levels for urban and rural health care providers, it would also provide a 3-year fix for the Medicare physician payment formula, resulting in a 6 percent increase in Medicare payments over the next 3 years rather than the 14.2 percent projected cut under current law.

For some time now, this Member has been aggressively pursuing an issue related to the formula used in the Medicare program to reimburse physicians and other health care providers for beneficiaries' medical care. The problem is that it does not accurately measure the cost of providing such services. The program reimburses physicians and other health care providers in a manner that favors urban providers in a manner that favors urban providers over rural providers. Instead, Medicare payment formulas should more accurately compensate physicians and providers who deliver high-quality, cost-effective services to Medicare beneficiaries in all areas of the country.

Accordingly, this Member is pleased that the Medicare Modernization and Prescription Drug Act of 2002 contains a compromise agreement that would establish a floor of 9.985 for the physician work adjuster in 2004 (only), thereby raising all localities with a work adjuster below 9.985 to that level. This change would be dependent upon the outcome of a General Accounting Office (GAO) study and secretarial discretion. The Secretary of the Department of Health and Human Services would determine, after taking into account the GAO report, if there is ''a sound economic rationale for the implementation'' of such a change. If so, the new floor would go into effect. The change would thereby allow 34 Medicare localities across the county, including this Member's home state of Nebraska, to receive a higher reimbursement rate without harming other localities. This language is a modified version of this Member's legislation, the Rural Equity Payment Index Reform Act (H.R. 3569), which is currently co-sponsored on a bipartisan basis by 60 Members of the House. The language included in the House Medicare Modernization and Prescription Drug Act is also a result of efforts by the distinguished gentlelady from New Mexico [Mrs. WILSON], and pushed hard to ensure such language was and the distinguished gentleman from Wisconsin [Mr. BARRETT], who pursued this issue in the House Energy and Commerce Committee. This Member joined his colleagues, especially the gentlelady from New Mexico (Mrs. WILSON), and pushed hard to ensure such language was included in the final Medicare bill brought to the House Floor for consideration today.

Establishing a floor of 0.985 to the Medicare physician work adjuster would translate into approximately a $4 million annual increase in Medicare payments to Nebraska physician and skilled health care professionals in 2004. This is an important first step toward achieving much needed Medicare reform.

This Member is also pleased that the bill would avert a series of projected cuts of nearly 15 percent in Medicare payments. On November 1, 2001, the Centers for Medicare and Medicaid Services (CMS) announces that it would lower payment rates for 2002 under the Medicare Physician Fee Schedule. Estimates indicate that this change would result in a $2.0 billion reduction in payments for 2002.

Reductions of this magnitude were completely unexpected and stemmed from two major factors: the downturn of the economy and the related reduction in the Gross Domestic Product that is used to establish the sustainable growth rate for physician spending, and an error on the part of the CMS in collecting physician payment information. This legislation addresses this serious health care issue.

The Medicare Modernization and Prescription Drug Act of 2002 also takes an important step forward in addressing the unintended consequences of the Balanced Budget Act, as well as improving payments for hospitals, particularly rural hospitals. For example, the bill provides increased payment rates for hospitals in rural areas or in metropolitan areas with a population of less than one million.

Under current law, Medicare pays for inpatient services in acute care hospitals in large urban areas using a standardized payment amount that is 1.6 percent larger than the standardized amount used to reimburse hospitals in rural areas and smaller urban areas. This legislation, over a 2-year period, would increase the standardized amount for hospitals in rural and small urban areas to the standardized amount paid to hospitals in large urban areas. According to the Nebraska Hospital Association, for example, this could mean an additional $6 million annually for hospitals in Nebraska.

Additionally, the bill increases payments to non-teaching rural and urban hospitals in states whose aggregate inpatient operating medical margins are negative for rural hospitals or less than three percent for urban hospitals. The Nebraska Hospital Association estimates that this could result in an additional $8 million annually for Nebraska's hospitals.

This Member will record two concerns about the initiation of any Medicare prescription drug plan and that is, first, the rather extraordinary cost of this new entitlement program which would have to be paid for employers, employees, and the self-employed, recognizing the high probability that these costs will be underestimated in this or any alternative proposals put before the Congress. That is the track record for all past Medicare and Medicaid initiatives.

However, the major concern this Member has is the near certainty that the cost of prescription drugs for Americans not eligible for the proposed Medicare prescription drug benefits will increase because of the Medicare prescription drug coverage offered to eligible senior citizens under this or other proposals. When, for example, Medicaid costs for nursing home care soared, cost restraints were imposed and the operators cost-shifted to the private-pay and insurance-pay residents. The same cost-shifting occurred when cost-restraints had to be established on Medicare costs for hospitalization and health professional fees. It is certain that some cost-shifting will occur in short order when restraints inevitably will be placed on Medicare prescription drug costs. The result will surely be that pharmaceutical costs will be cost-shifted by the drug industry to everyone else in America.

This legislation, in this crucial deficiency, does nothing to restrain pharmaceutical costs and domestic cost-shifting. However, after extensive consultation, House leadership has promised a vote to those of us demanding some method to directly keep Medicare prescription drug benefits of eligible senior citizens from causing prescription drug costs to resultantly increase for other Americans.

One such vote could be on an implementable drug re-importation program of FDA approved drugs for individual, wholesale, or retail uses. Turn loose the American entrepreneurial proclivities on this approach, and it will moderate the outrageously unacceptable level of international cost-shifting that now falls onto the backs of American consumers. Most other developed countries have imposed cost constraints on the prescription drug costs borne by their consumers; therefore, American and foreign-owned pharmaceutical firms are

charging what the market and tolerance of the American people will bear. This legislation thus far does not address this huge problem—ultimately providing Medicare drug benefits to eligible senior citizens will make the cost of prescription drugs more expensive for most Americans directly and indirectly through Medicare deductions from their paychecks and through its effects on their employer's bottom line.

Mr. Speaker, in conclusion, on balance, this Member supports H.R. 4954 because of the progress made in providing better access to quality health care in non-metropolitan areas through the Medicare finance reforms and because of the promised opportunity for a clear opportunity for the House to soon cast votes on legislation which can restrain or lower prescription drug costs for those Americans not eligible for prospective Medicare prescription drug benefits. This Member will support the advancement of H.R. 4954 to a stage where conferees can craft what this Member would hope to be better legislation if the other body passes its version of a Medicare reform and prescription drug bill.

Mr. CHAMBLISS. Mr. Speaker, we need to strengthen, simplify, and improve Medicare and provide prescription drug coverage for all seniors and disabled Americans. It has been entirely too long that seniors have done without substantial help in affording their prescription drugs. I am committed to working hard to pass prescription drug relief for America's seniors.

Tonight we will pass a fiscally responsible bill that allows seniors and disabled Americans to purchase quality and affordable prescription drugs, offers seniors third party buying power, and provides the security of knowing they are protected from catastrophic pharmaceutical bills.

We desperately need this prescription drug plan. Seniors need this plan to finally receive prescription drug coverage they deserve along with greater choice and flexibility. Further, this plan will substantially help nursing facilities, home health agencies, rural hospitals and local doctors provide better health services and ensure quality health care for folks throughout Georgia.

This bill will not force folks into a Federal Government-run, one-size-fits-all prescription drug plan that has too many rules, regulations, and restrictions and that allows Washington bureaucrats to decide what medicines can and can't be prescribed. This plan is voluntary, and protects those seniors who are already satisfied with their current prescription drug benefit by allowing them to stay in the existing program.

With all these benefits, we need to make sure this legislation is friendly to small businesses and our local pharmacies. I have heard from a number of constituents and share their serious concerns that pharmacists may lose access to networks and our seniors will not gain access to benefits at their local pharmacy. Our hometown pharmacies play a critical role in providing health care in our local communities. We need to ensure that they are not put out of business by this legislation and that pharmacists will have the same opportunity to negotiate price reductions and provide discounted drugs to their customers. It is important that pharmacists be involved in the decision making process for these plans and have the same opportunities to deliver lower costs to the consumer. I want our pharmacists to be able to continue giving customers top-notch care, and I hope that as the process moves forward on this important bill, these critical issues will be adequately addressed.

It is no secret that prescription drug costs are an overwhelming burden on the health and financial security of seniors and disabled Americans. Too many senior citizens and disabled Americans face decisions between putting food on their table and being able to afford the prescription drugs they need. In the wealthiest country in the world, our seniors should not be forced to make these decisions or do without medication that would allow them to live longer healthier more enjoyable lives, and I look forward to passing a responsible prescription drug plan that helps America's seniors.

Mr. EVANS. Mr. Speaker, today's seniors increasingly depend on prescription drugs to live healthy lives. But with prescription drug prices skyrocketing, medication is out-of-reach for too many of our Nation's seniors. All too often, we hear of seniors on tight budgets who are forced to choose between medication and their next meal. Congress must ensure that all seniors have access to affordable prescription drug coverage, but the plan that the Republicans have offered falls short. A voluntarily benefit added to Medicare would guarantee all seniors access to affordable coverage.

I support a plan that provides a voluntary, guaranteed, defined benefit under the Medicare program. A Medicare prescription drug plan would leave nothing to surprise. Seniors would know how much to expect to pay in premiums and co-payments. All seniors would be eligible to participate. Moreover, this plan would allow Medicare to negotiate the same price breaks for Medicare beneficiaries that are currently enjoyed by other large scale buyers like HMOs and insurance companies.

The Republican plan is riddled with flaws. First, it is not a Medicare benefit, rather it relies on private insurers who have already made clear that they have no intention of providing drug only plans to Medicare beneficaries. Second, the Republican proposal falls to rein in the high costs of prescription drugs for seniors. Private insurers will not be limited to what they may charge Medicare beneficiaries and will do little to reduce the high out-of-pocket costs that seniors already pay. Third, the GOP plan will only create more hardships for seniors who will be forced to jump through the hoops of their private insurer and be subjected to limited power provider and drug choices.

Mr. SMITH of Texas. Mr. Speaker, I support this legislation because it provides a prescription drug benefit to all seniors using Medicare.

In these items of escalating prescription drug prices, it is essential that seniors have access to affordable drugs to meet their medical needs.

The best way to accomplish this goal is to lower the costs of prescription drugs, ensure that all seniors have prescription drug coverage and increase choices of coverage plans.

Patients who live in rural areas and communities deserve the same access to physicians as their urban counterparts. As a member of the Rural Health Care Caucus, I am pleased that this bill addresses inequities between payments made to rural and urban hospitals, wage adjustments for physicians in rural areas and funding for health care organizations.

Not only does this legislation help consumers of prescription drugs, but it also recognizes the importance of pharmacists in providing prescription drugs, helps states cover their Medicare costs and enhances employer-sponsored health care benefits for retirees.

My Democratic colleagues have proposed a bill that costs over $800 billion and sunsets after ten years. But what happens after ten years?

This bill is a common sense, realistic approach that provides permanent coverage for seniors at a sensible cost. It gives special attention to the needs of low-income seniors and those facing exorbitant costs due to catastrophic illness.

The SPEAKER pro tempore. All time for debate has expired.

Pursuant to House Resolution 467, the previous question is ordered on the bill, as amended.

The question is on engrossment and third reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. GEPHARDT

Mr. GEPHARDT. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. GEPHARDT. I am in its current form, Mr. Speaker.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. GEPHARDT moves to recommit the bill H.R. 4954 jointly to the Committee on Ways and Means and the Committee on Energy and Commerce with instructions to report the same back to the House promptly with the following amendment:

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; REFERENCES IN ACT; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Rx Drug Benefit and Discount Act of 2002''.

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

(c) BIPA; SECRETARY.—In this Act:

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

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

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

TITLE I—PRESCRIPTION DRUG PROVISIONS

Sec. 101. Voluntary medicare outpatient prescription medicine program.

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

''Sec. 1859. Medicare outpatient prescription medicine benefit.

''Sec. 1859A. Negotiating fair prices with pharmaceutical manufacturers.

''Sec. 1859B. Contract authority.

''Sec. 1859C. Eligibility; voluntary enrollment; coverage.
''Sec. 1859D. Provision of, and entitlement to, benefits.
''Sec. 1859E. Administration; quality assurance.
''Sec. 1859F. Federal Medicare Prescription Medicine Trust Fund.
''Sec. 1859G. Compensation for employers covering retiree medicine costs.
''Sec. 1859H. Medicare Prescription Medicine Advisory Committee.
Sec. 102. Provision of medicare outpatient prescription medicine coverage under the Medicare+Choice program.
Sec. 103. Medigap revisions.
Sec. 104. Transitional assistance for low income beneficiaries.
Sec. 105. Expansion of membership and duties of Medicare Payment Advisory Commission (MedPAC).

TITLE II—MEDICARE+CHOICE REVITALIZATION AND MEDICARE+CHOICE COMPETITION PROGRAM

Sec. 201. Medicare+Choice improvements.
Sec. 202. Making permanent change in Medicare+Choice reporting deadlines and annual, coordinated election period.
Sec. 203. Specialized Medicare+Choice plans for special needs beneficiaries.
Sec. 204. Extension of reasonable cost and SHMO contracts.
Sec. 205. Continuous open enrollment and disenrollment.
Sec. 206. Limitation on Medicare+Choice cost-sharing.
Sec. 207. Extension of municipal health service demonstration projects.

TITLE III—RURAL HEALTH CARE IMPROVEMENTS

Sec. 301. Reference to full market basket increase for sole community hospitals.
Sec. 302. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.
Sec. 303. 2-year phased-in increase in the standardized amount in rural and small urban areas to achieve a single, uniform standardized amount.
Sec. 304. More frequent update in weights used in hospital market basket.
Sec. 305. Improvements to critical access hospital program.
Sec. 306. Extension of temporary increase for home health services furnished in a rural area.
Sec. 307. Reference to 10 percent increase in payment for hospice care furnished in a frontier area and rural hospice demonstration project.
Sec. 308. Reference to priority for hospitals located in rural or small urban areas in redistribution of unused graduate medical education residencies.
Sec. 309. GAO study of geographic differences in payments for physicians' services.
Sec. 310. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.
Sec. 311. Relief for certain non-teaching hospitals.

TITLE IV—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

Sec. 401. Revision of acute care hospital payment updates.
Sec. 402. Freeze in level of adjustment for indirect costs of medical education (IME) through fiscal year 2007.
Sec. 403. Recognition of new medical technologies under inpatient hospital PPS.
Sec. 404. Phase-in of Federal rate for hospitals in Puerto Rico.
Sec. 405. Reference to provision relating to enhanced disproportionate share hospital (DSH) payments for rural hospitals and urban hospitals with fewer than 100 beds.
Sec. 406. Reference to provision relating to 2-year phased-in increase in the standardized amount in rural and small urban areas to achieve a single, uniform standardized amount.
Sec. 407. Reference to provision for more frequent updates in the weights used in hospital market basket.
Sec. 408. Reference to provision making improvements to critical access hospital program.

Subtitle B—Skilled Nursing Facility Services

Sec. 411. Payment for covered skilled nursing facility services.

Subtitle C—Hospice

Sec. 421. Coverage of hospice consultation services.
Sec. 422. 10 percent increase in payment for hospice care furnished in a frontier area.
Sec. 423. Rural hospice demonstration project.

Subtitle D—Other Provisions

Sec. 431. Demonstration project for use of recovery audit contractors for part A services.

TITLE V—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

Sec. 501. Revision of updates for physicians' services.
Sec. 502. Studies on access to physicians' services.
Sec. 503. MedPAC report on payment for physicians' services.
Sec. 504. 1-year extension of treatment of certain physician pathology services under medicare.
Sec. 505. Physician fee schedule wage index revision.

Subtitle B—Other Services

Sec. 511. Competitive acquisition of certain items and services.
Sec. 512. Payment for ambulance services.
Sec. 513. 5-year extension of moratorium on therapy caps; provisions relating to reports.
Sec. 514. Accelerated implementation of 20 percent coinsurance for hospital outpatient department (OPD) services; other OPD provisions.
Sec. 515. Coverage of an initial preventive physical examination.
Sec. 516. Renal dialysis services.
Sec. 517. Improved payment for certain mammography services.
Sec. 518. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.
Sec. 519. Coverage of cholesterol and blood lipid screening.

TITLE VI—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

Sec. 601. Elimination of 15 percent reduction in payment rates under the prospective payment system.
Sec. 602. Update in home health services.
Sec. 603. OASIS Task Force; suspension of certain OASIS data collection requirements pending Task Force submittal of report.
Sec. 604. MedPAC study on medicare margins of home health agencies.

Subtitle B—Direct Graduate Medical Education

Sec. 611. Redistribution of unused resident positions.
Sec. 612. Increasing for 5 years to 100 percent of the locality adjusted national average per resident amount the payment floor for direct graduate medical education payments under the medicare program.

Subtitle C—Other Provisions

Sec. 621. Modifications to Medicare Payment Advisory Commission (MedPAC).
Sec. 622. Demonstration project for disease management for certain medicare beneficiaries with diabetes.
Sec. 623. Demonstration project for medical adult day care services.
Sec. 624. Publication on final written guidance concerning prohibitions against discrimination by national origin with respect to health care services.

TITLE VII—MEDICAID PROVISIONS

Sec. 701. DSH provisions.
Sec. 702. 1-year extension of Q–I1 program.

TITLE I—PRESCRIPTION MEDICINE PROVISIONS

Subtitle A—MEDICARE PRESCRIPTION MEDICINE BENEFIT

SEC. 101. VOLUNTARY MEDICARE OUTPATIENT PRESCRIPTION MEDICINE PROGRAM.

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

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

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

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

''MEDICARE OUTPATIENT PRESCRIPTION MEDICINE BENEFIT

''SEC. 1859. Subject to the succeeding provisions of this part, the voluntary prescription medicine benefit program under this part provides the following:

''(1) PREMIUM.—The monthly premium is $25.

''(2) DEDUCTIBLE.—The annual deductible is $100.

''(3) COINSURANCE.—The coinsurance is 20 percent.

''(4) OUT-OF-POCKET LIMIT.—The annual limit on out-of-pocket spending on covered medicines is $2,000.

''NEGOTIATING FAIR PRICES WITH PHARMACEUTICAL MANUFACTURERS

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

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

''CONTRACT AUTHORITY

''SEC. 1859B. (a) CONTRACT AUTHORITY.—

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

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

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

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

''(C) provides for the termination (and nonrenewal) of a contract in the case of a contractor's failure to meet the requirements of the contract and this part.

''(3) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into contracts under this part.

''(4) TERMS AND CONDITIONS.—Such contracts shall have such terms and conditions as the Secretary shall specify and shall be for such terms (of at least 2 years, but not to exceed 5 years) as the Secretary shall specify consistent with this part.

''(5) USE OF PHARMACY CONTRACTORS IN PRICE NEGOTIATIONS.—Such contracts shall require the contractor involved to negotiate contracts with manufacturers that provide for maximum prices for covered outpatient prescription medicines that are lower than the maximum prices negotiated under section 1859A(a), if applicable. The price reductions shall be passed on to eligible beneficiaries and the Secretary shall hold the contractor accountable for meeting performance requirements with respect to price reductions and limiting price increases.

''(6) AREA FOR CONTRACTS.—

''(A) REGIONAL BASIS.—

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

''(ii) PARTIAL REGIONAL BASIS.—

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

''(II) REQUIREMENTS.—If the Secretary permits administration pursuant to subclause (I), the Secretary shall ensure that the partial region in which administration is effected is no smaller than a State and is at least the size of the commercial service area of the contractor for that area.

''(B) DETERMINATION.—

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

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

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

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

''(7) SUBMISSION OF BIDS.—

''(A) SUBMISSION.—

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

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

''(B) REQUIRED INFORMATION.—The bids described in subparagraph (A) shall include—

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

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

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

''(iv) a detailed description of the performance requirements for which the administrative fee of the entity will be subject to risk pursuant to subsection (c)(4)(A)(ii);

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

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

''(I) selecting preferred prescription medicines; and

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

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

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

''(ix) such other information that the Secretary determines is necessary in order to carry out this part, including information relating to the bidding process under this part.

The procedures under clause (vi) shall include the use of a pharmaceutical and therapeutics committee the members of which include practicing pharmacists.

''(8) AWARDING OF CONTRACTS.—

''(A) NUMBER OF CONTRACTS.—The Secretary shall, consistent with the requirements of this part and the goals of providing quality care and of containing costs under this part, award in a competitive manner at least 2 contracts to administer benefits under this part in each area specified under paragraph (6), unless only 1 pharmacy contractor submitting a bid meets the minimum standards specified under this part and by the Secretary.

''(B) DETERMINATION.—In determining which of the pharmacy contractors that submitted bids that meet the minimum standards specified under this part and by the Secretary to award a contract, the Secretary shall consider the comparative merits of each bid, as determined on the basis of relevant factors, with respect to—

''(i) how well the contractor meets such minimum standards;

''(ii) the amount that the contractor will charge the Secretary for administering the benefits under the contract;

''(iii) the performance standards established under subsection (c)(2) and performance requirements for which the administrative fee of the entity will be subject to risk pursuant to subsection (c)(4)(A)(ii);

''(iv) the proposed negotiated prices of covered outpatient medicines and annual increases in such prices;

''(v) factors relating to benefits, quality and performance, beneficiary cost-sharing, and consumer satisfaction;

''(vi) past performance and prior experience of the contractor in administering a prescription medicine benefit program;

''(vii) effectiveness of the contractor in containing costs through pricing incentives and utilization management; and

''(viii) such other factors as the Secretary deems necessary to evaluate the merits of each bid.

''(C) EXCEPTION TO CONFLICT OF INTEREST RULES.—In awarding contracts with pharmacy contractors under this part, the Secretary may waive conflict of interest laws generally applicable to Federal acquisitions (subject to such safeguards as the Secretary may find necessary to impose) in circumstances where the Secretary finds that such waiver—

''(i) is not inconsistent with the—

''(I) purposes of the programs under this part; or

''(II) best interests of beneficiaries enrolled under this part; and

''(ii) permits a sufficient level of competition for such contracts, promotes efficiency of benefits administration, or otherwise serves the objectives of the program under this part.

''(D) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of the Secretary to award or not award a contract to a pharmacy contractor under this part shall not be subject to administrative or judicial review.

''(9) ACCESS TO BENEFITS IN CERTAIN AREAS.—

''(A) AREAS NOT COVERED BY CONTRACTS.—The Secretary shall develop procedures for the provision of covered outpatient prescription medicines under this part to each eligible beneficiary enrolled under this part that resides in an area that is not covered by any contract under this part.

''(B) BENEFICIARIES RESIDING IN DIFFERENT LOCATIONS.—The Secretary shall develop procedures to ensure that each eligible beneficiary enrolled under this part that resides in different areas in a year is provided the benefits under this part throughout the entire year.

''(b) QUALITY, FINANCIAL, AND OTHER STANDARDS AND PROGRAMS.—In consultation with appropriate pharmacy contractors, pharmacists, and health care professionals with expertise in prescribing, dispensing, and the appropriate use of prescription medicines, the Secretary shall establish standards and programs for the administration of this part to ensure appropriate prescribing, dispensing, and utilization of outpatient medicines under this part, to avoid adverse medicine reactions, and to continually reduce errors in the delivery of medically appropriate covered benefits. The Secretary shall not award a contract to a pharmacy contractor under this part unless the Secretary finds that the contractor agrees to comply with such standards and programs and other terms and conditions as the Secretary shall specify. The standards and programs under this subsection shall be applied

to any administrative agreements described in subsection (a) the Secretary enters into. Such standards and programs shall include the following:

''(1) ACCESS.—

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

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

''(C) GUARANTEED ACCESS TO MEDICINES IN RURAL AND HARD-TO-SERVE AREAS.—The Secretary shall ensure that all beneficiaries have guaranteed access to the full range of pharmaceuticals under this part, and shall give special attention to access, pharmacist counseling, and delivery in rural and hard-to-serve areas, including through the use of incentives such as bonus payments to retail pharmacists in rural areas and extra payments to the pharmacy contractor for the cost of rapid delivery of pharmaceuticals and any other actions necessary.

''(D) PREFERRED PHARMACY NETWORKS.—

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

''(ii) STANDARDS.—In establishing standards under clause (i), the Secretary shall take into account reasonable distances to pharmacy services in both urban and rural areas.

''(E) ADHERENCE TO NEGOTIATED PRICES.—The pharmacy contractor shall have in place procedures to assure compliance of pharmacies with the requirements of subsection (d)(3)(C) (relating to adherence to negotiated prices).

''(F) CONTINUITY OF CARE.—

''(i) IN GENERAL.—The pharmacy contractor shall ensure that, in the case of an eligible beneficiary who loses coverage under this part with such entity under circumstances that would permit a special election period (as established by the Secretary under section 1859C(b)(3)), the contractor will continue to provide coverage under this part to such beneficiary until the beneficiary enrolls and receives such coverage with another pharmacy contractor under this part or, if eligible, with a Medicare+Choice organization.

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

''(2) ENROLLEE GUIDELINES.—The pharmacy contractor shall, consistent with State law, apply guidelines for counseling enrollees regarding—

''(A) the proper use of covered outpatient prescription medicine: and

''(B) interactions and contra-indications.

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

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

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

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

''(D) inappropriate use of antibiotics;

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

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

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

''(5) COST DATA.—

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

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

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

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

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

Discounts referred to in subparagraphs (A) and (B) shall include all volume discounts, manufacturer rebates, prompt payment discounts, free goods, in-kind services, or any other thing of financial value provided explicitly or implicitly in exchange for the purchase of a covered outpatient prescription medicine.

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

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

''(B) utilization of benefits under this part;

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

''(D) grievances and appeals.

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

''(8) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The pharmacy contractor shall comply with requirements of section 1851(h) (relating to marketing material and application forms) with respect to this part in the same manner as such requirements apply under part C, except that the provisions of paragraph (4)(A) of such section shall not apply with respect to discounts or rebates provided in accordance with this part.

''(c) INCENTIVES FOR COST AND UTILIZATION MANAGEMENT AND QUALITY IMPROVEMENT.—

''(1) IN GENERAL.—The Secretary shall include in a contract awarded under subsection (b) with a pharmacy contractor such incentives for cost and utilization management and quality improvement as the Secretary may deem appropriate. The contract may provide financial or other incentives to encourage greater savings to the program under this part.

''(2) PERFORMANCE STANDARDS.—The Secretary shall provide for performance standards (which may include monetary bonuses if the standards are met and penalties if the standards are not met), including standards relating to the time taken to answer member and pharmacy inquiries (written or by telephone), the accuracy of responses, claims processing accuracy, online system availability, appeal procedure turnaround time, system availability, the accuracy and timeliness of reports, and level of beneficiary satisfaction.

''(3) OTHER INCENTIVES.—Such incentives under this subsection may also include—

''(A) financial incentives under which savings derived from the substitution of generic and other preferred multi-source medicines in lieu of nongeneric and nonpreferred medicines are made available to pharmacy contractors, pharmacies, beneficiaries, and the Federal Medicare Prescription Medicine Trust Fund; and

''(B) any other incentive that the Secretary deems appropriate and likely to be effective in managing costs or utilization or improving quality that does not reduce the access of beneficiaries to medically necessary covered outpatient medicines.

''(4) REQUIREMENTS FOR PROCEDURES.—

''(A) IN GENERAL.—The Secretary shall establish procedures for making payments to each pharmacy contractor with a contract under this part for the administration of the benefits under this part. The procedures shall provide for the following:

''(i) ADMINISTRATIVE PAYMENT.—Payment of administrative fees for such administration.

''(ii) RISK REQUIREMENT.—An adjustment of a percentage (determined under subparagraph (B)) of the administrative fee payments made to a pharmacy contractor to ensure that the contractor, in administering the benefits under this part, pursues performance requirements established by the Secretary, including the following:

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

''(II) QUALITY CLINICAL CARE.—The contractor provides such beneficiaries with quality clinical care, as measured by such factors as providing notification to such beneficiaries and to providers in order to prevent adverse drug reactions and reduce medication errors and specific clinical suggestions to improve health and patient and prescriber education as appropriate.

''(III) CONTROL OF MEDICARE COSTS.—The contractor contains costs under this part to the Federal Medicare Prescription Medicine Trust Fund and enrollees, as measured by generic substitution rates, price discounts, and other factors determined appropriate by the Secretary that do not reduce the access of beneficiaries to medically necessary covered outpatient prescription medicines.

''(B) PERCENTAGE OF PAYMENT TIED TO RISK.—

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

''(ii) LIMITATION ON RISK TO ENSURE PROGRAM STABILITY.—In order to provide for program stability, the Secretary may not establish a percentage to be adjusted under this paragraph at a level that jeopardizes the ability of a pharmacy contractor to administer the benefits under this part or administer such benefits in a quality manner.

''(C) RISK ADJUSTMENT OF PAYMENTS BASED ON ENROLLEES IN PLAN.—To the extent that a pharmacy contractor is at risk under this paragraph, the procedures established under this paragraph may include a methodology for risk adjusting the payments made to such contractor based on the differences in actuarial risk of different enrollees being served if the Secretary determines such adjustments to be necessary and appropriate.

''(d) AUTHORITY RELATING TO PHARMACY PARTICIPATION.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, a pharmacy contractor may establish consistent with this part conditions for the participation of pharmacies, including conditions relating to quality (including reduction of medical errors) and technology.

''(2) AGREEMENTS WITH PHARMACIES.—Each pharmacy contractor shall enter into a participation agreement with any pharmacy that meets the requirements of this subsection and section 1859E to furnish covered outpatient prescription medicines to individuals enrolled under this part.

''(3) TERMS OF AGREEMENT.—An agreement under this subsection shall include the following terms and conditions:

''(A) APPLICABLE REQUIREMENTS.—The pharmacy shall meet (and throughout the contract period continue to meet) all applicable Federal requirements and State and local licensing requirements.

''(B) ACCESS AND QUALITY STANDARDS.—The pharmacy shall comply with such standards as the Secretary (and such a pharmacy contractor) shall establish concerning the quality of, and enrolled individuals' access to, pharmacy services under this part. Such standards shall require the pharmacy—

''(i) not to refuse to dispense covered outpatient prescription medicines to any individual enrolled under this part;

''(ii) to keep patient records (including records on expenses) for all covered outpatient prescription medicines dispensed to such enrolled individuals;

''(iii) to submit information (in a manner specified by the Secretary to be necessary to administer this part) on all purchases of such medicines dispensed to such enrolled individuals; and

''(iv) to comply with periodic audits to assure compliance with the requirements of this part and the accuracy of information submitted.

''(C) ADHERENCE TO NEGOTIATED PRICES.—(i) The total charge for each medicine dispensed by the pharmacy to an enrolled individual under this part, without regard to whether the individual is financially responsible for any or all of such charge, shall not exceed the price negotiated under section 1859A(a) or, if lower, negotiated under subsection (a)(5) (or, if less, the retail price for the medicine involved) with respect to such medicine plus a reasonable dispensing fee determined contractually with the pharmacy contractor.

''(ii) The pharmacy does not charge (or collect from) an enrolled individual an amount that exceeds the individual's obligation (as determined in accordance with the provisions of this part) of the applicable price described in clause (i).

''(D) ADDITIONAL REQUIREMENTS.—The pharmacy shall meet such additional contract requirements as the applicable pharmacy contractor specifies under this section.

''(4) APPLICABILITY OF FRAUD AND ABUSE PROVISIONS.—The provisions of section 1128 through 1128C (relating to fraud and abuse) apply to pharmacies participating in the program under this part.

''ELIGIBILITY; VOLUNTARY ENROLLMENT; COVERAGE

''SEC. 1859C. (a) ELIGIBILITY.—Each individual who is entitled to hospital insurance benefits under part A or is eligible to be enrolled in the medical insurance program under part B is eligible to enroll in accordance with this section for outpatient prescription medicine benefits under this part.

''(b) VOLUNTARY ENROLLMENT.—

''(1) IN GENERAL.—An individual may enroll under this part only in such manner and form as may be prescribed by regulations, and only during an enrollment period prescribed in or under this subsection.

''(2) INITIAL ENROLLMENT PERIOD.—

''(A) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who satisfies subsection (a) as of November 1, 2004, the initial general enrollment period shall begin on August 1, 2004, and shall end on March 1, 2005.

''(B) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who first satisfies subsection (a) on or after November 1, 2004, the individual's initial enrollment period shall begin on the first day of the third month before the month in which such individual first satisfies such paragraph and shall end seven months later. The Secretary shall apply rules similar to the rule described in the second sentence of section 1837(d).

''(3) SPECIAL ENROLLMENT PERIODS (WITHOUT PREMIUM PENALTY).—

''(A) EMPLOYER COVERAGE AT TIME OF INITIAL GENERAL ENROLLMENT PERIOD.—In the case of an individual who—

''(i) at the time the individual first satisfies subsection (a) is enrolled in a group health plan (including continuation coverage) that provides outpatient prescription medicine coverage by reason of the individual's (or the individual's spouse's) current (or, in the case of continuation coverage, former) employment status, and

''(ii) has elected not to enroll (or to be deemed enrolled) under this subsection during the individual's initial enrollment period,

there shall be a special enrollment period of 6 months beginning with the first month that includes the date of the individual's (or individual's spouse's) retirement from or termination of current employment status with the employer that sponsors the plan, or, in the case of continuation coverage, that includes the date of termination of such coverage, or that includes the date the plan substantially terminates outpatient prescription medicine coverage.

''(B) DROPPING OF RETIREE PRESCRIPTION MEDICINE COVERAGE.—In the case of an individual who—

''(i) at the time the individual first satisfies subsection (a) is enrolled in a group health plan that provides outpatient prescription medicine coverage other than by reason of the individual's (or the individual's spouse's) current employment; and

''(ii) has elected not to enroll (or to be deemed enrolled) under this subsection during the individual's initial enrollment period,

there shall be a special enrollment period of 6 months beginning with the first month that includes the date that the plan substantially terminates outpatient prescription medicine coverage and ending 6 months later.

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

''(D) LOSS OF MEDICAID PRESCRIPTION MEDICINE COVERAGE.—In the case of an individual who—

''(i) satisfies subsection (a);

''(ii) loses eligibility for benefits (that include benefits for prescription medicine) under a State plan after having been enrolled (or determined to be eligible) for such benefits under such plan; and

''(iii) is not otherwise enrolled under this subsection at the time of such loss of eligibility,

there shall be a special enrollment period specified by the Secretary of not less than 6 months beginning with the first month that includes the date that the individual loses such eligibility.

''(4) LATE ENROLLMENT WITH PREMIUM PENALTY.—The Secretary shall permit an individual who satisfies subsection (a) to enroll other than during the initial enrollment period under paragraph (2) or a special enrollment period under paragraph (3). But, in the case of such an enrollment, the amount of the monthly premium of the individual is subject to an increase under section 1859C(e)(1).

''(5) INFORMATION.—

''(A) IN GENERAL.—The Secretary shall broadly distribute information to individuals who satisfy subsection (a) on the benefits provided under this part. The Secretary shall periodically make available information on the cost differentials to enrollees for the use of generic medicines and other medicines.

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

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

''(c) COVERAGE PERIOD.—

''(1) IN GENERAL.—The period during which an individual is entitled to benefits under this part (in this subsection referred to as the individual's 'coverage period') shall begin on such a date as the Secretary shall establish consistent with the type of coverage rules described in subsections (a) and (e) of section 1838, except that in no case shall a coverage period begin before January 1, 2005. No payments may be made under this part with respect to the expenses of an individual unless such expenses were incurred by such individual during a period which, with respect to the individual, is a coverage period.

''(2) TERMINATION.—The Secretary shall provide for the application of provisions under this subsection similar to the provisions in section 1838(b).

''(d) PROVISION OF BENEFITS TO MEDICARE+CHOICE ENROLLEES.—In the case of an individual who is enrolled under this part and is enrolled in a Medicare+Choice plan under part C, the individual shall be provided the benefits under this part through such plan and not through payment under this part.

''(e) LATE ENROLLMENT PENALTIES; PAYMENT OF PREMIUMS.—

''(1) LATE ENROLLMENT PENALTY.—

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

''(B) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under subparagraph (A), there shall be taken into account months of lapsed coverage in a manner comparable to that applicable under the second sentence of section 1839(b).

''(C) PERIODS NOT TAKEN INTO ACCOUNT.—

''(i) IN GENERAL.—For purposes of calculating any 12-month period under subparagraph (A), subject to clause (ii), there shall not be taken into account months for which the enrollee can demonstrate that the enrollee was covered under a group health plan that provides coverage of the cost of prescription medicines whose actuarial value (as defined by the Secretary) to the enrollee equals or exceeds the actuarial value of the benefits provided to an individual enrolled in the outpatient prescription medicine benefit program under this part.

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

''(2) INCORPORATION OF PREMIUM PAYMENT AND GOVERNMENT CONTRIBUTIONS PROVISIONS.—The provisions of sections 1840 and 1844(a)(1) shall apply to enrollees under this part in the same manner as they apply to individuals 65 years of age or older enrolled under part B. For purposes of this subsection, any reference in a section referred to in a previous subsection to the Federal Supplementary Medical Insurance Trust Fund is deemed a reference to the Federal Medicare Prescription Medicine Trust Fund.

''(f) ELECTION OF PHARMACY CONTRACTOR TO ADMINISTER BENEFITS.—The Secretary shall establish a process whereby each individual enrolled under this part and residing in a region may elect the pharmacy contractor that will administer the benefits under this part with respect to the individual. Such process shall permit the individual to make an initial election and to change such an election on at least an annual basis and under such other circumstances as the Secretary shall specify.

''PROVISION OF, AND ENTITLEMENT TO, BENEFITS

''SEC. 1859D. (a) BENEFITS.—Subject to the succeeding provisions of this section, the benefits provided to an enrollee by the program under this part shall consist of the following:

''(1) COVERED OUTPATIENT PRESCRIPTION MEDICINE BENEFITS.—Entitlement to have payment made on the individual's behalf for covered outpatient prescription medicines.

''(2) LIMITATION ON COST-SHARING FOR PART B OUTPATIENT PRESCRIPTION MEDICINES.—

''(A) IN GENERAL.—Once an enrollee has incurred aggregate countable cost-sharing (as defined in subparagraph (B)) equal to the stop-loss limit specified in subsection (c)(4) for expenses in a year, entitlement to the elimination of cost-sharing otherwise applicable under part B for additional expenses incurred in the year for outpatient prescription medicines or biologicals for which payment is made under part B.

''(B) COUNTABLE COST-SHARING DEFINED.—For purposes of this part, the term 'countable cost-sharing' means—

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

''(ii) cost-sharing under subsections (c)(3)(B) and (c)(3)(C)(i).

''(b) COVERED OUTPATIENT PRESCRIPTION MEDICINE DEFINED.—

''(1) IN GENERAL.—Except as provided in paragraph (2), for purposes of this part the term 'covered outpatient prescription medicine' means any of the following products:

''(A) A medicine which may be dispensed only upon prescription, and—

''(i) which is approved for safety and effectiveness as a prescription medicine under section 505 of the Federal Food, Drug, and Cosmetic Act;

''(ii)(I) which was commercially used or sold in the United States before the date of enactment of the Drug Amendments of 1962 or which is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a medicine, and (II) which has not been the subject of a final determination by the Secretary that it is a 'new drug' (within the meaning of section 201(p) of the Federal Food, Drug, and Cosmetic Act) or an action brought by the Secretary under section 301, 302(a), or 304(a) of such Act to enforce section 502(f) or 505(a) of such Act; or

''(iii)(I) which is described in section 107(c)(3) of the Drug Amendments of 1962 and for which the Secretary has determined there is a compelling justification for its medical need, or is identical, similar, or related (within the meaning of section 310.6(b)(1) of title 21 of the Code of Federal Regulations) to such a medicine, and (II) for which the Secretary has not issued a notice of an opportunity for a hearing under section 505(e) of the Federal Food, Drug, and Cosmetic Act on a proposed order of the Secretary to withdraw approval of an application for such medicine under such section because the Secretary has determined that the medicine is less than effective for all conditions of use prescribed, recommended, or suggested in its labeling.

''(B) A biological product which—

''(i) may only be dispensed upon prescription;

''(ii) is licensed under section 351 of the Public Health Service Act; and

''(iii) is produced at an establishment licensed under such section to produce such product.

''(C) Insulin approved under appropriate Federal law, and needles, syringes, and disposable pumps for the administration of such insulin.

''(D) A prescribed medicine or biological product that would meet the requirements of subparagraph (A) or (B) but that is available over-the-counter in addition to being available upon prescription, but only if the particular dosage form or strength prescribed and required for the individual is not available over-the-counter.

''(E) Smoking cessation agents (as specified by the Secretary).

''(2) EXCLUSION.—The term 'covered outpatient prescription medicine' does not include—

''(A) medicines or classes of medicines, 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), 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 part;

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

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

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

''(c) PAYMENT OF BENEFITS.—

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

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

''(B) a reasonable dispensing fee.

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

''(2) DEDUCTIBLE.—The amount of payment under paragraph (1) for expenses incurred in a year, beginning with 2005, shall be reduced by an annual deductible equal to the amount specified in section 1859(2) (subject to adjustment under paragraph (8)). Only expenses for countable cost-sharing (as defined in subsection (a)(2)(B)) shall be taken into account in applying this paragraph.

''(3) COINSURANCE.—

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

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

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

''(i) 20 percent of the price for lowest price preferred medicine that is within the same therapeutic class; and

''(ii) the amount by which—

''(I) the price at which the nonpreferred medicine is made available to the enrollee; exceeds

''(II) the price of such lowest price preferred medicine.

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

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

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

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

''(A) PROCEDURES REGARDING THE DETERMINATION OF MEDICINES THAT ARE MEDICALLY

NECESSARY.—Each pharmacy contractor shall have in place procedures on a case-by-case basis to treat a nonpreferred medicine as a preferred medicine under this part if the preferred medicine is determined to be not as effective for the enrollee or to have significant adverse effect on the enrollee. Such procedures shall require that such determinations are based on professional medical judgment, the medical condition of the enrollee, and other medical evidence.

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

''(i) a timely internal review for resolution of denials of coverage (in whole or in part and including those regarding the coverage of nonpreferred medicines) in accordance with the medical exigencies of the case and a timely resolution of complaints, by enrollees in the plan, or by providers, pharmacists, and other individuals acting on behalf of each such enrollee (with the enrollee's consent) in accordance with requirements (as established by the Secretary) that are comparable to such requirements for Medicare+Choice organizations under part C;

''(ii) that the entity complies in a timely manner with requirements established by the Secretary that (I) provide for an external review by an independent entity selected by the Secretary of denials of coverage described in clause (i) not resolved in the favor of the beneficiary (or other complainant) under the process described in such clause and (II) are comparable to the external review requirements established for Medicare+Choice organizations under part C; and

''(iii) that enrollees are provided with information regarding the appeals procedures under this part at the time of enrollment with a pharmacy contractor under this part and upon request thereafter.

''(6) TRANSFER OF FUNDS TO COVER COSTS OF PART B PRESCRIPTION MEDICINE CATASTROPHIC BENEFIT.—With respect to benefits described in subsection (a)(2), there shall transferred from the Federal Medicare Prescription Medicine Trust Fund to the Federal Supplementary Medical Insurance Trust Fund amounts equivalent to the elimination of cost-sharing described in such subsection.

''(7) PERMITTING APPLICATION UNDER PART B OF NEGOTIATED PRICES.—For purposes of making payment under part B for medicines that would be covered outpatient prescription medicines but for the exclusion under subparagraph (B) or (C) of subsection (b)(2), the Secretary may elect to apply the payment basis used for payment of covered outpatient prescription medicines under this part instead of the payment basis otherwise used under such part, if it results in a lower cost to the program.

''(8) INFLATION ADJUSTMENT.—

''(A) IN GENERAL.—With respect to expenses incurred in a year after 2005—

''(i) the deductible under paragraph (2) is equal to the deductible determined under such paragraph (or this subparagraph) for the previous year increased by the percentage increase in per capita program expenditures (as estimated in advance for the year involved under subparagraph (B)); and

''(ii) the stop-loss limit under paragraph (3) is equal to the stop-loss limit determined under such paragraph (or this subparagraph) for the previous year increased by such percentage increase.

The Secretary shall adjust such percentage increase in subsequent years to take into account misestimations made of the per capita program expenditures under clauses (i) and (ii) in previous years. Any increase under this subparagraph that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''(B) ESTIMATION OF INCREASE IN PER CAPITA PROGRAM EXPENDITURES.—The Secretary shall before the beginning of each year (beginning with 2006) estimate the percentage increase in average per capita aggregate expenditures from the Federal Medicare Prescription Medicine Trust Fund for the year involved compared to the previous year.

''(C) RECONCILIATION.—The Secretary shall also compute (beginning with 2007) the actual percentage increase in such aggregate expenditures in order to provide for reconciliation of deductibles, stop-loss limits, and premiums under the second sentence of subparagraph (A) and under section 1859D(d)(2).

''(d) AMOUNT OF PREMIUMS.—

''(1) MONTHLY PREMIUM RATE IN 2005.—The monthly premium rate in 2005 for prescription medicine benefits under this part is the amount specified in section 1859(1).

''(2) INFLATION ADJUSTMENT FOR SUBSEQUENT YEARS.—The monthly premium rate for a year after 2005 for prescription medicine benefits under this part is equal to the monthly premium rate for the previous year under this subsection increased by the percentage increase in per capita program expenditures (as estimated in advance for the year involved under subsection (c)(8)(B)). The Secretary shall adjust such percentage in subsequent years to take into account misestimations made of the per capita program expenditures under the previous sentence in previous years. Any increase under this paragraph that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

''ADMINISTRATION; QUALITY ASSURANCE

''SEC. 1859E. (a) RULES RELATING TO PROVISION OF BENEFITS.—

''(1) PROVISION OF BENEFITS.—

''(A) IN GENERAL.—In providing benefits under this part, the Secretary (directly or through the contracts with pharmacy contractors) shall employ mechanisms to provide benefits appropriately and efficiently, and those mechanisms may include—

''(i) the use of—

''(I) price negotiations (consistent with subsection (b));

''(II) reduced coinsurance (below 20 percent) to encourage the utilization of appropriate preferred medicines; and

''(III) methods to reduce medication errors and encourage appropriate use of medications; and

''(ii) permitting pharmacy contractors, as approved by the Secretary, to make exceptions to section 1859D(c)(3)(C) (relating to cost-sharing for non-preferred medicines) to secure best prices for enrollees so long as the payment amount under section 1859D(c)(1) does not equal zero.

''(B) CONSTRUCTION.—Nothing in this subsection shall be construed to prevent the Secretary (directly or through the contracts with pharmacy contractors) from using incentives to encourage enrollees to select generic or other cost-effective medicines, so long as—

''(i) such incentives are designed not to result in any increase in the aggregate expenditures under the Federal Medicare Prescription Medicine Trust Fund; and

''(ii) a beneficiary's coinsurance shall be no greater than 20 percent in the case of a preferred medicine (including a nonpreferred medicine treated as a preferred medicine under section 1859D(c)(5)).

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

''(A) educating prescribing providers, pharmacists, and enrollees about medical and cost benefits of preferred medicines;

''(B) requesting prescribing providers to consider a preferred medicine prior to dispensing of a nonpreferred medicine, as long as such request does not unduly delay the provision of the medicine;

''(C) using mechanisms to encourage enrollees under this part to select cost-effective medicines or less costly means of receiving or administering medicines, including the use of therapeutic interchange programs, disease management programs, and notification to the beneficiary that a more affordable generic medicine equivalent was not selected by the prescribing provider and a statement of the lost cost savings to the beneficiary;

''(D) using price negotiations to achieve reduced prices on covered outpatient prescription medicines, including new medicines, medicines for which there are few therapeutic alternatives, and medicines of particular clinical importance to individuals enrolled under this part; and

''(E) utilizing information on medicine prices of OECD countries and of other payors in the United States in the negotiation of prices under this part.

''(b) PRICE NEGOTIATIONS PROCESS.—

''(1) REQUIREMENTS WITH RESPECT TO PREFERRED MEDICINES.—Negotiations of contracts with manufacturers with respect to covered outpatient prescription medicines under this part shall be conducted in a manner so that—

''(A) there is at least a contract for a medicine within each therapeutic class (as defined by the Secretary in consultation with such Medicare Prescription Medicine Advisory Committee);

''(B) if there is more than 1 medicine available in a therapeutic class, there are contracts for at least 2 medicines within such class unless determined clinically inappropriate in accordance with standards established by the Secretary; and

''(C) if there are more than 2 medicines available in a therapeutic class, there is a contract for at least 2 medicines within such class and a contract for generic medicine substitute if available unless determined clinically inappropriate in accordance with standards established by the Secretary.

''(2) ESTABLISHMENT OF THERAPEUTIC CLASSES.—The Secretary, in consultation with the Medicare Prescription Medicine Advisory Committee (established under section 1859H), shall establish for purposes of this part therapeutic classes and assign to such classes covered outpatient prescription medicines.

''(3) DISCLOSURE CONCERNING PREFERRED MEDICINES.—The Secretary shall provide, through pharmacy contractors or otherwise, for—

''(A) disclosure to current and prospective enrollees and to participating providers and pharmacies in each service area a list of the preferred medicines and differences in applicable cost-sharing between such medicines and nonpreferred medicines; and

''(B) advance disclosure to current enrollees and to participating providers and pharmacies in each service area of changes to any such list of preferred medicines and differences in applicable cost-sharing.

''(4) NO REVIEW.—The Secretary's establishment of therapeutic classes and the assignment of medicines to such classes and the Secretary's determination of what is a breakthrough medicine are not subject to administrative or judicial review.

''(c) CONFIDENTIALITY.—The Secretary shall ensure that the confidentiality of individually identifiable health information relating to the provision of benefits under this part is protected, consistent with the standards for the privacy of such information promulgated by the Secretary under the Health Insurance Portability and Accountability Act of 1996, or any subsequent comprehensive

and more protective set of confidentiality standards enacted into law or promulgated by the Secretary. Nothing in this subsection shall be construed as preventing the coordination of data with a State prescription medicine program so long as such program has in place confidentiality standards that are equal to or exceed the standards used by the Secretary.

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

''FEDERAL MEDICARE PRESCRIPTION MEDICINE TRUST FUND

''SEC. 1859F. (a) ESTABLISHMENT.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Medicare Prescription Medicine Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part.

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

''COMPENSATION FOR EMPLOYERS COVERING RETIREE MEDICINE COSTS

''SEC. 1859G. (a) IN GENERAL.—In the case of an individual who is eligible to be enrolled under this part and is a participant or beneficiary under a group health plan that provides outpatient prescription medicine coverage to retirees the actuarial value of which is not less than the actuarial value of the coverage provided under this part, the Secretary shall make payments to such plan subject to the provisions of this section. Such payments shall be treated as payments under this part for purposes of sections 1859F and 1859C(e)(2). In applying the previous sentence with respect to section 1859C(e)(2), the amount of the Government contribution referred to in section 1844(a)(1)(A) is deemed to be equal to the aggregate amount of the payments made under this section.

''(b) REQUIREMENTS.—To receive payment under this section, a group health plan shall comply with the following requirements:

''(1) COMPLIANCE WITH REQUIREMENTS.—The group health plan shall comply with the requirements of this Act and other reasonable, necessary, and related requirements that are needed to administer this section, as determined by the Secretary.

''(2) ANNUAL ASSURANCES AND NOTICE BEFORE TERMINATION.—The sponsor of the plan shall—

''(A) annually attest, and provide such assurances as the Secretary may require, that the coverage offered under the group health plan meets the requirements of this section and will continue to meet such requirements for the duration of the sponsor's participation in the program under this section; and

''(B) guarantee that it will give notice to the Secretary and covered enrollees—

''(i) at least 120 days before terminating its plan, and

''(ii) immediately upon determining that the actuarial value of the prescription medicine benefit under the plan falls below the actuarial value required under subsection (a).

''(3) BENEFICIARY INFORMATION.—The sponsor of the plan shall report to the Secretary, for each calendar quarter for which it seeks a payment under this section, the names and social security numbers of all enrollees described in subsection (a) covered under such plan during such quarter and the dates (if less than the full quarter) during which each such individual was covered.

''(4) AUDITS.—The sponsor or plan seeking payment under this section shall agree to maintain, and to afford the Secretary access to, such records as the Secretary may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription medicine coverage, the accuracy of payments made, and such other matters as may be appropriate.

''(c) PAYMENT.—

''(1) IN GENERAL.—The sponsor of a group health plan that meets the requirements of subsection (b) with respect to a quarter in a calendar year shall be entitled to have payment made on a quarterly basis of the amount specified in paragraph (2) for each individual described in subsection (a) who during the quarter is covered under the plan and was not enrolled in the insurance program under this part.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—The amount of the payment for a quarter shall approximate, for each such covered individual, ⅔ of the sum of the monthly Government contribution amounts (computed under subparagraph (B)) for each of the 3 months in the quarter.

''(B) COMPUTATION OF MONTHLY GOVERNMENT CONTRIBUTION AMOUNT.—For purposes of subparagraph (A), the monthly Government contribution amount for a month in a year is equal to the amount by which—

''(i) 1/12 of the average per capita aggregate expenditures, as estimated under section 1859D(c)(8) for the year involved; exceeds

''(ii) the monthly premium rate under section 1859D(d) for the month involved.

''MEDICARE PRESCRIPTION MEDICINE ADVISORY COMMITTEE

''SEC. 1859H. (a) ESTABLISHMENT OF COMMITTEE.—There is established a Medicare Prescription Medicine Advisory Committee (in this section referred to as the 'Committee').

''(b) FUNCTIONS OF COMMITTEE.—The Committee shall advise the Secretary on policies related to—

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

''(2) the development of—

''(A) standards required of pharmacy contractors under section 1859D(c)(5) for determining if a medicine is as effective for an enrollee or has a significant adverse effect on an enrollee under this part;

''(B) standards for—

''(i) defining therapeutic classes;

''(ii) adding new therapeutic classes;

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

''(iv) identifying breakthrough medicines;

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

''(D) procedures for negotiations, and standards for entering into contracts, with manufacturers, including identifying medicines or classes of medicines where Secretarial negotiation is most likely to yield savings under this part significantly above those that which could be achieved by a pharmacy contractor; and

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

For purposes of this part, a medicine is a 'breakthrough medicine' if the Secretary, in consultation with the Committee, determines it is a new product that will make a significant and major improvement by reducing physical or mental illness, reducing mortality, or reducing disability, and that no other product is available to beneficiaries that achieves similar results for the same condition. The Committee may consider cost-effectiveness in establishing standards for defining therapeutic classes and assigning drugs to such classes under subparagraph (B).

''(c) STRUCTURE AND MEMBERSHIP OF THE COMMITTEE.—

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

''(2) MEMBERSHIP.—

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

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

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

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

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

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

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

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

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

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

''(d) TERMS OF APPOINTMENT.—Each member of the Committee shall serve for a term determined appropriate by the Secretary. The terms of service of the members initially appointed shall begin on January 1, 2004.

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

''(f) COMMITTEE PERSONNEL MATTERS.—

''(1) MEMBERS.—

''(A) COMPENSATION.—Each member of the Committee who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the Committee. All members of the Committee who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

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

''(2) STAFF.—The Committee may appoint such personnel as the Committee considers appropriate.

''(g) OPERATION OF THE COMMITTEE.—

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

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

''(h) FEDERAL ADVISORY COMMITTEE ACT.—Section 14 of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to the Committee.

''(i) TRANSFER OF PERSONNEL, RESOURCES, AND ASSETS.—For purposes of carrying out its duties, the Secretary and the Committee may provide for the transfer to the Committee of such civil service personnel in the employ of the Department of Health and Human Services (including the Centers for Medicare & Medicaid Services), and such resources and assets of the Department used in carrying out this title, as the Committee requires.

''(j) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out the purposes of this section.''.

(b) APPLICATION OF GENERAL EXCLUSIONS FROM COVERAGE.—

(1) APPLICATION TO PART D.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended in the matter preceding paragraph (1) by striking ''part A or part B'' and inserting ''part A, B, or D''.

(2) PRESCRIPTION MEDICINES NOT EXCLUDED FROM COVERAGE IF APPROPRIATELY PRESCRIBED.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)) is amended—

(A) in subparagraph (H), by striking ''and'' at the end;

(B) in subparagraph (I), by striking the semicolon at the end and inserting '', and''; and

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

''(J) in the case of prescription medicines covered under part D, which are not prescribed in accordance with such part;''.

(c) CONFORMING AMENDMENTS.—(1) Part C of title XVIII is amended—

(A) in section 1851(a)(2)(B) (42 U.S.C. 1395w–21(a)(2)(B)), by striking ''1859(b)(3)'' and inserting ''1858(b)(3)'';

(B) in section 1851(a)(2)(C) (42 U.S.C. 1395w–21(a)(2)(C)), by striking ''1859(b)(2)'' and inserting ''1858(b)(2)'';

(C) in section 1852(a)(1) (42 U.S.C. 1395w–22(a)(1)), by striking ''1859(b)(3)'' and inserting ''1858(b)(3)'';

(D) in section 1852(a)(3)(B)(ii) (42 U.S.C. 1395w–22(a)(3)(B)(ii)), by striking ''1859(b)(2)(B)'' and inserting ''1858(b)(2)(B)'';

(E) in section 1853(a)(1)(A) (42 U.S.C. 1395w–23(a)(1)(A)), by striking ''1859(e)(4)'' and inserting ''1858(e)(4)''; and

(F) in section 1853(a)(3)(D) (42 U.S.C. 1395w–23(a)(3)(D)), by striking ''1859(e)(4)'' and inserting ''1858(e)(4)''.

(2) Section 1171(a)(5)(D) (42 U.S.C. 1320d(a)(5)(D)) is amended by striking ''or (C)'' and inserting ''(C), or (D)''.

SEC. 102. PROVISION OF MEDICARE OUTPATIENT PRESCRIPTION MEDICINE COVERAGE UNDER THE MEDICARE+CHOICE PROGRAM.

(a) REQUIRING AVAILABILITY OF AN ACTUARIALLY EQUIVALENT PRESCRIPTION MEDICINE BENEFIT.—Section 1851 (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

''(j) AVAILABILITY OF PRESCRIPTION MEDICINE BENEFITS.—

''(1) IN GENERAL.—Notwithstanding any other provision of this part, each Medicare+Choice organization that makes available a Medicare+Choice plan described in section 1851(a)(2)(A) shall make available such a plan that offers coverage of covered outpatient prescription medicines that is at least actuarially equivalent to the benefits provided under part D. Information respecting such benefits shall be made available in the same manner as information on other benefits provided under this part is made available. Nothing in this paragraph shall be construed as requiring the offering of such coverage separate from coverage that includes benefits under parts A and B.

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

(b) APPLICATION OF QUALITY STANDARDS.—Section 1852(e)(2)(A) (42 U.S.C. 1395w–22(e)(2)(A)) is amended—

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

(2) by striking the period at the end of clause (xii) and inserting '', and''; and

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

''(xiii) comply with the standards, and apply the programs, under section 1859B(b) for covered outpatient prescription medicines under the plan.''.

(c) PAYMENT SEPARATE FROM PAYMENT FOR PART A AND B BENEFITS.—Section 1853 (42 U.S.C. 1395w–23) is amended—

(1) in subsection (a)(1)(A), by striking ''and (i)'' and inserting ''(i), and (j)''; and

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

''(j) PAYMENT FOR PRESCRIPTION MEDICINE COVERAGE OPTION.—

''(1) IN GENERAL.—In the case of a Medicare+Choice plan that provides prescription medicine benefits described in section 1851(j)(1), the amount of payment otherwise made to the Medicare+Choice organization offering the plan shall be increased by the amount described in paragraph (2). Such payments shall be made in the same manner and time as the amount otherwise paid, but such amount shall be payable from the Federal Medicare Prescription Medicine Trust Fund.

''(2) AMOUNT.—The amount described in this paragraph is the monthly Government contribution amount computed under section 1859G(c)(2)(B), but subject to adjustment under paragraph (3). Such amount shall be uniform geographically and shall not vary based on the Medicare+Choice payment area involved.

''(3) RISK ADJUSTMENT.—The Secretary shall establish a methodology for the adjustment of the payment amount under this subsection in a manner that takes into account the relative risks for use of outpatient prescription medicines by Medicare+Choice enrollees. Such methodology shall be designed in a manner so that the total payments under this title (including part D) are not changed as a result of the application of such methodology.''.

(d) SEPARATE APPLICATION OF ADJUSTED COMMUNITY RATE (ACR).—Section 1854 (42 U.S.C. 1395w–24) is amended by adding at the end the following:

''(i) APPLICATION TO PRESCRIPTION MEDICINE COVERAGE.—The Secretary shall apply the previous provisions of this section (including the computation of the adjusted community rate) separately with respect to prescription medicine benefits described in section 1851(j)(1).''.

(f) CONFORMING AMENDMENTS.—

(1) Section 1851 (42 U.S.C. 1395w–21) is amended—

(A) in subsection (a)(1)(A), by striking ''parts A and B'' and inserting ''parts A, B, and D''; and

(B) in subsection (i) by inserting ''(and, if applicable, part D)'' after ''parts A and B''.

(2) Section 1852(a)(1)(A) (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting ''(and under part D to individuals also enrolled under such part)'' after ''parts A and B''.

(3) Section 1852(d)(1) (42 U.S.C. 1395w–22(d)(1)) is amended—

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

(B) by striking the period at the end of subparagraph (E) and inserting ''; and''; and

(C) by adding at the end the following:

''(F) the plan for part D benefits guarantees coverage of any specifically named prescription medicine for an enrollee to the extent that it would be required to be covered under part D.

In carrying out subparagraph (F), a Medicare+Choice organization has the same authority to enter into contracts with respect to coverage of preferred medicines as the Secretary has under part D, but subject to an independent contractor appeal or other appeal process that would be applicable to determinations by such a pharmacy contractor consistent with section 1859D(c)(5).''.

(e) LIMITATION ON COST-SHARING.—Section 1854(e) (42 U.S.C. 1395w–24(e)) is amended by adding at the end the following new paragraph:

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

SEC. 103. MEDIGAP REVISIONS.

(a) REQUIRED COVERAGE OF COVERED OUTPATIENT PRESCRIPTION MEDICINES.—Section 1882(p)(2)(B) (42 U.S.C. 1395ss(p)(2)(B)) is amended by inserting before ''and'' at the end the following: ''including a requirement that an appropriate number of policies provide coverage of medicines which complements but does not duplicate the medicine benefits that beneficiaries are otherwise eligible for benefits under part D of this title (with the Secretary and the National Association of Insurance Commissioners determining the appropriate level of medicine benefits that each benefit package must provide and ensuring that policies providing such coverage are affordable for beneficiaries;''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2005.

(c) TRANSITION PROVISIONS.—

(1) IN GENERAL.—If the Secretary of Health and Human Services identifies a State as requiring a change to its statutes or regulations to conform its regulatory program to the amendments made by this section, the State regulatory program shall not be considered to be out of compliance with the requirements of section 1882 of the Social Security Act due solely to failure to make such change until the date specified in paragraph (4).

(2) NAIC STANDARDS.—If, within 9 months after the date of enactment of this Act, the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') modifies its NAIC Model Regulation relating to section 1882 of the Social Security Act (referred to in such section as the 1991 NAIC Model Regulation, as subsequently modified) to conform to the amendments made by this section, such revised regulation

incorporating the modifications shall be considered to be the applicable NAIC model regulation (including the revised NAIC model regulation and the 1991 NAIC Model Regulation) for the purposes of such section.

(3) SECRETARY STANDARDS.—If the NAIC does not make the modifications described in paragraph (2) within the period specified in such paragraph, the Secretary of Health and Human Services shall make the modifications described in such paragraph and such revised regulation incorporating the modifications shall be considered to be the appropriate regulation for the purposes of such section.

(4) DATE SPECIFIED.—

(A) IN GENERAL.—Subject to subparagraph (B), the date specified in this paragraph for a State is the earlier of—

(i) the date the State changes its statutes or regulations to conform its regulatory program to the changes made by this section; or

(ii) 1 year after the date the NAIC or the Secretary first makes the modifications under paragraph (2) or (3), respectively.

(B) ADDITIONAL LEGISLATIVE ACTION REQUIRED.—In the case of a State which the Secretary identifies as—

(i) requiring State legislation (other than legislation appropriating funds) to conform its regulatory program to the changes made in this section; but

(ii) having a legislature which is not scheduled to meet in 2003 in a legislative session in which such legislation may be considered;

the date specified in this paragraph is the first day of the first calendar quarter beginning after the close of the first legislative session of the State legislature that begins on or after January 1, 2003. For purposes of the previous sentence, in the case of a State that has a 2-year legislative session, each year of such session shall be deemed to be a separate regular session of the State legislature.

SEC. 104. TRANSITIONAL ASSISTANCE FOR LOW INCOME BENEFICIARIES.

(a) QMB COVERAGE OF PREMIUMS AND COST-SHARING.—Section 1905(p)(3) (42 U.S.C. 1396d(p)(3)) is amended—

(1) in subparagraph (A)—

(A) by striking ''and'' at the end of clause (i),

(B) by adding ''and'' at the end of clause (ii), and

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

''(iii) premiums under section 1859D(d).'';

(2) in subparagraph (B), by inserting ''and section 1859D(c)(3)(B) and 1859D(c)(3)(C)(i)'' after ''1813''; and

(3) in subparagraph (C), by striking ''and section 1833(b)'' and inserting '', section 1833(b), and section 1859D(c)(2)''.

(b) EXPANDED SLMB ELIGIBILITY.—Section 1902(a)(10)(E) (42 U.S.C. 1396a(a)(10)(E)) is amended—

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

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

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

''(v)(I) for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(iii) and medicare cost-sharing described in section 1905(p)(3)(B) and section 1905(p)(3)(C) but only insofar as it relates to benefits provided under part D of title XVIII, subject to section 1905(p)(4), for individuals (other than qualified medicare beneficiaries) who are enrolled under part D of title XVIII and are described in section 1905(p)(1)(B) or would be so described but for the fact that their income exceeds 100 percent, but is less than 150 percent, of the official poverty line (referred to in such section) for a family of the size involved;

''(II) subject to section 1905(p)(4), for individuals (other than qualified medicare beneficiaries and individuals described in subclause (I)) who are enrolled under part D of title XVIII and would be described in section 1905(p)(1)(B) but for the fact that their income exceeds 150 percent, but is less than 175 percent, of the official poverty line (referred to in such section) for a family of the size involved, for making medical assistance available for medicare cost-sharing described in section 1905(p)(3)(A)(iii) and medicare cost-sharing described in section 1905(p)(3)(B) and section 1905(p)(3)(C) but only insofar as it relates to benefits provided under part D of title XVIII, and the assistance for medicare cost-sharing described in section 1905(p)(3)(A)(iii) is reduced (on a sliding scale based on income) from 100 percent to 0 percent as the income increases from 150 percent to 175 percent of such poverty line;''.

(c) FEDERAL FINANCING.—The third sentence of section 1905(b) (42 U.S.C. 1396d(b)) is amended by inserting before the period at the end the following: ''and with respect to amounts expended that are attributable to section 1902(a)(10)(E)(v) (other than for individuals described in section 1905(p)(1)(B))''.

(d) TREATMENT OF TERRITORIES.—

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

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

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

''(5)(A) In the case of a State, other than the 50 States and the District of Columbia—

''(i) the provisions of paragraph (3) insofar as they relate to section 1859D and the provisions of section 1902(a)(10)(E)(v) shall not apply to residents of such State; and

''(ii) if the State establishes a plan described in subparagraph (B) (for providing medical assistance with respect to the provision of prescription medicines to medicare beneficiaries), 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 subparagraph (C).

''(B) The plan described in this subparagraph is a plan that—

''(i) provides medical assistance with respect to the provision of covered outpatient medicines (as defined in section 1859D(b)) to low-income medicare beneficiaries; and

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

''(C)(i) The amount specified in this subparagraph for a State for a year is equal to the product of—

''(I) the aggregate amount specified in clause (ii); 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.

''(ii) The aggregate amount specified in this clause for—

''(I) 2005, is equal to $25,000,000; or

''(II) a subsequent year, is equal to the aggregate amount specified in this clause for the previous year increased by annual percentage increase specified in section 1859D(c)(8)(B) for the year involved.

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

(2) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting ''and section 1905(p)(5)(A)(ii)'' after ''Subject to subsection (g)''.

(e) APPLICATION OF COST-SHARING.—Section 1902(n)(2) (42 U.S.C. 1396a(n)(2)) is amended by adding at the end the following: ''The previous sentence shall not apply to medicare cost-sharing relating to benefits under part D of title XVIII.''.

(f) EFFECTIVE DATE.—The amendments made by this section apply to medical assistance for premiums and cost-sharing incurred on or after January 1, 2005, with regard to whether regulations to implement such amendments are promulgated by such date.

SEC. 105. EXPANSION OF MEMBERSHIP AND DUTIES OF MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXPANSION OF MEMBERSHIP.—

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

(A) in paragraph (1), by striking ''17'' and inserting ''19''; and

(B) in paragraph (2)(B), by inserting ''experts in the area of pharmacology and prescription medicine benefit programs,'' after ''other health professionals,''.

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

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

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

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

(B) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2003.

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

''(D) PRESCRIPTION MEDICINE BENEFIT PROGRAM.—Specifically, the Commission shall review, with respect to the prescription medicine benefit program under part D, the following:

''(i) The methodologies used for the management of costs and utilization of prescription medicines.

''(ii) The prices negotiated and paid, including trends in such prices and applicable discounts and comparisons with prices under section 1859E(a)(2)(E).

''(iii) The relationship of pharmacy acquisition costs to the prices so negotiated and paid.

''(iv) The methodologies used to ensure access to covered outpatient prescription medicines and to ensure quality in the appropriate dispensing and utilization of such medicines.

''(v) The impact of the program on promoting the development of breakthrough medicines.''.

TITLE II—MEDICARE+CHOICE REVITALIZATION AND MEDICARE+CHOICE COMPETITION PROGRAM

SEC. 201. MEDICARE+CHOICE IMPROVEMENTS.

(a) EQUALIZING PAYMENTS BETWEEN FEE-FOR-SERVICE AND MEDICARE+CHOICE.—

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

''(D) BASED ON 100 PERCENT OF FEE-FOR-SERVICE COSTS.—

''(i) IN GENERAL.—For 2003 and 2004, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for the Medicare+Choice payment area for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare+Choice plan under this part for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

''(ii) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under clause (i) for a year, such cost shall be adjusted to include the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.''.

(2) CONFORMING AMENDMENT.—Such section is further amended, in the matter before subparagraph (A), by striking ''or (C)'' and inserting ''(C), or (D)''.

(b) REVISION OF BLEND.—

(1) REVISION OF NATIONAL AVERAGE USED IN CALCULATION OF BLEND.—Section 1853(c)(4)(B)(i)(II) (42 U.S.C. 1395w–23(c)(4)(B)(i)(II)) is amended by inserting ''who (with respect to determinations for 2003 and for 2004) are enrolled in a Medicare+Choice plan'' after ''the average number of medicare beneficiaries''.

(2) CHANGE IN BUDGET NEUTRALITY.—Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(A) in paragraph (1)(A), by inserting ''(for a year before 2003)'' after ''multiplied''; and

(B) in paragraph (5), by inserting ''(before 2003)'' after ''for each year''.

(c) REVISION IN MINIMUM PERCENTAGE INCREASE FOR 2003 AND 2004.—Section 1853(c)(1)(C) (42 U.S.C. 1395w–23(c)(1)(C)) is amended by striking clause (iv) and inserting the following:

''(iv) For 2002, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2001.

''(v) For 2003 and 2004, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(iv) For 2005 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.''.

(d) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICARE+CHOICE PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w–23(c)(3)) is amended—

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

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

''(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2003), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to include in the rate the Secretary's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Defense or the Department of Veterans Affairs.''.

(e) ANNOUNCEMENT OF REVISED MEDICARE+CHOICE PAYMENT RATES.—Within 2 weeks after the date of the enactment of this Act, the Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties) Medicare+Choice capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2003, revised in accordance with the provisions of this section.

(f) MEDPAC STUDY OF AAPCC.—

(1) STUDY.—The Medicare Payment Advisory Commission shall conduct a study that assesses the method used for determining the adjusted average per capita cost (AAPCC) under section 1876(a)(4) of the Social Security Act (42 U.S.C. 1395mm(a)(4)). Such study shall examine—

(A) the bases for variation in such costs between different areas, including differences in input prices, utilization, and practice patterns;

(B) the appropriate geographic area for payment under the Medicare+Choice program under part C of title XVIII of such Act; and

(C) the accuracy of risk adjustment methods in reflecting differences in costs of providing care to different groups of beneficiaries served under such program.

(2) REPORT.—Not later than 9 months after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study conducted under paragraph (1). Such report shall include recommendations regarding changes in the methods for computing the adjusted average per capita cost among different areas.

(g) APPLYING LIMITATIONS ON BALANCE BILLING TO MEDICARE MSAs.—Section 1852(k)(1) (42 U.S.C. 1395w–22(k)(1)) is amended by inserting ''or with an organization offering a MSA plan'' after ''section 1851(a)(2)(A)''.

(h) REPORT ON IMPACT OF INCREASED FINANCIAL ASSISTANCE TO MEDICARE+CHOICE PLANS.—Not later than July 1, 2003, the Secretary shall submit to Congress a report that describes the impact of additional financing provided under this Act and other Acts (including the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and BIPA) on the availability of Medicare+Choice plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

SEC. 202. MAKING PERMANENT CHANGE IN MEDICARE+CHOICE REPORTING DEADLINES AND ANNUAL, COORDINATED ELECTION PERIOD.

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

(b) DELAY IN ANNUAL, COORDINATED ELECTION PERIOD.—Section 1851(e)(3)(B) (42 U.S.C. 1395w–21(e)(3)(B)), as amended by section 532(c)(1)(A) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended by striking ''and after 2005, the month of November before such year and with respect to 2003, 2004, and 2005'' and inserting '', the month of November before such year and with respect to 2003 and any subsequent year''.

(c) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—Section 1853(b)(1) (42 U.S.C. 1395w–23(b)(1)), as amended by section 532(d)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended by striking ''and after 2005 not later than March 1 before the calendar year concerned and for 2004 and 2005'' and inserting ''not later than March 1 before the calendar year concerned and for 2004 and each subsequent year''.

(d) REQUIRING PROVISION OF AVAILABLE INFORMATION COMPARING PLAN OPTIONS.—The first sentence of section 1851(d)(2)(A)(ii) (42 U.S.C. 1395w–21(d)(2)(A)(ii)) is amended by inserting before the period the following: ''to the extent such information is available at the time of preparation of materials for the mailing''.

SEC. 203. SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.

(a) TREATMENT AS COORDINATED CARE PLAN.—Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is amended by adding at the end the following new sentence: ''Specialized Medicare+Choice plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.''.

(b) SPECIALIZED MEDICARE+CHOICE PLAN FOR SPECIAL NEEDS BENEFICIARIES DEFINED.—Section 1859(b) (42 U.S.C. 1395w–29(b)) is amended by adding at the end the following new paragraph:

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

''(A) IN GENERAL.—The term 'specialized Medicare+Choice plan for special needs beneficiaries' means a Medicare+Choice plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

''(B) SPECIAL NEEDS BENEFICIARY.—The term 'special needs beneficiary' means a Medicare+Choice eligible individual who—

''(i) is institutionalized (as defined by the Secretary);

''(ii) is entitled to medical assistance under a State plan under title XIX; or

''(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized Medicare+Choice plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.''.

(c) RESTRICTION ON ENROLLMENT PERMITTED.—Section 1859 (42 U.S.C. 1395w–29) is amended by adding at the end the following new subsection:

''(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2007, the plan may restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs beneficiaries.''.

(d) REPORT TO CONGRESS.—Not later than December 31, 2005, the Secretary shall submit to Congress a report that assesses the impact of specialized Medicare+Choice plans for special needs beneficiaries on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the medicare program as a result of amendments made by subsections (a), (b), and (c).

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a), (b), and (c) shall take effect upon the date of the enactment of this Act.

(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.—No later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall issue final regulations to establish requirements for special needs beneficiaries under section 1859(b)(4)(B)(iii) of the Social Security Act, as added by subsection (b).

SEC. 204. EXTENSION OF REASONABLE COST AND SHMO CONTRACTS.

(a) REASONABLE COST CONTRACTS.—

(1) IN GENERAL.—Section 1876(h)(5)(C) (42 U.S.C. 1395mm(h)(5)(C)) is amended—

(A) by inserting ''(i)'' after ''(C)'';

(B) by inserting before the period the following: '', except (subject to clause (ii)) in the case of a contract for an area which is not covered in the service area of 1 or more coordinated care Medicare+Choice plans under part C''; and

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

''(ii) In the case in which—

''(I) a reasonable cost reimbursement contract includes an area in its service area as of a date that is after December 31, 2003;

''(II) such area is no longer included in such service area after such date by reason of the operation of clause (i) because of the inclusion of such area within the service area of a Medicare+Choice plan; and

''(III) all Medicare+Choice plans subsequently terminate coverage in such area;

such reasonable cost reimbursement contract may be extended and renewed to cover such area (so long as it is not included in the service area of any Medicare+Choice plan).''.

(2) STUDY.—The Secretary shall conduct a study of an appropriate transition for plans offered under reasonable cost contracts under section 1876 of the Social Security Act on and after January 1, 2005. Such a transition may take into account whether there are one or more coordinated care Medicare+Choice plans being offered in the areas involved. Not later than February 1, 2004, the Secretary shall submit to Congress a report on such study and shall include recommendations regarding any changes in the amendment made by paragraph (1) as the Secretary determines to be appropriate.

(b) EXTENSION OF SOCIAL HEALTH MAINTENANCE ORGANIZATION (SHMO) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—Section 4018(b)(1) of the Omnibus Budget Reconciliation Act of 1987 is amended by striking ''the date that is 30 months after the date that the Secretary submits to Congress the report described in section 4014(c) of the Balanced Budget Act of 1997'' and inserting ''December 31, 2004''.

(2) SHMOS OFFERING MEDICARE+CHOICE PLANS.—Nothing in such section 4018 shall be construed as preventing a social health maintenance organization from offering a Medicare+Choice plan under part C of title XVIII of the Social Security Act.

SEC. 205. CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT.

(a) IN GENERAL.—Section 1851(e)(2) (42 U.S.C. 1395w–21(e)(2)) is amended to read as follows:

''(2) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT.—Subject to paragraph (5), a Medicare+Choice eligible individual may change the election under subsection (a)(1) at any time.''.

(b) CONFORMING AMENDMENTS.—

(1) MEDICARE+CHOICE.—Section 1851(e) (42 U.S.C. 1395w–21(e)) is amended—

(A) in paragraph (4)—

(i) by striking ''Effective as of January 1, 2002, an'' and inserting ''An'';

(ii) by striking ''other than during an annual, coordinated election period'';

(iii) by inserting ''in a special election period for such purpose'' after ''make a new election under this section''; and

(iv) by striking the second sentence; and

(B) in paragraphs (5)(B) and (6)(A), by striking ''the first sentence of''.

(2) PERMITTING ENROLLMENT IN MEDIGAP WHEN M+C PLANS REDUCE BENEFITS OR WHEN PROVIDER LEAVES A M+C PLAN.—

(A) IN GENERAL.—Clause (ii) of section 1882(s)(3)(B) (42 U.S.C. 1395ss(s)(3)(B)) is amended—

(i) by inserting ''(I)'' after ''(ii)'';

(ii) by striking ''under the first sentence of'' each place it appears and inserting ''during a special election period provided for under'';

(iii) by inserting ''the circumstances described in subclause (II) are present or'' before ''there are circumstances''; and

(iv) by adding at the end the following new subclause:

''(II) The circumstances described in this subclause are, with respect to an individual enrolled in a Medicare+Choice plan, a reduction in benefits (including an increase in cost-sharing) offered under the Medicare+Choice plan from the previous year or a provider of services or physician who serves the individual no longer participating in the plan (other than because of good cause relating to quality of care under the plan).''.

(B) CONFORMING AMENDMENT.—Clause (iii) of such section is amended—

(i) by inserting ''the circumstances described in clause (ii)(II) are met or'' after ''policy described in subsection (t), and''; and

(ii) by striking ''under the first sentence of'' and inserting ''during a special election period provided for under''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2003, and shall apply to reductions in benefits and changes in provider participation occurring on or after such date.

SEC. 206. LIMITATION ON MEDICARE+CHOICE COST-SHARING.

(a) IN GENERAL.—Section 1852(a) (42 U.S.C. 1395w–22(a)) is amended by adding at the end the following new paragraph:

''(6) LIMITATION ON COST-SHARING.—

''(A) IN GENERAL.—Subject to subparagraph (B), in no case shall the cost-sharing with respect to an item or service under a Medicare+Choice plan exceed the cost-sharing otherwise applicable under parts A and B to an individual who is not enrolled in a Medicare+Choice plan under this part.

''(B) PERMITTING FLAT COPAYMENTS.—Subparagraph (A) shall not be construed as preventing the application of flat dollar copayment amounts (in place of a percentage coinsurance), such as a fixed copayment for a doctor's visit, so long as such amounts are reasonable and appropriate and do not adversely affect access to items and services (as determined by the Secretary).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply as of January 1, 2003.

SEC. 207. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as previously amended, is amended by striking ''December 31, 2004, but only with respect to'' and all that follows and inserting ''December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated and so long as the total number of individuals participating in the project does not exceed the number of such individuals participating as of January 1, 1996.''.

TITLE III—RURAL HEALTH CARE IMPROVEMENTS

SEC. 301. REFERENCE TO FULL MARKET BASKET INCREASE FOR SOLE COMMUNITY HOSPITALS.

For provision eliminating any reduction from full market basket in the update for inpatient hospital services for sole community hospitals, see section 401.

SEC. 302. ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

(a) BLENDING OF PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by adding at the end the following new clause:

''(xiv)(I) In the case of discharges in a fiscal year beginning on or after October 1, 2002, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the old blend proportion (specified under subclause (III)) of the disproportionate share adjustment percentage otherwise determined under the respective clause and 100 percent minus such old blend proportion of the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

''(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 10 percent for a hospital that is not classified as a rural referral center under subparagraph (C).

''(III) For purposes of subclause (I), the old blend proportion for fiscal year 2003 is 66⅔ percent, for fiscal year 2004 is 33⅓ percent subsequent year, and for each fiscal year beginning with 2005 is 0 percent.''.

(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in each of subclauses (II), (III), (IV), (V), and (VI) of clause (iv), by inserting ''subject to clause (xiv) and'' before ''for discharges occurring'';

(B) in clause (viii), by striking ''The formula'' and inserting ''Subject to clause (xiv), the formula''; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking ''For purposes'' and inserting ''Subject to clause (xiv), for purposes''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to discharges occurring on or after October 1, 2002.

SEC. 303. 2-YEAR PHASED-IN INCREASE IN THE STANDARDIZED AMOUNT IN RURAL AND SMALL URBAN AREAS TO ACHIEVE A SINGLE, UNIFORM STANDARDIZED AMOUNT.

Section 1886(d)(3)(A)(iv) (42 U.S.C. 1395ww(d)(3)(A)(iv)) is amended—

(1) by striking ''(iv) For discharges'' and inserting ''(iv)(I) Subject to the succeeding provisions of this clause, for discharges''; and

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

''(II) For discharges occurring during fiscal year 2003, the average standardized amount for hospitals located other than in a large urban area shall be increased by ½ of the difference between the average standardized amount determined under subclause (I) for hospitals located in large urban areas for such fiscal year and such amount determined (without regard to this subclause) for other hospitals for such fiscal year.

''(III) For discharges occurring in a fiscal year beginning with fiscal year 2004, the Secretary shall compute an average standardized amount for hospitals located in any area within the United States and within each region equal to the average standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2005, for hospitals located in any area) increased by the applicable percentage increase under subsection (b)(3)(B)(i).''.

SEC. 304. 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 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, 2003, 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. 305. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) REINSTATEMENT OF PERIODIC INTERIM PAYMENT (PIP).—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

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

(2) by adding ''and'' at the end of subparagraph (D); and

(3) by inserting after subparagraph (D) the following new subparagraph:

''(E) inpatient critical access hospital services;''.

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

(c) FLEXIBILITY IN BED LIMITATION FOR HOSPITALS WITH STRONG SEASONAL CENSUS FLUCTUATIONS.—Section 1820 (42 U.S.C. 1395i–4) is amended—

(1) in subsection (c)(2)(B)(iii), by inserting ''subject to paragraph (3)'' after ''(iii) provides'';

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

''(3) INCREASE IN MAXIMUM NUMBER OF BEDS FOR HOSPITALS WITH STRONG SEASONAL CENSUS FLUCTUATIONS.—

''(A) IN GENERAL.—In the case of a hospital that demonstrates that it meets the standards established under subparagraph (B), the bed limitations otherwise applicable under paragraph (2)(B)(iii) and subsection (f) shall be increased by 5 beds.

''(B) STANDARDS.—The Secretary shall specify standards for determining whether a critical access hospital has sufficiently strong seasonal variations in patient admissions to justify the increase in bed limitation provided under subparagraph (A).''; and

(3) in subsection (f), by adding at the end the following new sentence: ''The limitations in numbers of beds under the first sentence are subject to adjustment under subsection (c)(3).''.

(d) 5-YEAR EXTENSION OF THE AUTHORIZATION FOR APPROPRIATIONS FOR GRANT PROGRAM.—Section 1820(j) (42 U.S.C. 1395i–4(j)) is amended by striking ''through 2002'' and inserting ''through 2007''.

(e) PROHIBITION OF RETROACTIVE RECOUPMENT.—The Secretary shall not recoup (or otherwise seek to recover) overpayments made for outpatient critical access hospital services under part B of title XVIII of the Social Security Act, for services furnished in cost reporting periods that began before October 1, 2002, insofar as such overpayments are attributable to payment being based on 80 percent of reasonable costs (instead of 100 percent of reasonable costs minus 20 percent of charges).

(f) EFFECTIVE DATES.—

(1) REINSTATEMENT OF PIP.—The amendments made by subsection (a) shall apply to payments made on or after January 1, 2003.

(2) PHYSICIAN PAYMENT ADJUSTMENT CONDITION.—The amendment made by subsection (b) 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).

(3) FLEXIBILITY IN BED LIMITATION.—The amendments made by subsection (c) shall apply to designations made on or after January 1, 2003, but shall not apply to critical access hospitals that were designated as of such date.

SEC. 306. EXTENSION OF TEMPORARY INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—Section 508(a) of BIPA (114 Stat. 2763A–533) is amended—

(1) by striking ''24-MONTH INCREASE BEGINNING APRIL 1, 2001'' and inserting ''IN GENERAL''; and

(2) by striking ''April 1, 2003'' and inserting ''January 1, 2005''.

(b) CONFORMING AMENDMENT.—Section 547(c)(2) of BIPA (114 Stat. 2763A–553) is amended by striking ''the period beginning on April 1, 2001, and ending on September 30, 2002,'' and inserting ''a period under such section''.

SEC. 307. REFERENCE TO 10 PERCENT INCREASE IN PAYMENT FOR HOSPICE CARE FURNISHED IN A FRONTIER AREA AND RURAL HOSPICE DEMONSTRATION PROJECT.

For—

(1) provision of 10 percent increase in payment for hospice care furnished in a frontier area, see section 422; and

(2) provision of a rural hospice demonstration project, see section 423.

SEC. 308. REFERENCE TO PRIORITY FOR HOSPITALS LOCATED IN RURAL OR SMALL URBAN AREAS IN REDISTRIBUTION OF UNUSED GRADUATE MEDICAL EDUCATION RESIDENCIES.

For provision providing priority for hospitals located in rural or small urban areas in redistribution of unused graduate medical education residencies, see section 611.

SEC. 309. 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. 310. 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. 311. RELIEF FOR CERTAIN NON-TEACHING HOSPITALS.

(a) IN GENERAL.—In the case of a non-teaching hospital that meets the condition of subsection (b), for its cost reporting period beginning in each of fiscal years 2003, 2004, and 2005 the amount of payment made to the hospital under section 1886(d) of the Social Security Act for discharges occurring during such fiscal year only shall be increased as though the applicable percentage increase (otherwise applicable to discharges occurring during such fiscal year under section 1886(b)(3)(B)(i) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(i)) had been increased by 5 percentage points. The previous sentence shall be applied for each such fiscal year separately without regard to its application in a previous fiscal year and shall not affect payment for discharges for any hospital occurring during a fiscal year after fiscal year 2005.

(b) CONDITION.—A non-teaching hospital meets the condition of this paragraph if—

(1) it is located in a rural area and the amount of the aggregate payments under subsection (d) of such section for non-teaching hospitals located in rural areas in the State for their cost reporting periods beginning during fiscal year 1999 is less than the aggregate allowable operating costs of inpatient hospital services (as defined in section

1886(a)(4) of such Act) for all such hospitals in such areas in such State with respect to such cost reporting periods; or

(2) it is located in an urban area and the amount of the aggregate payments under subsection (d) of such section for non-teaching hospitals located in urban areas in the State for their cost reporting periods beginning during fiscal year 1999 is less than 103 percent of the aggregate allowable operating costs of inpatient hospital services (as defined in section 1886(a)(4) of such Act) for all such hospitals in such areas in such State with respect to such cost reporting periods.

The amounts under paragraphs (1) and (2) shall be determined by the Secretary of Health and Human Services based on data of the Medicare Payment Advisory Commission.

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

(1) NON-TEACHING HOSPITAL.—The term ''non-teaching hospital'' means, for a cost reporting period, a subsection (d) hospital (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B))) that is not receiving any additional payment under section 1886(d)(5)(B) of such Act (42 U.S.C. 1395ww(d)(5)(B)) or a payment under section 1886(h) of such Act (42 U.S.C. 1395ww(h)) for discharges occurring during the period.

(2) RURAL; URBAN.—The terms ''rural'' and ''urban'' have the meanings given such terms for purposes of section 1886(d) of the Social Security Act (42 U.S.C. 1395ww(d)).

TITLE IV—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

SEC. 401. REVISION OF ACUTE CARE HOSPITAL PAYMENT UPDATES.

Subclause (XVIII) of section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended to read as follows:

''(XVIII) for fiscal year 2003, the market basket percentage increase for sole community hospitals and such increase minus 0.25 percentage points for other hospitals, and''.

SEC. 402. FREEZE IN LEVEL OF ADJUSTMENT FOR INDIRECT COSTS OF MEDICAL EDUCATION (IME) THROUGH FISCAL YEAR 2007.

Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (VI), by inserting ''and each succeeding fiscal year through fiscal year 2007'' after ''2002''; and

(2) in subclause (VII), by striking ''2002'' and inserting ''2007''.

SEC. 403. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PPS.

(a) IMPROVING TIMELINESS OF DATA COLLECTION.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is amended by adding at the end the following new clause:

''(vii) Under the mechanism under this subparagraph, the Secretary shall provide for the addition of new diagnosis and procedure codes in April 1 of each year, but the addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-related group classification) under this subsection until the fiscal year that begins after such date.''.

(b) ELIGIBILITY STANDARD.—

(1) MINIMUM PERIOD FOR RECOGNITION OF NEW TECHNOLOGIES.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)) is amended—

(A) by inserting ''(I)'' after ''(vi)''; and

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

''(II) Under such criteria, a service or technology shall not be denied treatment as a new service or technology on the basis of the period of time in which the service or technology has been in use if such period ends before the end of the 2-to-3-year period that begins on the effective date of implementation of a code under ICD–9–CM (or a successor coding methodology) that enables the identification of a significant sample of specific discharges in which the service or technology has been used.''.

(2) ADJUSTMENT OF THRESHOLD.—Section 1886(d)(5)(K)(ii)(I) (42 U.S.C. 1395ww(d)(5)(K)(ii)(I)) is amended by inserting ''(applying a threshold specified by the Secretary that is the lesser of 50 percent of the national average standardized amount for operating costs of inpatient hospital services for all hospitals and all diagnosis-related groups or one standard deviation for the diagnosis-related group involved)'' after ''is inadequate''.

(3) CRITERION FOR SUBSTANTIAL IMPROVEMENT.—Section 1886(d)(5)(K)(vi) (42 U.S.C. 1395ww(d)(5)(K)(vi)), as amended by paragraph (1), is further amended by adding at the end the following subclause:

''(III) The Secretary shall by regulation provide for further clarification of the criteria applied to determine whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries. Under such criteria, in determining whether a new service or technology represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries, the Secretary shall deem a service or technology as meeting such requirement if the service or technology is a drug or biological that is designated under section 506 or 526 of the Federal Food, Drug, and Cosmetic Act, approved under section 314.510 or 601.41 of title 21, Code of Federal Regulations, or designated for priority review when the marketing application for such drug or biological was filed or is a medical device for which an exemption has been granted under section 520(m) of such Act, or for which priority review has been provided under section 515(d)(5) of such Act.''.

(4) PROCESS FOR PUBLIC INPUT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)), as amended by paragraph (1), is amended—

(A) in clause (i), by adding at the end the following: ''Such mechanism shall be modified to meet the requirements of clause (viii).''; and

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

''(viii) The mechanism established pursuant to clause (i) shall be adjusted to provide, before publication of a proposed rule, for public input regarding whether a new service or technology not described in the second sentence of clause (vi)(III) represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries as follows:

''(I) The Secretary shall make public and periodically update a list of all the services and technologies for which an application for additional payment under this subparagraph is pending.

''(II) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

''(III) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, medicare beneficiaries, manufacturers, and any other interested party may present comments, recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking regarding whether service or technology represents a substantial improvement.''.

(c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is further amended by adding at the end the following new clause:

''(ix) Before establishing any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology. Within such groups the Secretary shall assign an eligible new technology into a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. In such case, no add-on payment under this subparagraph shall be made with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii).''.

(d) IMPROVEMENT IN PAYMENT FOR NEW TECHNOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by inserting after ''the estimated average cost of such service or technology'' the following: ''(based on the marginal rate applied to costs under subparagraph (A))''.

(e) EFFECTIVE DATE.—

(1) IN GENERAL.—The Secretary shall implement the amendments made by this section so that they apply to classification for fiscal years beginning with fiscal year 2004.

(2) RECONSIDERATIONS OF APPLICATIONS FOR FISCAL YEAR 2003 THAT ARE DENIED.—In the case of an application for a classification of a medical service or technology as a new medical service or technology under section 1886(d)(5)(K) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(K)) that was filed for fiscal year 2003 and that is denied—

(A) the Secretary shall automatically reconsider the application as an application for fiscal year 2004 under the amendments made by this section; and

(B) the maximum time period otherwise permitted for such classification of the service or technology shall be extended by 12 months.

SEC. 404. PHASE-IN OF FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)'' and inserting ''the applicable Puerto Rico percentage (specified in subparagraph (E))''; and

(B) in clause (ii), by striking ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)'' and inserting ''the applicable Federal percentage (specified in subparagraph (E))''; and

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

''(E) For purposes of subparagraph (A), for discharges occurring—

''(i) between October 1, 1987, and September 30, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

''(ii) on or after October 1, 1997, and before October 1, 2003, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

''(iii) during fiscal year 2004, the applicable Puerto Rico percentage is 45 percent and the applicable Federal percentage is 55 percent;

''(iv) during fiscal year 2005, the applicable Puerto Rico percentage is 40 percent and the applicable Federal percentage is 60 percent;

''(v) during fiscal year 2006, the applicable Puerto Rico percentage is 35 percent and the applicable Federal percentage is 65 percent;

''(vi) during fiscal year 2007, the applicable Puerto Rico percentage is 30 percent and the

applicable Federal percentage is 70 percent; and

''(vii) on or after October 1, 2007, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.''.

SEC. 405. REFERENCE TO PROVISION RELATING TO ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

For provision enhancing disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds, see section 302.

SEC. 406. REFERENCE TO PROVISION RELATING TO 2-YEAR PHASED-IN INCREASE IN THE STANDARDIZED AMOUNT IN RURAL AND SMALL URBAN AREAS TO ACHIEVE A SINGLE, UNIFORM STANDARDIZED AMOUNT.

For provision phasing in over a 2-year period an increase in the standardized amount for rural and small urban areas to achieve a single, uniform, standardized amount, see section 303.

SEC. 407. REFERENCE TO PROVISION FOR MORE FREQUENT UPDATES IN THE WEIGHTS USED IN HOSPITAL MARKET BASKET.

For provision providing for more frequent updates in the weights used in hospital market basket, see section 304.

SEC. 408. REFERENCE TO PROVISION MAKING IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

For provision providing making improvements to critical access hospital program, see section 305.

Subtitle B—Skilled Nursing Facility Services

SEC. 411. PAYMENT FOR COVERED SKILLED NURSING FACILITY SERVICES.

(a) 5-YEAR EXTENSION OF TEMPORARY INCREASE IN NURSING COMPONENT OF PPS FEDERAL RATE.—Section 312(a) of BIPA is amended by striking '', and before October 1, 2002'' and inserting ''and before October 1, 2007''.

(b) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—

(1) IN GENERAL.—Paragraph (12) of section 1888(e) (42 U.S.C. 1395yy(e)) is amended to read as follows:

''(12) ADJUSTMENT FOR RESIDENTS WITH AIDS.—

''(A) IN GENERAL.—Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise applicable shall be increased by 128 percent to reflect increased costs associated with such residents.

''(B) SUNSET.—Subparagraph (A) shall not apply on and after such date as the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 2003.

Subtitle C—Hospice

SEC. 421. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 1812(a) (42 U.S.C. 1395d(a)) is amended—

(1) by striking ''and'' at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting ''; and''; and

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

''(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician who is the medical director or an employee of a hospice program and that consist of—

''(A) an evaluation of the individual's need for pain and symptom management;

''(B) counseling the individual with respect to end-of-life issues and care options; and

''(C) advising the individual regarding advanced care planning.''.

(b) PAYMENT.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(4) The amount paid to a hospice program with respect to the services under section 1812(a)(5) for which payment may be made under this part shall be equal to an amount equivalent to the amount established for an office or other outpatient visit for evaluation and management associated with presenting problems of moderate severity under the fee schedule established under section 1848(b), other than the portion of such amount attributable to the practice expense component.''.

(c) CONFORMING AMENDMENT.—Section 1861(dd)(2)(A)(i) (42 U.S.C. 1395x(dd)(2)(A)(i)) is amended by inserting before the comma at the end the following: ''and services described in section 1812(a)(5)''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2004.

SEC. 422. 10 PERCENT INCREASE IN PAYMENT FOR HOSPICE CARE FURNISHED IN A FRONTIER AREA.

(a) IN GENERAL.—Section 1814(i)(1) (42 U.S.C. 1395f(i)(1)) is amended by adding at the end the following new subparagraph:

''(D) With respect to hospice care furnished in a frontier area on or after January 1, 2003, and before January 1, 2008, the payment rates otherwise established for such care shall be increased by 10 percent. For purposes of this subparagraph, the term 'frontier area' means a county in which the population density is less than 7 persons per square mile.''.

(b) REPORT ON COSTS.—Not later than January 1, 2007, the Comptroller General of the United States shall submit to Congress a report on the costs of furnishing hospice care in frontier areas. Such report shall include recommendations regarding the appropriateness of extending, and modifying, the payment increase provided under the amendment made by subsection (a).

SEC. 423. RURAL HOSPICE DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary shall conduct a demonstration project for the delivery of hospice care to medicare beneficiaries in rural areas. Under the project medicare beneficiaries who are unable to receive hospice care in the home for lack of an appropriate caregiver are provided such care in a facility of 20 or fewer beds which offers, within its walls, the full range of services provided by hospice programs under section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)).

(b) SCOPE OF PROJECT.—The Secretary shall conduct the project under this section with respect to no more than 3 hospice programs over a period of not longer than 5 years each.

(c) COMPLIANCE WITH CONDITIONS.—Under the demonstration project—

(1) the hospice program shall comply with otherwise applicable requirements, except that it shall not be required to offer services outside of the home or to meet the requirements of section 1861(dd)(2)(A)(iii) of the Social Security Act; and

(2) payments for hospice care shall be made at the rates otherwise applicable to such care under title XVIII of such Act.

The Secretary may require the program to comply with such additional quality assurance standards for its provision of services in its facility as the Secretary deems appropriate.

(d) REPORT.—Upon completion of the project, the Secretary shall submit a report to Congress on the project and shall include in the report recommendations regarding extension of such project to hospice programs serving rural areas.

Subtitle D—Other Provisions

SEC. 431. DEMONSTRATION PROJECT FOR USE OF RECOVERY AUDIT CONTRACTORS.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under this section (in this section referred to as the ''project'') to demonstrate the use of recovery audit contractors under the Medicare Integrity Program in identifying and recouping overpayments under the medicare program for services for which payment is made under part A of title XVIII of the Social Security Act. Under the project—

(1) payment may be made to such a contractor on a contingent basis;

(2) a percentage of the amount recovered may be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) the Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION.—The project shall cover at least 2 States and at least 3 contractors and shall last for not longer than 3 years.

(c) WAIVER.—The Secretary of Health and Human Services shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (a).

(d) QUALIFICATIONS OF CONTRACTORS.—

(1) IN GENERAL.—The Secretary shall enter into a recovery audit contract under this section with an entity only if the entity has staff that has knowledge of and experience with the payment rules and regulations under the medicare program or the entity has or will contract with another entity that has such knowledgeable and experienced staff.

(2) INELIGIBILITY OF CERTAIN CONTRACTORS.—The Secretary may not enter into a recovery audit contract under this section with an entity to the extent that the entity is a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h), a carrier under section 1842 of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act, or any other entity that carries out the type of activities with respect to providers of services under part A that would constitute a conflict of interest, as determined by the Secretary.

(3) PREFERENCE FOR ENTITIES WITH DEMONSTRATED PROFICIENCY WITH PRIVATE INSURERS.—In awarding contracts to recovery audit contractors under this section, the Secretary shall give preference to those entities that the Secretary determines have demonstrated proficiency in recovery audits with private insurers or under the medicaid program under title XIX of such Act.

(e) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of

the project on savings to the medicare program and recommendations on the cost-effectiveness of extending or expanding the project.

TITLE V—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

SEC. 501. REVISION OF UPDATES FOR PHYSICIANS' SERVICES.

(a) UPDATE FOR 2003 THROUGH 2006.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraphs:

''(5) UPDATE FOR 2003.—The update to the single conversion factor established in paragraph (1)(C) for 2003 is 2 percent.

''(6) SPECIAL RULES FOR UPDATE FOR 2004, 2005, AND 2006.—The following rules apply in determining the update adjustment factors under paragraph (4)(B) for 2004, 2005, and 2006:

''(A) USE OF 2002 DATA IN DETERMINING ALLOWABLE COSTS.—

''(i) The reference in clause (ii)(I) of such paragraph to April 1, 1996, is deemed to be a reference to January 1, 2002.

''(ii) The allowed expenditures for 2002 is deemed to be equal to the actual expenditures for physicians' services furnished during 2002, as estimated by the Secretary.

''(B) 1 PERCENTAGE POINT INCREASE IN GDP UNDER SGR.—The annual average percentage growth in real gross domestic product per capita under subsection (f)(2)(C) for each of 2003, 2004, 2005, and 2006 is deemed to be increased by 1 percentage point.''.

(2) CONFORMING AMENDMENT.—Paragraph (4)(B) of such section is amended, in the matter before clause (i), by inserting ''and paragraph (6)'' after ''subparagraph (D)''.

(3) NOT TREATED AS CHANGE IN LAW AND REGULATION IN SUSTAINABLE GROWTH RATE DETERMINATION.—The amendments made by this subsection shall not be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w–4(f)(2)(D)).

(b) USE OF 10-YEAR ROLLING AVERAGE IN COMPUTING GROSS DOMESTIC PRODUCT.—

(1) IN GENERAL.—Section 1848(f)(2)(C) (42 U.S.C. 1395w–4(f)(2)(C)) is amended—

(A) by striking ''projected'' and inserting ''annual average''; and

(B) by striking ''from the previous applicable period to the applicable period involved'' and inserting ''during the 10-year period ending with the applicable period involved''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to computations of the sustainable growth rate for years beginning with 2002.

(c) ELIMINATION OF TRANSITIONAL ADJUSTMENT.—Section 1848(d)(4)(F) (42 U.S.C. 1395w–4(d)(4)(F)) is amended by striking ''subparagraph (A)'' and all that follows and inserting ''subparagraph (A), for each of 2001 and 2002, of −0.2 percent.''

SEC. 502. STUDIES ON ACCESS TO PHYSICIANS' SERVICES.

(a) GAO STUDY ON BENEFICIARY ACCESS TO PHYSICIANS' SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on access of medicare beneficiaries to physicians' services under the medicare program. The study shall include—

(A) an assessment of the use by beneficiaries of such services through an analysis of claims submitted by physicians for such services under part B of the medicare program;

(B) an examination of changes in the use by beneficiaries of physicians' services over time;

(C) an examination of the extent to which physicians are not accepting new medicare beneficiaries as patients.

(2) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include a determination whether—

(A) data from claims submitted by physicians under part B of the medicare program indicate potential access problems for medicare beneficiaries in certain geographic areas; and

(B) access by medicare beneficiaries to physicians' services may have improved, remained constant, or deteriorated over time.

(b) STUDY AND REPORT ON SUPPLY OF PHYSICIANS.—

(1) STUDY.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to conduct a study on the adequacy of the supply of physicians (including specialists) in the United States and the factors that affect such supply.

(2) REPORT TO CONGRESS.—Not later than 2 years after the date of enactment of this section, the Secretary shall submit to Congress a report on the results of the study described in paragraph (1), including any recommendations for legislation.

SEC. 503. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS' SERVICES.

Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the effect of refinements to the practice expense component of payments for physicians' services in the case of services for which there are no physician work relative value units, after the transition to a full resource-based payment system in 2002, under section 1848 of the Social Security Act (42 U.S.C. 1395w–4). Such report shall examine the following matters by physician specialty:

(1) The effect of such refinements on payment for physicians' services.

(2) The interaction of the practice expense component with other components of and adjustments to payment for physicians' services under such section.

(3) The appropriateness of the amount of compensation by reason of such refinements.

(4) The effect of such refinements on access to care by medicare beneficiaries to physicians' services.

(5) The effect of such refinements on physician participation under the medicare program.

SEC. 504. 1-YEAR EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of BIPA is amended by striking ''2-year period'' and inserting ''3-year period''.

SEC. 505. PHYSICIAN FEE SCHEDULE WAGE INDEX REVISION.

(a) IN GENERAL.—Notwithstanding any other provision of law, for purposes of payment under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services furnished during 2004, in no case may the work geographic index otherwise calculated under section 1848(e)(1)(A)(iii) of such Act (42 U.S.C. 1395w–4(e)(1)(A)(iii)) be less than 0.985.

(b) EXEMPTION FROM LIMITATION ON ANNUAL ADJUSTMENTS.—The increase in expenditures attributable to subsection (a) during 2004 shall not be taken into account in applying section 1848(c)(2)(B)(ii)(II) of such Act (42 U.S.C. 1395w–4(c)(2)(B)(ii)(II)) for that year.

(c) GAO REPORT.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to evaluate the following:

(A) The economic basis of the current methodology for geographic adjustment of the work component of the physician payment rate under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(B) Whether the adjustment under subsection (a) should be continued, and whether there is an economic basis for the continuation of such adjustment, in those areas in which the adjustment applies.

(C) The effect of the methodology on physician location and retention in areas affected by such adjustment.

(D) The differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas.

(E) The mobility of physicians, including specialists, over the last decade.

(F) The effect of raising the floor of the geographic index to a value of 1.0 for adjustment of the work component.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than 1 year after the date of the enactment of this Act.

Subtitle B—Other Services

SEC. 511. COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES.

(a) IN GENERAL.—Section 1847 (42 U.S.C. 1395w–3) is amended to read as follows:

''COMPETITIVE ACQUISITION OF CERTAIN ITEMS AND SERVICES

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

''(1) IMPLEMENTATION OF PROGRAMS.—

''(A) IN GENERAL.—The Secretary shall establish and implement programs under which, beginning in 2008, competitive acquisition areas are established throughout the United States for contract award purposes for the furnishing under this part of competitively priced items and services (described in paragraph (2)) for which payment is made under this part. Such areas may differ for different items and services.

''(B) PHASED-IN IMPLEMENTATION.—The programs shall be phased-in among competitive acquisition areas over a period of not longer than 3 years in a manner so that the competition under the programs occurs in—

''(i) at least ⅓ of such areas in 2008; and

''(ii) at least ⅔ of such areas in 2009.

''(C) WAIVER OF CERTAIN PROVISIONS.—In carrying out the programs, the Secretary may waive such provisions of the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, other than provisions relating to confidentiality of information and such other provisions as the Secretary determines appropriate.

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

''(A) DURABLE MEDICAL EQUIPMENT AND INHALATION DRUGS USED IN CONNECTION WITH DURABLE MEDICAL EQUIPMENT.—Covered items (as defined in section 1834(a)(13)) for which payment is otherwise made under section 1834(a), other than items used in infusion, and inhalation drugs used in conjunction with durable medical equipment.

''(B) OFF-THE-SHELF ORTHOTICS.—Orthotics (described in section 1861(s)(9)) for which payment is otherwise made under section 1834(h) which require minimal self-adjustment for appropriate use and does not require expertise in trimming, bending, molding, assembling, or customizing to fit to the patient.

''(3) EXEMPTION AUTHORITY.—In carrying out the programs under this section, the Secretary may exempt—

''(A) areas that are not competitive due to low population density; and

''(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

''(b) PROGRAM REQUIREMENTS.—

''(1) IN GENERAL.—The Secretary shall conduct a competition among entities supplying items and services described in subsection (a)(2) for each competitive acquisition area in which the program is implemented under subsection (a) with respect to such items and services.

''(2) CONDITIONS FOR AWARDING CONTRACT.—

''(A) IN GENERAL.—The Secretary may not award a contract to any entity under the competition conducted in an competitive acquisition area pursuant to paragraph (1) to furnish such items or services unless the Secretary finds all of the following:

''(i) The entity meets quality and financial standards specified by the Secretary or developed by accreditation entities or organizations recognized by the Secretary.

''(ii) The total amounts to be paid under the contract (including costs associated with the administration of the contract) are expected to be less than the total amounts that would otherwise be paid.

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

''(iv) Beneficiary liability is limited to the applicable percentage of contract award price.

''(B) QUALITY STANDARDS.—The quality standards specified under subparagraph (A)(i) shall not be less than the quality standards that would otherwise apply if this section did not apply and shall include consumer services standards. The Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of physicians, practitioners, and suppliers to review (and advise the Secretary concerning) such quality standards.

''(3) CONTENTS OF CONTRACT.—

''(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

''(B) TERM OF CONTRACTS.—The Secretary shall rebid contracts under this section not less often than once every 3 years.

''(4) LIMIT ON NUMBER OF CONTRACTORS.—

''(A) IN GENERAL.—The Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services covered under the contracts. In awarding contracts, the Secretary shall take into account the ability of bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of beneficiaries for such items or services in the geographic area covered under the contract on a timely basis.

''(B) MULTIPLE WINNERS.—The Secretary shall award contracts to more than one entity submitting a bid in each area for an item or service.

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

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

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

''(6) AUTHORITY TO CONTRACT FOR EDUCATION, OUTREACH AND COMPLAINT SERVICES.—The Secretary may enter into a contract with an appropriate entity to address complaints from beneficiaries who receive items and services from an entity with a contract under this section and to conduct appropriate education of and outreach to such beneficiaries with respect to the program.

''(c) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual management report on the programs under this section. Each such report shall include information on savings, reductions in cost-sharing, access to items and services, and beneficiary satisfaction.

''(d) DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

''(1) IN GENERAL.—The Secretary shall, beginning in 2008, conduct a demonstration project on the application of competitive acquisition under this section to clinical diagnostic laboratory tests—

''(A) for which payment is otherwise made under section 1833(h) or 1834(d)(1) (relating to colorectal cancer screening tests); and

''(B) which are furnished without a face-to-face encounter between the individual and the hospital or physician ordering the tests.

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

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

''(A) an initial report on the project not later than December 31, 2009; and

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

(b) CONTINUATION OF CERTAIN DEMONSTRATION PROJECTS.—Notwithstanding the amendment made by subsection (a), with respect to demonstration projects implemented by the Secretary under section 1847 of the Social Security Act (42 U.S.C. 1395w–3) (relating to the establishment of competitive acquisition areas) that was in effect on the day before the date of the enactment of this Act, each such demonstration project may continue under the same terms and conditions applicable under that section as in effect on that date.

(c) REPORT ON DIFFERENCES IN PAYMENT FOR LABORATORY SERVICES.—Not later than 18 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report that analyzes differences in reimbursement between public and private payors for clinical diagnostic laboratory services.

(d) MEDPAC REPORT ON IMPACT OF DEMONSTRATION PROJECTS ON BENEFICIARY ACCESS TO SERVICES.—Not later than 1 year after the date of the enactment of this Act, the Medicare Pyament Advisory Commission shall submit to Congress a report that analyzes the impact of demonstration projects carried out under section 1847 of the Social Security Act, as in effect on June 1, 2002, on access by medicare beneficiaries to durable medical equipment for which payment was made under the demonstration project.

SEC. 512. PAYMENT FOR AMBULANCE SERVICES.

(a) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended—

(1) in paragraph (2)(E), by inserting ''consistent with paragraph (10)'' after ''in an efficient and fair manner'';

(2) by redesignating the paragraph (8) added by section 221(a) of BIPA as paragraph (9); and

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

''(10) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of service furnished in a year before January 1, 2007, the portion of the payment amount that is based on the fee schedule shall not be less than the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

''(A) For 2003, the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

''(B) For 2004, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

''(C) For 2005, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

''(D) For 2006, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the 9 Census divisions using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.''.

(b) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—Section 1834(l), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

''(11) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after January 1, 2003, and before January 1, 2008, regardless of where the transportation originates, the fee schedule established under this subsection shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by ¼ of the payment per mile otherwise applicable to such miles.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to ambulance services furnished on or after January 1, 2003.

SEC. 513. 5-YEAR EXTENSION OF MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO REPORTS.

(a) 5-YEAR EXTENSION OF MORATORIUM ON THERAPY CAPS.—Section 1833(g)(4) (42 U.S.C. 1395l(g)(4)) is amended by striking ''and 2002'' and inserting ''2002, 2003, 2004, 2005, 2006, and 2007''.

(b) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES.—Not later than December 31, 2002, the Secretary shall submit to Congress the reports required under section 4541(d)(2) of the Balanced Budget Act of 1997 (relating to alternatives to a single annual dollar cap on outpatient therapy) and under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (relating to utilization patterns for outpatient therapy).

(c) IDENTIFICATION OF CONDITIONS AND DISEASES JUSTIFYING WAIVER OF THERAPY CAP.—

(1) STUDY.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to identify conditions or diseases that should justify conducting an assessment of the need to waive the therapy caps under section 1833(g)(4) of the Social Security Act (42 U.S.C. 1395l(g)(4)).

(2) REPORTS TO CONGRESS.—Not later than July 1, 2003, the Secretary shall submit to Congress a preliminary report on the conditions and diseases identified under paragraph (1) and not later than September 1, 2003, a final report on the conditions and diseases so identified.

(d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL THERAPIST SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on access to physical therapist services in States authorizing such services without a physician referral and in States that require such a physician referral. The study shall—

(A) examine the use of and referral patterns for physical therapist services for patients age 50 and older in States that authorize such services without a physician referral and in States that require such a physician referral;

(B) examine the use of and referral patterns for physical therapist services for patients who are medicare beneficiaries;

(C) examine the potential effect of prohibiting a physician from referring patients to physical therapy services owned by the physician and provided in the physician's office;

(D) examine the delivery of physical therapists' services within the facilities of Department of Defense; and

(E) analyze the potential impact on medicare beneficiaries and on expenditures under the medicare program of eliminating the need for a physician referral and physician certification for physical therapist services under the medicare program.

(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than 1 year after the date of the enactment of this Act.

SEC. 514. ACCELERATED IMPLEMENTATION OF 20 PERCENT COINSURANCE FOR HOSPITAL OUTPATIENT DEPARTMENT (OPD) SERVICES; OTHER OPD PROVISIONS.

(a) ACCELERATED IMPLEMENTATION OF COINSURANCE REDUCTIONS.—Section 1833(t)(8)(C)(ii) (42 U.S.C. 1395l(t)(8)(C)(ii)) is amended by striking subclauses (III) through (V) and inserting the following:

''(III) For procedures performed in 2004, 45 percent.

''(IV) For procedures performed in 2005, 40 percent.

''(V) For procedures performed in 2006, 2007, 2008 and 2009, 35 percent.

''(VI) For procedures performed in 2010, 30 percent.

''(VII) For procedures performed in 2011, 25 percent.

''(VIII) For procedures performed in 2012 and thereafter, 20 percent.''.

(b) TREATMENT OF TEMPERATURE MONITORED CRYOABLATION.—

(1) IN GENERAL.—Section 1833(t)(6)(A)(ii) (42 U.S.C. 1395l(t)(6)(A)(ii)) is amended by striking ''or temperature monitored cryoablation''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) applies to payment for services furnished on or after January 1, 2003.

SEC. 515. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), is amended—

(1) in subparagraph (U), by striking ''and'' at the end;

(2) in subparagraph (V), by inserting ''and'' at the end; and

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

''(W) an initial preventive physical examination (as defined in subsection (ww));''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x) is amended by adding at the end the following new subsection:

''Initial Preventive Physical Examination

''(ww) The term 'initial preventive physical examination' means physicians' services consisting of a physical examination with the goal of health promotion and disease detection and includes items and services specified by the Secretary in regulations.''.

(c) WAIVER OF DEDUCTIBLE AND COINSURANCE.—

(1) DEDUCTIBLE.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(A) by striking ''and'' before ''(6)'', and

(B) by inserting before the period at the end the following: '', and (7) such deductible shall not apply with respect to an initial preventive physical examination (as defined in section 1861(ww))''.

(2) COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395l(a)(1)) is amended—

(A) in clause (N), by inserting ''(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))'' after ''80 percent''; and

(B) in clause (O), by inserting ''(or 100 percent in the case of an initial preventive physical examination, as defined in section 1861(ww))'' after ''80 percent''.

(d) PAYMENT AS PHYSICIANS' SERVICES.—Section 1848(j)(3) (42 U.S.C. 1395w–4(j)(3)) is amended by inserting ''(2)(W),'' after ''(2)(S),''.

(e) OTHER CONFORMING AMENDMENTS.—Section 1862(a) (42 U.S.C. 1395y(a)) is amended—

(1) in paragraph (1)—

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

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

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

''(J) in the case of an initial preventive physical examination, which is performed not later than 6 months after the date the individual's first coverage period begins under part B;''; and

(2) in paragraph (7), by striking ''or (H)'' and inserting ''(H), or (J)''.

(f) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004, but only for individuals whose coverage period begins on or after such date.

SEC. 516. RENAL DIALYSIS SERVICES.

(a) REPORT ON DIFFERENCES IN COSTS IN DIFFERENT SETTINGS.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report containing—

(1) an analysis of the differences in costs of providing renal dialysis services under the medicare program in home settings and in facility settings;

(2) an assessment of the percentage of overhead costs in home settings and in facility settings; and

(3) an evaluation of whether the charges for home dialysis supplies and equipment are reasonable and necessary.

(b) RESTORING COMPOSITE RATE EXCEPTIONS FOR PEDIATRIC FACILITIES.—

(1) IN GENERAL.—Section 422(a)(2) of BIPA is amended—

(A) in subparagraph (A), by striking ''and (C)'' and inserting '', (C), and (D)'';

(B) in subparagraph (B), by striking ''In the case'' and inserting ''Subject to subparagraph (D), in the case''; and

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

''(D) INAPPLICABILITY TO PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate described in subparagraph (C) in effect on such date. For purposes of this subparagraph, the term 'pediatric facility' means a renal facility at least 50 percent of whose patients are individuals under 18 years of age.''.

(2) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by striking ''The Secretary'' and inserting ''Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, the Secretary''.

(c) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES FURNISHED IN 2004.—Notwithstanding any other provision of law, with respect to payment under part B of title XVIII of the Social Security Act for renal dialysis services furnished in 2004, the composite payment rate otherwise established under section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)) shall be increased by 1.2 percent.

SEC. 517. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting before the period at the end the following: ''and does not include screening mammography (as defined in section 1861(jj)) and unilateral and bilateral diagnostic mammography''.

(b) ADJUSTMENT TO TECHNICAL COMPONENT.—For diagnostic mammography performed on or after January 1, 2004, for which payment is made under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4), the Secretary, based on the most recent cost data available, shall provide for an appropriate adjustment in the payment amount for the technical component of the diagnostic mammography.

(c) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to mammography performed on or after January 1, 2004.

SEC. 518. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) WAIVER OF PENALTY.—

(1) IN GENERAL.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: ''No increase in the premium shall be effected for a month in the case of an individual who is 65 years of age or older, who enrolls under this part during 2001, 2002, or 2003, and who demonstrates to the Secretary before December 31, 2003, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to premiums for months beginning with January 2003. The Secretary of Health and Human Services shall establish a method for providing rebates of premium penalties paid for months on or after January 2003 for which a penalty does not apply under such amendment but for which a penalty was previously collected.

(b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—In the case of any individual who, as of the date of the enactment of this Act, is 65 years of age or older, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act, and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary of Health and Human Services shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin as soon as possible after the date of the enactment of this Act and shall end on December 31, 2003.

(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 519. COVERAGE OF CHOLESTEROL AND BLOOD LIPID SCREENING.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 515(a), is amended—

(1) in subparagraph (V), by striking ''and'' at the end;

(2) in subparagraph (W), by inserting ''and'' at the end; and

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

''(X) cholesterol and other blood lipid screening tests (as defined in subsection (xx));''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 515(b), is amended by adding at the end the following new subsection:

''Cholesterol and Other Blood Lipid Screening Test

''(xx)(1) The term 'cholesterol and other blood lipid screening test' means diagnostic testing of cholesterol and other lipid levels of the blood for the purpose of early detection of abnormal cholesterol and other lipid levels.

''(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cholesterol and other blood lipid screening tests, except that such frequency may not be more often than once every 2 years.''.

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by section 515(e), is amended

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

(2) by striking the semicolon at the end of subparagraph (J) and inserting ''; and''; and

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

''(K) in the case of a cholesterol and other blood lipid screening test (as defined in section 1861(xx)(1)), which is performed more frequently than is covered under section 1861(xx)(2).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2004.

TITLE VI—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 601. ELIMINATION OF 15 PERCENT REDUCTION IN PAYMENT RATES UNDER THE PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1895(b)(3)(A) (42 U.S.C. 1395fff(b)(3)(A)) is amended to read as follows:

''(A) INITIAL BASIS.—Under such system the Secretary shall provide for computation of a standard prospective payment amount (or amounts) as follows:

''(i) Such amount (or amounts) shall initially be based on the most current audited cost report data available to the Secretary and shall be computed in a manner so that the total amounts payable under the system for fiscal year 2001 shall be equal to the total amount that would have been made if the system had not been in effect and if section 1861(v)(1)(L)(ix) had not been enacted.

''(ii) For fiscal year 2002 and for the first quarter of fiscal year 2003, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for the previous fiscal year, updated under subparagraph (B).

''(iii) For 2003, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for fiscal year 2002, updated under subparagraph (B) for 2003.

''(iv) For 2004 and each subsequent year, such amount (or amounts) shall be equal to the amount (or amounts) determined under this paragraph for the previous year, updated under subparagraph (B).

Each such amount shall be standardized in a manner that eliminates the effect of variations in relative case mix and area wage adjustments among different home health agencies in a budget neutral manner consistent with the case mix and wage level adjustments provided under paragraph (4)(A). Under the system, the Secretary may recognize regional differences or differences based upon whether or not the services or agency are in an urbanized area.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect as if included in the amendments made by section 501 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 1(a)(6) of Public Law 106–554).

SEC. 602. UPDATE IN HOME HEALTH SERVICES.

(a) CHANGE TO CALENDAR YEAR UPDATE.—

(1) IN GENERAL.—Section 1895(b) (42 U.S.C. 1395fff(b)(3)) is amended—

(A) in paragraph (3)(B)(i)—

(i) by striking ''each fiscal year (beginning with fiscal year 2002)'' and inserting ''fiscal year 2002 and for each subsequent year (beginning with 2003)''; and

(ii) by inserting ''or year'' after ''the fiscal year'';

(B) in paragraph (3)(B)(ii)—

(i) in subclause (II), by striking ''fiscal year'' and inserting ''year'' and by redesignating such subclause as subclause (III); and

(ii) in subclause (I), by striking ''each of fiscal years 2002 and 2003'' and inserting the following: ''fiscal year 2002, the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points;

''(II) 2003'';

(C) in paragraph (3)(B)(iii), by inserting ''or year'' after ''fiscal year'' each place it appears;

(D) in paragraph (3)(B)(iv)—

(i) by inserting ''or year'' after ''fiscal year'' each place it appears; and

(ii) by inserting ''or years'' after ''fiscal years''; and

(E) in paragraph (5), by inserting ''or year'' after ''fiscal year''.

(2) TRANSITION RULE.—The standard prospective payment amount (or amounts) under section 1895(b)(3) of the Social Security Act for the calendar quarter beginning on October 1, 2002, shall be such amount (or amounts) for the previous calendar quarter.

(b) CHANGES IN UPDATES FOR 2003, 2004, AND 2005.—Section 1895(b)(3)(B)(ii) (42 U.S.C. 1395fff(b)(3)(B)(ii)), as amended by subsection (a)(1)(B), is amended—

(1) in subclause (II), by striking ''the home health market basket percentage increase (as defined in clause (iii)) minus 1.1 percentage points'' and inserting ''2.0 percentage points'';

(2) by striking ''or'' at the end of subclause (II);

(3) by redesignating subclause (III) as subclause (V); and

(4) by inserting after subclause (II) the following new subclause:

''(III) 2004, 1.1 percentage points;

''(IV) 2005, 2.7 percentage points; or''.

(c) PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1895(b)(5) (42 U.S.C. 1395fff(b)(5)) is amended by striking ''5 percent'' and inserting ''3 percent''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to years beginning with 2003.

SEC. 603. OASIS TASK FORCE; SUSPENSION OF CERTAIN OASIS DATA COLLECTION REQUIREMENTS PENDING TASK FORCE SUBMITTAL OF REPORT.

(a) ESTABLISHMENT.—The Secretary of Health and Human Services shall establish and appoint a task force (to be known as the ''OASIS Task Force'') to examine the data collection and reporting requirements under OASIS. For purposes of this section, the term ''OASIS'' means the Outcome and Assessment Information Set required by reason of section 4602(e) of Balanced Budget Act of 1997 (42 U.S.C. 1395fff note).

(b) COMPOSITION.—The OASIS Task Force shall be composed of the following:

(1) Staff of the Centers for Medicare & Medicaid Services with expertise in post-acute care.

(2) Representatives of home health agencies.

(3) Health care professionals and research and health care quality experts outside the Federal Government with expertise in post-acute care.

(4) Advocates for individuals requiring home health services.

(c) DUTIES.—

(1) REVIEW AND RECOMMENDATIONS.—The OASIS Task Force shall review and make recommendations to the Secretary regarding changes in OASIS to improve and simplify data collection for purposes of—

(A) assessing the quality of home health services; and

(B) providing consistency in classification of patients into home health resource groups (HHRGs) for payment under section 1895 of the Social Security Act (42 U.S.C. 1395fff).

(2) SPECIFIC ITEMS.—In conducting the review under paragraph (1), the OASIS Task Force shall specifically examine—

(A) the 41 outcome measures currently in use;

(B) the timing and frequency of data collection; and

(C) the collection of information on comorbidities and clinical indicators.

(3) REPORT.—The OASIS Task Force shall submit a report to the Secretary containing its findings and recommendations for changes in OASIS by not later than 18 months after the date of the enactment of this Act.

(d) SUNSET.—The OASIS Task Force shall terminate 60 days after the date on which the report is submitted under subsection (c)(2).

(e) NONAPPLICATION OF FACA.—The provisions of the Federal Advisory Committee Act shall not apply to the OASIS Task Force.

(f) SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS PENDING TASK FORCE REPORT.—

(1) IN GENERAL.—During the period described in paragraph (2), the Secretary of Health and Human Services may not require, under section 4602(e) of the Balanced Budget Act of 1997 or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act.

(2) PERIOD OF SUSPENSION.—The period described in this paragraph—

(A) begins on January 1, 2003, and

(B) ends on the last day of the 2nd month beginning after the date the report is submitted under subsection (c)(2).

SEC. 604. MEDPAC STUDY ON MEDICARE MARGINS OF HOME HEALTH AGENCIES.

(a) STUDY.—The Medicare Payment Advisory Commission shall conduct a study of payment margins of home health agencies under the home health prospective payment system under section 1895 of the Social Security Act (42 U.S.C. 1395fff). Such study shall examine whether systematic differences in payment margins are related to differences in case mix (as measured by home health resource groups (HHRGs)) among such agencies. The study shall use the partial or full-year cost reports filed by home health agencies.

(b) REPORT.—Not later than 2 years after the date of the enactment of this Act, the Commission shall submit to Congress a report on the study under subsection (a).

Subtitle B—Direct Graduate Medical Education

SEC. 611. 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, 2003, 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, 2001.

''(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, 2002.

''(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, 2003, 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, 2004.

''(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) NO APPLICATION OF INCREASE 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 clause (i) of subparagraph (I) of subsection (h)(4) shall apply with respect to the first sentence of this clause in the same manner as it applies with respect to subparagraph (F) of such subsection, but the provisions of clause (ii) of such subparagraph shall not apply.''.

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2004, 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. 612. INCREASING FOR 5 YEARS TO 100 PERCENT OF THE LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT THE PAYMENT FLOOR FOR DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS UNDER THE MEDICARE PROGRAM.

Section 1886(h)(2)(D)(iii) (42 U.S.C. 1395ww(h)(2)(D)(iii)), as amended by section 511 of BIPA, is amended—

(1) by striking ''and'' after ''70 percent,''; and

(2) by inserting after ''85 percent,'' the following: ''and for cost reporting periods beginning during the period beginning on October 1, 2002, and ending on September 31, 2007, shall not be less than 100 percent,''.

Subtitle C—Other Provisions

SEC. 621. MODIFICATIONS TO MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXAMINATION OF BUDGET CONSEQUENCES.—Section 1805(b) (42 U.S.C. 1395b–6(b)) is amended by adding at the end the following new paragraph:

''(8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.''.

(b) CONSIDERATION OF EFFICIENT PROVISION OF SERVICES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b–6(b)(2)(B)(i)) is amended by inserting ''the efficient provision of'' after ''expenditures for''.

(c) ADDITIONAL REPORTS.—

(1) DATA NEEDS AND SOURCES.—The Medicare Payment Advisory Commission shall conduct a study, and submit a report to Congress by not later than June 1, 2003, on the need for current data, and sources of current data available, to determine the solvency and financial circumstances of hospitals and other medicare providers of services. The Commission shall examine data on uncompensated care, as well as the sahre of uncompensated care accounted for by the expenses for treating illegal aliens.

(2) USE OF TAX-RELATED RETURNS.—Using return information provided under Form 990 of the Internal Revenue Service, the Commission shall submit to Congress, by not later than June 1, 2003, a report on the following:

(A) Investments and capital financing of hospitals participating under the medicare program and related foundations.

(B) Access to capital financing for private and for not-for-profit hospitals.

SEC. 622. DEMONSTRATION PROJECT FOR DISEASE MANAGEMENT FOR CERTAIN MEDICARE BENEFICIARIES WITH DIABETES.

(a) IN GENERAL.—The Secretary of Health and Human Services shall conduct a demonstration project under this section (in this section referred to as the ''project'') to demonstrate the impact on costs and health outcomes of applying disease management to certain medicare beneficiaries with diagnosed diabetes. In no case may the number of participants in the project exceed 30,000 at any time.

(b) VOLUNTARY PARTICIPATION.—

(1) ELIGIBILITY.—Medicare beneficiaries are eligible to participate in the project only if—

(a) they are Hispanic, as determined by the Secretary;

(A) they meet specific medical criteria demonstrating the appropriate diagnosis and the advanced nature of their disease;

(B) their physicians approve of participation in the project; and

(C) they are not enrolled in a Medicare+Choice plan.

(2) BENEFITS.—A medicare beneficiary who is enrolled in the project shall be eligible—

(A) for disease management services related to their diabetes; and

(B) for payment for all costs for prescription drugs without regard to whether or not they relate to the diabetes, except that the project may provide for modest cost-sharing with respect to prescription drug coverage.

(c) CONTRACTS WITH DISEASE MANAGEMENT ORGANIZATIONS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall carry out the project through contracts with up to three disease management organizations. The Secretary shall not enter into such a contract with an organization unless the organization demonstrates that it can produce improved health outcomes and reduce aggregate medicare expenditures consistent with paragraph (2).

(2) CONTRACT PROVISIONS.—Under such contracts—

(A) such an organization shall be required to provide for prescription drug coverage described in subsection (b)(2)(B);

(B) such an organization shall be paid a fee negotiated and established by the Secretary in a manner so that (taking into account savings in expenditures under parts A and B of the medicare program under title XVIII of the Social Security Act) there will be no net increase, and to the extent practicable, there

will be a net reduction in expenditures under the medicare program as a result of the project; and

(C) such an organization shall guarantee, through an appropriate arrangement with a reinsurance company or otherwise, the prohibition on net increases in expenditures described in subparagraph (B).

(3) PAYMENTS.—Payments to such organizations shall be made in appropriate proportion from the Trust Funds established under title XVIII of the Social Security Act.

(4) WORKING GROUP.—The Secretary shall establish within the Department of Health and Human Services a working group consisting of employees of the Department to carry out the following:

(A) To oversee the project.

(B) To establish policy and criteria for medicare disease management programs within the Department, including the establishment of policy and criteria for such programs.

(C) To identify targeted medical conditions and targeted individuals.

(D) To select areas in which such programs are carried out.

(E) To monitor health outcomes under such programs.

(F) To measure the effectiveness of such programs in meeting any budget neutrality requirements.

(G) Otherwise to serve as a central focal point within the Department for dissemination of information on medicare disease management programs.

(d) APPLICATION OF MEDIGAP PROTECTIONS TO DEMONSTRATION PROJECT ENROLLEES.—(1) Subject to paragraph (2), the provisions of section 1882(s)(3) (other than clauses (i) through (iv) of subparagraph (B)) and 1882(s)(4) of the Social Security Act shall apply to enrollment (and termination of enrollment) in the demonstration project under this section, in the same manner as they apply to enrollment (and termination of enrollment) with a Medicare+Choice organization in a Medicare+Choice plan.

(2) In applying paragraph (1)—

(A) any reference in clause (v) or (vi) of section 1882(s)(3)(B) of such Act to 12 months is deemed a reference to the period of the demonstration project; and

(B) the notification required under section 1882(s)(3)(D) of such Act shall be provided in a manner specified by the Secretary of Health and Human Services.

(e) DURATION.—The project shall last for not longer than 3 years.

(f) WAIVER.—The Secretary of Health and Human Services shall waive such provisions of title XVIII of the Social Security Act as may be necessary to provide for payment for services under the project in accordance with subsection (c)(3).

(g) REPORT.—The Secretary of Health and Human Services shall submit to Congress an interim report on the project not later than 2 years after the date it is first implemented and a final report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on costs and health outcomes and recommendations on the cost-effectiveness of extending or expanding the project.

(h) GAO STUDY ON DISEASE MANAGEMENT PROGRAMS.—The Comptroller General of the United States shall conduct a study that compares disease management programs under title XVIII of the Social Security Act with such programs conducted in the private sector, including the prevalence of such programs and programs for case management. The study shall identify the cost-effectiveness of such programs and any savings achieved by such programs. The Comptroller General shall submit a report on such study to Congress by not later than 18 months after the date of the enactment of this Act.

SEC. 623. DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY CARE SERVICES.

(a) ESTABLISHMENT.—Subject to the succeeding provisions of this section, the Secretary of Health and Human Services shall establish a demonstration project (in this section referred to as the ''demonstration project'') under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a medical adult day care facility or a home health agency, directly or under arrangements with a medical adult day care facility, to provide medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary's home.

(b) PAYMENT.—

(1) IN GENERAL.—The amount of payment for an episode of care for home health services, a portion of which consists of substitute medical adult day care services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 U.S.C. 1395fff). In no case may a a medical adult day care facility or home health agency, or a medical adult day care facility under arrangements with a home health agency, separately charge a beneficiary for medical adult day care services furnished under the plan of care.

(2) BUDGET NEUTRALITY FOR DEMONSTRATION PROJECT.—Notwithstanding any other provision of law, the Secretary shall provide for an appropriate reduction in the aggregate amount of additional payments made under section 1895 of the Social Security Act (42 U.S.C. 1395fff) to reflect any increase in amounts expended from the Trust Funds as a result of the demonstration project conducted under this section.

(c) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in not more than 5 sites in States selected by the Secretary that license or certify providers of services that furnish medical adult day care services.

(d) DURATION.—The Secretary shall conduct the demonstration project for a period of 3 years.

(e) VOLUNTARY PARTICIPATION.—Participation of medicare beneficiaries in the demonstration project shall be voluntary. The total number of such beneficiaries that may participate in the project at any given time may not exceed 15,000.

(f) PREFERENCE IN SELECTING AGENCIES.—In selecting medical adult day care facilities and home health agencies to participate under the demonstration project, the Secretary shall give preference to those facilities and agencies that—

(1) are currently licensed or certified to furnish medical adult day care services; and

(2) have furnished medical adult day care services to medicare beneficiaries for a continuous 2-year period before the beginning of the demonstration project.

(g) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act as may be necessary for the purposes of carrying out the demonstration project, other than waiving the requirement that an individual be homebound in order to be eligible for benefits for home health services.

(h) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the clinical and cost effectiveness of the demonstration project. Not later 30 months after the commencement of the project, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(1) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the project as compared to such outcomes and costs to beneficiaries receiving only home health services for the same health conditions.

(2) Such recommendations regarding the extension, expansion, or termination of the project as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

(1) HOME HEALTH AGENCY.—The term ''home health agency'' has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(2) MEDICAL ADULT DAY CARE FACILITY.—The term ''medical adult day care facility'' means a facility that—

(A) has been licensed or certified by a State to furnish medical adult day care services in the State for a continuous 2-year period;

(B) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(C) meets such standards established by the Secretary to assure quality of care and such other requirements as the Secretary finds necessary in the interest of the health and safety of individuals who are furnished services in the facility; and

(D) provides medical adult day care services.

(3) MEDICAL ADULT DAY CARE SERVICES.—The term ''medical adult day care services'' means—

(A) home health service items and services described in paragraphs (1) through (7) of section 1861(m) furnished in a medical adult day care facility;

(B) a program of supervised activities furnished in a group setting in the facility that—

(i) meet such criteria as the Secretary determines appropriate; and

(ii) is designed to promote physical and mental health of the individuals; and

(C) such other services as the Secretary may specify.

(4) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means an individual entitled to benefits under part A of this title, enrolled under part B of this title, or both.

SEC. 624. PUBLICATION ON FINAL WRITTEN GUIDANCE CONCERNING PROHIBITIONS AGAINST DISCRIMINATION BY NATIONAL ORIGIN WITH RESPECT TO HEALTH CARE SERVICES.

Not later than January 1, 2003, the Secretary shall issue final written guidance concerning the application of the prohibition in title VI of the Civil Rights Act of 1964 against national origin discrimination as it affects persons with limited English proficiency with respect to access to health care services under the medicare program.

TITLE VII—MEDICAID AND OTHER HEALTH PROVISIONS

SEC. 701. DSH PROVISIONS.

(a) CONTINUATION OF MEDICAID DSH ALLOTMENT ADJUSTMENTS UNDER BIPA 2000.—

(1) IN GENERAL.—Section 1923(f) (42 U.S.C. 1396r–4(f))—

(A) in paragraph (2)—

(i) in the heading, by striking ''THROUGH 2002'' and inserting ''THROUGH 2000'';

(ii) by striking ''ending with fiscal year 2002'' and inserting ''ending with fiscal year 2000''; and

(iii) in the table in such paragraph, by striking the columns labeled ''FY 01'' and ''FY02'';

(B) in paragraph (3)(A), by striking ''paragraph (2)'' and inserting ''paragraph (4)''; and

(C) in paragraph (4), as added by section 701(a)(1) of BIPA—

(i) by striking ''FOR FISCAL YEARS 2001 AND 2002'' in the heading;

(ii) in subparagraph (A), by striking ''Notwithstanding paragraph (2), the'' and inserting ''The'';

(iii) in subparagraph (C)—

(I) by striking ''NO APPLICATION'' and inserting ''APPLICATION''; and

(II) by striking ''without regard to'' and inserting ''taking into account''.

(2) INCREASE IN MEDICAID DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—

(A) IN GENERAL.—Effective for DSH allotments beginning with fiscal year 2002, the item in the table contained in section 1923(f)(2) of the Social Security Act (42 U.S.C. 1396r–4(f)(2)) for the District of Columbia for the DSH allotment for FY 00 (fiscal year 2000) is amended by striking ''32'' and inserting ''49''.

(B) CONSTRUCTION.—Nothing in subparagraph (A) shall be construed as preventing the application of section 1923(f)(4) of the Social Security Act (as amended by subsection (a)) to the District of Columbia for fiscal year 2002 and subsequent fiscal years.

(b) INCREASE IN FLOOR FOR TREATMENT AS AN EXTREMELY LOW DSH STATE TO 3 PERCENT IN FISCAL YEAR 2002.—

(1) INCREASE IN DSH FLOOR.—Section 1923(f)(5) (42 U.S.C. 1396r–4(f)(5)) is amended—

(A) by striking ''fiscal year 1999'' and inserting ''fiscal year 2001'';

(B) by striking ''August 31, 2000'' and inserting ''August 31, 2002'';

(C) by striking ''1 percent'' each place it appears and inserting ''3 percent''; and

(D) by striking ''fiscal year 2001'' and inserting ''fiscal year 2003''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) take effect on October 1, 2002, and apply to DSH allotments under title XIX of the Social Security Act for fiscal year 2003 and each fiscal year thereafter.

SEC. 702. 1-YEAR EXTENSION OF Q–I1 PROGRAM.

Section 1902(a)(10)(E)(E)(iv) (42 U.S.C. 1396a(a)(10)(E)(E)(iv)) is amended by striking ''2002'' and inserting ''2003''.

Mr. GEPHARDT (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

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

Mr. NUSSLE. Mr. Speaker, I reserve all points of order against this motion, and I object to the unanimous consent request to dispense with the reading.

The SPEAKER pro tempore. The Clerk will continue to read.

The Clerk continued the reading of the motion to recommit.

□ 0130

Mr. GEPHARDT (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

The SPEAKER pro tempore (Mr. THORNBERRY). Is there objection to the request of the gentleman from Missouri?

There was no objection.

Mr. TAUZIN. Mr. Speaker, I claim the time in opposition to the motion to recommit.

The SPEAKER pro tempore. The gentleman from Missouri (Mr. GEPHARDT) is recognized for 5 minutes in support of his motion.

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

Mr. GEPHARDT. Mr. Speaker, I ask Members to vote ''yes'' on this motion to recommit and to vote ''no'' on the Republican plan.

I guess I would like to start tonight's debate with a question: Why did you not allow us to have an alternative to this drug plan? A Democratic House gave Republicans an alternative in 1965 when we debated Medicare. We represent 49 percent of the American people. This is one of the most important issues that we will vote on in this Congress, yet we are not afforded the opportunity to have a clean vote on a clear alternative. Are you afraid? Do you think that too many of Republican Members would vote for our plan?

This process tonight is not worthy of this House of Representatives. This is the people's House. Here the people must be heard. I am deeply disappointed that we were not afforded the opportunity for a clear alternative on this very, very important issue. This is an important issue to all the senior citizens of our country. The Greatest Generation that fought our wars, paid their taxes, raised their children, and made this country great, that Greatest Generation now is too often getting on buses and going to Canada or going to Mexico to get their prescription drugs at prices they can afford. They are making choices between food and taking their drugs. There are senior citizens tonight that are cutting their pills in half because they cannot afford to pay for a whole month's worth.

And tonight, those people are only afforded a vote on a flawed, deficient, wrong plan. If we stack that plan up against what these people are asking for, it fails. It fails. In fact, I would say it is a fraud. I give you what Webster called a fraud: a deception, deliberately practiced to secure unfair or unlawful gain. A piece of trickery. A trick.

The Republican plan has no set premium. They say it might be $35. We are told in States where they have done what the Republicans are doing it is $85. There is no defined benefit. Republicans are turning seniors over to the private insurance market.

This is the same debate that we had in 1965. This is a replay of that debate. If this were 1965, we would not have dreamed of having a Medicare program without a prescription drug benefit. Prescription drugs are now the treatment for most maladies that people face. Why would we not just add this benefit to the Medicare program? Our plan that is in the motion to recommit is simple. It is Medicare: $100 deductible, $25 premium. The government pays 80 percent of the drug cost. The recipient pays 20 percent, and when they hit $2,000 out of pocket, the government picks it all up.

This is what seniors are asking for. They are not asking to go into private insurance. They want a Medicare drug benefit, and they want all the seniors to be amassed to get leverage to get the price of prescription drugs down, down, down.

□ 0145

In the end, I suspect many of you do not support Medicare. I suspect you still want to privatize it. Your plans for Social Security call for privatizing it. In 1965, Republicans predicted Medicare would lead to socialized medicine. One said, ''If we pass Medicare, one day we will be telling our children what it was like in America when people were free.'' Your majority leader has said Medicare is a program that I would have no part of in a free world. He said he deeply resented the fact that when he was 65 he would have to enroll in Medicare.

So you have reverted to form. In the end, this Republican bill listens not to the people of this country. It listens to the pharmaceutical companies and to the insurance companies and is not good for the people's House of Representatives. It should not be passed.

In closing, I would ask all of you to simply tonight think of the people you represent, people like my mother. She is 94 years old. She lives in St. Louis. Every time I go home, she asks me about what is going to happen with the cost of her drugs. She had a stroke about 5 years ago, and the doctor said she will probably never talk again; she will probably never be able to cook or to do household duties. She was able to get the drugs and she is back and she is talking. She is asking me every time I see her about what she is going to do about the cost of her drugs. She has glaucoma and she gets a little bitty bottle of drops that cost $100 a bottle and lasts for 2 weeks. She is lucky. She has got my brother and me, and we send her the money every month so that she can get her drugs.

Think about the thousands of people in your district who are not as lucky as my mother. Think about them. Think about whether they can afford a premium more than $25. Think about whether they can put up with benefits ending in the middle of the year when they cannot get their needed drugs. Think about them when you are not getting the price of drugs down so that they can afford to buy the drugs.

In 1965, this Congress took a historic step, and it passed the greatest program that this country has ever put together. It is the reason that people are living to 80 and 90 and 100 in this country with quality in their lives. We should honor that program tonight and expand it as it should have been many years ago. I am sure there were Members on that day or night in 1965 that voted against the Medicare program and regretted it through the rest of their career and their life. Do not regret your vote tonight. Stand for Medicare and stand for the American people that you represent.

The SPEAKER pro tempore (Mr. THORNBERRY). Any point of order to be reserved on the motion has now been withdrawn.

The Chair recognizes the gentleman from Louisiana (Mr. TAUZIN) for 5 minutes.

Mr. TAUZIN. Mr. Speaker, there is trickery about this place. There is fraud about this House. We could have a motion to recommit forthwith, but that is not what happened tonight. What happened tonight was a motion to recommit promptly. My friend, the chairman of Ways and Means, will explain in just a minute the trickery in that motion.

You see, that motion has a very special effect regarding this debate tonight and the possibility of us passing a prescription drug benefit for the seniors of America tonight. The gentleman from California will explain it to you in just a minute. But if we were to even consider the proposal offered in this motion to recommit seriously, it is almost identical, I believe, to the proposal that was made before the Committee on Energy and Commerce.

It has been scored by CBO now at $971 billion, although our budget, as you know, allocated $350 billion to this effort. It is more expensive than the plan prepared on the Senate side by Senator BOB GRAHAM. The BOB GRAHAM plan is estimated to drive Medicare into insolvency by the year 2016. Just imagine how much sooner Medicare goes bankrupt under the plan our friends on the other side are offering in the motion to recommit.

That is saving the Medicare program, driving it into bankruptcy? We are not alone in that assessment. The AARP looked at our plans, too; and this is what they said about ours: ''We appreciate your efforts to contain drug costs, because a Medicare drug benefit alone without effective cost controls will be difficult to sustain as our growing population of older Americans increases its drug utilization.''

Our assessment in the committee of this plan, believe it or not, actually raises drug prices to seniors. We asked CBO a simple question. We asked CBO if the Medicare Modernization and Prescription Drug Act before us that we presented to this House tonight would lower drug expenditures more than any other House bill introduced in the Congress and scored by CBO, and this is what they responded: ''The answer to your question is yes.'' Yes, lower drug costs. Yes, prescription drug benefits for our seniors. Tonight, not promptly. Yes, it is time to pass this bill tonight for all our moms and dads.

Mr. Speaker, I yield to the gentleman from California (Mr. THOMAS).

Mr. THOMAS. I thank the gentleman for yielding.

The gentleman from Missouri mentioned several times 1965; 1965 was 10 years before a Member of this Congress was born, ADAM PUTNAM. For more than 30 of those 37 years, you were in the majority. You never put prescription drugs in Medicare. You had your chance. You never did. And your argument is that you have now in front of us a plan.

The gentleman from Missouri read a definition from Webster's. What my mother would have said, you should have washed your mouth out, because for you to cite the definition of fraud and call it trickery is for everyone to understand what this motion to recommit really is. It is a little word called ''forthwith.'' If this motion had said Mr. GEPHARDT moves to recommit the bill forthwith, it would not have been fraud, and it would not have been trickery. But because that little word is missing and it requires it to be reported promptly, the effect of this motion to recommit is to kill this bill. All of the statements that the gentleman from Missouri made in the well were simply trickery, it was a fraud, because this bill cannot come back and be made law. You are wasting the House's time. Obviously, some of you do not understand the rules under which this House operates.

Mr. Speaker, had they had the guts to put ''forthwith'' in this motion to recommit, this bill would have come back to the floor, and we could have debated it. You did not put ''forthwith'' in it. Your motion to recommit is a motion to kill the bill.

Mr. WALDEN of Oregon. Mr. Speaker, the House is not in order. The gentleman deserves to be heard as was the minority leader.

The SPEAKER pro tempore. The House will be in order.

Mr. THOMAS. Actually, nobody deserves to be heard on this motion to recommit. It is 119 pages of nothing. The way you constructed it, knowingly and on purpose, was to pull a charade on seniors. Nothing in this bill will be available to seniors because you did not put a little word in there, a word that would have proved honesty, a word that would have proved courage, a word that would have let seniors know——

Mr. TAUZIN. Mr. Speaker, the House is not in order.

Mr. Speaker, we listened very patiently to the minority leader. I believe the gentleman deserves to be heard.

The SPEAKER pro tempore. The time in opposition to the motion to recommit has expired.

Mr. THOMAS. Mr. Speaker, I urge my colleagues to vote ''no'' on the motion to recommit.

The SPEAKER pro tempore. Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

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

RECORDED VOTE

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

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 204, noes 223, not voting 8, as follows:

[Roll No. 281]

AYES—204

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldacci
Baldwin
Barcia
Barrett
Becerra
Bentsen
Berkley
Berman
Berry
Bishop
Blagojevich
Blumenauer
Bonior
Borski
Boswell
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Capps
Capuano
Cardin
Carson (IN)
Carson (OK)
Clayton
Clement
Clyburn
Condit
Conyers
Costello
Coyne
Cramer
Crowley
Cummings
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley
Doyle
Edwards
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank
Frost
Gephardt
Gonzalez
Gordon
Green (TX)
Hall (OH)
Hall (TX)
Harman
Hastings (FL)
Hill
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind (WI)
Kleczka
Kucinich
LaFalce
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Luther
Lynch
Maloney (CT)
Maloney (NY)
Markey
Mascara
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Mink
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Peterson (MN)
Phelps
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Ross
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schakowsky
Schiff
Scott
Serrano
Sherman
Shows
Skelton
Slaughter
Smith (WA)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Thompson (CA)
Thurman
Tierney
Turner
Udall (CO)
Udall (NM)
Velazquez
Visclosky
Waters
Watson (CA)
Watt (NC)
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOES—223

Aderholt
Akin
Armey
Bachus
Baker
Ballenger
Barr
Bartlett
Barton
Bass
Bereuter
Biggert
Bilirakis
Blunt
Boehlert
Boehner
Bonilla
Bono
Boozman
Brady (TX)
Brown (SC)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Cannon
Cantor
Capito
Castle
Chabot
Chambliss
Coble
Collins
Combest
Cooksey
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal
DeLay
DeMint
Diaz-Balart
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
Emerson
English
Everett
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Frelinghuysen
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Goode
Goodlatte

Goss
Graham
Granger
Graves
Green (WI)
Greenwood
Grucci
Gutknecht
Hansen
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hilleary
Hobson
Hoekstra
Horn
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
Kerns
King (NY)
Kingston
Kirk
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCrery
McHugh
McInnis
McKeon
Mica
Miller, Dan
Miller, Gary
Miller, Jeff
Moran (KS)
Morella
Myrick
Nethercutt
Ney
Northup
Norwood
Nussle
Osborne
Ose
Otter
Oxley
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Reynolds
Riley
Roemer
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schaffer
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skeen
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Stump
Sullivan
Sununu
Sweeney
Tancredo
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Tiberi
Toomey
Upton
Vitter
Walden
Walsh
Wamp
Watkins (OK)
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOT VOTING—8

Clay
Gutierrez
Jefferson
Paul
Roukema
Thompson (MS)
Towns
Traficant

□ 0215

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. THORNBERRY.) The question is on the passage of the bill.

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

RECORDED VOTE

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

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 221, noes 208, not voting 6, as follows:

[Roll No. 282]

AYES—221

Aderholt
Akin
Armey
Bachus
Baker
Ballenger
Barr
Bartlett
Barton
Bass
Bereuter
Biggert
Bilirakis
Blunt
Boehlert
Boehner
Bonilla
Bono
Boozman
Boswell
Brady (TX)
Brown (SC)
Bryant
Burr
Burton
Buyer
Callahan
Calvert
Camp
Cannon
Cantor
Capito
Castle
Chabot
Chambliss
Coble
Combest
Condit
Cooksey
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal
DeLay
DeMint
Diaz-Balart
Doolittle
Dreier
Duncan
Dunn
Ehlers
Ehrlich
English
Everett
Ferguson
Fletcher
Foley
Forbes
Fossella
Frelinghuysen
Gallegly
Ganske
Gekas
Gibbons
Gilchrest
Gillmor
Gilman
Goode
Goodlatte
Goss
Graham
Granger
Graves
Green (WI)
Greenwood
Grucci
Hall (TX)
Hansen
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Herger
Hilleary
Hobson
Hoekstra
Horn
Houghton
Hulshof
Hunter
Hyde
Isakson
Israel
Issa
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
Kerns
King (NY)
Kingston
Kirk
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Maloney (CT)
Matheson
McCrery
McHugh
McInnis
McKeon
Mica
Miller, Dan
Miller, Gary
Miller, Jeff
Moran (KS)
Morella
Myrick
Nethercutt
Ney
Northup
Norwood
Nussle
Osborne
Ose
Otter
Oxley
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Reynolds
Riley
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schaffer
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skeen
Smith (NJ)
Smith (TX)
Souder
Stearns
Stump
Sullivan
Sununu
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Thune
Tiahrt
Tiberi
Toomey
Upton
Vitter
Walden
Walsh
Wamp
Watkins (OK)
Watts (OK)
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOES—208

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldacci
Baldwin
Barcia
Barrett
Becerra
Bentsen
Berkley
Berman
Berry
Bishop
Blagojevich
Blumenauer
Bonior
Borski
Boucher
Boyd
Brady (PA)
Brown (FL)
Brown (OH)
Capps
Capuano
Cardin
Carson (IN)
Carson (OK)
Clayton
Clement
Clyburn
Collins
Conyers
Costello
Coyne
Cramer
Crowley
Cummings
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley
Doyle
Edwards
Emerson
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Flake
Ford
Frank
Frost
Gephardt
Gonzalez
Gordon
Green (TX)
Gutierrez
Gutknecht
Hall (OH)
Harman
Hastings (FL)
Hill
Hilliard
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley
Hostettler
Hoyer
Inslee
Istook
Jackson (IL)
Jackson-Lee (TX)
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind (WI)
Kleczka
Kucinich
LaFalce
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Luther
Lynch
Maloney (NY)
Manzullo
Markey
Mascara
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McKinney
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Millender-McDonald
Miller, George
Mink
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Phelps
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rivers
Rodriguez
Roemer
Ross
Rothman
Roybal-Allard
Rush
Sabo
Sanchez
Sanders
Sandlin
Sawyer
Schakowsky
Schiff
Scott
Serrano
Sherman
Shows
Skelton
Slaughter
Smith (MI)
Smith (WA)
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Thurman
Tierney
Turner
Udall (CO)
Udall (NM)
Velazquez
Visclosky
Waters
Watson (CA)
Watt (NC)
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—6

Clay
Jefferson
Paul
Roukema
Towns
Traficant

□ 0232

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

SUPPORT OF AMERICAN EAGLE SILVER BULLION PROGRAM ACT

Mr. TIBERI. Mr. Speaker, I ask unanimous consent that the Committee on Financial Services be discharged from further consideration of the Senate bill (S. 2594) to authorize the Secretary of the Treasury to purchase silver on the open market when the silver stockpile is depleted, to be used to mint coins, and ask for its immediate consideration in the House.

The Clerk read the title of the Senate bill.

The SPEAKER pro tempore (Mr. THORNBERRY). Is there objection to the request of the gentleman from Ohio?

There was no objection.

The Clerk read the Senate bill, as follows:

S. 2594

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Support of American Eagle Silver Bullion Program Act''.

SEC. 2. FINDINGS.

Congress finds that—

(1) the American Eagle Silver Bullion coin leads the global market, and is the largest and most popular silver coin program in the United States;

(2) established in 1986, the American Eagle Silver Bullion Program is the most successful silver bullion program in the world;

(3) from fiscal year 1995 through fiscal year 2001, the American Eagle Silver Bullion Program generated—

(A) revenues of $264,100,000; and

(B) sufficient profits to significantly reduce the national debt;