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MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003—Continued

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

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

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

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

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

Members might further ask how would the contracts be awarded under this privatization of Medicare, and the answer in a fairy tale world would be shared risk capitation of performance. But the truth is this is not a fairy tale. It happens to be the truth. That was the Democratic proposal on Medicare prescription drugs, but tonight Democrats have come to the floor one after the other and criticized this plan because it contained many of those same features. Different, however, in some respects because this plan provides better coverage for seniors on the bottom. In fact, while some of my friends came to the floor and called this a sad day and said how sorry they were for the citizens of California, this bill we proposed would put 1.4 million California senior citizens in plans that would cost them no premiums, no deductibles, free entry for drugs in California for 1.4 million senior citizens, half a million in Indiana, half a million in Ohio, half a million in Pennsylvania, almost a million in Texas, and so on and so forth, free drug coverage under this plan, and yet the fantasy plan offered by the Clinton administration just a few years ago containing many of the same elements is somehow forgotten. It is somehow put away in a closet. It is somehow not to be remembered, and this plan is to be attacked. When we test credibility of arguments on the floor of the House, test them against the reality of the plan offered by the Democrats and the reality of the plan offered today.

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

I ask the gentleman from California (Mr. STARK), do you really believe that? God bless them. That is the sort of unstatesmanship that should never enter the halls of this House.

There is nobody in this House that loves their mother more than I love my mother. I challenge Members on that. She is a three-time cancer survivor, she is 84 years old, and she won first place at the Senior Olympics this year in shotput, and if you give her trouble, I will sic her on you.

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

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

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committee report is back after a compromise with the Senate, you might want to join us then.

Mr. ISTOOK. Mr. Speaker, this bill will hasten the day when Medicare will go bankrupt, and it also threatens to unravel our children's future.

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

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

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

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

What should we be doing?

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

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

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

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

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

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

Mr. UDALL of New Mexico. Mr. Speaker, for far too long, as I traveled around the state of New Mexico, seniors have told me their heartbreaking stories of being forced to choose between purchasing their medicine and purchasing groceries as a result of the exploding costs of prescription drugs. Today we have an excellent opportunity to address this tragic situation by providing a prescription drug benefit for Medicare beneficiaries and put an end to the outrageous dilemma facing our seniors throughout the country. In addition, we have an historic opportunity to modernize the incredibly important Medicare program, including updating formulas for our health care providers in rural areas—an issue that is of particular importance to my constituents and me.

Thankfully, H.R. 1 does address the latter concern, but unfortunately falls far short on the critically important issue of prescription drug coverage. The prescription drug benefit provided under H.R. 1 would be the first step toward privatizing one of the most successful government programs in history, leaves seniors at the mercy of insurance companies, forces seniors into HMOs, has an incredible gap in coverage, and does nothing to control the exploding costs of prescription drugs. As such, I am forced to vote against H.R. 1.

Under this bill, seniors and disabled Medicare beneficiaries can obtain their prescription drug coverage only from HMOs and private insurance companies. Given the history of HMOs and other private health plans in rural areas, I have serious concerns about this approach. In fact, in 1997 in the state of New Mexico, HMOs dropped approximately 18,000 individuals because of rising costs. These individuals were left with nowhere to turn.

H.R. 1 would put beneficiaries at a similar risk by relying on untested private drug-only plans, which can decide whether or not to serve rural areas, and they can decide to leave every 12 months. Further contributing to the risk of this provision is the fact that there is no fallback option to allow traditional Medicare to provide prescription drug coverage if private plans decline to provide coverage in rural areas. Because much of my district is rural, this legislation would put the seniors in my district at particular risk. I cannot support this.

This is greatly disappointing to me given the several major rural healthcare provisions that are including in this legislation. The labor share revision, the geographic physician payment adjustment, equalizing the Medicare disproportionate share payments, increasing home health services furnished in rural areas, critical access hospital improvements—these are all incredibly important provisions that I strongly support in order to help strengthen the health care system in rural areas. I cannot, however, vote in support of H.R. 1 with the extremely flawed prescription drug benefit included with these strong rural health provisions.

Mr. Speaker, I strongly support adding a voluntary prescription drug benefit to Medicare. I strongly believe that we must take action to provide relief for our nation's seniors. I simply do not believe, however, that H.R. 1 is the most effective way to do so. Tonight I will be voting in support of the substitute being offered by Mr. RANGEL and Mr. DINGELL.

In addition to including stronger rural provisions than those included in the Majority's bill, the substitute includes a guaranteed benefit of a $25 premium, a $100 deductible, 20% co-insurance, and a $2,000 catastrophic protection. The substitute also allows for lower drug prices by granting the Secretary of Health and Human Services the authority to use the collective purchasing power of Medicare's 40 million beneficiaries to negotiate lower drug prices. Also, the substitute grants access to generic drugs, and allows the safe re-importation of pharmaceuticals, providing further tools to seniors for gaining access to cheaper prescription drugs.

Perhaps most importantly, the substitute will not force seniors to leave traditional Medicare to get drug coverage. Nor will they be forced to join a private insurance plan that will restrict access to needed drugs, deny coverage for the medicine their doctor prescribes, or force them to change pharmacies.

Mr. Speaker, our seniors deserve a real prescription drug benefit, not the flawed benefit included in H.R. 1. I urge my colleagues to vote against H.R. 1 and support the substitute. Our seniors should not be forced into the unconscionable position of being forced to choose between medications and groceries any longer, and, unfortunately, H.R. 1 will not adequately address this situation.

Mr. SHAYS. Mr. Speaker, I rise in support of H.R. 1, the Medicare Modernization and Prescription Drug Act. I want to begin by appreciating the incredible time and energy that my colleague, NANCY JOHNSON, has put into crafting what I consider to be a good product, and thank her for her efforts.

When Medicare was created in 1965, the program's principal purpose was to help seniors pay for their hospital costs. Since that time, Medicare has not kept pace with how health care is delivered. Today, we are bringing this program into the 21st Century by including coverage for prescription drugs.

Our seniors need and deserve prescription drug coverage under Medicare. This legislation will give them tremendous assistance. After a $250 deductible, seniors will get 80 percent of their first $2,000 paid for by the program, catastrophic protection from any cost over $3,700, and discount on all their pharmaceutical costs from an Rx Drug Discount Card. The card will save beneficiaries between 10 and 25 percent on every purchase.

I believe this bill takes a positive step towards injecting competition into Medicare, but I regret we did not go further in reforming the program to ensure its solvency for future generations.

I also believe anything free, even health care, is over-utilized. I support the House proposal to add a small co-payment to home health care and to index Part B deductibles to inflation, and I support the Senate proposal to have seniors pay a portion of their catastrophic costs. This way, seniors have a greater incentive to get care because they need it, not just because it is offered.

Finally, we must be concerned with what this program will ultimately cost. It could go well over the $400 billion we budgeted and accelerate the program's financial demise if we are not vigilant.

There is a lot to like in the bill we hope to pass tonight, and the Senate has already passed a plan I can support. My hope is the House and Senate conferees will draft a final bill that takes the best approaches from each chamber and that we can ultimately send the President a Medicare prescription drug bill supported by both sides of the aisle. I urge my colleagues to support H.R. 1.

Mr. DAVIS of Illinois. Mr. Speaker, late last night, the House Rules Committee sent a terrible message to our Nation's seniors and hospitals. Two amendments I proposed were not allowed to pass onto the House floor. The first amendment would have stricken the language regarding the ''market basket'' index. Under the current bill hospitals would lose $12 billion over the next ten years. My amendment would have kept the funding streams toward hospitals level so that hospitals would not be forced to make difficult cuts in services and jeopardize patient care.

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

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

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

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

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

The most distressing aspect of this bill, to me, to my constituents, and to the AARP, is that it takes the entire Medicare program down a short road to privatization. By the year 2010, Medicare would be converted to a voucher program with competition between managed care plans and traditional fee-for-service—only the deck would be stacked against the traditional plans. Seniors would find themselves have forced to enroll in managed care programs like the Medicare+Choice programs that have failed so miserably in central New Jersey.

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

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

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

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

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

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

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

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

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

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

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

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

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

And we need to make it reliable—no holes to fall through when they might need it most;

No dropping them like hot potatoes like happened with Medicare + choice.

Finally tonight, we have such a bill in the Democratic, Rangel/Dingell substitute.

In this bill, there are no slight of hands. What you see is what you get.

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

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

I want for Medicare beneficiaries, who have played an important role in making this country what it is, and paved the way for all of us, and those who have special needs, what I want for my family and myself.

The Democratic substitute, developed under the leadership of JOHN DINGELL and CHARLES RINGELL, is the only bill before either body, which honors our seniors' gift to all of us.

Let us do the right thing. Reject the Republican bill and pass the Democratic substitute.

Mr. HINOJOSA. Mr. Speaker, I rise today in opposition to the Republican prescription drug bill. For years, our seniors have been begging for help to obtain affordable prescription drugs. Unfortunately, however, the bill before us today gives relief not to our vulnerable seniors, but to the large drug companies.

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

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

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

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

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

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

The proposed House bill would fail to offer meaningful prescription drug coverage to the millions of low-income women with incomes below the 135 percent poverty level who do not meet the requirements of asset tests. Also, the House bill would raise the amount of copayments that our country's poorest women Medicare beneficiaries are forced to pay.

Unlike the House bill, the Senate proposal, while not perfect, would be far more helpful to elderly women who range from 74 to 160 percent of the poverty level. Under the House bill, the out-of-pocket costs paid by elderly women will still make it difficult for them to get their much-needed prescriptions filled. If the House bill is enacted, our struggling women seniors who are in greatest need of assistance will receive up to 40 percent fewer prescriptions than those seniors who are able to afford private insurance. Our elderly women, who are among our most vulnerable citizens, deserve far better treatment than this. It is critical that as Members of Congress, we help women and all seniors by expanding Medicare to offer a prescription drug benefit that is universal, affordable, dependable, and voluntary. We can do no less than to offer elderly women access to adequate healthcare that they can afford and easily access.

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

Furthermore, the House plan would force seniors to purchase their own private insurance, a tactic that will benefit insurance companies, and not seniors. This is a catastrophe we can avoid if we craft the right policy to benefit our elderly now. When it come to our elderly women, we know that:

Women make up 58 percent of the Medicare population at age 65, and 71 percent of the Medicare population at age 85.

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

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

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

As compared to married women, widows are four times as likely, and divorced or single women are five times as likely to live in poverty upon retiring.

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

Once retired, women earn less than men because:

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

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

Minority women are much more likely to earn less and live in poverty than are White women. Even when they have similar educational backgrounds, minority women tend to earn less money and own fewer assets.

The sad fact is, the older and poorer a woman is, the higher her out-of-pocket health care costs will be, and the more help an elderly woman requires, the less likely she is to receive assistance. As a nation, though we are facing a great economic crisis, we are still obligated to provide assistance to our most needy citizens. Let us take good care of our elderly women and men by not enacting a prescription drug policy that will force them to choose between either buying food or paying for necessary medication.

Mr. COSTELLO. Mr. Speaker, I rise in strong opposition to H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003. I recently informed over 70,000 seniors in my district that I would not support legislation that would fundamentally change the nature of Medicare and provide a prescription drug benefit that relies solely on insurance companies. I am opposing the bill because it does just that.

Medicare has been a success because it provides guaranteed coverage for all elderly and disabled Americans. H.R. 1 would end Medicare as we know it and may particularly harm rural areas that depend on the traditional Medicare program. Beginning in 2010, H.R. 1 would force the Medicare fee-for-service program for doctors and hospitals visits to compete with private insurance plans. People who wanted to remain in traditional Medicare would find their premiums going up as other beneficiaries opted for bargain private insurance coverage. Seniors and the disabled would essentially be forced out of the traditional fee-for-service program and into some form of managed care.

In addition, the Republican approach does not guarantee the same benefits for all seniors. Seniors who live where hospitals and doctors negotiate lucrative contracts with managed care plans would have to pay more; seniors with higher incomes would have to pay more; seniors in rural areas would have fewer choices of doctors and pharmacies; and seniors with low incomes but with assets such as a savings account might get nothing at all. These provisions violate the central promise of Medicare: to provide a consistent, guaranteed benefit that allows everyone, no matter where they live, how much they have, or how sick they are, access to quality medical care.

Finally, H.R. 1 is flawed because it offers seniors an inadequate prescription drug benefit. I support a voluntary prescription drug benefit paid for by Medicare. I am committee to providing a comprehensive benefit that is affordable and dependable for all beneficiaries with no gaps or gimmicks in its coverage. The Senate is currently working on a prescription drug bill that provides a government fallback provision, providing Americans with more of a reliable, consistent benefit. The Senate is moving in the right direction and I am hopeful, progress will continue to be made when this legislation goes to conference.

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

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

Mr. FILNER. Mr. Speaker, I rise today to discuss the prescription drug benefit proposal that my colleagues on the other side of the aisle have rammed through the legislative process. I rise to decry this bill because it does not give seniors what they deserve. It seems pretty simple to me: a prescription drug benefit under Medicare ought to work the same way that Medicare has always worked. That is, it is a guaranteed benefit for all seniors, no matter where they live, how ill they are, or what kind of illness they have.

This bill proposes to turn the prescription drug benefit over to HMOs and the private insurance industry. That means, for one thing, that premium prices are not guaranteed—the insurance industry would be able to charge what ever they wanted for the premium. In addition, it would be the insurance companies that get to decide which drugs would be covered. What this means for seniors is that there will not be a consistent, reliable program for all seniors is that there will not be a consistent, reliable program for all seniors across the country. Seniors in my district might pay higher premiums and get less coverage than their counterparts in other areas of the country. Or, they may get better coverage for lower premiums. We just don't know because it will be left up to the private insurance companies and the HMOs.

This bill also raises out-of-pocket costs for those who need the protection that Medicare had traditionally provided: the sickest and the poorest beneficiaries. In addition to the ''mystery'' premium, seniors will have to pay for the first $250 worth of drugs without any help from the Federal Government. After they have paid $250, they must pay 20 percent of all their drug costs. Once they reach $2,000 worth of medications, they must pay all of their drug costs until they reach $4,900 worth of drug costs. So, once they get to $2,000, in addition to the premium, the $250, the 20 percent copay, they must cover all of their prescription costs until they get to $4,900. That is quite a lot of money.

Allowing HMOs and private insurance companies to take over the Medicare Prescription Drug benefit also presents a problem for rural areas. A very large portion of my district is rural. Everyone knows that for private companies, the bottom line rules. Rural areas aren't as profitable for insurance companies, so there is less incentive for them to offer benefits in those area. This means that there will be fewer choices—if any choices at all—for seniors in rural areas.

In one fell swoop, this bill takes the great success story that is Medicare: Universal healthcare for all beneficiaries, and crushes it. Under this Republican bill, your benefits and your costs depend on your income, where you live and the whim of the insurance company or HMO that is running the program in your area.

Mr. Speaker, I have received many letters and calls from my constituents who are worried about this proposal. They know that this proposal will cost them more money, may not even be available to them if they live in rural areas, and will not cover all their medication needs—especially for those with diabetes or even cancer. I will read one example from my constituent, Edna Monk:

Dear Sir, I am writing my Senators and Representatives to plead our case regarding Medicare proposals that could endanger patent access to chemotherapy. I am a lung cancer survivor, age 71, and my husband, age 78, is now undergoing chemo, for liver cancer. Chemo drugs are required for my husband's quality of life now and MRI's have shown the tumors have diminished in size, so ''it's working!''

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Their plan will convert Medicare from a defined benefit plan to a defined contribution voucher plan. In plain English, it means that seniors will lose the guaranteed coverage and the security of knowing which benefits are covered. Instead of having predictability about Medicare premiums and copayments, seniors will essentially receive a voucher for services to cover the lowest-cost private insurance plan. If this plan does not pay for the services they need, seniors will have to cover the difference—which could be a big figure—out of their own meager income.

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

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

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

In contrast, the Democratic plan is guaranteed, defined, dependable, and understandable. It sets a premium of $25 a month; a $100 per year deductible; a 20 percent co-insurance payment for beneficiaries, with Medicare paying 80 percent; and a limit of $2,000 in out-of-pocket costs per beneficiary per year.

Health care is essential in greater Minnesota. The hospitals in many small communities throughout northern and northeastern Minnesota are the major employer in town, and the health care they offer is critical for economic development and tourism. The Rangel/Dingell bill offers a substantial improvement in payments to the hospitals and doctors in rural Minnesota who provide those critical health care services.

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

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

The Democratic plan would provide an additional $6 billion for all rural ambulance providers by increasing payments for ambulance services. The increases we propose would ensure the financial solvency of St. Mary's Life Flight, enabling it to continue assisting, for example, people who are injured while vacationing in the Boundary Waters Canoe Area Wilderness.

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

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

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

The $400 billion allocated for the Medicare drug benefit is not being spent widely under this legislation. High-income Medicare beneficiaries like Warren Buffett are subsidized 73 percent by the Federal government for their drug-only insurance plans. Low-income seniors who are not dually eligible have no cost-sharing assistance for their drug spending between $2,000 and $3,500. The Secretary is commanded to negotiate with insurance companies who will game the system to receive a 99.99-percent subsidy when 73 percent would have been fine. Mr. Speaker, that's not a negotiation—the insurance company will hold all of the cards. No money is being spent on a fallback plan. Seniors in rural areas of North Carolina will not have drug coverage if insurance companies refuse to offer a plan, even when the companies are bribed with an almost no-risk contract. This bill would benefit insurance companies, not extend a benefit to our Nation's seniors.

Yet insurance companies do not want any part of this legislation. For four years insurance companies have been telling Congress

that they do not want to insure Medicare beneficiaries' drug expenditures, but we keep throwing money at them in the hope that they will finally say yes. The premium subsidy used to be 67 percent, now it is 73 percent and Congress demands that it grow to 99.99 percent if need be. At the end of the day, who are we kidding? Of course it will be 99.99 percent.

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

Where do my colleagues think the extra money is going to come from? When CBO realizes that their estimated insurance penetration rate was off by 10 percent that money will come out of future physician, hospital, nursing home, and home health care reimbursement rates. If only 85 percent of seniors sign up for drug coverage and plans' subsidies skyrocket, that money will come out of Food and Drug Administration modernization efforts, National Institutes of Health research, and bioterrorism preparedness. Congress is working with a limited pot of money, but we are promising a defined benefit. Obviously, the experiences of the private sector have taught us nothing.

If Congress listened to the private sector, we would mirror the success of defined contribution plans and individual empowerment by offering choice. Seniors could choose between twenty different discount drug cards based on the cards' formularies, pharmacy networks, and drug discounts. The government would set up accounts and contribute money to those accounts based on the seniors' needs. Seniors, their family members, friends, and former employers could put money into the accounts and receive a tax deduction. And insurance companies would offer catastrophic coverage that is subsidized by the federal government for low-income seniors. Unfortunately, that plan is not on the floor today.

Mr. Speaker, I wanted to be able to come to the floor today and vote for a good Medicare prescription drug benefit because of the bills passed by the House in the last 3 years this one has the greatest chance of actually becoming law. But not only does this bill contain a bad drug benefit, it also contains a cut in the overall hospital market basket update, a new home health copayment, multiple reimportantion provisions that will harm our Nation's drug supply, and a reduction in the overall reimbursement rate for physicians such as oncologists and rheumatologists who administer Part B drugs. It also constitutes a threat to the very future of our health care system.

I can only compare my feelings today to my experience in 1997, when I voted against the Balanced Budget Act. I was one of only 32 Republicans who opposed that bill. I came to Congress to balance the federal budget, but in the end I could not vote for the legislation because of the drastic and thoughtless cuts in Medicare reimbursements. Since 1997, Congress has done nothing substantive in Medicare except try to fix the damage done under the BBA. I cannot support this legislation that builds on and magnifies those 6-year-old mistakes.

I regret that I cannot and will not vote for this legislation.

Mr. UDALL of Colorado. Mr. Speaker, I want to support a Medicare prescription drug bill, but I can't support the one we are considering today. It is inadequate, unreliable, will force seniors into HMOs, and will endanger drug benefits that many seniors get through their retirement plans. In fact, instead of drafting a Medicare drug benefit bill, the Republican Majority has used this opportunity to try to end Medicare as we know it.

I have long believed that Congress should act to help seniors with their prescription drug expenses. Nearly everyone agrees that Medicare should be updated with a drug benefit; it is the right and sensible thing to do. How we design that benefit is where the rub is. I had hoped that we would vote on a bill similar to the one in the Senate because I think it's a good start toward building a workable, financially sound prescription drug benefit. But the House bill is not the same as the Senate bill.

First, I think Congress should give seniors greater choice in coverage, however, it should provide an equal prescription drug benefit to all beneficiaries, regardless of whether they enroll in a private health plan or traditional fee-for-service Medicare. We shouldn't force seniors into managed care, which I believe this bill will do by opening the traditional Medicare program up to competitive bidding against private insurers in 2010.

Second, the House bill does not include an important ''fallback'' provision that requires that traditional Medicare would step in as a backup if private insurers show no interest in selling drug plans in a particular area. Currently, private plans don't exist in many parts of the country, including many smaller cities, rural and mountain areas in Colorado. I've heard from many seniors in my district who have been dropped from their Medicare HMO and are now having trouble finding a doctor. In addition, 88 percent of all Medicare beneficiaries are enrolled in traditional Medicare. So, without this ''fallback'' safety net provision, seniors would have no coverage in regions where insurers say it's unprofitable to provide it, especially rural areas.

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

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

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

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

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

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

Second, this bill guarantees coverage under Medicare.

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

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

Fourth, this bill has no gaps in coverage. Under the Democratic plan, when a senior has spent $2,000 on drugs, the government picks up the remaining costs.

When a senior has spent $2,000 under the Republican plan, they're dropped. They get zero coverage until they've spent $4,900.

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

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

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

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

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

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

First, the legislation before us has the government assuming 73 percent of the risk of offering the insurance, 43 percent of the initial

benefit and 30 percent of reinsurance retrospectively. This is the floor! We must all understand that the taxpayer's exposure to risk can only increase. The bill permits the government to assume more risk, up to 99.9 percent if it is necessary to entice an insurance product into a region. And this is an unknown factor. We simply do not, nor cannot, know what this provision will cost the taxpayers.

Today, Medicare already consumes nearly 12 percent of the federal budget. It is expected to be 30 percent or 35 percent of the federal budget in 2030 without the addition of prescription drugs, or any other benefit. It is irresponsible of this Congress to simply add a prescription drug benefit without also addressing the budgetary impact of this benefit. H.R. 1 leaves the federal budget and the taxpayers exposed to unknown expenditure levels in the future. I do not believe that this drug bill will remain within the proposed budget of $400 billion over the next 10 years.

Second, there is no provision in the House bill on how to provide a benefit to seniors in areas where two insurance products are not available in January 2006. It is simply neither realistic, nor fair, for seniors in one region to have products available and seniors in another region to not have choice because two plans have not been forthcoming.

Furthermore, I am adamantly opposed to the proposal by some, especially in the other body, that the government provide this coverage. This will only lead to the government determining what prescription drugs a senior can have and ultimately the imposition of price controls that will have a chilling effect upon research and development of pharmaceutical therapies.

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

I am also concerned about a number of modifications made under the bill to reimbursement for providers and to the last minute inclusion of language regarding the Patent Term Restoration Act, the so-called Hatch-Waxman legislation. Although some very necessary provider reimbursement changes were made in the bill, particurlary regarding doctors and rural areas, nonetheless, I am concerned about the changes to the market basket update for hospitals, as well as the changes to skilled nursing facilities and home health care providers. In addition, I share the concern of others regarding the sufficiency of the reimbursement to oncologists. It is very true that the Congress needed to address the use of the ''average wholesale price,'' which was neither average nor wholesale, and left Medicare beneficiaries paying 20 percent of an inflated drug price, but oncologists need to be reasonably compensated for the level of care they provide to Medicare patients. I am not convinced that this has been sufficiently addressed.

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

The vast majority of seniors have drug coverage today through either an existing government program or through the private sector. However, 27 percent of seniors have nothing. These seniors pay the highest prices when they go to the pharmacy because they have no means to bargain for lower costs. These seniors also tend to be those between 100 percent and 175 percent of the federal poverty level (FPL). A Medicare drug benefit should not displace existing coverage and should address the needs of those seniors who do not have coverage.

The government should encourage employers, families and others to help seniors with the purchase of expensive prescription drugs. It is time that we admit that no proposal that comes to the House floor that meets the budget requirements will fully address all the prescription drug requirements of seniors. Every plan will have a ''so-called donut hole.'' There should be a way to tackle this without putting our heads in the sand and expecting it to simply ''work out.''

We live by a system of checks and balances. We run into the limitations with everything that we do. How can we then create a system that is dependent upon the unknown? The government's assistance to beneficiaries should be a defined contribution. This type of benefit would be manageable and known.

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

Along with four of my colleagues on the Energy and Commerce Committee, we submitted legislation, that would address these issues and provide a prescription drug benefit under Medicare. I testified before the Rules Committee to request a vote on our bill. The request was denied. This benefit would have been delivered through a prescription drug discount, or value, card that would be available to all seniors on a voluntary basis for an annual $30 fee. This is an approach that has been recommended by the President.

Any entity qualified by the Centers for Medicare and Medicaid Services could offer a drug value card to seniors. Card issuers would negotiate with pharmaceutical manufacturers for discounts on drug utilizing the same techniques that are found in the marketplace today. These discounts would range from 15 percent to 35 percent of current retail prices. The competition among these card issuers would result in attractive offerings to beneficiaries.

Recognizing that some beneficiaries need financial assistance to pay for prescription drugs, this legislation would tie the drug value card to an account to which the federal government would provide assistance related to the income of the beneficiary. Others could add contributions on a tax preferred basis up to $5,000 for a beneficiary and family; and $5,000 for an employer. Non-profit organizations, like local churches, and State pharmaceutical assistance programs could add contributions to the accounts. Contributions on the accounts would roll over from year to year.

Protection from catastrophic drug expenses would also be offered at $10,000 through the private sector, with federal subsidies on the premium for those with low incomes.

In my opinion, this delivery mechanism for a prescription drug benefit works best for the beneficiary, and best for the taxpayers. Beneficiaries would have access to negotiated discounts and some financial assistance to buy drugs. The taxpayers would have a defined contribution that could be planned from year to year in the federal budget.

My colleagues, this has been a long road for us all. But, it is nothing compared to what could happen if Congress gets this wrong. Please be mindful of our obligations to our nation, not just to seniors.

It is my opinion that Congress needs to grasp this opportunity to provide a prescription drug benefit with a full appreciation of the duty and responsibility this nation has to our seniors, taxpayers, and future generations. To do anything less, we break the trust of all Americans.

Because the margin for error is so thin, my hope is that the majority is right. However, my intellect and instincts tell me that this bill will not fulfill the desired result. I must vote against final passage of this measure.

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. 1 nor the alternative allows seniors the ability to control their own health care. Both plans give a large bureaucracy the power to determine which prescription drugs senior citizens can receive. Under both plans, federal spending and control over health care will rise dramatically. The only difference is that the alternative puts seniors under the total control of the federal bureaucracy, while H.R. 1 shares this power with ''private'' health maintenance organizations and insurance companies. No wonder supporters of nationalized health care are celebrating the greatest expansion of federal control over health care since the Great Society.

I am pleased that the drafters of H.R. 1 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. 1 contains several good provisions addressing the congressionally-created crisis in rural health and attempts 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. 1 provides seniors a choice between staying in traditionally Medicare or joining an HMO or a Preferred Provider Organization (PPO). No matter which option the senior selects, choices about which pharmaceuticals are available to seniors will be made by a public or private sector bureaucrat. Furthermore, the bureaucrats will have poor to determine the aggregate prices charged to the plans. Being forced to choose between types of bureaucrats is not choice.

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 Medicare and/or HMO bureaucrats attempt to control costs by reducing the reimbursements paid to pharmacists to below-market levels (thus causing pharmacists to refuse to participate in Medicare), and restricting the type of pharmacies seniors may use in the name of ''cost effectiveness.'' Bureaucrats may even go so far as to forbid seniors from using their own money to purchase Medicare-covered pharmaceuticals. I remind may colleagues that today the federal government prohibits seniors from using their own money to obtain health care services that differ from those ''approved'' of by the Medicare bureaucracy!

This bill is even more pernicious when one realizes that this plan provides a perverse incentive for private plans to dump seniors into the government plans. In what is likely to be a futile effort to prevent this from happening, H.R. 1 extends federal subsidies to private insurers to bribe them to keep providing private drug coverage to senior citizens. However, the Joint Economic Committee has estimated that nearly 40 percent of private plans that currently provide prescription drug coverage to seniors will stop providing such coverage if this plan is enacted. This number is certain to skyrocket once the pharmaceutical companies begin passing on any losses caused by Medicare price controls to private plans.

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

Setting up a system where by many of those currently receiving private coverage are hired into the government program exacerbates one of the major problems with this bill: it hastens the bankruptcy of the Medicare program and the federal government. According to Medicare Trustee, and professor of economics at Texas A&M University, Tom Saving, the costs of this bill could eventually amount to two-thirds of the current public-held debt of $3.8 trillion! Of course, estimates such as this often widely underestimate the costs of government programs. For example, in 1965, the government estimate that the Medicare Part B hospitalization program would cost $9 billion in 1990, but Medicare Part B costs $66 billion in 1990!

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

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

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

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

Supporters of H.R. 1 claim that this bill does liberalize the rules governing the importation of prescription drugs. However, H.R. 1's importation provision allows the Secretary of Health and Human Services to arbitrarily restrict the ability of American consumers to import prescription drugs—and HHS Secretary Thompson has already gone on record as determined to do all he can to block a free trade in pharmaceuticals! Thus, the importation language in H.R. 1 is a smokescreen designed to fool the gullible into thinking Congress is acting to create a free market in pharmaceuticals.

The alternative suffers from the same flaws, and will have the same (if not worse) negative consequences for seniors as will H.R. 1. There are only two differences between the two: First, under the alternative, seniors will not be able to choice to have a federally subsidized HMO bureaucrat deny them their choice of prescription drugs; instead, seniors will have to accept the control of bureaucrats at the Center for Medicare and Medicaid Services (CMS). Second, the alternative is even more fiscally irresponsible than H.R. 1.

Mr. Speaker, our seniors deserve better than a ''choice'' between whether a private or a public sector bureaucrat 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. 1617 provides seniors the ability to use Medicare dollars to cover the costs of prescription drugs in a manner that increases seniors' control over their own health care.

H.R. 1617 removes the numerical limitations and sunset provisions in the Medicare Medical Savings Accounts (MSA) program. Medicare MSAs 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 that seniors have access to a wide variety of health care services by minimizing the role of the federal bureaucracy. As many of my colleagues know, an increasing number of health care providers have withdrawn from the Medicare program because of the paperwork burden and constant interference with their practice by bureaucrats from the Center for Medicare and Medicaid Services. The MSA program frees seniors and providers from this burden, thus making it more likely that quality providers will remain in the Medicare program!

There are claims that this bill provides seniors access to MSAs. It is true that this bill lifts the numerical caps on Medicare MSAs; however, it also imposes price controls and bureaucratic requirements on MSA programs. Thus, the MSAs contained in this bill do nothing to free seniors and health care providers from third party control of health care decisions!

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

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

In conclusion, Mr. Speaker, both H.R. 1 and the alternative force seniors to cede control over which prescription medicines they may receive. The only difference between them is that H.R. 1 gives federally funded HMO bureaucrats control over seniors' prescription drugs, whereas the alternative gives government functionaries the power to tell seniors which 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 that gives all seniors access to Medicare Medical Savings Accounts.

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

One fact is that Medicare is currently headed toward financial collapse. The last report of the Medicare trustees shows that in nine years the income of the Medicare trust fund will not be enough to cover its expenses. After that, the problem gets much worse with the retirement of the baby boom generation.

A second clear fact is that Medicare was enacted in 1965 and has been largely unchanged since then. It does not reflect modern

medical practices, including our reliance upon prescription drugs. If we were designing a new federal health care program for seniors today—rather than in 1965 when Medicare was created—we would unquestionably include some form of prescription drug coverage.

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

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

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

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

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

Mr. KIND. Mr. Speaker, providing affordable Medicare prescription drug coverage for our nation's seniors is one of the most pressing issues facing our country today. Even though the elderly use the most prescriptions, more than 75 percent of seniors on Medicare lack reliable 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?

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

I came to Congress to work toward a real solution to this problem. Unfortunately, today's debate is a sham. We will not have the opportunity to discuss this issue in a fair and open process. There were several alternatives presented at the Rules Committee late last night and they should be debated on the floor today. The majority, however, chose to dedicate only one day to this debate and allowed only one alternative and no amendments to be made in order. 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 policies which they have said they won't offer. Further, there is no fall back option. So, if insurance companies won't offer these policies, how will seniors actually obtain prescription drug coverage under the leadership plan?

Providing a drug benefit through private plans could be problematic, specifically for folks living in rural and small communities. There are no requirements as to what has to be covered and the coverage may vary from area to area depending on the plan. Because is there is no guaranteed benefit, Wisconsin may end up on the short end of the stick like we have in the past under Medicare.

The biggest problem with the leadership bill is the fact that it will fully privatize Medicare in 2010. This is a radical provision that will be the demise of the traditional Medicare program on which our seniors have depended for nearly 40 years. In 2010, seniors will be given a lump sum to purchase health isuruance, including traditional Medicare. There is concern that the healthy seniors will leave traditional Medicare and the premiums will increase dramatically, up to 47 percent. In addition, under the leadership bill, each local area will have a different premium for fee-for-service Medicare. For example, seniors in Wisconsin might have to pay more to enroll in fee-for-service Medicare than seniors in Florida. This is a drastic departure from Medicare's fundamental principle that seniors across the country pay the same premium for the fee-for-service benefit.

We must provide a real solution to the problem of prescription drug coverage for our seniors. The Republican plan falls woefully short.

All of the Democratic alternatives offered at the Rules Committee would be better than the leadership bill. One proposal, the Medicare Rx NOW Act, is a simple straightforward plan that provides assistance to the seniors most in need, those with low incomes and seniors with high drug costs. This proposal builds on the Medicare program seniors know and provides them with a guaranteed benefit for no additional premium.

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

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

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

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

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

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

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

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

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

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

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

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

In addition to the excellent work and leadership of Chairman THOMAS and Chairman JOHNSON, I want to thank two unsung staff heroes—John McManus and Deb Williams—who have worked so tirelessly on these provisions.

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

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

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

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

For millions of Americans, this plan will replace traditional Medicare with vouchers that won't guarantee benefits.

It forces seniors into risky HMO plans and new private fee-for-service plans that will not cover all of seniors' costs!

Forty-seven percent of seniors in Medicare will have a $1,900 gap in their drug coverage. How are our seniors supposed to make up for that gap?

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

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

This plan will not give taxpaying pregnant women and children benefits!

It will not help the twenty million Hispanics without Health insurance!

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

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

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

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

This is not safe and it is not fair.

I am angered when I think about all of the people that the Republicans are leaving behind in this plan!

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

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

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

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

According to Republicans, that is wealthy!

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

This is an outrage!

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

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

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

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

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

Under the Republican plan they may start in Medicare.

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

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

My constituents deserve better than the Republican plan!

They deserve more!

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

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

A plan that actually works for America's seniors!

A plan that offers coverage to all seniors—even Hispanics!

It's time to take seniors off the bus to Tijuana!

Mr. MICHAUD. Mr. Speaker, tonight the House of Representatives considered a plan that would supposedly create a Medicare prescription drug benefit. While some touted the plan as an innovative approach, the fact is that when you look past the smoke and mirrors, it turns out to be a very bad deal for Maine's seniors. In fact, the House plan could make the current situation for seniors a lot worse: it will do nothing to control rising prescription costs, it will jeopardize the traditional Medicare fee-for-service plan that seniors enjoy right now, it has a large gap in coverage that will force seniors to pay thousands of dollars out of their pockets, and it may cause employers to drop their health coverage.

We all know that drug prices are spiraling out of control. Maine seniors are forced to take bus trips to Canada to buy affordable prescription drugs. Our best hope for getting affordable medicines to people is to lower prices—that is why Maine passed the innovative Maine Rx law, and that's why I introduced a national version of the bill called America Rx. Yet, the House legislation does nothing to control rising costs. In fact, this plan expressly prohibits the Secretary of Health and Human Services from ever negotiating with drug companies for better prices. Pharmaceutical companies are reaping huge profits while seniors are often forced to choose between medicine and food.

Furthermore, this plan doesn't guarantee a prescription benefit for seniors and it actually jeopardizes current Medicare coverage. The proposed benefit is entirely run by the private insurance industry and has no fallback provision of areas with no private plan. Without a fallback provision, there is no guarantee that private plans will be established in largely rural areas like Maine—so our seniors will be left in the cold. This has happened before with Medicare Plus Choice, and it is very likely to happen again, meaning that Maine's seniors would get nothing from this bill.

In addition, this bill also contains a ''premium assistance'' provision that aims to phase out traditional fee-for-service Medicare and replace it with a voucher program. This is just another step toward total privatization of Medicare and the elimination of the only plan available to seniors in areas such as Maine—the traditional Medicare plan. Forcing seniors into private plans, and making them give up Medicare, is not the right approach—but that's what this bill would do.

This bill also has a very large gap in coverage seniors would have to continue to pay a monthly premium, but would receive absolute no benefit fro drug costs between $2,000–$4,900. Having this kind of a gap in coverage is like telling people that their auto insurance doesn't cover accidents in June, July and August.

Finally, and perhaps worst of all, there is a provision in this bill that does not allow for retiree coverage to count toward the out-of-pocket spending cap. It has been estimated that the bill passed by the House would result in up to ⅓ of employers dropping their retiree coverage, the seniors who enjoy these plans would be forced into a Medicare plan with fewer benefits. The House should not pass a plan that forces seniors to lose what benefits they have.

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

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

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

In particular, I want to call attention to the fact that this bill does nothing to address the rapidly rising costs of prescription drugs. It not only fails to address this crisis, it contains a ''noninterference'' clause prohibiting the agents of the Department of Health & Human Services from using the bulk purchasing power of Medicare beneficiaries to negotiate for lower prices for senior citizens. Without taking measures to curb the escalating prices of the medications our seniors need to stay alive, the benefit is rendered meaningless. Seniors will pay more out of pocket in 2007 with the prescription drug benefit than they are paying in 2003 without it.

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

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

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

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

In those 2½ years, I have focused on a health care crisis for seniors on Long Island. We used to have 12 Medicare HMOs in my communities. Now we have two

left. Eighty-five thousand seniors have been tossed out of their Medicare HMOs. One out of five is skipping their medication because they can't afford them.

And in those 2½ years, I have listened to Republicans blame Democrats for this crisis; Democrats blame Republicans; the House blame the Senate; the Senate blame the House; Congress blame the White House; the White House blame Congress; and everyone blame the insurance companies.

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

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

Mr. Speaker, I believe the Democrats are right. It will take at least $800 billion to provide America's seniors with a truly comprehensive, voluntary prescription drug plan.

Is an $800 billion prescription drugs program better than a $400 billion program that's before us today? Of course. $400 billion is only half as good as $800 billion . . . but it is $400 billion better than nothing. And nothing is exactly what we will leave our seniors if we reject this proposal today.

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

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

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

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

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

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

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

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

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

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

Mr. EVANS. Mr. Speaker, this Republican Medicare bill falls well short of what our country's retirees deserve. And I believe, that if this Congress and this President had not squandered the budget surplus we could afford to give our seniors a benefit they deserve.

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

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

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

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

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

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

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

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

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

A better alternative to H.R. 2473 is The Medicare RX Drug Benefit an Discount Act (H.R. 1199) offered by my friend CHARLIE RANGEL of New York. This prescription drug plan would guarantee that every Medicare beneficiary, no matter where they live, could have a benefit with a $25 monthly premium, $100 annual deductible, 20 percent co-insurance and $2000 out-of-pocket limit. The bill would also:

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

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

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

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

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

Since its inception 1965, Medicare has provided important protection for millions of aged and disabled persons. H.R. 2473 would be a detriment to improving and securing this system. I lend my voice in opposition and urge my colleagues to vote against H.R. 4273 and to support H.R. 1199.

Ms. WATERS. Mr. Speaker, I rise to oppose this Medicare privatization plan, which is masquerading as a prescription drug bill.

This bill would force seniors who want prescription drug coverage to get it from private insurance companies. It provides no guarantee that insurance plans will be available, and when they are, premiums and benefits will vary widely. The bill also provides no coverage when a senior's prescription drug costs are between $2,000 and $4,900 per year. This huge coverage gap affects 47 percent of Medicare beneficiaries.

This bill is also a give-away to pharmaceutical companies, as it prohibits the Secretary of Health and Human Services from negotiating lower drug prices. The primary beneficiaries of this bill are not the beneficiaries of Medicare. They are the wealthy special interests in the pharmaceutical industry and the insurance industry that give campaign contributions to Republicans.

However, the most outrageous aspect of this bill is what it does to traditional Medicare. The bill would increase seniors' cost for visits to the doctor's office by raising the Medicare Part B deductible and indexing it for inflation. This could cost American seniors an estimated $8 billion. While this may seem like a tiny fraction of the Republicans' $350 billion tax-cut-for-the-rich, it is a huge expense for senior citizens, many of whom live on limited incomes.

This bill also divides Medicare into 10 or more regional plans in 2006 and then converts the entire Medicare program into a voucher program depending upon private insurance companies in 2010. If the Republicans really want to privatize Medicare, they should be honest with the American people and call this plan what it is, the Medicare Privatization Act.

The Democrats alternative prescription drug plan on the other hand provides prescription drug coverage under Medicare with guaranteed and affordable premiums and benefits for all American seniors and no gaps in coverage. It is time for Congress to make prescription drugs available to all seniors who need them.

I urge my colleagues to oppose the Republican Medicare Privatization Act and support the Democratic alternative.

Mr. ISTOOK. Mr. Speaker, this bill will hasten the day when Medicare will go bankrupt, and it also threatens to unravel our children's future.

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

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

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

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

What should we be doing?

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

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

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

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

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

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

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

Nursing home residents are not in a position to fill prescriptions like everyone else. They cannot simply walk into a pharmacy and have their prescription filled. Many nursing home residents, because of their physical or mental condition, are not able to take their prescription drugs on their own, especially if they have to take multiple medications throughout the day. Their unique circumstances require specialized pharmacy care that retail and mail order pharmacies do not provide. Long-term care pharmacies meet these special needs. They contract with nursing homes to provide specialized packaging, 24-hour delivery, infusion therapy services, geriatric-specific formularies, clinical consultation and other services that are critical to a nursing home. Importantly, long-term pharmacies play a critical role in preventing medication errors that add to the cost of care and suffering of Medicare patients. In fact, one study estimates $3.6 billion in medication errors have been avoided as a result of long term pharmacy care. I believe it makes sense to preserve specialty pharmacies' ability to perform these vital services for nursing home residents, and I want to point out how H.R. 1 does this.

First, the bill requires the Secretary of Health and Human Services to review the current standards of practice for pharmacy services provide to patients in nursing facilities. Prior to implementation of the prescription drug benefit, the Secretary will submit its findings to Congress on how long-term pharmacy services will be available to nursing home residents, including appropriate reimbursement levels for the specialty pharmacies that currently serve these nursing home residents. The Secretary's report is to include a detailed description of its plans to implement the provisions of this legislation in a manner consistent with state and federal laws designed to protect the safety and quality of care of nursing facility patients.

Second, H.R. 1 directs plan sponsors to implement medication therapy management programs as a tool to reduce medication errors and improve patient outcomes. Long-term care pharmacies currently employ such initiatives to meet the complex medication needs of nursing facility patients, and the bill appropriately allows plan sponsors' programs to distinguish between services provided in ambulatory and institutional settings.

Finally, the bill includes provisions to ensure that beneficiaries are guaranteed access to pharmacy services, including emergency services. These provisions are vitally important to maintain the high standard of care for all beneficiaries, but particularly for patients in nursing facilities, who receive specialized pharmacy services 25 hours-a-day, seven days-a-week, through networks of long-term care pharmacies that contract with nursing facilities to meet their patients' needs.

Mr. Speaker, I believe these long-term pharmacy provisions take a significant step toward ensuring that our nation's most frail and elderly citizens will have affordable, appropriate prescription drugs and delivery services.

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

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

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

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

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

Beginning October 1, Medicare reimbursements to rural areas would finally mirror those for large urban ones. Having lamented for a

number of years over the inequity of this provision within the Medicare reimbursement system, I am particularly pleased that this is being addressed in the bill.

A drug benefit for seniors and a rejuvenation of the Medicare system are essential to seniors and their caretakers. The delivery of medical care has changed enormously since this program was first conceived, and the program ought to be modernized to reflect the increases in medical technology and the utilization of a wide range of care options.

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

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

Mr. KNOLLENBERG. Mr. Speaker, today we have an opportunity to provide our seniors with a new prescription drug benefit and improved access to health care. It is a long overdue step in updating and improving Medicare.

Today's legislation will provide help for those who need it most. Our 6.5 million low-income seniors will receive a fully covered premium and a cost sharing benefit when their drug benefit switches from Medicaid to Medicare, paying no more than $2 per generic prescription, and no more than $5 for name brand drugs. This will also save states about $6.8 billion a year in Medicaid costs.

It is imperative that Medicare advance with technology. Prescription drugs are an increasingly important part of modern medicine, helping to relieve pain, cure disease, and enhance the lives of millions of Americans. Adding a drug benefit and updating how existing benefits are provided will be a very significant accomplishment.

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

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

We in Congress have been talking for years now about the necessity of adding a prescription drug benefit to Medicare. We know, as seniors know, that this talk has been cheap and it is imperative that a compromise be reached this year. The Senate has been proceeding in a bipartisan way toward a compromise that adds a substantial, but not perfect, benefit to Medicare and protects the long-term integrity of this social insurance program.

Instead of following the Senate's lead and working toward a compromise that will improve Medicare, a wildly popular and successful program, the House Republican leadership has chosen instead of add provisions to this legislation that attack the foundation of the Medicare program. The bill does not include a federal fallback if private plans choose not to offer a benefit. The experience that my constituents have had with Medicare+Choice show that private health care plans are at best an unstable partner for Medicare, and financial analysts have consistently publicly questioned whether ''drug only'' plans will ever be offered. For these reasons, it is absolutely vital that Medicare provide a viable and guaranteed fallback for all Medicare beneficiaries.

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

The Senate has crafted legislation that has broad support among Senators across the ideological spectrum. This legislation has won the support of both President Bush and Senator TED KENNEDY. Together with Representative THOMPSON and the Blue Dog Caucus, I am supporting legislation that uses the framework of the Senate compromise and improves on it, making it a much stronger bill. The Thompson plan includes a provision phasing in employer contributions to they will count toward the out-of-pocket limit for catastrophic coverage, thus giving employers an incentive to keep offering retiree benefits. The substitute guarantees a Medicare fall-back plan for all areas that do not have two private plans available. It also gives relief to state Medicaid plans by making Medicare the primary payer for all individuals eligible for Medicare and Medicaid. Finally, the Blue Dog substitute includes language that will reduce the high cost of prescription drugs by allowing Americans to reimport drugs from Canada and speeding approval of generic drugs.

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

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

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

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

This bill allows private insurance companies to decide premiums, prescription drug coverage benefits and even where coverage will be offered. This proposal threatens to dismantle Medicare and replace it with private health insurance coverage for all seniors. This is precisely the problem many seniors face—they cannot afford private insurance, and depend on Medicare.

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

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

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

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

In addition, the brunt of the bill is about providing voluntary prescription drug coverage to Medicare eligible individuals. There is a conservative critique that the program is far too expensive, and a liberal critique that it is not generous enough. Both philosophical perspectives have a degree of validity, but the big picture is that Congress is moving in a direction of providing health security for millions of citizens. Low income individuals will, for the most part, be provided full comprehensive prescription drug coverage. Higher income citizens on a sliding scale will be provided partial coverage and all citizens will be provided coverage for catastrophic expenses.

There will be a cost to society in providing these benefits but the benefits far outweigh the costs. There may be better approaches that can be envisioned now or developed later, but this is the only framework approach that has a chance of receiving majority support in both bodies without a Presidential veto. It may not be enough and it may be too deferred in implementation but it nevertheless marks an important first step to meeting the most challenging need of many senior citizens.

Ms. DEGETTE. Mr. Speaker, I want to highlight a piece of the Dingell/Rangel substitute that pertains to Disproportionate Share Hospitals.

This was an amendment I offered in the Energy & Commerce Committee and I understand that since our mark-up the DSH allocation has been increased and I want to commend this action. I know there is real bipartisan support on this issue and I want to just reiterate how important it is that we get funding to our DSH hospitals right away.

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

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

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

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

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

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

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

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

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

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

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

Unfortunately, the legislation before the House this week fails on both counts. It does not deliver an acceptable or adequate prescription drug benefit and it will not hold down the cost of drugs.

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

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

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

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

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

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

Mr. Speaker, we must provide a meaningful drug plan with guaranteed, defined benefits—with no gaps and no doughnut holes. We should act to contain costs by giving the Secretary of HHS the authority to negotiate lower prices so that seniors will not have to pay more than seniors in other countries for the same drug.

And perhaps most importantly we should honor our social contract with America's seniors by not privatizing Medicare and subjecting seniors to the uncertainties of the private health care market. We should not be penalizing seniors who live in rural communities, where pharmacies and private plans are scarce at best. We should be giving them a plan fully contained within the Medicare system, where seniors will not be forced to shop around for a plan only to be unceremoniously dropped soon thereafter. Giving them a plan that seniors have come to rely on and feel safe with is what we should be doing. That is real economic security. Medicare—the same plan my 89 year-old mother relies on today.

This debate is as important and historic as any I have been a part of in this body. If we allow this bill to become law, we are essentially tearing that social contract up—a contract my friend from Michigan, Mr. DINGELL, fought to pass 38 years ago. And by doing so, we would be saying that guaranteed health care for our seniors is no longer an obligation or responsibility of this government.

I did not come to Congress to preside over the dismantling of Medicare. That contract must be honored. I urge my colleagues to support a plan that does that.

Ms. LINDA T. SÁNCHEZ of California. Mr. Speaker, I rise in strong opposition to H.R. 1, the Medicare Prescription Drug and Modernization Act. I want to thank Congresswoman LYNN WOOLSEY for her hard work in bringing Democratic women together to speak against the Republican's shameful Prescription Drug bill.

As a freshman Member of Congress, I came here with a tremendous sense of optimism. By nature, I am an eternal optimist. But I am no fool, and the American people shouldn't be fooled either. Unfortunately, that is exactly what the Republicans are trying to do with their sham Prescription drug bill.

If you believe the Republican bill solves the prescription drug crisis facing our seniors . . . If you think that seniors will get the medications they need, at a price they can afford . . . If you believe private insurance companies—the same people who brought you HMOs—will provide better coverage for seniors than a reformed Medicare system . . . or if you think you can get all the drugs your doctor prescribed, including the most expensive, at your local pharmacy. . . . Then you should be listening to that old country song by George Strait called "Ocean Front Property." It goes something like this:

> I've got some ocean front property in Arizona from my front porch you can see the sea.
>
> I've got some ocean front property in Arizona and if you'll buy that I'll throw the Golden Gate in free.

Republicans are just like scam artists trying to sell you an ocean front property in the desert. But now they are trying to sell you a phony prescription drug package. We must not fall for it, especially when this is not what seniors want.

I say to my Republican colleagues, it is time to stop this heinous scam on seniors! It is time to show the greatest generation in our country the respect they deserve. After all, they are the people who served us in times of war, got us through the Great Depression, raised their children and made countless contributions to this country.

Worst of all, the Republican bill ignores the reality of older women, the face of Medicare. Women constitute 58 percent of the Medicare population at 65 and 71 percent at the age of 85. Since women normally outlive their male counterparts and many women spend time out of the workforce, caring for their children and sometimes, their own parents, Medicare beneficiaries are disproportionately female.

We need to make sure that every prescription is covered without a gap. Seniors, particularly women, must retain their right to see their

doctor of choice. We must empower seniors to make the right choices, not insurance companies. This is exactly what the democratic plan does and exactly what seniors want. In fact, according to a survey conducted by AARP: 4 out of 5 seniors don't want the GOP proposal.

Today, Mr. Speaker, I urge my colleagues not to support H.R. 1. Let's tell the Republicans don't try to sell seniors something they don't want.

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

BUSINESS FOR AFFORDABLE MEDICINE,
Washington, DC, June 24, 2003.

Hon. DENNIS HASTERT,
Speaker, U.S. House of Representatives, Washington, DC.

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

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

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

Specifically, BAM supports the proposed limit of one 30-month stay against FDA approval of generic products, as well as provisions to prevent the use of ''late-listed'' patents—those filed after generic applications are submitted—to obtain additional stays. Litigation under the Hatch-Waxman Act is increasingly tied to patents that have been listed after the filing of generic applications, resulting in the need for legislation to restrict the use of 30-month stays to only those patents listed in the Orange Book prior to the filing of related generic applications. We also support changes to provisions in the law that allow drug manufacturers to intentionally delay litigation on certain drug patents until the end of any 30-month stay.

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

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

Sincerely,

GOVERNOR M.J. ''MIKE'' FOSTER, JR.,
Louisiana,
GOVERNOR BOB WISE,
West Virginia.
GOVERNOR BRAD HENRY,
Oklahoma.
GOVERNOR BOB HOLDEN,
Missouri.
GOVERNOR RONNIE MUSGROVE,
Mississippi.
GOVERNOR THOMAS VILSACK,
Iowa.

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

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

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

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

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

First and foremost, we must reduce the costs of prescription drugs. Modern medicine relies on these life-saving drugs more than ever, and doctors shown no signs of slowing the expected growth in prescriptions. But with Alabama seniors now paying an average of $1,200 per year for prescriptions, these costs are getting out of hand.

Consider seniors on fixed incomes, Mr. Speaker. These Alabamians, already strapped with highly monthly bills, now face the costs of prescriptions rising beyond their means. We've already seen prescription drugs double or even triple in cost over the years. What will these seniors do when these drugs are priced out of reach? Will they be faced with filling their medicine cabinet or their pantry?

Mr. Speaker, this simply cannot continue. The U.S. House of Representatives has drafted a bill, the Medicare Prescription Drug Modernization Act of 2003, which includes a prescription drug benefit for seniors in both the traditional fee-for-service and in the new integrated health plans. The bill is not limited to adding prescription drug coverage for our state's seniors, but also includes much-needed modernizations to Medicare and improvements for health care providers, such as an increase in Medicare payments to doctors to ensure that seniors continue to have access to physician services. Most importantly, the bill includes improvements and increased funding for rural hospitals in the Third District.

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

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

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

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

GENERAL LEAVE

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

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

There was no objection.

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

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

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

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

Amendment in the nature of a substitute offered by Mr. RANGEL:

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 Prescription Drug and Modernization Act of 2003''.

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

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term ''BIPA'' means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 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 MEDICINE BENEFIT

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).
Sec. 106. State Pharmaceutical Assistance Transition Commission.

TITLE II—MEDICARE+CHOICE

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

TITLE III—COMBATTING WASTE, FRAUD, AND ABUSE

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

TITLE IV—RURAL HEALTH CARE IMPROVEMENTS

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

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

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

Subtitle B—Other Provisions

Sec. 511. Payment for covered skilled nursing facility services.
Sec. 512. Coverage of hospice consultation services.

TITLE VI—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

Sec. 601. Revision of updates for physicians' services.
Sec. 602. Studies on access to physicians' services.
Sec. 603. MedPAC report on payment for physicians' services.

Subtitle B—Preventive Services

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

Subtitle C—Other Services

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

TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

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

Subtitle B—Chronic Care Improvement

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

Subtitle C—Other Provisions

Sec. 731. Modifications to Medicare Payment Advisory Commission (MedPAC).
Sec. 732. Demonstration project for medical adult day care services.
Sec. 733. Improvements in national and local coverage determination process to respond to changes in technology.
Sec. 734. Treatment of certain physician pathology services.
Sec. 735. Medicare pancreatic islet cell transplant demonstration project.

TITLE VIII—MEDICAID

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

TITLE IX—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

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

Subtitle B—Contracting Reform

Sec. 911. Increased flexibility in medicare administration.
Sec. 912. Requirements for information security for medicare administrative contractors.

Subtitle C—Education and Outreach

Sec. 921. Provider education and technical assistance.
Sec. 922. Small provider technical assistance demonstration program.
Sec. 923. Medicare provider ombudsman; medicare beneficiary ombudsman.
Sec. 924. Beneficiary outreach demonstration program.
Sec. 925. Inclusion of additional information in notices to beneficiaries about skilled nursing facility benefits.
Sec. 926. Information on medicare-certified skilled nursing facilities in hospital discharge plans.

Subtitle D—Appeals and Recovery

Sec. 931. Transfer of responsibility for medicare appeals.

Sec. 932. Process for expedited access to review.
Sec. 933. Revisions to medicare appeals process.
Sec. 934. Prepayment review.
Sec. 935. Recovery of overpayments.
Sec. 936. Provider enrollment process; right of appeal.
Sec. 937. Process for correction of minor errors and omissions without pursuing appeals process.
Sec. 938. Prior determination process for certain items and services; advance beneficiary notices.

Subtitle V—Miscellaneous Provisions

Sec. 941. Policy development regarding evaluation and management (E & M) documentation guidelines.
Sec. 942. Improvement in oversight of technology and coverage.
Sec. 943. Treatment of hospitals for certain services under medicare secondary payor (MSP) provisions.
Sec. 944. EMTALA improvements.
Sec. 945. Emergency medical treatment and active labor act (EMTALA) technical advisory group.
Sec. 946. Authorizing use of arrangements to provide core hospice services in certain circumstances.
Sec. 947. Application of OSHA bloodborne pathogens standard to certain hospitals.
Sec. 948. BIPA-related technical amendments and corrections.
Sec. 949. Conforming authority to waive a program exclusion.
Sec. 950. Treatment of certain dental claims.
Sec. 951. Furnishing hospitals with information to compute dsh formula.
Sec. 952. Revisions to reassignment provisions.
Sec. 953. Other provisions.

TITLE X—IMPORTATION OF PRESCRIPTION DRUGS

Sec. 1001. Importation of prescription drugs.

TITLE XI—ACCESS TO AFFORDABLE PHARMACEUTICALS

Sec. 1101. Short title.
Sec. 1102. 30-month stay-of-effectiveness period.
Sec. 1103. Forfeiture of 180-day exclusivity period.
Sec. 1104. Bioavailability and bioequivalence.
Sec. 1105. Remedies for infringement.
Sec. 1106. Conforming amendments.

TITLE I—MEDICARE PRESCRIPTION MEDICINE BENEFIT

SEC. 101. VOLUNTARY MEDICARE OUTPATIENT PRESCRIPTION MEDICINE PROGRAM.

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

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

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

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

''MEDICARE OUTPATIENT PRESCRIPTION MEDICINE BENEFIT

''SEC. 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, 2005, the initial general enrollment period shall begin on August 1, 2005, and shall end on March 1, 2006.

''(B) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who first satisfies subsection (a) on or after November 1, 2005, 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, 2006. 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 2006, 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 2006—

''(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 2007) 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 2008) 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 2006.—The monthly premium rate in 2006 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 2006 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, 2005.

''(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, 2006.

(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 2004 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, 2004. 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) 2006, 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, 2006, 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, 2004.

(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.''.

SEC. 106. STATE PHARMACEUTICAL ASSISTANCE TRANSITION COMMISSION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established, as of the first day of the third month beginning after the date of the enactment of this Act, a State Pharmaceutical Assistance Transition Commission (in this section referred to as the ''Commission'') to develop a proposal for addressing the unique transitional issues facing State pharmaceutical assistance programs, and program participants, due to the implementation of the medicare prescription drug program under part D of title XVIII of the Social Security Act.

(2) DEFINITIONS.—For purposes of this section:

(A) STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—The term ''State pharmaceutical assistance program'' means a program (other than the medicaid program) operated by a State (or under contract with a State) that provides as of the date of the enactment of this Act assistance to low-income medicare beneficiaries for the purchase of prescription drugs.

(B) PROGRAM PARTICIPANT.—The term ''program participant'' means a low-income medicare beneficiary who is a participant in a State pharmaceutical assistance program.

(b) COMPOSITION.—The Commission shall include the following:

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

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

(3) Representatives of organizations that have an inherent interest in program participants or the program itself, as appointed by the Secretary but not to exceed the number of representatives under paragraphs (1) and (2).

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

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

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

(c) DEVELOPMENT OF PROPOSAL.—The Commission shall develop the proposal described in subsection (a) in a manner consistent with the following principles:

(1) Protection of the interests of program participants in a manner that is the least disruptive to such participants and that includes a single point of contact for enrollment and processing of benefits.

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

(3) Principles of medicare modernization provided under title II of this Act.

(d) REPORT.—By not later than January 1, 2005, the Commission shall submit to the President and the Congress a report that contains a detailed proposal (including specific legislative or administrative recommendations, if any) and such other recommendations as the Commission deems appropriate.

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

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

TITLE II—MEDICARE+CHOICE

SEC. 201. MEDICARE+CHOICE IMPROVEMENTS.

(a) EQUALIZING PAYMENTS WITH FEE-FOR-SERVICE.—

(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 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 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 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 2004)'' after ''multiplied''; and

(B) in paragraph (5), by inserting ''(before 2004)'' after ''for each year''.

(c) INCREASING MINIMUM PERCENTAGE INCREASE TO NATIONAL GROWTH RATE.—

(1) IN GENERAL.—Section 1853(c)(1) (42 U.S.C. 1395w–23(c)(1)) is amended—

(A) in subparagraph (B)(iv), by striking ''and each succeeding year'' and inserting '', 2003, and 2004'';

(B) in subparagraph (C)(iv), by striking ''and each succeeding year'' and inserting ''and 2003''; and

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

''(v) For 2004 and each succeeding year, the greater of—

''(I) 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year; or

''(II) the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6) for that succeeding year, but not taking into account any adjustment under paragraph (6)(C) for a year before 2004.''.

(2) CONFORMING AMENDMENT.—Section 1853(c)(6)(C) (42 U.S.C. 1395w–23(c)(6)(C)) is amended by inserting before the period at the end the following: '', except that for purposes of paragraph (1)(C)(v)(II), no such adjustment shall be made for a year before 2004''.

(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 2004), 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) EXTENDING SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS TO REHABILITATION HOSPITALS.—

(1) IN GENERAL.—Section 1853(g) (42 U.S.C. 1395w–23(g)) is amended—

(A) by inserting ''or from a rehabilitation facility (as defined in section 1886(j)(1)(A))'' after ''1886(d)(1)(B))''; and

(B) in paragraph (2)(B), by inserting ''or section 1886(j), as the case may be,'' after ''1886(d)''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to contract years beginning on or after January 1, 2004.

(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)) as applied under section 1853(c)(1)(A) of such Act (as amended by subsection (a)). Such study shall include an examination of—

(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 18 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).

(g) REPORT ON IMPACT OF INCREASED FINANCIAL ASSISTANCE TO MEDICARE+CHOICE PLANS.—Not later than July 1, 2006, the Medicare Benefits Administrator 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.

(h) LIMITATION ON APPLICATION TO 2004 AND 2005.—Notwithstanding any other provision of law, the amendments made by this section shall only apply to payment rates for 2004 and 2005 and for subsequent years the payment shall be made on the basis of law as in effect before the date of the enactment of this Act.

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''.

(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—

(1) by striking ''and after 2005''; and

(2) by striking '', 2004, and 2005'' and inserting ''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—

(1) by striking ''and after 2005''; and

(2) by striking ''and 2005'' and inserting ''and each subsequent year''.

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 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. 204. 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)''.

SEC. 205. EXTENSION OF REASONABLE COST CONTRACTS.

Subparagraph (C) of section 1876(h)(5) (42 U.S.C. 1395mm(h)(5)) is amended to read as follows:

''(C)(i) Subject to clause (ii), may be extended or renewed under this subsection indefinitely.

''(ii) For any period beginning on or after January 1, 2008, a reasonable cost reimbursement contract under this subsection may not be extended or renewed for a service area insofar as such area, during the entire previous year, was within the service area of 2 or more plans which were coordinated care Medicare+Choice plans under part C or 2 or more enhanced fee-for-service plans under part E and each of which plan for that previous year for the area involved meets the following minimum enrollment requirements:

''(I) With respect to any portion of the area involved that is within a Metropolitan Statistical Area with a population of more than 250,000 and counties contiguous to such Metropolitan Statistical Area, 5,000 individuals.

''(II) With respect to any other portion of such area, 1,500 individuals.''.

SEC. 206. 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—COMBATTING WASTE, FRAUD, AND ABUSE

SEC. 301. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot

reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

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

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

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

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

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

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

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

SEC. 302. 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—

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

''(I) at least ⅓ of such areas in 2009; and

''(II) at least ⅔ of such areas in 2010; and

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

''(C) WAIVER OF CERTAIN PROVISIONS.—In carrying out the programs, the Secretary may waive 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 MEDICAL SUPPLIES.—Covered items (as defined in section 1834(a)(13)) for which payment is otherwise made under section 1834(a), including items used in infusion and drugs and supplies used in conjunction with durable medical equipment, but excluding class III devices under the Federal Food, Drug, and Cosmetic Act.

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

''(C) OFF-THE-SHELF ORTHOTICS.—Orthotics (described in section 1861(s)(9)) for which payment is otherwise made under section 1834(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) EXCEPTION AUTHORITY.—In carrying out the programs under this section, the Secretary may exempt—

''(A) rural areas and areas with low population density within urban areas that are not competitive, unless there is a significant national market through mail order for a particular item or service; and

''(B) items and services for which the application of competitive acquisition is not likely to result in significant savings.

''(4) SPECIAL RULE FOR CERTAIN RENTED ITEMS OF DURABLE MEDICAL EQUIPMENT.—In the case of a covered item for which payment is made on a rental basis under section 1834(a), the Secretary shall establish a process by which rental agreements for the covered items entered into before the application of the competitive acquisition program under this section for the item may be continued notwithstanding this section. In the case of any such continuation, the supplier involved shall provide for appropriate servicing and replacement, as required under section 1834(a).

''(5) PHYSICIAN AUTHORIZATION.—The Secretary may establish a process under which a physician may prescribe a particular brand or mode of delivery of an item or service if the item or service involved is clinically more appropriate than other similar items or services.

''(6) APPLICATION.—For each competitive acquisition area in which the program is implemented under this subsection with respect to items and services, the payment basis determined under the competition conducted under subsection (b) shall be substituted for the payment basis otherwise applied under section 1834(a).

''(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 the Program Advisory and Oversight Committee established under subsection (c).

''(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 20 percent of the applicable contract award price, except in such cases where a supplier has furnished an upgraded item and has executed an advanced beneficiary notice.

''(B) DEVELOPMENT OF QUALITY STANDARDS FOR DME PRODUCTS.—

''(i) IN GENERAL.—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. Not later than July 1, 2007, the Secretary shall establish new quality standards for products subject to competitive acquisition under this section. Such standards shall be applied prospectively and shall be published on the website of the Department of Health and Human Services.

''(ii) CONSULTATION WITH PROGRAM ADVISORY AND OVERSIGHT COMMITTEE.—The Secretary shall consult with the Program Advisory and Oversight Committee (established under subsection (c)) to review (and advise the Secretary concerning) the quality standards referred to in clause (i).

''(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 recompete 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 multiple entities submitting bids in each area for an item or service.

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

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

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

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

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

''(7) CONSIDERATION IN DETERMINING CATEGORIES FOR BIDS.—The Secretary shall consider the similarity of the clinical efficiency and value of specific codes and products, including products that may provide a therapeutic advantage to beneficiaries, before delineating the categories and products that will be subject to bidding.

''(8) AUTHORITY TO CONTRACT FOR EDUCATION, MONITORING, 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 and monitoring quality of services with respect to the program.

''(c) PROGRAM ADVISORY AND OVERSIGHT COMMITTEE.—

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

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

''(3) DUTIES.—

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

''(i) The implementation of the program under this section.

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

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

''(B) ADDITIONAL DUTIES.—The Committee shall perform such additional functions to assist the Secretary in carrying out this section as the Secretary may specify.

''(4) INAPPLICABILITY OF FACA.—The provisions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply.

''(d) 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 beneficiary cost-sharing, access to and quality of items and services, and beneficiary satisfaction.

''(e) 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 by entities that did not have a face-to-face encounter with the individual.

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

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

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

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

(b) CONFORMING AMENDMENTS.—

(1) DURABLE MEDICAL EQUIPMENT; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended—

(A) in paragraph (1)(B), by striking ''The payment basis'' and inserting ''Subject to subparagraph (E)(i), the payment basis'';

(B) in paragraph (1)(C), by striking ''This subsection'' and inserting ''Subject to subparagraph (E)(ii), this subsection'';

(C) by adding at the end of paragraph (1) the following new subparagraph:

''(E) APPLICATION OF COMPETITIVE ACQUISITION; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—In the case of covered items and services that are included in a competitive acquisition program in a competitive acquisition area under section 1847(a)—

''(i) the payment basis under this subsection for such items and services furnished in such area shall be the payment basis determined under such competitive acquisition program; and

''(ii) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847 and in the case of such adjustment, paragraph (10)(B) shall not be applied.''; and

(D) in paragraph (10)(B), by inserting ''in an area and with respect to covered items and services for which the Secretary does not make a payment amount adjustment under paragraph (1)(E)'' after ''under this subsection''.

(2) OFF-THE-SHELF ORTHOTICS; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—Section 1834(h) (42 U.S.C. 1395m(h)) is amended—

(A) in paragraph (1)(B), by striking ''and (E)'' and inserting '', (E) , and (H)(i)'';

(B) in paragraph (1)(D), by striking ''This subsection'' and inserting ''Subject to subparagraph (H)(ii), this subsection'';

(C) by adding at the end of paragraph (1) the following new subparagraph:

''(H) APPLICATION OF COMPETITIVE ACQUISITION TO ORTHOTICS; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—In the case of orthotics described in paragraph (2)(B) of section 1847(a) that are included in a competitive acquisition program in a competitive acquisition area under such section—

''(i) the payment basis under this subsection for such orthotics furnished in such area shall be the payment basis determined under such competitive acquisition program; and

''(ii) the Secretary may use information on the payment determined under such competitive acquisition programs to adjust the payment amount otherwise recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847, and in the case of such adjustment, paragraphs (8) and (9) of section 1842(b) shall not be applied.''.

(c) REPORT ON ACTIVITIES OF SUPPLIERS.—The Secretary shall conduct a study to determine the extent to which (if any) suppliers of covered items of durable medical equipment that are subject to the competitive acquisition program under section 1847 of the Social Security Act, as amended by subsection (a), are soliciting physicians to prescribe certain brands or modes of delivery of covered items based on profitability.

SEC. 303. REFORM OF PAYMENT FOR DRUGS AND BIOLOGICALS UNDER THE MEDICARE PROGRAM.

(a) PAYMENT REFORM.—

(1) IN GENERAL.—Section 1842(o) (42 U.S.C. 1395u(o)) is amended to read as follows:

''(o) PAYMENT FOR DRUGS AND BIOLOGICALS.—

''(1) GENERAL RULE.—If a physician's, supplier's, or any other person's bill or request for payment for services includes a charge for a drug or biological for which payment may be made under this part and the drug or biological is not paid on a cost or prospective payment basis as otherwise provided in this part, the amount payable for the drug or biological shall be based on the following:

''(A) MULTI-SOURCE (GENERIC) DRUGS.—In the case of a drug or biological that meets the requirements for a multi-source drug under subclauses (I) and (II) of section 1927(k)(7)(A)(i), 105 percent of the volume-weighted median average acquisition price for any drug or biological covered under the same medicare HCPCS code.

''(B) SINGLE SOURCE (BRAND) DRUGS AND BIOLOGICALS.—In the case of a drug or biological that meets the requirements for a single source drug under section 1927(k)(7)(A)(iv), 105 percent of the average acquisition price for the drug or biological.

''(C) ACCESS EXCEPTION.—The Secretary may modify the rate otherwise applicable in order to assure access to necessary drugs and biologicals in the case of sole community providers in rural and other areas where the providers are not reasonably able to obtain the drugs and biologicals at the payment rates otherwise applicable. Such modification shall not result in a change of more than 15 percent of the rate otherwise applicable.

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

''(E) APPLICATION OF NDC CODES.—If the Secretary determines that it is appropriate to provide for payment under this subsection using national drug code (NDC) instead of HCPCS codes, in applying subparagraph (A) the reference to the same HCPCS code shall be deemed a reference to the appropriate national drug codes for those drugs or biologicals that are therapeutically and pharmaceutically equivalent and bioequivalent (as defined for purposes of section 1927(k)(7)(A)).

''(2) DEFINITION OF AVERAGE ACQUISITION PRICE.—

''(A) IN GENERAL.—For purposes of this subsection, the term 'average acquisition price' means, with respect to a drug or biological and with respect to each dosage form and strength of the drug or biological product (without regard to any special packaging, labeling, or identifiers on the dosage form or

product or package), the average of all final sales prices charged by the manufacturer of the drug or biological product in the United States, excluding sales exempt from inclusion in the calculation of best price under section 1927(c)(1)(C) (other than under clause (ii)(III) of such section) and excluding sales subject to a rebate under section 1927, as reported under paragraph (3).

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

''(i) Volume discounts.

''(ii) Prompt pay discounts and cash discounts.

''(iii) Charge-backs.

''(iv) Short-dated product discounts (for spoilage and other factors).

''(v) Free goods and services.

''(vi) Rebates.

''(vii) All other price concessions provided by the drug manufacturer.

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

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

''(i) the sum of all final prices charged by the manufacturer (net of the adjustments made under subparagraph (B)) for sales in the period involved that are included in subparagraph (A) for the drug or biological, by

''(ii) the total number of units of such sales in the period.

''(D) DISTRIBUTION OF REPORTS.—The Secretary shall promptly distribute applicable payment rates under this subsection to carriers and fiscal intermediaries and other contractors that make payment for drugs and biologicals under this section in order to apply a uniform reimbursement rate under this section.

''(3) PRICE REPORTING REQUIREMENT.—

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

''(i) report, on a quarterly basis, to the Secretary (or the Secretary's designee) the manufacturer's average acquisition price and the information required under subparagraph (C) for all drugs and biologicals of the manufacturer by national drug code (NDC);

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

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

''(B) PENALTIES.—The provisions of section 1927(b)(3)(C) shall apply with respect to the reporting of information under subparagraph (A) in the same manner as it applies to the reporting of information under section 1927(b)(3)(A), except that the reference in clause (i) of such section to $10,000 is deemed a reference to $100,000 and any reference to a suspension of an agreement is deemed a reference to a suspension of payment for the drug or biological involved under this part. The Secretary shall promptly refer to the Inspector General of the Department of Health and Human Services and, if appropriate, to appropriate officials in the Department of Justice cases in which the Secretary becomes aware of a false price representation made in the information submitted under this paragraph.

''(C) FORM OF REPORTING.—Information required to be reported under subparagraph (A)(i) shall be reported in a form and manner specified by the Secretary. The information required to be reported shall include the identification of the generic name of the drug or biological and its brand name (if any), the national drug code (NDC) and the HCPCS code assigned to the drug or biological, the dosage form, strength, volume, and package size involved. The information for a quarter shall be submitted not later than 30 days after the end of the quarter. The information shall be accompanied by a written and signed certification by an officer of the manufacturer attesting to the accuracy of the information reported. Such information shall include updated information on the net price realized (taking into account rebates and other amounts affecting net price), regardless of the period for which such a rebate or other adjustment in net price might have been earned.

''(D) AUDITING.—The Secretary shall audit on a periodic basis information reported or required to be reported under this paragraph. The Secretary may conduct such independent price gathering activities, such as surveys and review of published catalog information or other transactional information, as may be appropriate to verify the accuracy of the information reported.

''(4) DISPENSING FEE.—If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary shall pay a dispensing fee (less the applicable deductible and coinsurance amounts) to the pharmacy. Such a dispensing fee shall be subject to adjustment from year to year based upon changes in the consumer price index over time and may be adjusted as the Secretary determines to be appropriate to reflect differences in the costs of dispensing different drugs and biologicals.

''(5) PAYMENT REQUIRED ON AN ASSIGNMENT-RELATED BASIS.—

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

''(B) APPLICATION OF ENFORCEMENT PROVISIONS.—The provisions of subsection (b)(18)(B) shall apply to charges for such drugs or biologicals in the same manner as they apply to services furnished by a practitioner described in subsection (b)(18)(C).''.

(2) EFFECTIVE DATE.—Subject to subsection (i)(2), the amendment made by paragraph (1) shall apply to drugs and biologicals furnished on or after January 1, 2004.

(b) MEDICARE PAYMENT FOR DRUG ADMINISTRATION SERVICES.—

(1) IN GENERAL.—The Secretary shall revise the practice expense relative value units for drug administration services for years beginning with the year 2005 in accordance with this subsection. For purposes of this subsection, the term ''drug administration services'' includes chemotherapy administration services, therapeutic and diagnostic infusions and injections, and such other services as the Secretary specifies.

(2) DIRECT COSTS EQUAL TO 100 PERCENT OF CPEP ESTIMATES.—Using the information, including estimates of clinical staff time, developed in the clinical practice expert panel process, including refinements by American Medical Association committees, the Secretary shall estimate the costs of the nursing and other clinical staff, supplies, and procedure-specific equipment (exceeding a cost specified by the Secretary) used in furnishing each type of drug administration service. The Secretary shall utilize without revision the minutes of clinical staff time determined in such process. The Secretary shall convert the information from such process to estimated costs by applying the most current available data on staff salary, supply, and equipment costs, and such costs shall be updated to 2005 based on estimated changes in prices since the date of such data.

(3) TOTAL PRACTICE EXPENSES.—The Secretary shall estimate the total practice expenses of each drug administration service by assuming that the direct costs for the service determined under paragraph (3) are 33.2 percent of such total practice expenses.

(4) CONVERSION TO RELATIVE VALUE UNITS.—The Secretary shall convert the total practice expenses determined under paragraph (3) to practice expense relative value units for each drug administration service by dividing such expenses by the conversion factor that will be in effect for the physician fee schedule for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for drug administration services under section 1848 of the Social Security Act (42 U.S.C. 1395w–4).

(5) UPDATES.—For years after 2005, the relative values determined under paragraph (4) shall continue in effect except that the Secretary shall revise them as necessary to maintain their accuracy, provided that such revisions are consistent with the methodology set forth in this subsection.

(6) MULTIPLE PUSHES.—In establishing the payment amounts under this subsection, the Secretary shall establish the payment amount for intravenous chemotherapy administration by push technique based on the administration of a single drug. The Secretary shall make the same payment for each additional drug administered by push technique during the same encounter, except to the extent that the Secretary finds that the cost of administering additional drugs is less than the cost of administering the first drug.

(c) PAYMENTS FOR CHEMOTHERAPY SUPPORT SERVICES.—

(1) GENERAL.—Beginning in 2005, the Secretary shall recognize and make payments under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for chemotherapy support services furnished incident to physicians' services. For the purposes of this section, the term ''chemotherapy support services'' are services furnished by the staff of physicians to patients undergoing treatment for cancer that were not included in the computation of clinical staff costs under subsection b(2). Such services include social worker services, nutrition counseling, psychosocial services, and similar services.

(2) DIRECT COSTS.—The Secretary shall estimate the cost of the salary and benefits of staff furnishing chemotherapy support services as they are provided in oncology practices that furnish these services to cancer patients in a manner that is considered to be high quality care. The estimate shall be based on the weekly cost of such services per patient receiving chemotherapy.

(3) TOTAL COSTS.—The Secretary shall estimate the total practice expenses of chemotherapy support services by assuming that the direct costs for the service determined under paragraph (2) are 33.2 percent of such total practice expenses.

(4) CONVERSION TO RELATIVE VALUE UNITS.—The Secretary shall convert the total practice expenses determined under paragraph (3) to practice expense relative value units for chemotherapy support services by dividing such expenses by the conversion factor that will be in effect for the physician fee schedule for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for chemotherapy support services under such section 1848.

(5) UPDATES.—For years after 2005, the relative values determined under paragraph (4) shall continue in effect except that the Secretary shall revise them as necessary to maintain their accuracy, provided that such

revisions are consistent with the methodology set forth in this subsection.

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

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

(f) REPORT TO CONGRESS.—Not later than April 1, 2004, the Secretary shall submit to Congress a report on the payment amounts that are projected to be adopted under subsections (b), (c), (d), and (e) of this section.

(g) INSTITUTE OF MEDICINE STUDY.—

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

(2) BASELINE STUDY.—The first phase of the study shall include the following objectives:

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

(B) The identification of the comprehensive range of services furnished to cancer patients in the outpatient setting, including support services such as psychosocial services and counseling, and recommendations regarding the types of services that ought to be furnished to medicare patients with cancer.

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

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

(E) The development of a framework for assessing how the amendments made by this act affect the provision of care to medicare patients with cancer in the various treatment settings.

(3) SECOND PHASE OF STUDY.—After the implementation of the amendments made by this section, the study shall determine whether and how those amendments affected the provision of care to medicare patients with cancer.

(4) CONSULTATION.—The Institute of Medicine shall consult with the National Cancer Policy Board and organizations representing cancer patients and survivors, oncologists, oncology nurses, social workers, cancer centers, and other healthcare professionals who treat cancer patients in planning and carrying out this study.

(5) DUE DATES.—

(A) The study required by paragraph (2) shall be submitted to the Congress and the Secretary of Health and Human Services no later than June 30, 2004.

(B) The study required by paragraph (3) shall be submitted to the Congress and the Secretary of Health and Human Services no later than December 31, 2006.

(i) STUDY OF PAYMENTS FOR BLOOD CLOTTING FACTORS AND OTHER BIOLOGICALS.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall provide for a study of the appropriateness of the medicare payment methodology for blood clotting factors and other biologicals under part B of title XVIII of the Social Security Act. Not later than 9 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report on such study and shall include in such report recommendations regarding whether to apply the payment methodology provided under the amendment made by subsection (a)(1) and alternative recommendations for appropriate dispensing fees.

(2) DELAY IN EFFECTIVE DATE.—The amendment made by subsection (a)(1) shall not apply to blood clotting factors furnished before the first day of the first calendar year that begins at least 6 months after the date the report under paragraph (1) has been submitted to the Congress.

SEC. 304. 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 or part B of title XVIII of the Social Security Act. Under the project—

(1) payment may be made to such a contractor on a contingent basis;

(2) a percentage of the amount recovered may be retained by the Secretary and shall be available to the program management account of the Centers for Medicare & Medicaid Services; and

(3) the Secretary shall examine the efficacy of such use with respect to duplicative payments, accuracy of coding, and other payment policies in which inaccurate payments arise.

(b) SCOPE AND DURATION.—

(1) SCOPE.—The project shall cover at least 2 States that are among the States with—

(A) the highest per capita utilization rates of medicare services, and

(B) at least 3 contractors.

(2) DURATION.—The project 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 the appropriate clinical 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 risk entities that the Secretary determines have demonstrated more than 3 years direct management experience and a proficiency in recovery audits with private insurers or under the medicaid program under title XIX of such Act.

(e) CONSTRUCTION RELATING TO CONDUCT OF INVESTIGATION OF FRAUD.—A recovery of an overpayment to a provider by a recovery audit contractor shall not be construed to prohibit the Secretary or the Attorney General from investigating and prosecuting, if appropriate, allegations of fraud or abuse arising from such overpayment.

(f) REPORT.—The Secretary of Health and Human Services shall submit to Congress a report on the project not later than 6 months after the date of its completion. Such reports shall include information on the impact of the project on savings to the medicare program and recommendations on the cost-effectiveness of extending or expanding the project.

TITLE IV—RURAL HEALTH CARE IMPROVEMENTS

SEC. 401. FAIRNESS IN THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT FOR RURAL HOSPITALS.

(a) EQUALIZING DSH PAYMENT AMOUNTS.—

(1) IN GENERAL.—Section 1886(d)(5)(F)(vii) (42 U.S.C. 1395ww(d)(5)(F)(vii)) is amended by inserting '', and, after October 1, 2004, for any other hospital described in clause (iv),'' after ''clause (iv)(I)'' in the matter preceding subclause (I).

(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in clause (iv)—

(i) in subclause (II)—

(I) by inserting ''and before October 1, 2004,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xiii)'';

(ii) in subclause (III)—

(I) by inserting ''and before October 1, 2004,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xii)'';

(iii) in subclause (IV)—

(I) by inserting ''and before October 1, 2004,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (x) or (xi)'';

(iv) in subclause (V)—

(I) by inserting ''and before October 1, 2004,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xi)''; and

(v) in subclause (VI)—

(I) by inserting ''and before October 1, 2004,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2004, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (x)'';

(B) in clause (viii), by striking ''The formula'' and inserting ''For discharges occurring before October 1, 2004, the formula''; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking ''For purposes'' and inserting ''With respect to discharges occurring before October 1, 2004, for purposes''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2004.

SEC. 402. IMMEDIATE ESTABLISHMENT OF UNIFORM STANDARDIZED AMOUNT IN RURAL AND SMALL URBAN AREAS.

(a) IN GENERAL.—Section 1886(d)(3)(A) (42 U.S.C. 1395ww(d)(3)(A)) is amended—

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

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

''(v) For discharges occurring in the fiscal year beginning on October 1, 2003, the average standardized amount for hospitals located in areas other than a large urban area shall be equal to the average standardized amount for hospitals located in a large urban area.''.

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking ''IN DIFFERENT AREAS'';

(B) in the matter preceding clause (i), by striking '', each of'';

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking ''and'' after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2004,'' before ''for hospitals''; and

(ii) in subclause (II), by striking the period at the end and inserting ''; and''; and

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

''(iii) for a fiscal year beginning after fiscal year 2003, for hospitals located in all areas, to the product of—

''(I) the applicable standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

''(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.''.

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional adjusted DRG prospective payment rate''; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional DRG prospective payment rate for each region,''.

SEC. 403. ESTABLISHMENT OF ESSENTIAL RURAL HOSPITAL CLASSIFICATION.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(C) QUALITY CARE.—The hospital inpatient score for quality of care is not less than the median hospital score for qualify of care for hospitals in the State, as established under standards of the utilization and quality control peer review organization under part B of title XI or other quality standards recognized by the Secretary.

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

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

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

''(11) In the case of a hospital classified as an essential rural hospital under section 1861(mm)(4) for a cost reporting period, the payment under this subsection for inpatient hospital services for discharges occurring during the period shall be based on 102 percent of the reasonable costs for such services. Nothing in this paragraph shall be construed as affecting the application or amount of deductibles or copayments otherwise applicable to such services under part A or as waiving any requirement for billing for such services.''.

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

''(B) SPECIAL RULE FOR ESSENTIAL RURAL HOSPITALS.—In the case of a hospital classified as an essential rural hospital under section 1861(mm)(4) for a cost reporting period, the payment under this subsection for covered OPD services during the period shall be based on 102 percent of the reasonable costs for such services. Nothing in this subparagraph shall be construed as affecting the application or amount of deductibles or copayments otherwise applicable to such services under this part or as waiving any requirement for billing for such services.''.

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

SEC. 404. MORE FREQUENT UPDATE IN WEIGHTS USED IN HOSPITAL MARKET BASKET.

(a) MORE FREQUENT UPDATES IN WEIGHTS.—After revising the weights used in the hospital market basket under section 1886(b)(3)(B)(iii) of the Social Security Act (42 U.S.C. 1395ww(b)(3)(B)(iii)) to reflect the most current data available, the Secretary shall establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every 5 years.

(b) REPORT.—Not later than October 1, 2004, the Secretary shall submit a report to Congress on the frequency established under subsection (a), including an explanation of the reasons for, and options considered, in determining such frequency.

SEC. 405. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) INCREASE IN PAYMENT AMOUNTS.—

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

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to payments for services furnished during cost reporting periods beginning on or after October 1, 2003.

(b) COVERAGE OF COSTS FOR CERTAIN EMERGENCY ROOM ON-CALL PROVIDERS.—

(1) IN GENERAL.—Section 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(A) in the heading—

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

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

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

(C) by striking ''physicians' services'' and inserting ''services covered under this title''.

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

(c) PERMITTING CAHS TO ALLOCATE SWING BEDS AND ACUTE CARE INPATIENT BEDS SUBJECT TO A TOTAL LIMIT OF 25 BEDS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended to read as follows:

''(iii) provides not more than a total of 25 extended care service beds (pursuant to an agreement under subsection (f)) and acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;''.

(2) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395i–4(f)) is amended by striking ''and the number of beds used at any time for acute care inpatient services does not exceed 15 beds''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall with respect to designations made on or after October 1, 2004.

(d) ELIMINATION OF THE ISOLATION TEST FOR COST-BASED CAH AMBULANCE SERVICES.—

(1) ELIMINATION.—

(A) IN GENERAL.—Section 1834(l)(8) (42 U.S.C. 1395m(l)(8)), as added by section 205(a) of BIPA (114 Stat. 2763A–482), is amended by striking the comma at the end of subparagraph (B) and all that follows and inserting a period.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to services furnished on or after January 1, 2005.

(2) TECHNICAL CORRECTION.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A–486), as paragraph (9).

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

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

(A) in the matter before subparagraph (A), by inserting '', in the cases described in subparagraphs (A) through (D)'' after ''1986''; and

(B) by striking ''and'' at the end of subparagraph (C);

(C) by adding ''and'' at the end of subparagraph (D); and

(D) by inserting after subparagraph (D) the following new subparagraph:

''(E) inpatient critical access hospital services;''.

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

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

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

(1) IN GENERAL.—Section 1834(g)(2) (42 U.S.C. 1395m(g)(2)) is amended by adding after and below subparagraph (B) the following:

''The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians who have not assigned such billing rights.''.

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

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

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

''(4) FUNDING.—

''(A) IN GENERAL.—Subject to subparagraph (B), payment for grants made under this subsection during fiscal years 2004 through 2008 shall be made from the Federal Hospital Insurance Trust Fund.

''(B) ANNUAL AGGREGATE LIMITATION.—In no case may the amount of payment provided for under subparagraph (A) for a fiscal year exceed $25,000,000.''.

(2) CONFORMING AMENDMENT.—Section 1820 (42 U.S.C. 1395i–4) is amended by striking subsection (j).

SEC. 406. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

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

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

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

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

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

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

''(I) IN GENERAL.—If a hospital's resident level (as defined in clause (iii)(I)) is less than the otherwise applicable resident limit (as defined in clause (iii)(II)) for each of the reference periods (as defined in subclause (II)), effective for cost reporting periods beginning on or after January 1, 2004, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in subclause (III) (or subclause (IV) if applicable).

''(II) REFERENCE PERIODS DEFINED.—In this clause, the term 'reference periods' means, for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been settled (or, if not, submitted) on or before September 30, 2002.

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

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

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

''(ii) REDISTRIBUTION.—

''(I) IN GENERAL.—The Secretary is authorized to increase the otherwise applicable resident limits for hospitals by an aggregate number estimated by the Secretary that does not exceed the aggregate reduction in such limits attributable to clause (i) (without taking into account any adjustment under subclause (IV) of such clause).

''(II) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2004, or before the date of the hospital's application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2005.

''(III) CONSIDERATIONS IN REDISTRIBUTION.—In determining for which hospitals the increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall take into account the need for such an increase by specialty and location involved, consistent with subclause (IV).

''(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals and residency training programs an increase in the otherwise applicable resident limit is provided under subclause (I), the Secretary shall first distribute the increase to programs of hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of subsection (d)) on a first-come-first-served basis (as determined by the Secretary) based on a demonstration that the hospital will fill the positions made available under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

''(V) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under this clause, notwithstanding any other provision of this subsection, the approved FTE resident amount is deemed to be equal to the locality adjusted national average per resident amount computed under subparagraph (E) for that hospital.

''(VI) CONSTRUCTION.—Nothing in this clause shall be construed as permitting the redistribution of reductions in residency positions attributable to voluntary reduction programs under paragraph (6) or as affecting the ability of a hospital to establish new medical residency training programs under subparagraph (H).

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

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

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

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

(c) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2005, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident limits under section 1886(h)(4)(I)(ii)(II) of the Social Security Act (as added by subsection (a)).

SEC. 407. TWO-YEAR EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND SOLE COMMUNITY HOSPITALS UNDER PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) HOLD HARMLESS PROVISIONS.—

(1) IN GENERAL.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended—

(A) in the heading, by striking ''SMALL'' and inserting ''CERTAIN'';

(B) by inserting ''or a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area'' after ''100 beds''; and

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

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

(b) STUDY; ADJUSTMENT.—

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

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

SEC. 408. EXCLUSION OF CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES FROM THE PROSPECTIVE PAYMENT SYSTEM FOR SKILLED NURSING FACILITIES.

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

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

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

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

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

''(II) Federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were not furnished by an individual affiliated with a rural health clinic or a Federally qualified health center.''.

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

SEC. 409. RECOGNITION OF ATTENDING NURSE PRACTITIONERS AS ATTENDING PHYSICIANS TO SERVE HOSPICE PATIENTS.

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

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

SEC. 410. IMPROVEMENT IN PAYMENTS TO RETAIN EMERGENCY CAPACITY FOR AMBULANCE SERVICES IN RURAL AREAS.

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

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

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

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

''(A) IN GENERAL.—In the case of ground ambulance services furnished on or after January 1, 2004, for which the transportation originates in a qualified rural area (as defined in subparagraph (B)), the Secretary shall provide for an increase in the base rate of the fee schedule for mileage for a trip established under this subsection. In establishing such increase, the Secretary shall, based on the relationship of cost and volume, estimate the average increase in cost per trip for such services as compared with the cost per trip for the average ambulance service.

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

SEC. 411. TWO-YEAR INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) during 2004 and 2005, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 10 percent.

(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

SEC. 412. 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(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)(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 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. 413. 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. 414. TREATMENT OF MISSING COST REPORTING PERIODS FOR SOLE COMMUNITY HOSPITALS.

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

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

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

SEC. 415. EXTENSION OF TELEMEDICINE DEMONSTRATION PROJECT.

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

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

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

SEC. 416. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

(a) IN GENERAL.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

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

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

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

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

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

''(II) HOLD HARMLESS FOR CERTAIN HOSPITALS.—If the application of subclause (I) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this clause had not been enacted.''.

(b) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: ''The Secretary shall apply the previous sentence for any period as if the amendments made by section 402(a) of the Medicare Prescription Drug and Modernization Act of 2003 had not been enacted.''.

SEC. 417. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS FOR PHYSICIAN SCARCITY.

(a) ADDITIONAL BONUS PAYMENT FOR CERTAIN PHYSICIAN SCARCITY AREAS.—

(1) IN GENERAL.—Section 1833 (42 U.S.C. 1395*l*) is amended by adding at the end the following new subsection:

''(u) INCENTIVE PAYMENTS FOR PHYSICIAN SCARCITY AREAS.—

''(1) IN GENERAL.—In the case of physicians' services furnished in a year—

''(A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or

''(B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),

in addition to the amount of payment that would otherwise be made for such services under this part, there also shall be paid an amount equal to 5 percent of the payment amount for the service under this part.

''(2) DETERMINATION OF RATIOS OF PHYSICIANS TO MEDICARE BENEFICIARIES IN AREA.—Based upon available data, the Secretary shall periodically determine, for each county or equivalent area in the United States, the following:

''(A) NUMBER OF PHYSICIANS PRACTICING IN THE AREA.—The number of physicians who furnish physicians' services in the active practice of medicine or osteopathy in that county or area, other than physicians whose practice is exclusively for the Federal Government, physicians who are retired, or physicians who only provide administrative services. Of such number, the number of such physicians who are—

''(i) primary care physicians; or

''(ii) physicians who are not primary care physicians.

''(B) NUMBER OF MEDICARE BENEFICIARIES RESIDING IN THE AREA.—The number of individuals who are residing in the county and are entitled to benefits under part A or enrolled under this part, or both.

''(C) DETERMINATION OF RATIOS.—

''(i) PRIMARY CARE RATIO.—The ratio (in this paragraph referred to as the 'primary care ratio') of the number of primary care physicians (determined under subparagraph (A)(i)), to number of medicare beneficiaries determined under subparagraph (B).

''(ii) SPECIALIST CARE RATIO.—The ratio (in this paragraph referred to as the 'specialist care ratio') of the number of other physicians (determined under subparagraph (A)(ii)), to number of medicare beneficiaries determined under subparagraph (B).

''(3) RANKING OF COUNTIES.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

''(4) IDENTIFICATION OF COUNTIES.—The Secretary shall identify—

''(A) those counties and areas (in this paragraph referred to as 'primary care scarcity counties') with the lowest primary care ratios that represent, if each such county or area were weighted by the number of medicare beneficiaries determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the medicare beneficiaries determined under such paragraph; and

''(B) those counties and areas (in this subsection referred to as 'specialist care scarcity counties') with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of medicare beneficiaries determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the medicare beneficiaries determined under such paragraph.

There is no administrative or judicial review respecting the identification of a county or area or the assignment of a specialty of any physician under this paragraph.

''(5) RURAL CENSUS TRACKS.—To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725) as an equivalent area for purposes of qualifying as a primary care scarcity county or specialist care scarcity county under this subsection.

''(6) PHYSICIAN DEFINED.—For purposes of this paragraph, the term 'physician' means a physician described in section 1861(r)(1) and the term 'primary care physician' means a physician who is identified in the available data as a general practitioner, family practice practitioner, general internist, or obstetrician or gynecologist.

''(7) PUBLICATION OF LIST OF COUNTIES.—In carrying out this subsection for a year, the Secretary shall include, as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the year, a list of all areas which will qualify as a primary care scarcity county or specialist care scarcity county under this subsection for the year involved.''.

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

(b) IMPROVEMENT TO MEDICARE INCENTIVE PAYMENT PROGRAM.—

(1) IN GENERAL.—Section 1833(m) (42 U.S.C. 1395*l*(m)) is amended—

(A) by inserting ''(1)'' after ''(m)''; and

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

''(2) The Secretary shall establish procedures under which the Secretary, and not the physician furnishing the service, is responsible for determining when a payment is required to be made under paragraph (1).

''(3) In carrying out paragraph (1) for a year, the Secretary shall include, as part of the proposed and final rule to implement the physician fee schedule under section 1848 for the year, a list of all areas which will qualify as a health professional shortage area under paragraph (1) for the year involved.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to physicians' services furnished or after January 1, 2004.

SEC. 418. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

''(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

''(A) PAYMENT ADJUSTMENT.—

''(i) IN GENERAL.—Notwithstanding any other provision of this section, for each cost reporting period (beginning with the cost reporting period that begins in fiscal year 2004), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in clause (iii)) for discharges occurring during that cost reporting period which is equal to the applicable percentage increase (determined under clause (ii)) in the amount paid to such hospital under this section for such discharges.

''(ii) APPLICABLE PERCENTAGE INCREASE.—The Secretary shall determine a percentage increase applicable under this paragraph that ensures that—

''(I) no percentage increase in payments under this paragraph exceeds 25 percent of the amount of payment that would (but for this paragraph) otherwise be made to a low-volume hospital under this section for each discharge;

''(II) low-volume hospitals that have the lowest number of discharges during a cost reporting period receive the highest percentage increases in payments due to the application of this paragraph; and

''(III) the percentage increase in payments to any low-volume hospital due to the application of this paragraph is reduced as the number of discharges per cost reporting period increases.

''(iii) LOW-VOLUME HOSPITAL DEFINED.—For purposes of this paragraph, the term 'low-volume hospital' means, for a cost reporting period, a subsection (d) hospital (as defined in paragraph (1)(B)) other than a critical access hospital (as defined in section 1861(mm)(1)) that—

''(I) the Secretary determines had an average of less than 2,000 discharges (determined with respect to all patients and not just individuals receiving benefits under this title) during the 3 most recent cost reporting periods for which data are available that precede the cost reporting period to which this paragraph applies; and

''(II) is located at least 15 miles from a like hospital (or is deemed by the Secretary to be so located by reason of such factors as the Secretary determines appropriate, including the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (after taking into account the location of such alternative source of inpatient care and any weather or travel conditions that may affect such travel time).

''(B) PROHIBITING CERTAIN REDUCTIONS.—Notwithstanding subsection (e), the Secretary shall not reduce the payment amounts under this section to offset the increase in payments resulting from the application of subparagraph (A).''.

SEC. 419. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A SOLE COMMUNITY HOSPITAL.

Notwithstanding subsections (a), (b), and (h) of section 1833 of the Social Security Act (42 U.S.C. 1395*l*) and section 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act that is furnished in 2004 or 2005 by a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))) as part of services furnished to patients of the hospital, the following rules shall apply:

(1) PAYMENT BASED ON REASONABLE COSTS.—The amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

(2) NO BENEFICIARY COST-SHARING.—Notwithstanding section 432, no coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under such part B shall apply with respect to such test.

SEC. 420. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC ADJUSTMENTS OF PAYMENTS FOR PHYSICIANS' SERVICES.

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

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

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

''(E) FLOOR FOR WORK GEOGRAPHIC INDICES.—

''(i) IN GENERAL.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2008, after calculating the work geographic indices in subparagraph (A)(iii), the Secretary shall increase the work geographic index to the work floor index for any locality for which such geographic index is less than the work floor index.

''(ii) WORK FLOOR INDEX.—For purposes of clause (i), the term 'applicable floor index' means—

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

''(II) 1.000 for services furnished during 2005, 2006, and 2007.

''(F) FLOOR FOR PRACTICE EXPENSE AND MALPRACTICE GEOGRAPHIC INDICES.—For purposes of payment for services furnished on or after January 1, 2005, and before January 1, 2008, after calculating the practice expense and malpractice indices in clauses (i) and (ii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.

SEC. 421. AMBULANCE PAYMENT RATES.

(a) PAYMENT RATES.—Section 1834(l)(3) (42 U.S.C. 1395m(l)(3)) is amended to read as follows:

''(3) PAYMENT RATES.—

''(A) IN GENERAL.—Subject to any adjustment under subparagraph (B) and paragraph (9) and the full payment of a national mileage rate pursuant to subparagraph (2)(E), in establishing such fee schedule, the following rules shall apply:

''(i) PAYMENT RATES IN 2003.—

''(I) GROUND AMBULANCE SERVICES.—In the case of ground ambulance services furnished under this part in 2003, the Secretary shall set the payment rates under the fee schedule for such services at a rate based on the average costs (as determined by the Secretary on the basis of the most recent and reliable information available) incurred by full cost ambulance suppliers in providing nonemergency basic life support ambulance services covered under this title, with adjustments to the rates for other ground ambulance service levels to be determined based on the rule established under paragraph (1). For the purposes of the preceding sentence, the term 'full cost ambulance supplier' means a supplier for which volunteers or other unpaid staff comprise less than 20 percent of the supplier's total staff and which receives less than 20 percent of space and other capital assets free of charge.

''(II) OTHER AMBULANCE SERVICES.—In the case of ambulance services not described in subclause (I) that are furnished under this part in 2003, the Secretary shall set the payment rates under the fee schedule for such services based on the rule established under paragraph (1).

''(ii) PAYMENT RATES IN SUBSEQUENT YEARS FOR ALL AMBULANCE SERVICES.—In the case of any ambulance service furnished under this part in 2004 or any subsequent year, the Secretary shall set the payment rates under the fee schedule for such service at amounts equal to the payment rate under the fee schedule for that service furnished during the previous year, increased by the percentage increase in the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with June of the previous year.

''(B) ADJUSTMENT IN RURAL RATES.—For years beginning with 2004, the Secretary, after taking into consideration the recommendations contained in the report submitted under section 221(b)(3) the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000, shall adjust the fee schedule payment rates that would otherwise apply under this subsection for ambulance services provided in low density rural areas based on the increased cost (if any) of providing such services in such areas.''.

(b) CONFORMING AMENDMENT.—Section 221(c) of BIPA is repealed.

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

SEC. 501. 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) by striking ''and'' at the end of subclause (VI);

(2) in subclause (VII)—

(A) by striking ''on or after October 1, 2002,'' and inserting ''during fiscal year 2003,''; and

(B) by striking the period at the end and inserting ''; and''; and

(3) by inserting after subclause (VII) the following new subclauses:

''(VIII) during each of fiscal years 2004 and 2005, 'c' is equal to 1.47; and

''(IX) on or after October 1, 2005, 'c' is equal to 1.35.''.

SEC. 502. 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 FOR TECHNOLOGY OUTLIERS.—

(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 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 75 percent of 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 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. Nothing in this subclause shall be construed as effecting the authority of the Secretary to determine whether items and services are medically necessary and appropriate under section 1862(a)(1).''.

(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, the new technology would no longer meet the threshold of exceeding 75 percent of the standard deviation for the diagnosis-related group involved under clause (ii)(I). 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) ESTABLISHMENT OF NEW FUNDING FOR HOSPITAL INPATIENT TECHNOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by striking ''subject to paragraph (4)(C)(iii),''.

(f) 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 2005.

(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 2004 and that is denied—

(A) the Secretary shall automatically reconsider the application as an application for fiscal year 2005 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. 503. INCREASE IN 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) on or after October 1, 1987, and before October 1, 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 41 percent and the applicable Federal percentage is 59 percent;

''(iv) during fiscal year 2005, the applicable Puerto Rico percentage is 33 percent and the applicable Federal percentage is 67 percent; and

''(v) on or after October 1, 2005, the applicable Puerto Rico percentage is 25 percent and the applicable Federal percentage is 75 percent.''.

SEC. 504. WAGE INDEX ADJUSTMENT RECLASSIFICATION REFORM .

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

''(11)(A) In order to recognize commuting patterns among Metropolitan Statistical Areas and between such Areas and rural areas, the Secretary shall establish a process, upon application of a subsection (d) hospital that establishes that it is a qualifying hospital described in subparagraph (B), for an increase of the wage index applied under paragraph (3)(E) for the hospital in the amount computed under subparagraph (D).

''(B) A qualifying hospital described in this subparagraph is a subsection (d) hospital—

''(i) the average wages of which exceed the average wages for the area in which the hospital is located; and

''(ii) which has at least 10 percent of its employees who reside in one or more higher wage index areas.

''(C) For purposes of this paragraph, the term 'higher wage index area' means, with respect to a hospital, an area with a wage index that exceeds that of the area in which the hospital is located.

''(D) The increase in the wage index under subparagraph (A) for a hospital shall be equal to the percentage of the employees of the hospital that resides in any higher wage index area multiplied by the sum of the products, for each higher wage index area of—

''(i) the difference between (I) the wage index for such area, and (II) the wage index of the area in which the hospital is located (before the application of this paragraph); and

''(ii) the number of employees of the hospital that reside in such higher wage index area divided by the total number of such employees that reside in all high wage index areas.

''(E) The process under this paragraph shall be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10) with respect to data submitted by hospitals to the Board on the location of residence of hospital employees and wages under the applicable schedule established for geographic reclassification.

''(F) A reclassification under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to terminate such reclassification before the end of such period.

''(G) A hospital that is reclassified under this paragraph for a period is not eligible for reclassification under paragraphs (8) or (10) during that period.

''(H) Any increase in a wage index under this paragraph for a hospital shall not be taken into account for purposes of—

''(i) computing the wage index for the area in which the hospital is located or any other area; or

''(ii) applying any budget neutrality adjustment with respect to such index under paragraph (8)(D).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall first apply to the wage index for cost reporting period beginning on or after October 1, 2004.

SEC. 505. CLARIFICATIONS TO CERTAIN EXCEPTIONS TO MEDICARE LIMITS ON PHYSICIAN REFERRALS.

(a) OWNERSHIP AND INVESTMENT INTERESTS IN WHOLE HOSPITALS.—

(1) IN GENERAL.—Section 1877(d)(3) (42 U.S.C. 1395nn(d)(3)) is amended—

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

(B) by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A) the following:

''(B) the hospital is not a specialty hospital (as defined in subsection (h)(7)); and''.

(2) DEFINITION.—Section 1877(h) (42 U.S.C. 1395nn(h)) is amended by adding at the end the following:

''(7) SPECIALTY HOSPITAL.—

''(A) IN GENERAL.—For purposes of this section, except as provided in subparagraph (B), the term 'specialty hospital' means a hospital that is primarily or exclusively engaged in the care and treatment of one of the following:

''(i) patients with a cardiac condition;

''(ii) patients with an orthopedic condition;

''(iii) patients receiving a surgical procedure; or

''(iv) any other specialized category of patients or cases that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

''(B) EXCEPTION.—For purposes of this section, the term 'specialty hospital' does not include any hospital—

''(i) determined by the Secretary—

''(I) to be in operation before June 12, 2003; or

''(II) under development as of such date;

''(ii) for which the number of beds and the number of physician investors at any time on or after such date is no greater than the number of such beds or investors as of such date; and

''(iii) that meets such other requirements as the Secretary may specify.''.

(b) EFFECTIVE DATE.—Subject to subsection (c), the amendments made by this section shall apply to referrals made for designated health services on or after January 1, 2004.

(c) APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT.—For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act, as added by subsection (a)(2), in determining whether a hospital is under development as of June 12, 2003, the Secretary shall consider—

(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

Subtitle B—Other Provisions

SEC. 511. PAYMENT FOR COVERED SKILLED NURSING FACILITY SERVICES.

(a) ADJUSTMENT TO RUGS FOR AIDS RESIDENTS.—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.''.

(b) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 2003.

SEC. 512. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) COVERAGE OF HOSPICE CONSULTATION SERVICES.—Section 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.

TITLE VI—PROVISIONS RELATING TO PART B

Subtitle A—Physicians' Services

SEC. 601. REVISION OF UPDATES FOR PHYSICIANS' SERVICES.

(a) UPDATE FOR 2004 AND 2005.—

(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(d)) is amended by adding at the end the following new paragraph:

''(5) UPDATE FOR 2004 AND 2005.—The update to the single conversion factor established in paragraph (1)(C) for each of 2004 and 2005 shall be not less than 1.5 percent.''.

(2) CONFORMING AMENDMENT.—Paragraph (4)(B) of such section is amended, in the matter before clause (i), by inserting ''and paragraph (5)'' 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 2003.

SEC. 602. 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.

(c) 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, 2004, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

SEC. 603. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS' SERVICES.

(a) PRACTICE EXPENSE COMPONENT.—Not later than 1 year after the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the 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.

(b) VOLUME OF PHYSICIAN SERVICES.—The Medicare Payment Advisory Commission shall submit to Congress a report on the extent to which increases in the volume of physicians' services under part B of the medicare program are a result of care that improves the health and well-being of medicare beneficiaries. The study shall include the following:

(1) An analysis of recent and historic growth in the components that the Secretary includes under the sustainable growth rate (under section 1848(f) of the Social Security Act).

(2) An examination of the relative growth of volume in physician services between medicare beneficiaries and other populations.

(3) An analysis of the degree to which new technology, including coverage determinations of the Centers for Medicare & Medicaid Services, has affected the volume of physicians' services.

(4) An examination of the impact on volume of demographic changes.

(5) An examination of shifts in the site of service of services that influence the number and intensity of services furnished in physicians' offices and the extent to which changes in reimbursement rates to other providers have affected these changes.

(6) An evaluation of the extent to which the Centers for Medicare & Medicaid Services takes into account the impact of law and regulations on the sustainable growth rate.

Subtitle B—Preventive Services

SEC. 611. 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. 612. COVERAGE OF CHOLESTEROL AND BLOOD LIPID SCREENING.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by section 611(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 611(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 611(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, 2005.

SEC. 613. WAIVER OF DEDUCTIBLE FOR COLORECTAL CANCER SCREENING TESTS.

(a) IN GENERAL.—The first sentence of section 1833(b) (42 U.S.C. 1395*l*(b)), as amended by section 611(c)(1), is amended—

(1) by striking ''and'' before ''(7)''; and

(2) by inserting before the period at the end the following: '', and (8) such deductible shall not apply with respect to colorectal cancer screening tests (as described in section 1861(pp)(1))''.

(b) CONFORMING AMENDMENTS.—Paragraphs (2)(C)(ii) and (3)(C)(ii) of section 1834(d) (42 U.S.C. 1395m(d)) are each amended—

(1) by striking ''DEDUCTIBLE AND'' in the heading; and

(2) in subclause (I), by striking ''deductible or'' each place it appears.

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to items and services furnished on or after Janaury 1, 2004.

SEC. 614. 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.

Subtitle C—Other Services

SEC. 621. HOSPITAL OUTPATIENT DEPARTMENT (HOPD) PAYMENT REFORM.

(a) PAYMENT FOR DRUGS.—

(1) MODIFICATION OF AMBULATORY PAYMENT CLASSIFICATION (APC) GROUPS.—Section 1833(t) (42 U.S.C. 1395l(t)) is amended—

(A) by redesignating paragraph (13) as paragraph (14); and

(B) by inserting after paragraph (12) the following new paragraph:

''(13) DRUG APC PAYMENT RATES.—

''(A) IN GENERAL.—With respect to payment for covered OPD services that includes a specified covered outpatient drug (defined in subparagraph (B)), the amount provided for payment for such drug under the payment system under this subsection for services furnished in—

''(i) 2004, 2005, or 2006, shall in no case—

''(I) exceed 95 percent of the average wholesale price for the drug; or

''(II) be less than the transition percentage (under subparagraph (C)) of the average wholesale price for the drug; or

''(ii) a subsequent year, shall be equal to the average price for the drug for that area and year established under the competitive acquisition program under section 1847A as calculated and applied by the Secretary for purposes of this paragraph.

''(B) SPECIFIED COVERED OUTPATIENT DRUG DEFINED.—

''(i) IN GENERAL.—In this paragraph, the term 'specified covered outpatient drug' means, subject to clause (ii), a covered outpatient drug (as defined in 1927(k)(2), that is—

''(I) a radiopharmaceutical; or

''(II) a drug or biological for which payment was made under paragraph (6) (relating to pass-through payments) on or before December 31, 2002.

''(ii) EXCEPTION.—Such term does not include—

''(I) a drug for which payment is first made on or after January 1, 2003, under paragraph (6); or

''(II) a drug for a which a temporary HCPCS code has not been assigned.

''(C) TRANSITION TOWARDS HISTORICAL AVERAGE ACQUISITION COST.—The transition percentage under this subparagraph for drugs furnished in a year is determined in accordance with the following table:

For the year—	The transition percentage for— Single source drugs are—	Innovator multiple source drugs are—	Generic drugs are—
2004	83%	81.5%	46%
2005	77%	75%	46%
2006	71%	68%	46%

''(D) PAYMENT FOR NEW DRUGS UNTIL TEMPORARY HCPCS CODE ASSIGNED.—With respect to payment for covered OPD services that includes a covered outpatient drug (as defined in 1927(k)) for a which a temporary HCPCS code has not been assigned, the amount provided for payment for such drug under the payment system under this subsection shall be equal to 95 percent of the average wholesale price for the drug.

''(E) CLASSES OF DRUGS.—For purposes of this paragraph, each of the following shall be treated as a separate class of drugs:

''(i) SOLE SOURCE DRUGS.—A sole source drug which for purposes of this paragraph means a drug or biological that is not a multiple source drug (as defined in subclauses (I) and (II) of section 1927(k)(7)(A)(i)) and is not a drug approved under an abbreviated new drug application under section 355(j) of the Federal Food, Drug, and Cosmetic Act.

''(ii) INNOVATOR MULTIPLE SOURCE DRUGS.—Innovator multiple source drugs (as defined in section 1927(k)(7)(A)(ii)).

''(iii) NONINNOVATOR MULTIPLE SOURCE DRUGS.—Noninnovator multiple source drugs (as defined in section 1927(k)(7)(A)(iii)).

''(F) INAPPLICABILITY OF EXPENDITURES IN DETERMINING CONVERSION FACTORS.—Additional expenditures resulting from this paragraph and paragraph (14)(C) in a year shall not be taken into account in establishing the conversion factor for that year.''.

(2) REDUCTION IN THRESHOLD FOR SEPARATE APCS FOR DRUGS.—Section 1833(t)(14), as redesignated by paragraph (1)(A), is amended by adding at the end the following new subparagraph:

''(B) THRESHOLD FOR ESTABLISHMENT OF SEPARATE APCS FOR DRUGS.—The Secretary shall reduce the threshold for the establishment of separate ambulatory procedure classification groups (APCs) with respect to drugs to $50 per administration.''.

(3) EXCLUSION OF SEPARATE DRUG APCS FROM OUTLIER PAYMENTS.—Section 1833(t)(5) is amended by adding at the end the following new subparagraph:

''(E) EXCLUSION OF SEPARATE DRUG APCS FROM OUTLIER PAYMENTS.—No additional payment shall be made under subparagraph (A) in the case of ambulatory procedure codes established separately for drugs.''.

(4) PAYMENT FOR PASS THROUGH DRUGS.—Clause (i) of section 1833(t)(6)(D) (42 U.S.C. 1395l(t)(6)(D)) is amended by inserting after ''under section 1842(o)'' the following: ''(or if the drug is covered under a competitive acquisition contract under section 1847A for an area, an amount determined by the Secretary equal to the average price for the drug for that area and year established under such section as calculated and applied by the Secretary for purposes of this paragraph)''.

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

(b) SPECIAL PAYMENT FOR BRACHYTHERAPY.—

(1) IN GENERAL.—Section 1833(t)(14), as so redesignated and amended by subsection (a)(2), is amended by adding at the end the following new subparagraph:

''(C) PAYMENT FOR DEVICES OF BRACHYTHERAPY AT CHARGES ADJUSTED TO COST.—Notwithstanding the preceding provisions of this subsection, for a device of brachytherapy furnished on or after January 1, 2004, and before January 1, 2007, the payment basis for the device under this subsection shall be equal to the hospital's charges for each device furnished, adjusted to cost.''.

(2) SPECIFICATION OF GROUPS FOR BRACHYTHERAPY DEVICES.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2) is amended—

(A) in subparagraph (F), by striking ''and'' at the end;

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

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

''(H) with respect to devices of brachytherapy, the Secretary shall create additional groups of covered OPD services that classify such devices separately from the other services (or group of services) paid for under this subsection in a manner reflecting the number, isotope, and radioactive intensity of such devices furnished, including separate groups for palladium-103 and iodine-125 devices.''.

(3) GAO REPORT.—The Comptroller General of the United States shall conduct a study to determine appropriate payment amounts under section 1833(t)(13)(B) of the Social Security Act, as added by paragraph (1), for devices of brachytherapy. Not later than January 1, 2005, the Comptroller General shall submit to Congress and the Secretary a report on the study conducted under this paragraph, and shall include specific recommendations for appropriate payments for such devices.

(c) APPLICATION OF FUNCTIONAL EQUIVALENCE TEST.—

(1) IN GENERAL.—Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION ON APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—The Secretary may not apply a 'functional equivalence' payment standard (including such standard promulgated on November 1, 2002) or any other similar standard in order to deem a particular drug or biological to be identical to or similar to another drug or biological with respect to its mechanism of action or clinical effect to deny pass-through status to new drugs or biologics or to remove such status of an existing eligible drug or biologic under this paragraph unless—

''(i) the Secretary develops by regulation (after providing notice and a period for public comment) criteria for the application of such standard; and

''(ii) such criteria provide for coordination with the Federal Food and Drug Administration and require scientific studies that show the clinical relationship between the drugs or biologicals treated as functionally equivalent.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of the enactment of this Act, unless such application was being made to such drug or biological prior to June 13, 2003.

(d) HOSPITAL ACQUISITION COST STUDY.—

(1) IN GENERAL.—The Secretary shall conduct a study on the costs incurred by hospitals in acquiring covered outpatient drugs for which payment is made under section 1833(t) of the Social Security Act (42 U.S.C. 1395l(t)).

(2) DRUGS COVERED.—The study in paragraph (1) shall not include those drugs for which the acquisition costs is less than $50 per administration.

(3) REPRESENTATIVE SAMPLE OF HOSPITALS.—In conducting the study under paragraph (1), the Secretary shall collect data from a statistically valid sample of hospitals with an urban/rural stratification.

(4) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), and shall include recommendations with respect to the following:

(A) Whether the study should be repeated, and if so, how frequently.

(B) Whether the study produced useful data on hospital acquisition cost.

(C) Whether data produced in the study is appropriate for use in making adjustments to payments for drugs and biologicals under section 1847A of the Social Security Act.

(D) Whether separate estimates can made of overhead costs, including handing and administering costs for drugs.

SEC. 622. 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)), as amended by section 410(a), is amended—

(1) in paragraph (2)(E), by inserting ''consistent with paragraph (11)'' after ''in an efficient and fair manner''; and

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

''(11) PHASE-IN PROVIDING FLOOR USING BLEND OF FEE SCHEDULE AND REGIONAL FEE SCHEDULES.—In carrying out the phase-in under paragraph (2)(E) for each level of service furnished in a year, the portion of the payment amount that is based on the fee schedule 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 2004, the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

''(B) For 2005, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

''(C) For 2006, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

''(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

''(E) For 2010 and each succeeding year, the blended rate shall be based 100 percent on the fee schedule under paragraph (1).

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the 9 Census divisions using the methodology (used in establishing the fee schedule under paragraph (1)) to calculate a regional conversion factor and a regional 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:

''(12) ADJUSTMENT IN PAYMENT FOR CERTAIN LONG TRIPS.—In the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2009, 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) GAO REPORT ON COSTS AND ACCESS.—Not later than December 31, 2005, the Comptroller General of the United States shall submit to Congress an initial report on how costs differ among the types of ambulance providers and on access, supply, and quality of ambulance services in those regions and States that have a reduction in payment under the medicare ambulance fee schedule (under section 1834(l) of the Social Security Act, as amended by this section). Not later than December 31, 2007, the Comptroller General shall submit to Congress a final report on such access and supply.

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

SEC. 623. RENAL DIALYSIS SERVICES.

(a) DEMONSTRATION OF ALTERNATIVE DELIVERY MODELS.—

(1) USE OF ADVISORY BOARD.—In carrying out the demonstration project relating to improving care for people with end-stage renal disease through alternative delivery models (as published in the Federal Register of June 4, 2003), the Secretary shall establish an advisory board comprised of representatives described in paragraph (2) to provide advice and recommendations with respect to the establishment and operation of such demonstration project.

(2) REPRESENTATIVES.—Representatives referred to in paragraph (1) include representatives of the following:

(A) Patient organizations.

(B) Clinicians.

(C) The medicare payment advisory commission, established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

(D) The National Kidney Foundation.

(E) The National Institute of Diabetes and Digestive and Kidney Diseases of National Institutes of Health.

(F) End-stage renal disease networks.

(G) Medicare contractors to monitor quality of care.

(I) providers of services and renal dialysis facilities furnishing end-stage renal disease services.

(J) Economists.

(K) Researchers.

(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)), as amended by subsection (b), is further amended by striking ''Until'' and inserting ''Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, and until''.

(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 1.6 percent.

SEC. 624. ONE-YEAR MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO REPORTS.

(a) 1-YEAR 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 2004''.

(b) PROMPT SUBMISSION OF OVERDUE REPORTS ON PAYMENT AND UTILIZATION OF OUTPATIENT THERAPY SERVICES.—Not later than December 31, 2003, the Secretary shall submit to Congress the reports required under section 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.—

(A) PRELIMINARY REPORT.—Not later than July 1, 2004, the Secretary shall submit to Congress a preliminary report on the conditions and diseases identified under paragraph (1).

(B) FINAL REPORT.—Not later than September 1, 2004, the Secretary shall submit to Congress a final report on such conditions and diseases.

(C) RECOMMENDATIONS.—Not later than October 1, 2004, the Secretary shall submit to Congress a recommendation of criteria, with respect to such conditions and disease, under which a waiver of the therapy caps would apply.

(d) GAO STUDY OF PATIENT ACCESS TO PHYSICAL THERAPIST SERVICES.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on 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. 625. ADJUSTMENT TO PAYMENTS FOR SERVICES FURNISHED IN AMBULATORY SURGICAL CENTERS.

Section 1833(i)(2)(C) (42 U.S.C. 1395l(i)(2)(C)) is amended in the last sentence by inserting ''and each of fiscal years 2004 through 2008'' after ''In each of the fiscal years 1998 through 2002''.

SEC. 626. PAYMENT FOR CERTAIN SHOES AND INSERTS UNDER THE FEE SCHEDULE FOR ORTHOTICS AND PROSTHETICS.

(a) IN GENERAL.—Section 1833(o) (42 U.S.C. 1395l(o)) is amended—

(1) in paragraph (1), by striking ''no more than the limits established under paragraph (2)'' and inserting ''no more than the amount of payment applicable under paragraph (2)''; and

(2) in paragraph (2), to read as follows:

''(2)(A) Except as provided by the Secretary under subparagraphs (B) and (C), the amount of payment under this paragraph for custom molded shoes, extra depth shoes, and inserts shall be the amount determined for such items by the Secretary under section 1834(h).

''(B) The Secretary or a carrier may establish payment amounts for shoes and inserts that are lower than the amount established under section 1834(h) if the Secretary finds that shoes and inserts of an appropriate quality are readily available at or below the amount established under such section.

''(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modification of such shoes instead of obtaining one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall substitute, for the payment amount established under section 1834(h), a payment amount that the Secretary estimates will assure that there is no net increase in expenditures under this subsection as a result of this subparagraph.''.

(b) CONFORMING AMENDMENTS.—(1) Section 1834(h)(4)(C) (42 U.S.C. 1395m(h)(4)(C)) is amended by inserting ''(and includes shoes described in section 1861(s)(12))'' after ''in section 1861(s)(9)''.

(2) Section 1842(s)(2) (42 U.S.C. 1395u(s)(2)) is amended by striking subparagraph (C).

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished on or after January 1, 2004.

SEC. 627. 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, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, 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 2004. The Secretary of Health and Human Services shall establish a method for providing rebates of premium penalties paid for months on or after January 2004 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, 2004.

(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. 628. EXTENSION OF COVERAGE OF INTRAVENOUS IMMUNE GLOBULIN (IVIG) FOR THE TREATMENT OF PRIMARY IMMUNE DEFICIENCY DISEASES IN THE HOME.

(a) IN GENERAL.—Section 1861 (42 U.S.C. 1395x), as amended by sections 611(a) and 612(a) is amended—

(1) in subsection (s)(2)—

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

(B) by adding ''and'' at the end of subparagraph (X); and

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

''(Y) intravenous immune globulin for the treatment of primary immune deficiency diseases in the home (as defined in subsection (yy));''; and

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

''Intravenous Immune Globulin

''(yy) The term 'intravenous immune globulin' means an approved pooled plasma derivative for the treatment in the patient's home of a patient with a diagnosed primary immune deficiency disease, but not including items or services related to the administration of the derivative, if a physician determines administration of the derivative in the patient's home is medically appropriate.''.

(b) PAYMENT AS A DRUG OR BIOLOGICAL.—Section 1833(a)(1)(S) (42 U.S.C. 1395l(a)(1)(S)) is amended by inserting ''(including intravenous immune globulin (as defined in section 1861(yy)))'' after ''with respect to drugs and biologicals''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished administered on or after January 1, 2004.

SEC. 629. MEDICARE COVERAGE OF DIABETES LABORATORY DIAGNOSTIC TESTS.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by sections 611 and 612, is amended—

(1) in subparagraph (W), by striking ''and'' at the end;

(2) in subparagraph (X), by adding ''and'' at the end; and

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

''(Y) diabetes screening tests and services (as defined in subsection (yy));''.

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by sections 611 and 612, is further amended by adding at the end the following new subsection:

''Diabetes Screening Tests and Services

''(yy)(1) The term 'diabetes screening tests' means diagnostic testing furnished to an individual at risk for diabetes (as defined in paragraph (2)) for the purpose of early detection of diabetes, including—

''(A) a fasting plasma glucose test; and

''(B) such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

''(2) For purposes of paragraph (1), the term 'individual at risk for diabetes' means an individual who has any, a combination of, or all of the following risk factors for diabetes:

''(A) A family history of diabetes.

''(B) Overweight defined as a body mass index greater than or equal to 25 kg/m2.

''(C) Habitual physical inactivity.

''(D) Belonging to a high-risk ethnic or racial group.

''(E) Previous identification of an elevated impaired fasting glucose.

''(F) Identification of impaired glucose tolerance.

''(G) Hypertension.

''(H) Dyslipidemia.

''(I) History of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

''(J) Polycystic ovary syndrome.

''(3) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.''.

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395y(a)(1)), as amended by sections 611 and 612, is amended—

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

(2) by striking the semicolon at the end of subparagraph (K) and inserting ''; and''; and

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

''(L) in the case of a diabetes screening tests or service (as defined in section 1861(yy)(1)), which is performed more frequently than is covered under section 1861(yy)(3).''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after the date that is 90 days after the date of enactment of this Act.

TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Home Health Services

SEC. 701. UPDATE IN HOME HEALTH SERVICES.

(a) CHANGE TO CALENDER 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 fiscal year 2003 and for each subsequent year (beginning with 2004)''; and

(ii) by inserting ''or year'' after ''the fiscal year'';

(B) in paragraph (3)(B)(ii)(II), by striking ''any subsequent fiscal year'' and inserting ''2004 and any subsequent year'';

(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, 2003, shall be such amount (or amounts) for the previous calendar quarter.

(b) CHANGES IN UPDATES FOR 2004, 2005, AND 2006.—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) by striking ''or'' at the end of subclause (I);

(2) by redesignating subclause (II) as subclause (III);

(3) in subclause (III), as so redesignated, by striking ''2004'' and inserting ''2007''; and

(4) by inserting after subclause (I) the following new subclause:

''(II) each of 2004, 2005, and 2006 the home health market basket percentage increase minus 0.4 percentage points; or''.

SEC. 702. 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. 703. DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall conduct a two-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic conditions described in subsection (b) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if the beneficiary—

(1) has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) requires the individual to receive assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the individual's life;

(3) requires 1 or more home health services to achieve a functional condition that gives the individual the ability to leave home; and

(4) requires technological assistance or the assistance of another person to leave the home.

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to medicare beneficiaries under the project—

(A) adversely effects the provision of home health services under the medicare program; or

(B) directly causes an unreasonable increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is a directly attributable to the demonstration project (expressed both in absolute dollar terms and as a percentage) above expenditures that would otherwise have been incurred for home health services under the medicare program; and

(3) specific recommendations to exempt permanently and severely disabled homebound beneficiaries from restrictions on the length, frequency and purpose of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the medicare program.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available to the Secretary under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of receipt of items or services under the medicare program.

(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Insurance Trust Fund under section 1841 of such Act (42 U.S.C. 1395t).

(j) DEFINITIONS.—In this section:

(1) MEDICARE BENEFICIARY.—The term ''medicare beneficiary'' means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) HOME HEALTH SERVICES.—The term ''home health services'' has the meaning given such term in section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)).

(3) ACTIVITIES OF DAILY LIVING DEFINED.—The term ''activities of daily living'' means eating, toileting, transferring, bathing, and dressing.

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

Subtitle B—Chronic Care Improvement

SEC. 721. VOLUNTARY CHRONIC CARE IMPROVEMENT UNDER TRADITIONAL FEE-FOR-SERVICE.

Title XVIII is amended by inserting after section 1806 the following new section:

''CHRONIC CARE IMPROVEMENT

''SEC. 1807. (a) IN GENERAL.—

''(1) IN GENERAL.—The Secretary shall establish a process for providing chronic care improvement programs in each CCIA region for medicare beneficiaries who are not enrolled under part C and who have certain chronic conditions, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), stroke, prostate and colon cancer, hypertension, or other disease as identified by the Secretary as appropriate for chronic care improvement. Such a process shall begin to be implemented no later than 1 year after the date of the enactment of this section.

''(2) TERMINOLOGY.—For purposes of this section:

''(A) CCIA REGION.—The term 'CCIA region' means a chronic care improvement administrative region delineated under subsection (b)(2).

''(B) CHRONIC CARE IMPROVEMENT PROGRAM.—The terms 'chronic care improvement program' and 'program' means such a program provided by a contractor under this section.

''(C) CONTRACTOR.—The term 'contractor' means an entity with a contract to provide a chronic care improvement program in a CCIA region under this section.

''(D) INDIVIDUAL PLAN.—The term 'individual plan' means a chronic care improvement plan established under subsection (c)(5) for an individual.

''(3) CONSTRUCTION.—Nothing in this section shall be construed as expanding the amount, duration, or scope of benefits under this title.

''(b) COMPETITIVE BIDDING PROCESS.—

''(1) IN GENERAL.—Under this section the Secretary shall award contracts to qualified

entities for chronic care improvement programs for each CCIA region under this section through a competitive bidding process.

''(2) PROCESS.—Under such process—

''(A) the Secretary shall delineate the United States into multiple chronic care improvement administrative regions; and

''(B) the Secretary shall select at least 2 winning bidders in each CCIA region on the basis of the ability of each bidder to carry out a chronic care improvement program in accordance with this section, in order to achieve improved health and financial outcomes.

''(3) ELIGIBLE CONTRACTOR.—A contractor may be a disease improvement organization, health insurer, provider organization, a group of physicians, or any other legal entity that the Secretary determines appropriate.

''(c) CHRONIC CARE IMPROVEMENT PROGRAMS.—

''(1) IN GENERAL.—Each contract under this section shall provide for the operation of a chronic care improvement program by a contractor in a CCIA region consistent with this subsection.

''(2) IDENTIFICATION OF PROSPECTIVE PROGRAM PARTICIPANTS.—Each contractor shall have a method for identifying medicare beneficiaries in the region to whom it will offer services under its program. The contractor shall identify such beneficiaries through claims or other data and other means permitted consistent with applicable disclosure provisions.

''(3) INITIAL CONTACT BY SECRETARY.—The Secretary shall communicate with each beneficiary identified under paragraph (2) as a prospective participant in one or more programs concerning participation in a program. Such communication may be made by the Secretary (or on behalf of the Secretary) and shall include information on the following:

''(A) A description of the advantages to the beneficiary in participating in a program.

''(B) Notification that the contractor offering a program may contact the beneficiary directly concerning such participation.

''(C) Notification that participation in a program is voluntary.

''(D) A description of the method for the beneficiary to select the single program in which the beneficiary wishes to participate and for declining to participate and a method for obtaining additional information concerning such participation.

''(4) PARTICIPATION.—A medicare beneficiary may participate in only one program under this section and may terminate participation at any time in a manner specified by the Secretary.

''(5) INDIVIDUAL CHRONIC CARE IMPROVEMENT PLANS.—

''(A) IN GENERAL.—For each beneficiary participating in a program of a contractor under this section, the contractor shall develop with the beneficiary an individualized, goal-oriented chronic care improvement plan.

''(B) ELEMENTS OF INDIVIDUAL PLAN.—Each individual plan developed under subparagraph (A) shall include a single point of contact to coordinate care and the following, as appropriate:

''(i) Self-improvement education for the beneficiary (such as education for disease management through medical nutrition therapy) and support education for health care providers, primary caregivers, and family members.

''(ii) Coordination of health care services, such as application of a prescription drug regimen and home health services.

''(iii) Collaboration with physicians and other providers to enhance communication of relevant clinical information.

''(iv) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

''(v) The provision of information about hospice care, pain and palliative care, and end-of-life care.

''(C) CONTRACTOR RESPONSIBILITIES.—In establishing and carrying out individual plans under a program, a contractor shall, directly or through subcontractors—

''(i) guide participants in managing their health, including all their co-morbidities, and in performing activities as specified under the elements of the plan;

''(ii) use decision support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

''(iii) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

''(6) ADDITIONAL REQUIREMENTS.—The Secretary may establish additional requirements for programs and contractors under this section.

''(7) ACCREDITATION.—The Secretary may provide that programs that are accredited by qualified organizations may be deemed to meet such requirements under this section as the Secretary may specify.

''(c) CONTRACT TERMS.—

''(1) IN GENERAL.—A contract under this section shall contain such terms and conditions as the Secretary may specify consistent with this section. The Secretary may not enter into a contract with an entity under this section unless the entity meets such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the population to be served.

''(2) USE OF SUBCONTRACTORS PERMITTED.—A contractor may carry out a program directly or through contracts with subcontractors.

''(3) BUDGET NEUTRAL PAYMENT CONDITION.—In entering into a contract with an entity under this subsection, the Secretary shall establish payment rates that assure that there will be no net aggregate increase in payments under this title over any period of 3 years or longer, as agreed to by the Secretary. Under this section, the Secretary shall assure that medicare program outlays plus administrative expenses (that would not have been paid under this title without implementation of this section), including contractor fees, shall not exceed the expenditures that would have been incurred under this title for a comparable population in the absence of the program under this section for the 3-year contract period.

''(4) AT RISK RELATIONSHIP.—For purposes of section 1128B(b)(3)(F), a contract under this section shall be treated as a risk-sharing arrangement referred to in such section.

''(5) PERFORMANCE STANDARDS.—Payment to contractors under this section shall be subject to the contractor's meeting of clinical and financial performance standards set by the Secretary.

''(6) CONTRACTOR OUTCOMES REPORT.—Each contractor offering a program shall monitor and report to the Secretary, in a manner specified by the Secretary, the quality of care and efficacy of such program in terms of—

''(A) process measures, such as reductions in errors of treatment and rehospitalization rates;

''(B) beneficiary and provider satisfaction;

''(C) health outcomes; and

''(D) financial outcomes.

''(7) PHASED IN IMPLEMENTATION.—Nothing in this section shall be construed as preventing the Secretary from phasing in the implementation of programs.

''(d) BIANNUAL OUTCOMES REPORTS.—The Secretary shall submit to the Congress biannual reports on the implementation of this section. Each such report shall include information on—

''(1) the scope of implementation (in terms of both regions and chronic conditions);

''(2) program design; and

''(3) improvements in health outcomes and financial efficiencies that result from such implementation.

''(e) CLINICAL TRIALS.—The Secretary shall conduct randomized clinical trials, that compare program participants with medicare beneficiaries who are offered, but decline, to participate, in order to assess the potential of programs to—

''(1) reduce costs under this title; and

''(2) improve health outcomes under this title.

''(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary, in appropriate part from the Hospital Insurance Trust Fund and the Supplementary Medical Insurance Trust Fund, such sums as may be necessary to provide for contracts with chronic care improvement programs under this section.

''(g) LIMITATION ON FUNDING.—In no case shall the funding under this section exceed $100,000,000 over a period of 3 years.''.

SEC. 722. CHRONIC CARE IMPROVEMENT UNDER MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—Section 1852 (42 U.S.C. 1395w–22) is amended—

(1) by amending subsection (e) to read as follows:

''(e) IMPLEMENTATION OF CHRONIC CARE IMPROVEMENT PROGRAMS FOR BENEFICIARIES WITH MULTIPLE OR SUFFICIENTLY SEVERE CHRONIC CONDITIONS.—

''(1) IN GENERAL.—Each Medicare+Choice organization with respect to each Medicare+Choice plan it offers shall have in effect, for enrollees with multiple or sufficiently severe chronic conditions, a chronic care improvement program that is designed to manage the needs of such enrollees and that meets the requirements of this subsection.

''(2) ENROLLEE WITH MULTIPLE OR SUFFICIENTLY SEVERE CHRONIC CONDITIONS.—For purposes of this subsection, the term 'enrollee with multiple or sufficiently severe chronic conditions' means, with respect to an enrollee in a Medicare+Choice plan of a Medicare+Choice organization, an enrollee in the plan who has one or more chronic conditions, such as congestive heart failure, diabetes, COPD, stroke, prostate and colon cancer, hypertension, or other disease as identified by the organization as appropriate for chronic care improvement.

''(3) GENERAL REQUIREMENTS.—

''(A) IN GENERAL.—Each chronic care improvement program under this subsection shall be conducted consistent with this subsection.

''(B) IDENTIFICATION OF ENROLLEES.—Each such program shall have a method for monitoring and identifying enrollees with multiple or sufficiently severe chronic conditions that meet the organization's criteria for participation under the program.

''(C) DEVELOPMENT OF PLANS.—For an enrollee identified under subparagraph (B) for participation in a program, the program shall develop, with the enrollee's consent, an individualized, goal-oriented chronic care improvement plan for chronic care improvement.

''(D) ELEMENTS OF PLANS.—Each chronic care improvement plan developed under subparagraph (C) shall include a single point of contact to coordinate care and the following, as appropriate:

''(i) Self-improvement education for the enrollee (such as education for disease management through medical nutrition therapy)

and support education for health care providers, primary caregivers, and family members.

''(ii) Coordination of health care services, such as application of a prescription drug regimen and home health services.

''(iii) Collaboration with physicians and other providers to enhance communication of relevant clinical information.

''(iv) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

''(v) The provision of information about hospice care, pain and palliative care, and end-of-life care.

''(E) ORGANIZATION RESPONSIBILITIES.—In establishing and carrying out chronic care improvement plans for participants under this paragraph, a Medicare+Choice organization shall, directly or through subcontractors—

''(i) guide participants in managing their health, including all their co-morbidities, and in performing the activities as specified under the elements of the plan;

''(ii) use decision support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

''(iii) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

''(3) ADDITIONAL REQUIREMENTS.—The Secretary may establish additional requirements for chronic care improvement programs under this section.

''(4) ACCREDITATION.—The Secretary may provide that chronic care improvement programs that are accredited by qualified organizations may be deemed to meet such requirements under this subsection as the Secretary may specify.

''(5) OUTCOMES REPORT.—Each Medicare+Choice organization with respect to its chronic care improvement program under this subsection shall monitor and report to the Secretary information on the quality of care and efficacy of such program as the Secretary may require.''; and

(2) by amending subparagraph (I) of subsection (c)(1) to read as follows:

''(I) CHRONIC CARE IMPROVEMENT PROGRAM.—A description of the organization's chronic care improvement program under subsection (e).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply for contract years beginning on or after 1 year after the date of the enactment of this Act.

SEC. 723. INSTITUTE OF MEDICINE REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall contract with the Institute of Medicine of the National Academy of Sciences to conduct a study of the barriers to effective integrated care improvement for medicare beneficiaries with multiple or severe chronic conditions across settings and over time and to submit a report under subsection (b).

(2) SPECIFIC ITEMS.—The study shall examine the statutory and regulatory barriers to coordinating care across settings for medicare beneficiaries in transition from one setting to another (such as between hospital, nursing facility, home health, hospice, and home). The study shall specifically identify the following:

(A) Clinical, financial, or administrative requirements in the medicare program that present barriers to effective, seamless transitions across care settings.

(B) Policies that impede the establishment of administrative and clinical information systems to track health status, utilization, cost, and quality data across settings.

(C) State-level requirements that may present barriers to better care for medicare beneficiaries.

(3) CONSULTATION.—The study under this subsection shall be conducted in consultation with experts in the field of chronic care, consumers, and family caregivers, working to integrate care delivery and create more seamless transitions across settings and over time.

(b) REPORT.—The report under this subsection shall be submitted to the Secretary and Congress not later than 18 months after the date of the enactment of this Act.

SEC. 724. MEDPAC REPORT.

(a) EVALUATION.—shall conduct an evaluation that includes a description of the status of the implementation of chronic care improvement programs under section 1807 of the Social Security Act, the quality of health care services provided to individuals in such program, the health status of the participants of such program, and the cost savings attributed to implementation of such program.

(b) REPORT.—Not later than 2 years after the date of implementation of such chronic care improvement programs, the Commission shall submit a report on such evaluation.

Subtitle C—Other Provisions

SEC. 731. 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) APPLICATION OF DISCLOSURE REQUIREMENTS.—

(1) IN GENERAL.—Section 1805(c)(2)(D) (42 U.S.C. 1395b–6(c)(2)(D)) is amended by adding at the end the following: ''Members of the Commission shall be treated as employees of the Congress for purposes of applying title I of the Ethics in Government Act of 1978 (Public Law 95-521).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on January 1, 2004.

(d) 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, 2004, 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, 2004, a report on the following:

(A) Investments, endowments, and fundraising of hospitals participating under the medicare program and related foundations.

(B) Access to capital financing for private and for not-for-profit hospitals.

SEC. 732. DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY CARE SERVICES.

(a) ESTABLISHMENT.—Subject to the succeeding provisions of this section, the Secretary of Health and Human Services shall establish a demonstration project (in this section referred to as the ''demonstration project'') under which the Secretary shall, as part of a plan of an episode of care for home health services established for a medicare beneficiary, permit a home health agency, directly or under arrangements with a medical adult day care facility, to provide medical adult day care services as a substitute for 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. 733. IMPROVEMENTS IN NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

(1) IN GENERAL.—Section 1862 (42 U.S.C. 1395y) is amended—

(A) in the third sentence of subsection (a) by inserting ''consistent with subsection (k)'' after ''the Secretary shall ensure''; and

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

''(k) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

''(1) CRITERIA AND EVIDENCE USED IN MAKING NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall make available to the public the criteria the Secretary uses in making national coverage determinations, including how evidence to demonstrate that a procedure or device is reasonable and necessary is considered.

''(2) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In the case of a request for a national coverage determination that—

''(A) does not require a technology assessment from an outside entity or deliberation from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

''(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 12 months after the date of the request.

''(3) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—At the end of the 6-month period that begins on the date a request for a national coverage determination is made, the Secretary shall—

''(A) make a draft of proposed decision on the request available to the public through the Medicare Internet site of the Department of Health and Human Services or other appropriate means;

''(B) provide a 30-day period for public comment on such draft;

''(C) make a final decision on the request within 60 days of the conclusion of the 30-day period referred to under subparagraph (B);

''(D) include in such final decision summaries of the public comments received and responses thereto;

''(E) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and.

''(F) in the case of a decision to grant the coverage determination, assign or temporary or permanent code during the 60-day period referred to in subparagraph (C).

''(4) CONSULTATION WITH OUTSIDE EXPERTS IN CERTAIN NATIONAL COVERAGE DETERMINATIONS.—With respect to a request for a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate outside clinical experts.

''(5) LOCAL COVERAGE DETERMINATION PROCESS.—With respect to local coverage determinations made on or after January 1, 2004—

''(A) PLAN TO PROMOTE CONSISTENCY OF COVERAGE DETERMINATIONS.—The Secretary shall develop a plan to evaluate new local coverage determinations to determine which determinations should be adopted nationally and to what extent greater consistency can be achieved among local coverage determinations.

''(B) CONSULTATION.—The Secretary shall require the fiscal intermediaries or carriers providing services within the same area to consult on all new local coverage determinations within the area.

''(C) DISSEMINATION OF INFORMATION.—The Secretary should serve as a center to disseminate information on local coverage determinations among fiscal intermediaries and carriers to reduce duplication of effort.

''(6) NATIONAL AND LOCAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection, the terms 'national coverage determination' and 'local coverage determination' have the meaning given such terms in paragraphs (1)(B) and (2)(B), respectively, of section 1869(f).''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to national and local coverage determinations as of January 1, 2004.

(b) MEDICARE COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS.—

(1) IN GENERAL.—With respect to the coverage of routine costs of care for beneficiaries participating in a qualifying clinical trial, as set forth on the date of the enactment of this Act in National Coverage Determination 30-1 of the Medicare Coverage Issues Manual, the Secretary shall deem clinical trials conducted in accordance with an investigational device exemption approved under section 520(g) of the Federal Food, Drug, and Cosmetic Act (42 U.S.C. 360j(g)) to be automatically qualified for such coverage.

(2) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed as authorizing or requiring the Secretary to modify the regulations set forth on the date of the enactment of this Act at subpart B of part 405 of title 42, Code of Federal Regulations, or subpart A of part 411 of such title, relating to coverage of, and payment for, a medical device that is the subject of an investigational device exemption by the Food and Drug Administration (except as may be necessary to implement paragraph (1)).

(3) EFFECTIVE DATE.—This subsection shall apply to clinical trials begun before, on, or after the date of the enactment of this Act and to items and services furnished on or after such date.

(c) ISSUANCE OF TEMPORARY NATIONAL CODES.—Not later than January 1, 2004, the Secretary shall implement revised procedures for the issuance of temporary national HCPCS codes under part B of title XVIII of the Social Security Act.

SEC. 734. TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES.

(a) IN GENERAL.—Section 1848(i) (42 U.S.C. 1395w–4(i)) is amended by adding at the end the following new paragraph:

''(4) TREATMENT OF CERTAIN INPATIENT PHYSICIAN PATHOLOGY SERVICES.—

''(A) IN GENERAL.—With respect to services furnished on or after January 1, 2001, and before January 1, 2006, if an independent laboratory furnishes the technical component of a physician pathology service to a fee-for-service medicare beneficiary who is an inpatient or outpatient of a covered hospital, the Secretary shall treat such component as a service for which payment shall be made to the laboratory under this section and not as an inpatient hospital service for which payment is made to the hospital under section 1886(d) or as a hospital outpatient service for which payment is made to the hospital under section 1833(t).

''(B) DEFINITIONS.—In this paragraph:

''(i) COVERED HOSPITAL.—

''(I) IN GENERAL.—The term 'covered hospital' means, with respect to an inpatient or outpatient, a hospital that had an arrangement with an independent laboratory that was in effect as of July 22, 1999, under which a laboratory furnished the technical component of physician pathology services to fee-for-service medicare beneficiaries who were hospital inpatients or outpatients, respectively, and submitted claims for payment for such component to a carrier with a contract under section 1842 and not to the hospital.

''(II) CHANGE IN OWNERSHIP DOES NOT AFFECT DETERMINATION.—A change in ownership with respect to a hospital on or after the date referred to in subclause (I) shall not affect the determination of whether such hospital is a covered hospital for purposes of such subclause.

''(ii) FEE-FOR-SERVICE MEDICARE BENEFICIARY.—The term 'fee-for-service medicare beneficiary' means an individual who is entitled to benefits under part A, or enrolled under this part, or both, but is not enrolled in any of the following:

''(I) A Medicare+Choice plan under part C.

''(II) A plan offered by an eligible organization under section 1876.

''(III) A program of all-inclusive care for the elderly (PACE) under section 1894.

''(IV) A social health maintenance organization (SHMO) demonstration project established under section 4018(b) of the Omnibus Budget Reconciliation Act of 1987 (Public Law 100–203).''.

(b) CONFORMING AMENDMENT.—Section 542 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–550), as enacted into law by section 1(a)(6) of Public Law 106–554, is repealed.

(c) EFFECTIVE DATES.—The amendments made by this section shall take effect as if included in the enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (Appendix F, 114 Stat. 2763A–463), as enacted into law by section 1(a)(6) of Public Law 106–554.

SEC. 735. MEDICARE PANCREATIC ISLET CELL TRANSPLANT DEMONSTRATION PROJECT.

(a) ESTABLISHMENT.—In order to test the appropriateness of pancreatic islet cell transplantation, not later than 120 days after the date of the enactment of this Act, the Secretary shall establish a demonstration project which the Secretary, provides for payment under the medicare program under title XVIII of the Social Security Act for pancreatic islet cell transplantation and related items and services in the case of medicare beneficiaries who have type I (juvenile) diabetes and have end stage renal disease.

(b) DURATION OF PROJECT.—The authority of the Secretary to conduct the demonstration project under this section shall terminate on the date that is 5 years after the date of the establishment of the project.

(c) EVALUATION AND REPORT.—The Secretary shall conduct an evaluation of the outcomes of the demonstration project. Not later than 120 days after the date of the termination of the demonstration project under subsection (b), the Secretary shall submit to Congress a report on the project, including recommendations for such legislative and administrative action as the Secretary deems appropriate.

(d) PAYMENT METHODOLOGY.—The Secretary shall establish an appropriate payment methodology for the provision of items and services under the demonstration project, which may include a payment methodology that bundles, to the maximum extent feasible, payment for all such items and services.

(e) WAIVER AUTHORITY.—The Secretary may waive compliance with the requirements of title XVIII of the Social Security Act to such extent and for such period as the Secretary determines is necessary to conduct the demonstration project.

TITLE VIII—MEDICAID

SEC. 801. CONTINUATION OF MEDICAID DSH ALLOTMENT ADJUSTMENTS UNDER BIPA 2000.

(a) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f))—

(1) in paragraph (2)—

(A) in the heading, by striking ''THROUGH 2002'' and inserting ''THROUGH 2000'';

(B) by striking ''ending with fiscal year 2002'' and inserting ''ending with fiscal year 2000''; and

(C) in the table in such paragraph, by striking the columns labeled ''FY 01'' and ''FY02'';

(2) in paragraph (3)(A), by striking ''paragraph (2)'' and inserting ''paragraph (4)''; and

(3) in paragraph (4), as added by section 701(a)(1) 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)—

(A) by striking ''FOR FISCAL YEARS 2001 AND 2002'' in the heading;

(B) in subparagraph (A), by striking ''Notwithstanding paragraph (2), the'' and inserting ''The'';

(C) in subparagraph (C)—

(i) by striking ''NO APPLICATION'' and inserting ''APPLICATION''; and

(ii) by striking ''without regard to'' and inserting ''taking into account''.

(b) INCREASE IN MEDICAID DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—

(1) IN GENERAL.—Effective for DSH allotments beginning with fiscal year 2003, 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''.

(2) CONSTRUCTION.—Nothing in paragraph (1) 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 2003 and subsequent fiscal years.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to DSH allotments for fiscal years beginning with fiscal year 2003.

SEC. 802. INCREASE IN FLOOR FOR TREATMENT AS AN EXTREMELY LOW DSH STATE TO 3 PERCENT IN FISCAL YEAR 2003.

(a) INCREASE IN DSH FLOOR.—Section 1923(f)(5) of the Social Security Act (42 U.S.C. 1396r–4(f)(5)) is amended—

(1) by striking ''fiscal year 1999'' and inserting ''fiscal year 2001'';

(2) by striking ''August 31, 2000'' and inserting ''August 31, 2002'';

(3) by striking ''1 percent'' each place it appears and inserting ''3 percent''; and

(4) by striking ''fiscal year 2001'' and inserting ''fiscal year 2003''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) take effect as if enacted on October 1, 2002, and apply to DSH allotments under title XIX of the Social Security Act for fiscal year 2003 and each fiscal year thereafter.

SEC. 803. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) (42 U.S.C. 1396r–8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following: ''(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)''.

TITLE IX—REGULATORY REDUCTION AND CONTRACTING REFORM

Subtitle A—Regulatory Reform

SEC. 901. 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. 902. ISSUANCE OF REGULATIONS.

(a) 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.

(b) LIMITATIONS ON NEW MATTER IN FINAL REGULATIONS.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)), as amended by subsection (a), is amended by adding at the end the following new paragraph:

''(4) If the Secretary publishes a final regulation that includes a provision that is not a logical outgrowth of a previously published notice of proposed rulemaking or interim final rule, such 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. 903. 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 902(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. 904. 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 one year after the date of the enactment of this Act.

(b) REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by section 902(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. 911. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

''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 the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

''(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

''(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—

''(A) IN GENERAL.—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, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

''(B) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the 'False Claims Act').

''(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, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this 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, 2010.

(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 a 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, 2004, the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes the plan for implementation of the amendments made by this section. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

SEC. 912. REQUIREMENTS FOR INFORMATION SECURITY FOR MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 911(a)(1), is amended by adding at the end the following new subsection:

''(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 paragraphs (1) through (8) of section 3544(b) of title 44, United States Code (other than the requirements under paragraphs (2)(D)(i), (5)(A), and (5)(B) 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 of 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, including policies and procedures as may be prescribed by the Director of the Office of Management and Budget and applicable information security standards promulgated under section 11331 of title 40, United States Code.

''(B) DEADLINE FOR INITIAL EVALUATION.—

''(i) NEW CONTRACTORS.—In the case of a medicare administrative contractor covered by this subsection that has not previously performed the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1816 or 1842, the first independent evaluation conducted pursuant 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 DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services and to the Secretary.

''(ii) TO CONGRESS.—The Inspector General of Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations, including assessments of the scope and sufficiency of such evaluations.

''(iii) AGENCY REPORTING.—The Secretary shall address the results of such evaluations in reports required under section 3544(c) of title 44, United States Code.''.

(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. 921. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—Title XVIII 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, 2004, 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 911(a)(1) and as amended by section 912(a), is amended by adding at the end the following new subsection:

''(f) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—The Secretary shall use specific claims payment error rates or similar methodology of medicare administrative contractors in the processing or reviewing of medicare claims in order to give such contractors an incentive to implement effective education and outreach programs for providers of services and suppliers.''.

(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, 2004, 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, 2004, 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 911(a)(1) and as amended by section 912(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, 2004.

(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 2005 and 2006 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, 2004.

(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, 2004.

(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. 922. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which 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 2005, $1,000,000, and

(2) for fiscal year 2006, $6,000,000.

SEC. 923. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 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 previously amended, is amended by inserting after section 1809 the following new section:

''MEDICARE BENEFICIARY OMBUDSMAN

''SEC. 1810. (a) IN GENERAL.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

''(b) DUTIES.—The Medicare Beneficiary Ombudsman shall—

''(1) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any 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;

''(B) assistance to such individuals with any problems arising from disenrollment from a Medicare+Choice plan under part C; and

''(C) assistance to such individuals in presenting information under section 1860D–2(b)(4)(D)(v); 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 1807 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (b), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

(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. 924. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A of title XVIII of the Social Security Act, or enrolled under part B of such title, or both, regarding the medicare program at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices 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.

SEC. 925. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY BENEFITS.

(a) IN GENERAL.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395b–7(a)) with respect to the provision of post-hospital extended care services under part A of title XVIII of the Social Security Act, there shall be included information on the number of days of coverage of such services remaining under such part for the medicare beneficiary and spell of illness involved.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 926. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) AVAILABILITY OF DATA.—The Secretary shall publicly provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL DISCHARGE PLANS.—

(1) IN GENERAL.—Section 1861(ee)(2)(D) (42 U.S.C. 1395x(ee)(2)(D)) is amended—

(A) by striking ''hospice services'' and inserting ''hospice care and post-hospital extended care services''; and

(B) by inserting before the period at the end the following: ''and, in the case of individuals who are likely to need post-hospital extended care services, the availability of such services through facilities that participate in the program under this title and that serve the area in which the patient resides''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than 6 months after the date the Secretary provides for availability of information under subsection (a).

Subtitle D—Appeals and Recovery

SEC. 931. TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) TRANSITION PLAN.—

(1) IN GENERAL.—Not later than October 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the 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, 2005, and not later than October 1, 2005, 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. In order to assure such independence, the Secretary shall place such judges in an administrative office that is organizationally and functionally separate from such Centers. Such judges shall report to, and be under the general supervision of, the Secretary, but shall not report to, or be subject to supervision by, another other officer of the Department.

(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 2005 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. 932. 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, 2004.

(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 2005 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. 933. 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 932(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, 2004.

(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 paragraphs:

''(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS.—With respect to an initial determination insofar as it results in a denial of a claim for benefits—

''(A) the written notice on the determination shall include—

''(i) the reasons for the determination, including whether a local medical review policy or a local coverage determination was used;

''(ii) the procedures for obtaining additional information concerning the determination, including the information described in subparagraph (B); and

''(iii) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination under this section; and

''(B) the person provided such notice may obtain, upon request, the specific provision of the policy, manual, or regulation used in making the determination.

''(5) REQUIREMENTS OF NOTICE OF REDETERMINATIONS.—With respect to a redetermination insofar as it results in a denial of a claim for benefits—

''(A) the written notice on the redetermination shall include—

''(i) the specific reasons for the redetermination;

''(ii) as appropriate, a summary of the clinical or scientific evidence used in making the redetermination;

''(iii) a description of the procedures for obtaining additional information concerning the redetermination; and

''(iv) notification of the right to appeal the redetermination and instructions on how to initiate such an appeal under this section;

''(B) such written notice 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; and

''(C) the person provided such notice may obtain, upon request, information on the specific provision of the policy, manual, or regulation used in making the redetermination.''.

(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'), a 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) REDUCING MINIMUM NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking ''not fewer than 12 qualified independent contractors under this subsection'' and inserting ''with a sufficient number of qualified independent contractors (but not fewer than 4 such contractors) to conduct reconsiderations consistent with the timeframes applicable under this subsection''.

(4) EFFECTIVE DATE.—The amendments made by paragraphs (1) and (2) shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, (114 Stat. 2763A–534).

(5) 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. 934. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 911(a)(1) and as amended by sections 912(b), 921(b)(1), and 921(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. 935. 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. 936. 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, 2004.

(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. 937. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS WITHOUT PURSUING APPEALS PROCESS.

(a) CLAIMS.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(g) of the Social Security Act, as inserted by section 301(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.

(b) PERMITTING USE OF CORRECTED AND SUPPLEMENTARY DATA.—

(1) IN GENERAL.—Section 1886(d)(10)(D)(vi) (42 U.S.C. 1395ww(d)(10)(D)(vi)) is amended by adding after subclause (II) at the end the following:

''Notwithstanding subclause (I), a hospital may submit, and the Secretary may accept upon verification, data that corrects or supplements the data described in such subclause without regard to whether the corrected or supplementary data relate to a cost report that has been settled.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to fiscal years beginning with fiscal year 2004.

(3) SUBMITTAL AND RESUBMITTAL OF APPLICATIONS PERMITTED FOR FISCAL YEAR 2004.—

(A) IN GENERAL.—Notwithstanding any other provision of law, a hospital may submit (or resubmit) an application for a change described in section 1886(d)(10)(C)(i)(II) of the Social Security Act for fiscal year 2004 if the hospital demonstrates on a timely basis to the satisfaction of the Secretary that the use of corrected or supplementary data under

the amendment made by paragraph (1) would materially affect the approval of such an application.

(B) APPLICATION OF BUDGET NEUTRALITY.—If one or more hospital's applications are approved as a result of paragraph (1) and subparagraph (A) for fiscal year 2004, the Secretary shall make a proportional adjustment in the standardized amounts determined under section 1886(d)(3) of the Social Security Act (42 U.S.C. 1395ww(d)(3)) for fiscal year 2004 to assure that approval of such applications does not result in aggregate payments under section 1886(d) of such Act that are greater or less than those that would otherwise be made if paragraph (1) and subparagraph (A) did not apply.

SEC. 938. 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 933(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 (5)) 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 V—Miscellaneous Provisions

SEC. 941. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT (E & M) DOCUMENTATION GUIDELINES.

(a) IN GENERAL.—The Secretary may not implement any new documentation guidelines for, or clinical examples of, 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, 2005, 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, 2005, 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. 942. IMPROVEMENT IN OVERSIGHT OF TECHNOLOGY AND COVERAGE.

(a) COUNCIL FOR TECHNOLOGY AND INNOVATION.—Section 1868 (42 U.S.C. 1395ee), as amended by section 921(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.''.

(b) 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, 2005 (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).''.

(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, 2004, the Comptroller General shall submit a report to Congress on the study under paragraph (1).

(d) PROCESS FOR ADOPTION OF ICD CODES AS DATA STANDARD.—Section 1172(f) (42 U.S.C. 1320d–1(f)) is amended by inserting after the first sentence the following: ''Notwithstanding the preceding sentence, if the National Committee on Vital and Health Statistics has not made a recommendation to the Secretary before the date of the enactment of this sentence, with respect to the adoption of the International Classification of Diseases, 10th Revision, Procedure Coding System ('ICD–10–PCS') and the International Classification of Diseases, 10th Revision, Clinical Modification ('ICD–10–CM') as a standard under this part for the reporting of diagnoses, the Secretary may implement ICD-10-PCS only with respect to inpatient services as such a standard.''.

SEC. 943. 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. 944. 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, 2004.

(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. 945. 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 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, pediatrics or a pediatric subspecialty, 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. 946. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

''(D) 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.

''(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.''.

(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. 947. APPLICATION OF OSHA BLOODBORNE PATHOGENS STANDARD TO CERTAIN HOSPITALS.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) in subsection (a)(1)—

(A) in subparagraph (R), by striking ''and'' 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, 2004.

SEC. 948. 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. 949. 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. 950. 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. 951. FURNISHING HOSPITALS WITH INFORMATION TO COMPUTE DSH FORMULA.

Beginning not later than 1 year after the date of the enactment of this Act, the Secretary shall furnish to subsection (d) hospitals (as defined in section 1886(d)(1)(B) of the Social Security Act, 42 U.S.C. 1395ww(d)(1)(B)) the data necessary for such hospitals to compute the number of patient days described in subclause (II) of section 1886(d)(5)(F)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(F)(vi)) used in computing the disproportionate patient percentage under such section for that hospital. Such data shall also be furnished to other hospitals which would qualify for additional payments under part A of title XVIII of the Social Security Act on the basis of such data.

SEC. 952. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) IN GENERAL.—Section 1842(b)(6)(A) (42 U.S.C. 1395u(b)(6)(A)) is amended by striking ''or (ii) (where the service was provided in a hospital, critical access hospital, clinic, or other facility) to the facility in which the service was provided if there is a contractual arrangement between such physician or other person and such facility under which such facility submits the bill for such service,'' and inserting ''or (ii) where the service was provided under a contractual arrangement between such physician or other person and an entity (as defined by the Secretary), to the entity if, under the contractual arrangement, the entity submits the bill for the service and the contractual arrangement meets such other program integrity and other safeguards as the Secretary may determine to be appropriate,''.

(b) CONFORMING AMENDMENT.—The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking ''except to an employer or facility'' and inserting ''except to an employer, entity, or other person''.

(c) EFFECTIVE DATE.—The amendments made by section shall apply to payments made on or after the date of the enactment of this Act.

SEC. 953. OTHER PROVISIONS.

(a) GAO REPORTS ON THE PHYSICIAN COMPENSATION.—

(1) SUSTAINABLE GROWTH RATE AND UPDATES.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the appropriateness of the updates in the conversion factor under subsection (d)(3) of section 1848 of the Social Security Act (42 U.S.C. 1395w–4), including the appropriateness of the sustainable growth rate formula under subsection (f) of such section for 2002 and succeeding years. Such report shall examine the stability and predictability of such updates and rate and alternatives for the use of such rate in the updates.

(2) PHYSICIAN COMPENSATION GENERALLY.—Not later than 12 months after the date of

the enactment of this Act, the Comptroller General shall submit to Congress a report on all aspects of physician compensation for services furnished under title XVIII of the Social Security Act, and how those aspects interact and the effect on appropriate compensation for physician services. Such report shall review alternatives for the physician fee schedule under section 1848 of such title (42 U.S.C. 1395w–4).

(b) ANNUAL PUBLICATION OF LIST OF NATIONAL COVERAGE DETERMINATIONS.—The Secretary 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.

(c) GAO REPORT ON FLEXIBILITY IN APPLYING HOME HEALTH CONDITIONS OF PARTICIPATION TO PATIENTS WHO ARE NOT MEDICARE BENEFICIARIES.—Not later than 6 months after the date of the enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the implications if there were flexibility in the application of the medicare conditions of participation for home health agencies with respect to groups or types of patients who are not medicare beneficiaries. The report shall include an analysis of the potential impact of such flexible application on clinical operations and the recipients of such services and an analysis of methods for monitoring the quality of care provided to such recipients.

(d) OIG REPORT ON NOTICES RELATING TO USE OF HOSPITAL LIFETIME RESERVE DAYS.—Not later than 1 year after the date of the enactment of this Act, the Inspector General of the Department of Health and Human Services shall submit a report to Congress on—

(1) the extent to which hospitals provide notice to medicare beneficiaries in accordance with applicable requirements before they use the 60 lifetime reserve days described in section 1812(a)(1) of the Social Security Act (42 U.S.C. 1395d(a)(1)); and

(2) the appropriateness and feasibility of hospitals providing a notice to such beneficiaries before they completely exhaust such lifetime reserve days.

TITLE X—IMPORTATION OF PRESCRIPTION DRUGS

SEC. 1001. IMPORTATION OF PRESCRIPTION DRUGS.

(a) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 804 and inserting the following:

"SEC. 804. IMPORTATION OF PRESCRIPTION DRUGS.

''(a) DEFINITIONS.—In this section:

''(1) IMPORTER.—The term 'importer' means a pharmacist or wholesaler.

''(2) PHARMACIST.—The term 'pharmacist' means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.

''(3) PRESCRIPTION DRUG.—The term 'prescription drug' means a drug subject to section 503(b), other than—

''(A) a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802));

''(B) a biological product (as defined in section 351 of the Public Health Service Act (42 U.S.C. 262));

''(C) an infused drug (including a peritoneal dialysis solution);

''(D) an intravenously injected drug; or

''(E) a drug that is inhaled during surgery.

''(4) QUALIFYING LABORATORY.—The term 'qualifying laboratory' means a laboratory in the United States that has been approved by the Secretary for the purposes of this section.

''(5) WHOLESALER.—

''(A) IN GENERAL.—The term 'wholesaler' means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A).

''(B) EXCLUSION.—The term 'wholesaler' does not include a person authorized to import drugs under section 801(d)(1).

''(b) REGULATIONS.—The Secretary, after consultation with the United States Trade Representative and the Commissioner of Customs, shall promulgate regulations permitting pharmacists and wholesalers to import prescription drugs from Canada into the United States.

''(c) LIMITATION.—The regulations under subsection (b) shall—

''(1) require that safeguards be in place to ensure that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug), with sections 501 and 502, and with other applicable requirements of this Act;

''(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e); and

''(3) contain any additional provisions determined by the Secretary to be appropriate as a safeguard to protect the public health or as a means to facilitate the importation of prescription drugs.

''(d) INFORMATION AND RECORDS.—

''(1) IN GENERAL.—The regulations under subsection (b) shall require an importer of a prescription drug under subsection (b) to submit to the Secretary the following information and documentation:

''(A) The name and quantity of the active ingredient of the prescription drug.

''(B) A description of the dosage form of the prescription drug.

''(C) The date on which the prescription drug is shipped.

''(D) The quantity of the prescription drug that is shipped.

''(E) The point of origin and destination of the prescription drug.

''(F) The price paid by the importer for the prescription drug.

''(G) Documentation from the foreign seller specifying—

''(i) the original source of the prescription drug; and

''(ii) the quantity of each lot of the prescription drug originally received by the seller from that source.

''(H) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

''(I) The name, address, telephone number, and professional license number (if any) of the importer.

''(J)(i) In the case of a prescription drug that is shipped directly from the first foreign recipient of the prescription drug from the manufacturer:

''(I) Documentation demonstrating that the prescription drug was received by the recipient from the manufacturer and subsequently shipped by the first foreign recipient to the importer.

''(II) Documentation of the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

''(III)(aa) In the case of an initial imported shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

''(bb) In the case of any subsequent shipment, documentation demonstrating that a statistically valid sample of the shipment was tested for authenticity and degradation.

''(ii) In the case of a prescription drug that is not shipped directly from the first foreign recipient of the prescription drug from the manufacturer, documentation demonstrating that each batch in each shipment offered for importation into the United States was statistically sampled and tested for authenticity and degradation.

''(K) Certification from the importer or manufacturer of the prescription drug that the prescription drug—

''(i) is approved for marketing in the United States; and

''(ii) meets all labeling requirements under this Act.

''(L) Laboratory records, including complete data derived from all tests necessary to ensure that the prescription drug is in compliance with established specifications and standards.

''(M) Documentation demonstrating that the testing required by subparagraphs (J) and (L) was conducted at a qualifying laboratory.

''(N) Any other information that the Secretary determines is necessary to ensure the protection of the public health.

''(2) MAINTENANCE BY THE SECRETARY.—The Secretary shall maintain information and documentation submitted under paragraph (1) for such period of time as the Secretary determines to be necessary.

''(e) TESTING.—The regulations under subsection (b) shall require—

''(1) that testing described in subparagraphs (J) and (L) of subsection (d)(1) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory;

''(2) if the tests are conducted by the importer—

''(A) that information needed to—

''(i) authenticate the prescription drug being tested; and

''(ii) confirm that the labeling of the prescription drug complies with labeling requirements under this Act;

be supplied by the manufacturer of the prescription drug to the pharmacist or wholesaler; and

''(B) that the information supplied under subparagraph (A) be kept in strict confidence and used only for purposes of testing or otherwise complying with this Act; and

''(3) may include such additional provisions as the Secretary determines to be appropriate to provide for the protection of trade secrets and commercial or financial information that is privileged or confidential.

''(f) REGISTRATION OF FOREIGN SELLERS.—Any establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment.

''(g) SUSPENSION OF IMPORTATION.—The Secretary shall require that importations of a specific prescription drug or importations by a specific importer under subsection (b) be immediately suspended on discovery of a pattern of importation of that specific prescription drug or by that specific importer of drugs that are counterfeit or in violation of any requirement under this section, until an investigation is completed and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported under subsection (b).

''(h) APPROVED LABELING.—The manufacturer of a prescription drug shall provide an importer written authorization for the importer to use, at no cost, the approved labeling for the prescription drug.

''(i) PROHIBITION OF DISCRIMINATION.—

''(1) IN GENERAL.—It shall be unlawful for a manufacturer of a prescription drug to discriminate against, or cause any other person to discriminate against, a pharmacist or wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

''(2) DISCRIMINATION.—For the purposes of paragraph (1), a manufacturer of a prescription drug shall be considered to discriminate against a pharmacist or wholesaler if the manufacturer enters into a contract for sale of a prescription drug, places a limit on supply, or employs any other measure, that has the effect of—

''(A) providing pharmacists or wholesalers access to prescription drugs on terms or conditions that are less favorable than the terms or conditions provided to a foreign purchaser (other than a charitable or humanitarian organization) of the prescription drug; or

''(B) restricting the access of pharmacists or wholesalers to a prescription drug that is permitted to be imported into the United States under this section.

''(j) CHARITABLE CONTRIBUTIONS.—Notwithstanding any other provision of this section, section 801(d)(1) continues to apply to a prescription drug that is donated or otherwise supplied at no charge by the manufacturer of the drug to a charitable or humanitarian organization (including the United Nations and affiliates) or to a government of a foreign country.

''(k) WAIVER AUTHORITY FOR IMPORTATION BY INDIVIDUALS.—

''(1) DECLARATIONS.—Congress declares that in the enforcement against individuals of the prohibition of importation of prescription drugs and devices, the Secretary should—

''(A) focus enforcement on cases in which the importation by an individual poses a significant threat to public health; and

''(B) exercise discretion to permit individuals to make such importations in circumstances in which—

''(i) the importation is clearly for personal use; and

''(ii) the prescription drug or device imported does not appear to present an unreasonable risk to the individual.

''(2) WAIVER AUTHORITY.—

''(A) IN GENERAL.—The Secretary may grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition of importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate.

''(B) GUIDANCE ON CASE-BY-CASE WAIVERS.—The Secretary shall publish, and update as necessary, guidance that accurately describes circumstances in which the Secretary will consistently grant waivers on a case-by-case basis under subparagraph (A), so that individuals may know with the greatest practicable degree of certainty whether a particular importation for personal use will be permitted.

''(3) DRUGS IMPORTED FROM CANADA.—In particular, the Secretary shall by regulation grant individuals a waiver to permit individuals to import into the United States a prescription drug that—

''(A) is imported from a licensed pharmacy for personal use by an individual, not for resale, in quantities that do not exceed a 90-day supply;

''(B) is accompanied by a copy of a valid prescription;

''(C) is imported from Canada, from a seller registered with the Secretary;

''(D) is a prescription drug approved by the Secretary under chapter V;

''(E) is in the form of a final finished dosage that was manufactured in an establishment registered under section 510; and

''(F) is imported under such other conditions as the Secretary determines to be necessary to ensure public safety.

''(l) STUDIES; REPORTS.—

''(1) BY THE INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES.—

''(A) STUDY.—

''(i) IN GENERAL.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct a study of—

''(I) importations of prescription drugs made under the regulations under subsection (b); and

''(II) information and documentation submitted under subsection (d).

''(ii) REQUIREMENTS.—In conducting the study, the Institute of Medicine shall—

''(I) evaluate the compliance of importers with the regulations under subsection (b);

''(II) compare the number of shipments under the regulations under subsection (b) during the study period that are determined to be counterfeit, misbranded, or adulterated, and compare that number with the number of shipments made during the study period within the United States that are determined to be counterfeit, misbranded, or adulterated; and

''(III) consult with the Secretary, the United States Trade Representative, and the Commissioner of Patents and Trademarks to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under Federal law.

''(B) REPORT.—Not later than 2 years after the effective date of the regulations under subsection (b), the Institute of Medicine shall submit to Congress a report describing the findings of the study under subparagraph (A).

''(2) BY THE COMPTROLLER GENERAL.—

''(A) STUDY.—The Comptroller General of the United States shall conduct a study to determine the effect of this section on the price of prescription drugs sold to consumers at retail.

''(B) REPORT.—Not later than 18 months after the effective date of the regulations under subsection (b), the Comptroller General of the United States shall submit to Congress a report describing the findings of the study under subparagraph (A).

''(m) CONSTRUCTION.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

''(n) EFFECTIVENESS OF SECTION.—

''(1) IN GENERAL.—If, after the date that is 1 year after the effective date of the regulations under subsection (b) and before the date that is 18 months after the effective date, the Secretary submits to Congress a certification that, in the opinion of the Secretary, based on substantial evidence obtained after the effective date, the benefits of implementation of this section do not outweigh any detriment of implementation of this section, this section shall cease to be effective as of the date that is 30 days after the date on which the Secretary submits the certification.

''(2) PROCEDURE.—The Secretary shall not submit a certification under paragraph (1) unless, after a hearing on the record under sections 556 and 557 of title 5, United States Code, the Secretary—

''(A)(i) determines that it is more likely than not that implementation of this section would result in an increase in the risk to the public health and safety;

''(ii) identifies specifically, in qualitative and quantitative terms, the nature of the increased risk;

''(iii) identifies specifically the causes of the increased risk; and

''(iv)(I) considers whether any measures can be taken to avoid, reduce, or mitigate the increased risk; and

''(II) if the Secretary determines that any measures described in subclause (I) would require additional statutory authority, submits to Congress a report describing the legislation that would be required;

''(B) identifies specifically, in qualitative and quantitative terms, the benefits that would result from implementation of this section (including the benefit of reductions in the cost of covered products to consumers in the United States, allowing consumers to procure needed medication that consumers might not otherwise be able to procure without foregoing other necessities of life); and

''(C)(i) compares in specific terms the detriment identified under subparagraph (A) with the benefits identified under subparagraph (B); and

''(ii) determines that the benefits do not outweigh the detriment.

''(o) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

''(p) CONDITIONS.—This section shall become effective only if the Secretary certifies to the Congress that implementation of this section will—

''(1) pose no additional risk to the public's health and safety; and

''(2) result in a significant reduction in the cost of covered products to the American consumer.''.

(b) CONFORMING AMENDMENTS.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301(aa) (21 U.S.C. 331(aa)), by striking ''covered product in violation of section 804'' and inserting ''prescription drug in violation of section 804''; and

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6), by striking ''covered product pursuant to section 804(a)'' and inserting ''prescription drug under section 804(b)''.

TITLE XI—ACCESS TO AFFORDABLE PHARMACEUTICALS

SEC. 1101. SHORT TITLE.

This title may be cited as the ''Greater Access to Affordable Pharmaceuticals Act''.

SEC. 1102. 30-MONTH STAY-OF-EFFECTIVENESS PERIOD.

(a) ABBREVIATED NEW DRUG APPLICATIONS.—Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended—

(1) in paragraph (2), by striking subparagraph (B) and inserting the following:

''(B) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—

''(i) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall include in the application a statement that the applicant will give notice as required by this subparagraph.

''(ii) TIMING OF NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall give notice as required under this subparagraph—

''(I) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

''(II) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of

whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

''(iii) RECIPIENTS OF NOTICE.—An applicant required under this subparagraph to give notice shall give notice to—

''(I) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

''(II) the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

''(iv) CONTENTS OF NOTICE.—A notice required under this subparagraph shall—

''(I) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

''(II) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed.''; and

(2) in paragraph (5)—

(A) in subparagraph (B)—

(i) by striking ''under the following'' and inserting ''by applying the following to each certification made under paragraph (2)(A)(vii)''; and

(ii) in clause (iii)—

(I) in the first sentence, by striking ''unless'' and all that follows and inserting ''unless, before the expiration of 45 days after the date on which the notice described in paragraph (2)(B) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under subsection (b)(1) or (c)(2) before the date on which the application (excluding an amendment or supplement to the application), which the Secretary later determines to be substantially complete, was submitted.''; and

(II) in the second sentence—

(aa) by striking subclause (I) and inserting the following:

''(I) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

''(aa) the date on which the court enters judgment reflecting the decision; or

''(bb) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;'';

(bb) by striking subclause (II) and inserting the following:

''(II) if before the expiration of such period the district court decides that the patent has been infringed—

''(aa) if the judgment of the district court is appealed, the approval shall be made effective on—

''(AA) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

''(BB) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

''(bb) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;'';

(cc) in subclause (III), by striking ''on the date of such court decision.'' and inserting ''as provided in subclause (I); or''; and

(dd) by inserting after subclause (III) the following:

''(IV) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in subclause (II).'';

(B) by redesignating subparagraphs (C) and (D) as subparagraphs (E) and (F), respectively; and

(C) by inserting after subparagraph (B) the following:

''(C) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

''(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent does not bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice given under paragraph (2)(B) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval.

''(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—

''(I) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or (c) on the ground that the patent does not claim either—

''(aa) the drug for which the application was approved; or

''(bb) an approved method of using the drug.

''(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

''(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under subparagraph (i) or a counterclaim under subparagraph (ii).''.

(b) APPLICATIONS GENERALLY.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subsection (b), by striking paragraph (3) and inserting the following:

''(3) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—

''(A) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall include in the application a statement that the applicant will give notice as required by this paragraph.

''(B) TIMING OF NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall give notice as required under this paragraph—

''(i) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

''(ii) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

''(C) RECIPIENTS OF NOTICE.—An applicant required under this paragraph to give notice shall give notice to—

''(i) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

''(ii) the holder of the approved application under this subsection for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

''(D) CONTENTS OF NOTICE.—A notice required under this paragraph shall—

''(i) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

''(ii) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed.''; and

(2) in subsection (c)(3)—

(A) in the first sentence, by striking ''under the following'' and inserting ''by applying the following to each certification made under subsection (b)(2)(A)(iv)'';

(B) in subparagraph (C)—

(i) in the first sentence, by striking ''unless'' and all that follows and inserting ''unless, before the expiration of 45 days after the date on which the notice described in subsection (b)(3) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under paragraph (2) or subsection (b)(1) before the date on which the application (excluding an amendment or supplement to the application) was submitted.'';

(ii) in the second sentence—

(I) by striking ''paragraph (3)(B)'' and inserting ''subsection (b)(3)'';

(II) by striking clause (i) and inserting the following:

''(i) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

''(I) the date on which the court enters judgment reflecting the decision; or

''(II) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;'';

(III) by striking clause (ii) and inserting the following:

''(ii) if before the expiration of such period the district court decides that the patent has been infringed—

''(I) if the judgment of the district court is appealed, the approval shall be made effective on—

''(aa) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

''(bb) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

''(II) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;'';

(IV) in clause (iii), by striking ''on the date of such court decision.'' and inserting ''as provided in clause (i); or''; and

(V) by inserting after clause (iii), the following:

''(iv) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in clause (ii).''; and

(iii) in the third sentence, by striking ''paragraph (3)(B)'' and inserting ''subsection (b)(3)'';

(C) by redesignating subparagraph (D) as subparagraph (E); and

(D) by inserting after subparagraph (C) the following:

''(D) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

''(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent does not bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice given under subsection (b)(3) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval.

''(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—

''(I) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or this subsection on the ground that the patent does not claim either—

''(aa) the drug for which the application was approved; or

''(bb) an approved method of using the drug.

''(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

''(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under clause (i) or a counterclaim under clause (ii).''.

(c) INFRINGEMENT ACTIONS.—Section 271(e) of title 35, United States Code, is amended by adding at the end the following:

''(5) The filing of an application described in paragraph (2) that includes a certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and the failure of the owner of the patent to bring an action for infringement of a patent that is the subject of the certification before the expiration of 45 days after the date on which the notice given under subsection (b)(3) or (j)(2)(B) of that section is received, shall establish an actual controversy between the applicant and the patent owner sufficient to confer subject matter jurisdiction in the courts of the United States in any action brought by the applicant under section 2201 of title 28 for a declaratory judgment that any patent that is the subject of the certification is invalid or not infringed.''.

(d) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by subsections (a), (b), and (c) apply to any proceeding under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) that is pending on or after the date of enactment of this Act regardless of the date on which the proceeding was commenced or is commenced.

(2) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—The amendments made by subsections (a)(1) and (b)(1) apply with respect to any certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) after the date of enactment of this Act in an application filed under subsection (b)(2) or (j) of that section or in an amendment or supplement to an application filed under subsection (b)(2) or (j) of that section.

(3) EFFECTIVE DATE OF APPROVAL.—The amendments made by subsections (a)(2)(A)(ii)(I) and (b)(2)(B)(i) apply with respect to any patent information submitted under subsection (b)(1) or (c)(2) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) made after the date of enactment of this Act.

SEC. 1103. FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.

(a) IN GENERAL.—Section 505(j)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)) (as amended by section 1102) is amended—

(1) in subparagraph (B), by striking clause (iv) and inserting the following:

''(iv) 180-DAY EXCLUSIVITY PERIOD.—

''(I) DEFINITIONS.—In this paragraph:

''(aa) 180-DAY EXCLUSIVITY PERIOD.—The term '180-day exclusivity period' means the 180-day period ending on the day before the date on which an application submitted by an applicant other than a first applicant could become effective under this clause.

''(bb) FIRST APPLICANT.—The term 'first applicant' means an applicant that, on the first day on which a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) is submitted for approval of a drug, submits a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) for the drug.

''(cc) SUBSTANTIALLY COMPLETE APPLICATION.—The term 'substantially complete application' means an application under this subsection that on its face is sufficiently complete to permit a substantive review and contains all the information required by paragraph (2)(A).

''(dd) TENTATIVE APPROVAL.—

''(AA) IN GENERAL.—The term 'tentative approval' means notification to an applicant by the Secretary that an application under this subsection meets the requirements of paragraph (2)(A), but cannot receive effective approval because the application does not meet the requirements of this subparagraph, there is a period of exclusivity for the listed drug under subparagraph (E) or section 505A, or there is a 7-year period of exclusivity for the listed drug under section 527.

''(BB) LIMITATION.—A drug that is granted tentative approval by the Secretary is not an approved drug and shall not have an effective approval until the Secretary issues an approval after any necessary additional review of the application.

''(II) EFFECTIVENESS OF APPLICATION.—Subject to subparagraph (D), if the application contains a certification described in paragraph (2)(A)(vii)(IV) and is for a drug for which a first applicant has submitted an application containing such a certification, the application shall be made effective on the date that is 180 days after the date of the first commercial marketing of the drug (including the commercial marketing of the listed drug) by any first applicant.''; and

(2) by inserting after subparagraph (C) the following:

''(D) FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.—

''(i) DEFINITION OF FORFEITURE EVENT.—In this subparagraph, the term 'forfeiture event', with respect to an application under this subsection, means the occurrence of any of the following:

''(I) FAILURE TO MARKET.—The first applicant fails to market the drug by the later of—

''(aa) the earlier of the date that is—

''(AA) 75 days after the date on which the approval of the application of the first applicant is made effective under subparagraph (B)(iii); or

''(BB) 30 months after the date of submission of the application of the first applicant; or

''(bb) with respect to the first applicant or any other applicant (which other applicant has received tentative approval), the date that is 75 days after the date as of which, as to each of the patents with respect to which the first applicant submitted a certification qualifying the first applicant for the 180-day exclusivity period under subparagraph (B)(iv), at least 1 of the following has occurred:

''(AA) In an infringement action brought against that applicant with respect to the patent or in a declaratory judgment action brought by that applicant with respect to the patent, a court enters a final decision from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the patent is invalid or not infringed.

''(BB) In an infringement action or a declaratory judgment action described in subitem (AA), a court signs a settlement order or consent decree that enters a final judgment that includes a finding that the patent is invalid or not infringed.

''(CC) The patent expires.

''(DD) The patent is withdrawn by the holder of the application approved under subsection (b).

''(II) WITHDRAWAL OF APPLICATION.—The first applicant withdraws the application or the Secretary considers the application to have been withdrawn as a result of a determination by the Secretary that the application does not meet the requirements for approval under paragraph (4).

''(III) AMENDMENT OF CERTIFICATION.—The first applicant amends or withdraws the certification for all of the patents with respect

to which that applicant submitted a certification qualifying the applicant for the 180-day exclusivity period.

''(IV) FAILURE TO OBTAIN TENTATIVE APPROVAL.—The first applicant fails to obtain tentative approval of the application within 30 months after the date on which the application is filed, unless the failure is caused by a change in or a review of the requirements for approval of the application imposed after the date on which the application is filed.

''(V) AGREEMENT WITH ANOTHER APPLICANT, THE LISTED DRUG APPLICATION HOLDER, OR A PATENT OWNER.—The first applicant enters into an agreement with another applicant under this subsection for the drug, the holder of the application for the listed drug, or an owner of the patent that is the subject of the certification under paragraph (2)(A)(vii)(IV), the Federal Trade Commission or the Attorney General files a complaint, and there is a final decision of the Federal Trade Commission or the court with regard to the complaint from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the agreement has violated the antitrust laws (as defined in section 1 of the Clayton Act (15 U.S.C. 12), except that the term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that that section applies to unfair methods of competition).

''(VI) EXPIRATION OF ALL PATENTS.—All of the patents as to which the applicant submitted a certification qualifying it for the 180-day exclusivity period have expired.

''(ii) FORFEITURE.—The 180-day exclusivity period described in subparagraph (B)(iv) shall be forfeited by a first applicant if a forfeiture event occurs with respect to that first applicant.

''(iii) SUBSEQUENT APPLICANT.—If all first applicants forfeit the 180-day exclusivity period under clause (ii)—

''(I) approval of any application containing a certification described in paragraph (2)(A)(vii)(IV) shall be made effective in accordance with subparagraph (B)(iii); and

''(II) no applicant shall be eligible for a 180-day exclusivity period.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall be effective only with respect to an application filed under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) after the date of enactment of this Act for a listed drug for which no certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act.

(2) COLLUSIVE AGREEMENTS.—If a forfeiture event described in section 505(j)(5)(D)(i)(V) of that Act occurs in the case of an applicant, the applicant shall forfeit the 180-day period under section 505(j)(5)(B)(iv) of that Act without regard to when the first certification under section 505(j)(2)(A)(vii)(IV) of that Act for the listed drug was made.

(3) DECISION OF A COURT WHEN THE 180-DAY EXCLUSIVITY PERIOD HAS NOT BEEN TRIGGERED.—With respect to an application filed before, on, or after the date of enactment of this Act for a listed drug for which a certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act and for which neither of the events described in subclause (I) or (II) of section 505(j)(5)(B)(iv) of that Act (as in effect on the day before the date of enactment of this Act) has occurred on or before the date of enactment of this Act, the term ''decision of a court'' as used in clause (iv) of section 505(j)(5)(B) of that Act means a final decision of a court from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken.

SEC. 1104. BIOAVAILABILITY AND BIOEQUIVALENCE.

(a) IN GENERAL.—Section 505(j)(8) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(8)) is amended—

(1) by striking subparagraph (A) and inserting the following:

''(A)(i) The term 'bioavailability' means the rate and extent to which the active ingredient or therapeutic ingredient is absorbed from a drug and becomes available at the site of drug action.

''(ii) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may assess bioavailability by scientifically valid measurements intended to reflect the rate and extent to which the active ingredient or therapeutic ingredient becomes available at the site of drug action.''; and

(2) by adding at the end the following:

''(C) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may establish alternative, scientifically valid methods to show bioequivalence if the alternative methods are expected to detect a significant difference between the drug and the listed drug in safety and therapeutic effect.''.

(b) EFFECT OF AMENDMENT.—The amendment made by subsection (a) does not alter the standards for approval of drugs under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

SEC. 1105. REMEDIES FOR INFRINGEMENT.

Section 287 of title 35, United States Code, is amended by adding at the end the following:

''(d) CONSIDERATION.—In making a determination with respect to remedy brought for infringement of a patent that claims a drug or a method or using a drug, the court shall consider whether information on the patent was filed as required under 21 U.S.C. 355 (b) or (c), and, if such information was required to be filed but was not, the court may refuse to award treble damages under section 284.''.

SEC. 1106. CONFORMING AMENDMENTS.

Section 505A of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355a) is amended—

(1) in subsections (b)(1)(A)(i) and (c)(1)(A)(i), by striking ''(j)(5)(D)(ii)'' each place it appears and inserting ''(j)(5)(F)(ii)'';

(2) in subsections (b)(1)(A)(ii) and (c)(1)(A)(ii), by striking ''(j)(5)(D)'' each place it appears and inserting ''(j)(5)(F)''; and

(3) in subsections (e) and (l), by striking ''505(j)(5)(D)'' each place it appears and inserting ''505(j)(5)(F)''.

The SPEAKER pro tempore. Pursuant to House Resolution 299, the gentleman from New York (Mr. RANGEL) and the gentleman from Louisiana (Mr. TAUZIN) each will control 30 minutes.

Mr. TAUZIN. Mr. Speaker, I yield 15 minutes to the gentleman from California (Mr. THOMAS) or his designee, and ask unanimous consent that he may control that time.

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

There was no objection.

Mr. RANGEL. Mr. Speaker, I yield 15 minutes to the gentleman from Michigan (Mr. DINGELL) and ask unanimous consent that he be permitted to further allocate that time.

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

There was no objection.

The SPEAKER pro tempore. The gentleman from New York (Mr. RANGEL) is recognized for 15 minutes.

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

Mr. Speaker, I appreciate the statement made by the gentleman from Louisiana (Mr. TAUZIN) that we all are concerned about our older citizens and those that are to follow, and certainly we all have to appreciate the fact that we are all here because we stand on someone else's shoulders, someone else who made the sacrifice, and I am very proud to share the responsibility of this bill with the gentleman from Michigan (Mr. DINGELL), who has dedicated his entire life, and his dad before him, in making certain that he and those of us who support him and what he believes in improves the quality of life of not only the seniors today.

It took us a long time to get where we are where people feel some degree of comfort that the Federal Government will be there for them, whether it is Social Security, whether it is Medicaid, whether it is Medicare. It has been government, yes, this government, this wonderful government, this government who gave me the GI bill, this government which allowed older citizens to have some degree of pride in having Social Security to cushion themselves from poverty, and this government that provided health care for the very poor, and under Medicare we had hoped that we would have provided prescription drugs for them.

I do not know when this animosity came against government, why we felt we had to starve these programs which some of us have been so proud of. Somebody asked how do you pay for your bill? This is a strange thing to ask, especially when the chairman of the Committee on the Budget is on the floor. He has been able to do magic with numbers over there. He started out with a $5.6 trillion surplus, and with magic converted it to a $3.4 trillion deficit. He can take $9 trillion and find some way to spend it in tax cuts. Even tonight, some $173 billion, $100 billion just found last night, and we will get $400 billion from what they have allocated, but we think that it takes twice that much.

Is that asking to do, is that something that we have to go to the Committee on the Budget for and ask? Can you sprinkle your magic powder on us and make it possible for the older people not to have gaps in services? Is it asking too much to treat them, not that they are wealthy in dollars and cents, but they are wealthy in terms of the investment they made in this country to make it possible for the multinationals and the wealthy people to get the tax breaks that they are getting, and it seems to me since compassion is not there, that maybe we can look at it as a cost savings vehicle.

How many senior citizens will not have to go to the hospitals which are so expensive, how much of a part of our health expenses is a part of the institutions which our seniors are forced to go

into? If you have to make a decision and you are in doubt, why not make the doubt in favor of the senior citizens? Everything that is missing in the Republican bill that is good, we put in our bill to make certain that it is better.

One thing that we are saying is this, do not hate the government until you do not have any need for it. And seniors when they read the difference of the bills, and you bet your life they can read, they may be old but they are not stupid. They can pick up the daily newspapers, and if they do not go to the pharmaceutical corporations but rather go to the local drugstore, they will find out in short order who is their best friend.

Do not knock the government. It is not as bad as some Members think. Give the people an opportunity so that we can say citizens, we appreciate all that you have done for us, and we in the Congress believe that the least we can do for you as you grow older is to ease your pain and, more important, the fear you have that once you go to the doctor that at least you will be able to get the drugs that are prescribed for your illness.

Mr. Speaker, we do not have to challenge each other's integrity, but I tell Members this, that there are Members on the other side of the aisle that hold Social Security in utter contempt. There are Members who talk about Medicare as though the communists created the package, and they resented it when it started, and they think it is worse than ever today.

What I am saying is let us do what they tell doctors to do, and do no harm. Let us leave here saying that at least on this day there was a substitute, they did not have to do it the way the majority would want.

Mr. Speaker, I yield the balance of my time to the gentleman from California (Mr. STARK), the ranking member of the Subcommittee on Health, and I ask unanimous consent that he may further allocate that time.

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

There was no objection.

(Mr. WILSON of South Carolina asked and was given permission to speak out of order and to revise and extend his remarks.)

SOUTH CAROLINA LOSES A LEGEND

Mr. WILSON of South Carolina. Mr. Speaker, it is with great sadness tonight that I announce that Senator Strom Thurmond passed away at 9:45. I was a former staff member of Senator Thurmond, my wife was a staff person for Senator Thurmond, and our three sons have been pages with his office.

With the death of Strom Thurmond, South Carolina has lost its greatest statesman of the 20th century, just as John Calhoun was the most revered South Carolinian of the 19th century. Strom Thurmond will never be replaced in the countless hearts of those who loved and respected him.

The entire Wilson family mourns this profound loss and we extend our sympathy to the Thurmond family.

Senator Strom Thurmond will endure as the leading example of a public servant due to his love and devotion to all the people of South Carolina regardless of status, race, politics or region.

He was our living legend. Strom's life was dedicated to achieving peace through strength, as shown by his military service in liberating Europe from Nazi fascists, his tireless work in fighting for a strong national defense in Congress which ultimately led to the defeat of Soviet communism.

□ 2300

He pioneered the development of the South Carolina Republican Party from effective nonexistence in the 1960s to majority status by the end of the century. He has been a role model of service to South Carolina's young people and our family has had three generations on his staff: my wife's two uncles were staff attorneys, my wife and I were interns, and our three oldest sons were pages. A distinguished highlight for our family was to host Senator Thurmond on the last Sunday before his last election in 1996 at the First Presbyterian Church in Columbia.

The legacy of Strom Thurmond will always be felt in South Carolina because of his steadfast integrity and the meaningful results of his thoughtful constituent service. He was my personal hero, and I will miss him dearly.

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

Let me join in expressing the sorrow of the folks in Louisiana for your loss in South Carolina. We will pray for his soul.

Mr. Speaker, the Democratic substitute in this debate can be summed up rather easily. According to CBO, it will spend over a trillion dollars. It busts the budget. Therefore, it is on the floor with a budget waiver. It at the same time excludes and does not contain any of the reforms that the base bill includes, that are designed to save Medicare from failure, from insolvency. I am not predicting Medicare's failure or insolvency. CBO is. CRS is. Everyone who has estimated the strength of our Medicare system predicts very soon, in our lifetimes, it will go insolvent. None of the reforms that are designed to save Medicare from insolvency are here. In fact, the Democratic substitute piles on a trillion dollars' worth of expenses to the Medicare system with no reforms to make sure the system is saved.

When I mentioned earlier that you ought to test the credibility of arguments on this floor by what is said and what is fact and what is of record, let me take you back to the statements of the distinguished gentlewoman from California who criticized the base bill because CBO said it might mean that as much as 30 percent or so of employers might drop their retiree coverage under the base bill in favor of the plans we offer. CBO estimated the Democratic substitute, too, on that point.

How credible is an argument against the base bill that complains about a potential 30 percent loss of employer coverage when CBO estimates that 100 percent of employers will drop retiree coverage under the Democratic substitute? That all taxpayer dollars will be used to substitute private dollars? And the Medicare system, already crushed and about to go into insolvency, will have to assume all that responsibility, too? If you really believe in Medicare, why would you burden it so? Why would you eliminate private coverage in America, as CBO estimates would happen under the Democratic substitute?

This substitute busts our budget. It purports to provide more drug coverage than the base bill but no reforms, it does not save Medicare; and on top of that it virtually eliminates private retiree coverage in America. Why would we want to go that direction? We rejected that direction during the Clinton years when Mrs. CLINTON presented us with one-size-fits-all health care for all Americans. We recognized then that if you do not have the competitive choices in America in health care, just as we do with so many other services, that things go bad in this country and that sooner or later the crushing weight of benefits added upon benefits added upon benefits means the working people of America have to pay more and more and more taxes. In fact, it is estimated that within 70 years, if we do not begin today making decisions like we ask the House to make, entitlements in America will eat up every tax dollar paid into the Treasury by every citizen in America, and we will have no money for any other function in this country. That is where this substitute takes us, and that is why we need to reject it.

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

Mr. DINGELL. Mr. Speaker, I yield myself 3 minutes.

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

Mr. DINGELL. My dear friends and colleagues, I lay before you the Republican plan. I ask you to look at it with a straight face, because it is inexplicable, and I cannot explain it to you with a straight face. The amendment which was offered by my dear friend, the gentleman from New York (Mr. RANGEL), on behalf of him and me, does the following things: it gives and sets forth a very clear set of benefits. Senior citizens pay $25 a month; they get 80 percent of drug costs from government after a $100 deductible. This is what you get if you get the Republican plan. But that is not the worst you get. If you are a senior citizen, you fall into a doughnut hole. After you get $2,000 in drugs that you get under the plan, all of a sudden your payments by the government stop; you have to keep on paying premiums, but you get no benefit

until you have got $5,100. They are going to privatize your Medicare in the year 2010. That is pretty bad.

But it is followed by other things: massive subsidies to the insurance companies which commence in 2 years, in 2006. But that is not all. No guarantee as to what it costs you in terms of what you have to pay in the way of premiums, no assurance that you will get any particular level of benefits. The only person who is going to cut a fat hog out of this deal are those good-hearted, flinty-hearted, cold-hearted folk in the insurance business who are going to all of a sudden get a key to the United States Treasury, the right to collect any amount of money they want and to sucker the Secretary of HHS any old way they are minded and to walk home and to pay the money perhaps to the senior citizens but possibly to their shareholders or in dividends or perhaps to pay it in salaries or in bonuses to their corporate officers. That is what you get under the Republican plan. And privatization of Social Security as you know it today.

The Republicans have said that they intend to do away with Social Security. Well, this is what is happening here. The Democratic plan compels the drug houses to negotiate with the Federal Government and the Secretary. The Republicans preclude him by absolutely prohibiting him from negotiating. We do not tolerate under the Democratic plan the Republican opportunity to privatize Medicare. And just wait till your senior citizens find out what you are doing to them with privatization and doing away with fee-for-service and substituting in lieu of this the kind of plan that you talk about where there is no assurance of protection for the senior citizens.

The Republicans say the bill costs too much. Well, it pays some $800 billion to 40 million senior citizens. Just last week, without a gasp of shame, my Republican friends set it up so that 200,000 families got the same amount of money. I think it is time we looked after the senior citizens and not the fat cats that my Republican colleagues and friends look after.

Vote for the Democratic plan. Vote down the Republican plan. Let us take care of the senior citizens. It is the right thing to do.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let us look at the facts behind the rhetoric here. What is going to be the impact of this Democratic substitute on seniors? My colleague from Louisiana just reminded us that 100 percent of employers are going to drop their plans. If there is one thing my senior citizens say to me when I go into senior centers it is, look, help those who need it, but do not destroy my employer-provided retiree plan. Do not touch it. This amendment destroys it, wipes it out. That is not in the interest of your seniors.

But let us look at what it will do to premiums. You were concerned that we did not sock a premium into law. Look what you do in your bill. You sock the premium into law and then you have it rise according to drug inflation. Drug inflation is double-digit. Do you not get it? Those premiums are going to rise steeply. Why would you do that to our seniors?

And let us look at the effect on prices. There is one thing seniors say to you over and over again, the prices are too high. Yet according to Dr. Holtz-Eakin's testimony of April 9, 2003, he says, ''If you subsidize 90 percent of any insurance product versus 70 percent of the product, the larger subsidy will lead to a lower incentive to control costs and will lead to higher prices and higher spending.'' Yours is a giveaway to the pharmaceutical industry. It will drive prices up because there is no incentive for the PBM or the plan to negotiate prices down and they can just pass it on to the government, because we are going to pay it all. Yours is going to drive prices up, premiums up and employer plans out of the market. I do not know why you think you are doing the seniors a good service.

And look at the impact on their kids, because they care about their kids and their grandkids. We have heard testimony over and over again that if you have a 10-year-old child, in 20 years when that kid is 30 and trying to pay back college loans, trying to buy a house, trying to get established, having to buy a car, that child will live in a Nation in which three-quarters of all the Federal revenues will go to Social Security, Medicare and Medicaid.

What is that child to do about education for their children? What is that young person to do to make a living? You shoulder so much debt on the next generation that they will not have public education the way we know it today. They will not have the roads and bridges that a strong economy depends on. They will not be able to defend this Nation in a world that is going to be far more dangerous than the one we have known. This is utterly irresponsible. It is so irresponsible that when the other body proposed this plan in the Senate the last session of Congress, they could not write a budget resolution because they did not know how to handle the extraordinary debt that this creates in the decades ahead.

I urge my colleagues to think that something that looks pretty for your seniors, in fact, will be terrible for their health.

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

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume. I know earlier I moved the distinguished gentleman from Louisiana, the chairman of the Committee on Energy and Commerce, to talk about his poverty and I wanted to join him in that. I too was raised poor. I was raised so poor that I never slept alone until I was married. I want to go on and suggest that I am not going to let you have that field all to yourself.

We have introduced a substitute. Unlike your bill, ours has specific benefits. Your bill, I would remind the gentlewoman from Connecticut, has no benefit in it. It is all estimates. It is all examples. There is no benefit in your bill, and indeed in our substitute there is. You have heard it. It is simple. It is $25 a month, 20 percent coinsurance, no gaps; and we pay out of pocket after $2,000.

Yes, you will say it costs a lot of money. The gentlewoman from Connecticut forgets about the $5.6 trillion surplus that Bush had when he came into office and which he squandered on tax cuts in the meantime. But we do have an income transfer as we have been accused of. It is very simple. You can look at it this way. You have given $800 billion to 10,000 of the richest families each year when you did away with the inheritance tax. No question about it. That is what it costs. Those are the beneficiaries. We would take that money as an alternative and give it to what will be in a short 10 years 100 million seniors. What you have given away to the richest seniors in this country would more than pay for a drug benefit of the magnitude that we offer, a standard Medicare drug benefit, and I suggest that that is a transfer worth making and that that defines the difference between us.

□ 2315

You give $800 billion to 10,000 families a year, the richest in America. We would give that $800 billion to 100 million seniors who needed a drug benefit that they can define, depend on and understand, and that is why the Members should support the Democratic substitute. It is defined. It is real. It solves the problem for seniors, and it is, I think, one of the highest priorities that this House has.

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

Mr. TAUZIN. Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. GREENWOOD), the chairman of the Oversight and Investigations Subcommittee of the Committee on Energy and Commerce.

Mr. GREENWOOD. Mr. Speaker, I thank the chairman of the committee for yielding me this time.

The gentleman from Michigan (Mr. DINGELL) and others have presented a chart earlier that purported to show that somehow our plan was too complicated. It is a complicated issue to provide prescription drug benefits to millions of Americans who have never had them.

Let me show another chart that describes our plan and it is not complicated at all. Today a senior citizen walks into a drugstore and wants to buy Lopressor, 100 milligrams. She has to pay, for 30 tabs, $45.99 right out of her pocket. Under our bill the price first comes down because of the group purchasing power to $36.79 and then what does she pay? She pays $7.36 and if she is low income she pays $5. That is a big difference from $46.

Let us look at Lipitor. An awful lot of Americans take Lipitor every day to keep their cholesterol down. I do. It costs $108.65 today because for 40 years the Democrats did not do anything about prescription drugs and for 8 years President Clinton did not do anything about prescription drugs, but under our plan Lipitor goes down to $86.92 because of our purchasing power, but the beneficiary pays, his/her share, $17.38. Pretty straightforward. Pretty simple. Nothing complicated about that.

Celebrex, an important anti-inflammatory drug for arthritis that so many seniors suffer from, a very popular drug, $86.28 today to get 30 tablets of that for 1 month. We bring it down to $69.02 because of our power of purchasing, but the beneficiary pays $13.80 for a month's supply and if they are a poor senior citizen, $5. $5, down from $86.28.

Zoloft, 100 milligrams, 30 tabs for a month, it is an antidepressant. A lot of elderly suffer from depression, unfortunately, at their age in part because they do not have good health care. We bring the price down to $63.17. The beneficiary pays $12.63 a month and, if she is poor, $5 a month.

This chart is pretty straightforward and pretty simple. This demonstrates what happens when good-minded people do very hard work with very smart staff, employing very good ideas. We get the job done for the elderly, a job that I am sorry to the gentleman from California (Mr. STARK), I am sorry to the gentleman from Michigan (Mr. DINGELL). They have been here for a long time and they have done nothing. A lot of talk tonight. A lot of good talk, a lot of bogeyman talk, a lot of scare-the-seniors talk tonight, but we will get this done. It will be very simple. It will be very straightforward. The senior citizens will love it, and as a measure of that you are all going to be voting for it next month.

Mr. DINGELL. Mr. Speaker, I yield myself 15 seconds.

I hope my colleagues look at that chart because it has the same factual value as Alice in Wonderland. There is no requirement that any of those drugs be made available. There is no requirement that they be made available at any particular price or that they have to be made available under the plan at any particular cost because of cost sharing with the insurance.

Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from California (Mr. WAXMAN).

Mr. WAXMAN. Mr. Speaker, today the House should be considering a Medicare prescription drug benefit for all America's seniors and disabled citizens that would be a benefit that is certain, a benefit that is affordable, and a benefit that helps Medicare beneficiaries with all of their drugs. It should not have large gaps in coverage as the Republican bill does. It should not let private insurance companies charge whatever premium they want and cover whatever drugs they want as the Republican bill does. It should be available in every part of the country, not only in areas where private insurers decide they can make a profit, and it should not cost seniors more if they live in Iowa instead of Virginia or California instead of Rhode Island. Most importantly, it should be a part of the Medicare program, just as dependable as the rest of the Medicare is for seniors and disabled people today.

The Republican bill fails all of these tests. It makes promises on the one hand and then takes them away when we read the fine print. It claims to give special help to America's low-income seniors so that they can afford to pay for the prescription drug program, but then it makes seniors subject to a detailed and invasive assets test before they can get help.

If they have over $6,000 in the bank, they do not get any help. When we figure out what they have got if they count the value of their car and it is worth more than $4,500, and what car is not? They do not get any help. They count the value of the clothes and furniture and appliances if they are worth more than $2,000. They can even count the value of their burial plot if it exceeds $1,500. So instead of making sure people of very modest income who need help to get in, they get the fine print eliminating a lot of these people who should be helped, and it makes all of them go through a demeaning and complex process to prove they have few assets.

All this to get help with their drug expenses. This is just wrong. Instead of spending the public's money to get the best possible drug benefit, this Republican bill spends our dollars to bribe insurance companies to sell a drug plan. It pays for profits for the insurance companies instead of the bills for our seniors.

What we should be doing is using the purchasing power of America's seniors, 40 million of them, to get good prices on their drugs as they do in Canada and get good coverage. That is what the Democratic substitute does. I urge my colleagues to vote for the Democratic substitute and against the Republican bill.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2 minutes to the gentleman from Iowa (Mr. NUSSLE), a member of the Committee on Ways and Means and esteemed chairman of the Committee on the Budget.

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

I would like to know where the new Democrat budget hawks are tonight, those new birds who seem to have flown the coop, who have spent the last many months here on the floor talking about the debt tax, something that does not exist but they have sure gotten a lot of ink about it. All sorts of national debt charts have been coming across the floor. In fact, they even one day used the pages, these young high school students, to demonstrate the national debt. But where are they tonight? Where are they when we read the letter from the Congressional Budget Office that says that their so-called substitute would add $1 trillion to the deficit? Where are they? They have flown the coop. We are not hearing about the deficit all of a sudden. In fact, what we heard about is that tax cuts have caused all of the problems.

In fact, one gentleman even had the audacity to stand up and act as though Washington hands money out to people. Tax relief, my friends, is money left in the pockets of people that they earned. We do not hand money out. Money comes from them. And if you are going to waste it on a $1 trillion program, that not only does not fit within the budget that controls tonight but did not even fit within your substitute budget of just 4 months ago.

In fact, if we add the Democrat budget together with the budget that controls today, you bust not only the Republican budget, you bust the Democrat budget, but you bust both budgets combined. That takes a lot of work, to be able to bust both budgets and add $1 trillion to the deficit and have all of these new deficit Democrat hawks whom we cannot find tonight.

It is interesting. Boy, we heard a lot from them all year long, nickeling and diming and worrying about all of that. But when you come to the floor with $1 trillion that says in the same letter that all the employers are going to drop their coverage for retirees, 100 percent are going to drop their coverage, and you have the audacity to present that kind of substitute that busts both budgets, do not come here any more this year and talk about the deficit.

Mr. STARK. Mr. Speaker, I yield myself 30 seconds.

I have the same letter, and it says nothing about employers dropping coverage.

Mr. Speaker, I yield 2 minutes to the gentleman from Washington (Mr. MCDERMOTT), a member of the Committee on Ways and Means, who understands that spending money to provide a decent drug benefit for seniors is not wasting money.

Mr. MCDERMOTT. Mr. Speaker, Members of the House and those listening to this, I think you ought to take a piece of paper right now and write this down. The premium is $25. The deductible is $100 a year. The coinsurance means you pay 20 percent, the government pays 80 percent for your drugs, and there is a cap on how much you can spend out of pocket, $2,000. That is written into our bill.

In contrast, we have this magic pill that has been given to us where the other side says trust us. Remember, these are the people who told us that there were weapons of mass destruction in Iraq. They were right there. They were going to be delivered in 45 minutes. And, in fact, the President of the United States stood right here and

said, Mr. Speaker, that he believed that they had tried to buy uranium from Niger. It was known that that was a lie. It was known. So now they come out here with this drug bill and they say listen, we think it will be about $35 and maybe you will get this and maybe you will get that, but nothing is written down. I want the people to remember those four things.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The Chair reminds the Member not to make personal remarks regarding the President of the United States.

Mr. TAUZIN. Mr. Speaker, it is almost like Minister of Information Baghdad Bob just arrived here.

Mr. Speaker, I yield myself 2 minutes.

PARLIAMENTARY INQUIRY

Mr. MCDERMOTT. Mr. Speaker, Parliamentary inquiry.

The SPEAKER pro tempore. The gentleman from Louisiana has the floor. Does the gentleman yield?

Mr. TAUZIN. Mr. Speaker, I do not yield.

Mr. MCDERMOTT. Point of personal privilege, Mr. Speaker. Were you making some reference about Baghdad whom? Is that appropriate for the Speaker of the House?

The SPEAKER pro tempore. The gentleman from Washington (Mr. MCDERMOTT) is not in order since the gentleman from Louisiana (Mr. TAUZIN) has the time and such a point may not challenge debate.

Mr. TAUZIN. Mr. Speaker, I want to illustrate one of the real inadequacies of the Democratic substitute. In the main bill we reformed something called average wholesale price. I hope everyone knows what that is. I am going to illustrate it for you tonight. Under average wholesale price systems built into Medicare by the Democratic Party all these years, this is what happens. A person goes in for cancer therapy, a senior citizen, and the doctor needs a drug that costs $10; so the doctor buys a chemotherapy drug for $10. The patient ought to have to pay $2 under that, 20 percent co-pay under law. But that is not what happens. Under the average wholesale price system devised by Democratic administrations in the past under Medicare, this is what happens. The government has a phony average wholesale price posted. It might be $200 for that drug that only costs the doctor $10, and the poor patient has to put up 20 percent, not of the $10 but 20 percent of the $200. The patient puts up $40 for a drug that only costs the doctor $10 when the patient should have put up $2. That is called the average wholesale price system. It is rotten. It stinks. Our bill gets rid of it. And we replace it by reimbursing oncologists in America for not one time what their practice expense really ought to be reimbursed under the law, but we double it.

□ 2330

We give them $430 million, twice what CMS estimates they ought to get.

So we get rid of this stinky system that is charging American seniors 20 percent of phoney prices and costing the government Medicare system tens of times what the drugs are really costing the doctors, and we replace it with a rational, a rational reimbursement system.

Now, the Democrats try to settle that system too. Let me tell my colleagues what they do in their substitute. They substitute this average wholesale price system with a system of reimbursement that, according to CBO estimates, is going to cost $14 billion over 10 years; and it is going to cost seniors another $3 billion of copays. We ought to reject that solution.

Mr. DINGELL. Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from New Jersey (Mr. PALLONE).

Mr. PALLONE. Mr. Speaker, the only thing that stinks here is the Republican bill, and it stinks for a lot of reasons.

First of all, because it is not going to give the seniors any benefit. They are not going to have really any drug benefit whatsoever. It is going to force them into an HMO. They will not have any choice of doctors. And fundamentally, in the end what the Republican bill does is kill Medicare by setting up a voucher system so we do not even have traditional Medicare.

I am sick and tired of hearing my Republican colleagues on the other side criticize traditional Medicare. Medicare is not insolvent. Medicare is a good program. Do not tell me that Medicare is broke or Medicare needs to be fixed. And I say to the gentlewoman from Connecticut, do not insult me and say the Democrats are irresponsible, the Democrats are putting us in debt. The Republicans are the ones that are putting us in debt, because you are borrowing from the trust fund so there is no money left in it because you want to kill Medicare. That is what you are all about.

These gentlemen over here, these Democrats who have been here for a long time, they are here tonight because they want to save Medicare. They understand that Medicare can be helped by putting on a prescription drug benefit, so they look at the tried and true system, they look at what we do in part B for our doctor bills, and they say, yes, let us just add a benefit like part B. We will have a low premium. We will have a low deductible. We will pay 80 percent of the cost on the Federal Government. We will have a catastrophic at 2,000. Just add the tried and true program, like we have in part B, and add a drug benefit. We do not need HMOs. We do not need all of these other gimmicks that the Republicans come up with.

And then these gentlemen, my colleagues, the gentleman from Michigan (Mr. DINGELL) and the gentleman from New York (Mr. RANGEL), they say, well, we can pay for this very easily by negotiating the price and giving the Secretary the power to lower the prices. That would cut the program in half. That is what our Democratic leader said. That would cut the cost of the program in half so we would not have to go into debt. We would not have to borrow from the trust fund and make it insolvent, which is what my Republican colleagues have been doing here and what they are proposing.

Mr. Speaker, do not sell out to the HMOs and the insurance companies. That is what you are doing. You are selling out by saying everybody has got to go into an HMO because you are in bed with the insurance companies. You are selling out to the pharmaceutical industry because you want no price reductions, because you are going to get some benefit from the pharmaceutical industry.

And then you come up with: this is complicated. The gentleman from Pennsylvania (Mr. GREENWOOD) said, oh this is complicated. There is nothing complicated here. It is simple. We have had the program for years. We just add the prescription drug benefit, and we have a negotiated price. It is very simple.

Do not give me this chart. I mean, look at this garbage. How could anyone possibly understand it? I cannot even understand it myself, and you expect my mother or somebody's grandmother to understand this thing? You are making it complicated. You are destroying Medicare. Do not insult us as Democrats. We have been out there protecting it for years.

Mrs. JOHNSON of Connecticut. Mr. Speaker, it is my pleasure to yield 2 minutes to the gentleman from Wisconsin (Mr. RYAN), a member of the Committee on Ways and Means.

Mr. RYAN of Wisconsin. Mr. Speaker, I thank the gentlewoman for yielding me this time.

I want to calm down a little bit. There has been a lot of shouting around here, a lot of heated rhetoric, a lot of hyperbole. Let us just look at a couple of facts.

It is a fact that the Medicare actuaries are telling us that Medicare is going insolvent in 13 years. The entire trust fund goes bankrupt in 2036. It is a fact that if we add more money on top of Medicare without doing any reforms, you are going to accelerate the insolvency of Medicare. We can try and speak those facts away, but the fact remains that those are facts.

Now, what this Democrat substitute does is it costs over $1 trillion. It accelerates the bankruptcy of Medicare. The basic assumption in this CBO estimate is that every employer providing private drug coverage for the retirees is going to drop it. And why would they not? Why would they not drop it if the Federal Government is going to pay for it all?

What the facts are is that this plan is going to accelerate the bankruptcy of Medicare.

Now, what are we trying to achieve with the Republican bill? Mr. Speaker, there are parts of this bill that none of us all like. I have my own criticisms. But what we are trying to achieve is not only modernizing this program so it works for today's seniors by giving them cheaper drugs and coverage of drugs, but we are also trying to modernize this program and save it for the baby boom generation.

We have 77 million retirees coming in this country starting in 15 years; and if we accelerate the bankruptcy of this program as the Democrats are proposing to do, it is not going to be there for them.

So what we are doing with these market-based reforms and giving seniors more choices? We are giving them the chance that this program will be solvent for the boomers when they retire. That is the responsible thing to do here. The responsible thing is to make it work for today's seniors, make it modern, make it comprehensive, work on prescription drug prices, work on prescription drug coverage, but give seniors more choices, use competition, use the things that have worked in the past so we can save this program for the baby boomers. That is what the Republican bill does.

Mr. STARK. Mr. Speaker, I yield myself 30 seconds for a couple of housekeeping things.

In 13 years, the revenues start to decline, but it does not go insolvent for 24 years. And I say to the gentleman from Ohio (Mr. NUSSLE), if he has indeed the same letter that we are informed we have from CBO dated June 26, it says nothing in there about employers turning back Medicare, so he either misspoke or made it up, which, in my State, we call telling a lie. Unless he has a different letter, which I am assured by CBO he does not, then he made that up.

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

Mr. MENENDEZ. Mr. Speaker, I rise on behalf of my 84-year-old mother and millions like her across this country. She worked her entire life in the factories of New Jersey. Today she has Alzheimer's and spends over half of her social security check on prescription drugs. If it was not for my sister and me, she would not be able to live with the dignity she deserves.

Now, this Republican package is wrapped in a label that says, ''I care,'' but when you open it up, it contains nothing more than an empty promise.

Under this Republican plan, which lacks the compassion promised by the President and expected from our doctors, millions of seniors who want to stay in traditional Medicare with their own doctor would essentially be forced into HMOs and left without the choices they deserve. This bill is the road towards privatizing Medicare.

Republicans just cannot help themselves. Once again, they have chosen corporate interests over human interests. America's seniors deserve our respect. They have worked too hard, sacrificed too much to be forced to choose between paying their rent, putting food on the table, and having access to life-enhancing drugs.

Support the Democratic substitute that has a real prescription drug provision under Medicare.

Mr. TAUZIN. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from California (Mr. CUNNINGHAM), our fighter pilot commander extraordinaire.

Mr. CUNNINGHAM. Mr. Speaker, I had pneumonia about 5 years ago, and I went to pick up the prescription drug and I looked at it. It was 120 bucks. As I picked it up, I sat there and I thought, how does a family with three or four children afford 120 bucks per bottle of Augmentin to help them with the flu or with other antibiotics? It is a real fact. It is hard.

But Mr. Speaker, I say to the gentleman from Michigan (Mr. DINGELL), does he know the cost of my prescription drug? It cost me $17. Because my wife worked with the Encinitas school district and she had insurance. That is what we want, is a private-public partnership for those people that cannot afford prescription drugs to help them. Over 1.4 million people in California will have no copay, no cost whatsoever. But it will help them in our bill.

I think that your bill, with its costs, is devastating in the long run. It will not help.

If Democrats can demonize pharmaceutical companies, then what is left? The government. If you can demonize insurance companies, what is left for health care? Government-controlled health care. We rejected that in 1993 when the then First Lady offered it. I oppose government-controlled health care, and maybe that is the difference in us, because it will drive this country in debt.

I talked to some people from Canada. Do my colleagues know where they go to get their health care? They come clear down to Buffalo, New York to get it, because it is so bad with their government-controlled health care.

Let us defeat the Democratic substitute and support the primary bill.

Mr. DINGELL. Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from Michigan (Mr. STUPAK).

Mr. STUPAK. Mr. Speaker, the Republican prescription drug plan is bad for America and even worse for rural America.

Today I sent around a letter to Members explaining exactly why this GOP bill shortchanges rural areas like Northern Michigan, which I represent.

The Rangel-Dingell substitute ensures that rural areas are treated fairly. The Republican plan continues to put citizens in these areas at a huge disadvantage. The Rangel-Dingell bill goes far beyond the meager provisions for rural health care providers included in the GOP bill. Our bill, the Democratic bill, provides over $10 billion in additional relief for rural areas and removing the harmful Medicare privatization provisions that just have not worked in rural America.

Instead of helping seniors with their prescription drug plan, the Republican plan subsidizes private insurance companies. This plan tends to bribe private insurance companies to provide service in rural districts like mine. These insurance companies have come before our Committee on Energy and Commerce and have testified that they will not be providing the service, and the Republican plan just will not work.

If insurance companies do change their minds, there is nothing in this bill that will prevent them from shifting the added costs to our seniors. I had an amendment in the Committee on Energy and Commerce that would have prevented increases in the monthly premiums for seniors, no matter where they live. But unfortunately, it was voted down on a party line vote.

The GOP plan has a huge gap in coverage and does nothing to reduce the inflated prices big drug companies are charging for prescription drugs. In fact, the Republican plan has a noninterference clause that says the Health and Human Services Secretary will not, will not be allowed to negotiate lower prices for Americans.

The Rangel-Dingell bill will ensure that every senior, regardless of where they live, will be able to obtain the prescription drugs and the quality of health care they require to live a healthy life. This coverage will be provided through Medicare. Democrats are working to strengthen this program, not to do away with it, as the gentleman from California (Mr. THOMAS) called for when he said, and I quote him, ''To those who say the GOP bill will end Medicare as we know it, our answer is: We certainly hope so.'' Thus, the real motive behind the GOP plan is to do away with Medicare. Democrats proudly stand behind Medicare. Support the Rangel-Dingell substitute.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2 minutes to the gentleman from Arizona (Mr. HAYWORTH), a member of the Committee on Ways and Means.

Mr. HAYWORTH. Mr. Speaker, I thank my friend from Connecticut, and she has visited Arizona, and I know that the hour grows late and the debate grows heated and sometimes well-intentioned efforts from some are thrown in the confusion.

Mr. Speaker, I rise to urge this House to reject the Democratic substitute and to vote ''yes'' for H.R. 1, for reasonable, rational, clear-cut reform of Medicare that will bring Medicare into the 21st century with prescription drug coverage.

□ 2345

Mr. Speaker, we have read even tonight in Europe the development of a

cardiac drug that is estimated to cut heart attacks by 80 percent. We have made great gains in pharmacology; but we do not continue those gains, Mr. Speaker, if we opt for a trillion dollar travesty. And make no mistake, that is what the minority substitute is offering to us this evening.

It was interesting, my friend from Iowa, who pointed out that the deficit hawks on the other sides had flown the coop. It is interesting, so many on the left who are so quick to indict folks higher on the economic scale tonight are strangely silent when we offer a plan where we give the priorities to those who need the help first.

The irony is, my friends on the left in the trillion dollars travesty section say, do not worry. Let us break the bank. Let the good times roll. Take command and control, put it together with a trillion bucks. No worries. But we know what would happen under that plan. It is a prescription for bankruptcy. And it is a prescription to mortgage the future of the working families that my friends purport to support.

People of good will can have different opinions, and we certainly have them here in the House tonight. The question often comes down to this, when is enough enough? With the left it is never enough.

Reject insanity. Vote for rationality, ''yes'' to H.R. 1; ''no'' to the Democratic substitute.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The Chair would remind Members of the time remaining. The gentleman from Louisiana (Mr. TAUZIN) has 4½ minutes remaining and the right to close. The gentleman from California (Mr. STARK) has 3½ minutes remaining and would be next in line to close. The gentlewoman from Connecticut (Mrs. JOHNSON) has 5½ minutes remaining and would be the second to close. The gentleman from Michigan (Mr. DINGELL) has 4¼ minutes remaining and would be the first to close.

The Chair recognizes the gentleman from California.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. KUCINICH).

Mr. KUCINICH. Mr. Speaker, everyone in America knows the price of drugs is too high. Seniors know it best. Proponents of H.R. 1 are not representing the seniors of America. They represent the biggest campaign contributors in America, the private health insurance industry led by drug makers.

The Rangel-Dingell substitute will bring down the cost of the drugs. It allows Medicare to buy drugs in bulk and negotiate for lower prices, which the VA already does. Skyrocketing drug costs are not only driving up health care expenses but are causing seniors to make cruel choices between prescriptions and food, prescriptions and clothing. Some seniors are even splitting pills to make prescriptions last.

Seniors are crying out for help, but their pleas are drowned out by the cash registers humming away at the majority party headquarters, while insurance and pharmaceutical company lobbyists rush to the great Medicare sell-out event.

Yes, some of our friends are indeed trying to take care of people in their old age. Themselves.

Mr. TAUZIN. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, I want to point out that despite what you may have heard on the floor tonight, our basic package contains $27.2 billion of assistance to rural health care. That is the largest package of rural health care we have ever voted on all the times we have voted on Medicare prescription drugs.

Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. UPTON), the chairman of the Subcommittee on Telecommunications and the Internet of the Committee on Energy and Commerce.

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

Mr. UPTON. Mr. Speaker, I have heard a lot of criticism tonight about this drug bill; and I want to remind all of us as we go back to our districts, as we have heard for so many years at our town meetings and so many events, America wants and needs a prescription drug program for our seniors. I remind all of our colleagues here tonight that this program is voluntary. You do not have to participate if you do not want to, but for many Americans they will want to participate. They are going to participate.

Mr. Speaker, I want to relate a little story that happened to me in my district last summer. I was at my son's little league game. A woman ran up to me as I was getting in my car and packing up the gear. She said, My mom just had a stroke. It will cost her $600 a month to survive. We never had that in our budget. We cannot afford it. Is the plan that you passed last week, this was last year, is that going to help my mom? I put my hands on her shoulders and I said, Yes, I believe that it will. She will be able to benefit from this plan. You will be able to use the assets that you have and to have her survive in a meaningful way.

Yet, the other body never came back. The other body never came back with a plan and, in fact, that woman and her family were very distraught.

This is a plan tonight that can pass with bipartisan support, not only in this Chamber but the other Chamber on the other side of the Capitol. The President will sign this bill. It is within the budget. No, it is not perfect. But we can take a step to help the woman that I had talked to last year as well as the thousands of people that have come to our town meetings over the course of the last number of years.

Mr. Speaker, I urge my colleagues to defeat the Democratic substitute and, yes, support this plan that we take up a little bit later this morning.

Mr. DINGELL. Mr. Speaker, I yield 2¼ minutes to the distinguished gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, once upon a time in 1989, a group of very angry seniors chased their Congressman, the powerful chairman of the House Committee on Ways and Means, into his car because they wanted him to know that they did not like the catastrophic health care bill.

This happens to be the picture that appeared on the front page of the Chicago Tribune in August of 1989. This was a bill that passed this body with overwhelming bipartisan support and all of the national senior citizens organizations supported the bill. There was only one problem. No one had checked in with rank-and-file seniors around the country who sat down with their calculators and they figured out what the benefit would be that they would get and how much it would cost them, and they did not like the answer.

Now, I show you this photo not to revive the debate on catastrophic because within a couple of months the bill was repealed, something very unusual and usually very difficult. I show you this photo as a friendly warning. If you pass H.R. 1 tonight, you better also go out and buy some running shoes because senior citizens are too smart to be fooled by Republican speeches or anybody else's speeches. They will figure out on their own what this bill does, which is, as the current chairman of the powerful House Committee on Ways and Means hopes, destroy Medicare as we know it.

Seniors will get out their calculators and figure it out.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 1½ minutes to the gentleman from Ohio (Mr. PORTMAN).

Mr. PORTMAN. Mr. Speaker, it has been a very interesting debate, too, as you listen to this debate tonight. We had 3 hours of good debate on the Republican legislation, the underlying bill which provides historic prescription drug coverage and does so within the budget. Now is the opportunity for the Democrats to talk about their substitute. So what is your idea? And you know what we are having? More discussion of the underlying legislation. Again, historic legislation to add prescription drug coverage that is within the budget.

The Democrats are not talking about their bill. It adds $1 trillion to the deficit. That busts our budget. It busts their budget. In fact, it busts both budgets combined.

The Democrat legislation does so by loading up the bill, not by helping those seniors who need it the most. The underlying legislation provides for about 30 percent of the seniors that need it most, those under 150 percent of poverty, no deduction, no deductible, no cost sharing, a simple copay when you go to the pharmacy, total subsidy for the prescription drug coverage. Instead, the Democrat plan by going to a

trillion dollars would provide coverage for those who do not even need it. It sounds like what they accuse Republicans of.

I was really interested to see, when you look at page 12 of the Democrat bill, there is also something else interesting. They say we do not provide guaranteed access. We do provide guaranteed access. The government actually steps in when there are not plans available, negotiates down the risk which assures coverage.

If you look at page 12, what does the Democrat plan do? It says, ''The Secretary shall develop procedures to ensure coverage.''

That will give you some comfort. I can see why they are not talking about their legislation. I would not either. Vote for the underlying bill. Vote down this substitute that they will not talk about.

Mr. STARK. Mr. Speaker, I yield myself 1½ minutes.

Mr. Speaker, just to straighten out some of the figures, the Republicans do indeed add $26.7 billion for rural providers. We add $39.1 billion for rural providers. That is $2.5 billion more, and I would hope that the Republicans are not lying to the seniors.

You can lie to us because we are used to it. The White House has set the tone for that. But do not lie to the seniors. There is nothing in your bill. I say to the gentleman from Ohio (Mr. PORTMAN), there is nothing in your bill that guarantees anything, and to say that to the seniors is lying to them.

There is nothing in your bill that guarantees a thing to the seniors and you know it. And if you do not know it, read it again. Otherwise, you are lying to the seniors.

Our bill provides a Medicare benefit which is definable. Yours does not. You do not require any benefits if no insurance company steps up to the plate and there is nothing that requires it. There is not one line in your bill that requires an insurance company to provide anything. So it is all a fantasy. At least we are requiring the government to provide a benefit to the seniors in the same manner they are now familiar, under Medicare with a determined premium, a determined deductible, determined benefits, the same across the country. None of that is available through the Republican bill. To tell the seniors otherwise is lying. You have lied to us tonight and stop lying to the seniors. So support our substitute and vote down the great Republican lie.

Mr. DINGELL. Mr. Speaker, I have an inquiry as to time first before I yield the balance of my time. I believe the gentlewoman from Illinois (Ms. SCHAKOWSKY) did not get the full 2¼ minutes that I yielded to her. I would like to know how much time I have left and how much I can properly yield the gentlewoman from Illinois.

The SPEAKER pro tempore. The gentleman from Michigan has 3 minutes remaining.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, I thank the gentleman from Michigan (Mr. DINGELL) for yielding me time.

Again, this is just a warning, a friendly warning to you that if you pass H.R. 1 tonight, you better also go out and get your running shoes because the seniors are too smart to be fooled by your proposal. And you can trash Medicare all you want. You can call it an outdated program, antiquated; but I do not know who you are talking to.

I do believe that you love your mothers, but it is obvious to me that you do not call them enough. You do not go to senior centers enough. Not the ones I have gone to in my 5 years as director of the State Council of Senior Citizens. Seniors love their Medicare. The only thing they do not like is that it does not cover prescription drugs. And that is why if you are smart or out of shape and not able to be chased by seniors, you will vote for the Rangel-Dingell substitute.

The Democratic substitute is what seniors have been asking for and what every politician has been promising them, an understandable, defined, dependable Medicare prescription drug benefit. It has all the features of Medicare that our seniors know and love, a set premium, no copayments.

Vote for the substitute or start running.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 1½ minutes to the gentleman from Virginia (Mr. TOM DAVIS).

Mr. TOM DAVIS of Virginia. Mr. Speaker, I would like to engage in a colloquy with my colleague.

Can she confirm that the language in H.R. 1 includes plans under the Federal Employee Retirement Plan as an employment base plan?

□ 0000

Mrs. JOHNSON of Connecticut. Mr. Speaker, will the gentleman yield?

Mr. TOM DAVIS of Virginia. I yield to the gentlewoman from Connecticut.

Mrs. JOHNSON of Connecticut. Mr. Speaker, yes, that is correct.

Mr. TOM DAVIS of Virginia. This will allow OPM to take advantage of the subsidies in the bill just as other employees and unions will?

Mrs. JOHNSON of Connecticut. That is correct.

Mr. TOM DAVIS of Virginia. Mr. Speaker, I appreciate the gentlewoman's and the chairman's willingness to work with us on this issue. I think that allowing the subsidies H.R. 1 provides for will result in lower premiums and improved benefits for all FEHBP enrollees.

Mrs. JOHNSON of Connecticut. I thank the gentleman, and I look forward to working with the gentleman on this issue as the bill moves to conference.

Mr. TOM DAVIS of Virginia. Mr. Speaker, as I said, I appreciate the willingness of the gentlewoman to clarify that.

I have another concern, that Federal employees are often treated differently from current Federal employees in ways that are not always equitable. Retirees are different from current Federal employees. For example, current employees are allowed to pay their health insurance premiums from pre-tax dollars. Federal retirees are not.

FEHBP currently does not provide different benefits for retirees and current employees. One is simply a member of FEHBP. I think it is important that this dynamic remain once a Medicare prescription drug benefit is put into place, whichever plan passes.

As chairman of the Committee on Government Reform, I look at this from an employer's perspective. We do not want private employers to drop the prescription drug coverage they provide for their retirees. H.R. 1 provides incentives so that they will not do so, but we as the Federal Government have to lead by example.

I have introduced legislation that simply states that Federal retirees will continue to be treated on par with current Federal employees when it comes to prescription benefits. I regret we were unable to include this language in H.R. 1, but I am grateful to have the commitment of the Speaker and the majority leader to bring this bill to the floor as soon as we return from recess.

Mr. TAUZIN. Mr. Speaker, may I inquire how many minutes are left for each one of the four who have allocated time.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Louisiana (Mr. TAUZIN) has 2 minutes remaining and the right to close. The gentleman from California (Mr. STARK) has 1 minute remaining and would be next to close. The gentlewoman from Connecticut (Mrs. JOHNSON) has 2½ minutes remaining, and the gentleman from Michigan (Mr. DINGELL) has 2 minutes remaining.

Mr. TAUZIN. Mr. Speaker, we reserve the balance of our time. If anyone wants to use some more time at this time would be a good time to do it.

Mr. DINGELL. Mr. Speaker, I reserve the balance of my time, and I want to yield it to our leader.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 30 seconds.

This is a historic evening. It is our opportunity tonight to provide prescription drugs to all seniors under Medicare as an entitlement and to do it in a way that is fair, simple and generous and sustainable. It is our opportunity tonight to modernize the benefit program under Medicare to deal with chronic care for our seniors, a big concern for them, and to structure Medicare in such a way that it will be sustainable, the dollars will be there and Medicare will be able to provide the health retirement security in the future that it has in the past.

I urge support of H.R. 1 and defeat of the substitute.

CALL OF THE HOUSE

Mr. TAUZIN. Mr. Speaker, I move a call of the House.

The SPEAKER pro tempore. A quorum is not present.

A call of the House was ordered.

The call was taken by electronic device, and the following Members responded to their names:

[Roll No. 329]

ANSWERED ''PRESENT''—421

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baker
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Cubin
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeFazio
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
Leach
Lee
Levin
Lewis (CA)
Lewis (GA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Owens
Oxley
Pallone
Pascrell
Pastor
Paul
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
Rangel
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Rush
Ryan (OH)
Ryan (WI)
Ryun (KS)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schakowsky
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Spratt
Stearns
Stenholm
Strickland
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thompson (MS)
Thornberry
Tiahrt
Tiberi
Tierney
Toomey
Towns
Turner (OH)
Turner (TX)
Udall (CO)
Udall (NM)
Upton
Van Hollen
Velazquez
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Waters
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Wynn
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. HASTINGS of Washington) (during the vote). There are 2 minutes remaining in this vote.

□ 0022

The SPEAKER pro tempore. On this rollcall, 421 Members have recorded their presence by electronic device, a quorum.

Under the rule, further proceedings under the call are dispensed with.

MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003

The SPEAKER pro tempore. The gentleman from Michigan (Mr. DINGELL) is recognized.

Mr. DINGELL. Mr. Speaker, I yield the balance of my time to the distinguished gentleman from Arkansas (Mr. BERRY).

The SPEAKER pro tempore. The gentleman from Arkansas is recognized for 2 minutes.

Mr. BERRY. Mr. Speaker, we are here this evening on a very serious matter. It can literally mean life or death for many of our elderly citizens. Our great Nation was founded, and has so far been successful, based on the self-evident truth in the Declaration of Independence that all men are created equal. They are endowed by their Creator with certain inalienable rights, and that among these are life, liberty, and the pursuit of happiness.

Mr. Speaker, these founding truths were followed by a firm commitment from our Founding Fathers, the last sentence in the Declaration of Independence. It says: In support of this declaration, with a firm reliance on the protection of Divine Providence, we mutually pledge to each other our lives, our fortunes, and our sacred honor.

Mr. Speaker, I think that those men would be heartbroken to see what happens here this evening. As I said earlier, the Republicans are in charge. We recognize that. You can do what you want to do. You do, and I give you credit, for publicly acknowledging that you want to destroy Medicare. You do, and I give you credit, for some of your leaders publicly acknowledging that you would put us into bankruptcy just so we can make the government smaller, so we can do away with certain social programs that you do not like. And I give you credit for that. In fact, I think some of you, and I have seen it, have publicly proclaimed you are proud of it.

My dilemma is, why would you want to do what you are trying to do tonight to the greatest generation, the men and women that went through the Depression, fought World War II, and then built this great Nation into what it is today and turned it over to my generation?

I had a cute little remark in there, but I am not going to use it because I think this is far too serious, this business we take up this evening. A government should not make poor people poorer, rich people richer. It should not create a situation where no one has to be responsible, and it should not make it possible for a person or group of persons to be able to take advantage of others because of an act of that government.

If you do what you are talking about doing, you will make that exact thing possible. You will make it possible for insurance companies and pharmaceutical companies to rob the senior citizens of this country.

The SPEAKER pro tempore. The gentlewoman from Connecticut (Mrs. JOHNSON) is recognized.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield the balance of my time to the gentleman from Texas (Mr. DELAY), the majority leader.

Mr. DELAY. Mr. Speaker, I want to commend all those that have worked so hard on probably the most important issue that most of us will vote on in our career. There is very few times that you are going to have a vote like this.

□ 0030

Mr. Speaker, the gentleman from California (Mr. THOMAS), the gentlewoman from Connecticut (Mrs. JOHNSON), the gentleman from Louisiana (Mr. TAUZIN), the members of the Committee on Ways and Means, members of the Committee on Energy and Commerce, Members know this is incredibly important. The future of our seniors, the future of our children are at stake.

Yogi Berra said when you reach a fork in the road, take it. That is sort of where we are tonight, at that fork in the road. Many of us want to take it because we know, we have witnessed Medicare being a system at the present time that is a disaster waiting to happen.

We are spending $267-plus billion a year on Medicare. Payroll taxes only pay 57 percent of that, general revenue and other taxes pay 30 percent, and premiums pay 10 percent. In less than 20 years, the payroll taxes will only cover 30 percent, the rest will come from our children and their incomes. That is on top of the fact that there is over $13 trillion in unfunded liability. In just 5 years, we will be spending over $400 billion per year on Medicare. Now some on my side of the aisle think $400 billion is a lot of money over 10 years, and giving this benefit is really expensive.

But at the same time what are we getting for this system that has been designed to bankrupt this country? What we are getting is doctors refusing to take seniors as patients. We have hospitals closing. We have costs escalating through the roof. Medicare is driving other health care costs through the roof. Seniors are having to make spending decisions based upon the cost of their health care or their drugs. This is the system they want to preserve. This is the system that they want to see continue. But many of us, both Democrats and Republicans, think that this is a time that we have an incredible opportunity.

I came here to make a difference; and, frankly, since this Republican House has been in the majority we have made an incredible difference. Some Members wanted to preserve the old welfare system. We reformed welfare. Some of our Members have commented over the last few days that entitlements are forever. No, they are not. Welfare was an entitlement, and we changed it. We stood up and led and took the responsibility to do so. Tax relief, tax reform, paying down the debt, not one time in 40 years did the other side of the aisle balance the budget, we did. They spent 40 years driving up the debt on our children, we paid over $550 billion on that debt.

So what are we faced with on this road that forks? What is the solution? The Democrats have offered their solution, and I say to Members, we get a glimpse of the future. I hope Members watched the debate on their substitute because that is a glimpse of the future if this bill does not pass.

Let me tell Members what people have said about their substitute. According to Tom Saving, who is a current Medicare trustee, the Democrat plan would lead to Medicare consuming not only all of the Medicare payroll taxes, but also more than 54 percent of all Federal income taxes by the year 2040 and over 90 percent of all Federal income taxes by the year 2075. They want to continue the plan. The Democrat plan would add between $18 trillion and $30 trillion in unfunded liabilities to the Federal Government's balance sheet. They want to preserve Medicare, and that is what it would be.

Now what is the Senate's solution? More of the same. The Senate is writing a bill over there that Senator KENNEDY is very proud of. Well, the Senate has got to do what it has got to do.

What is our solution? It has been talked about over and over again, but what we are desperately trying to do is bend that growth curve and get a handle on this and still bring good quality health care to our senior citizens by bringing market forces into play, by addressing the third party payment problem through copayments, deductibles and so forth, but give seniors the right to choose the type of health care that they think is best suited for their needs, not what some government program tells them is going to suit their needs.

We want to start us down that fork to make Medicare a viable, reliable program for generations to come. I just ask my colleagues and Democrats to vote no. What is the alternative if this bill does not pass tonight? What is the alternative? I do not know the answer to that question. I have asked that question for the 6 months that we have been working on this piece of legislation. I do not know what the alternative is, but I do know we have an opportunity.

Mr. Speaker, sometimes things are not the way you want them to be. Sometimes a bill does not have quite as many reforms as Members want. This bill does not have as many reforms as I would like to see, but it is starting us on a different path, a path of fiscal responsibility, a path that provides quality health care to our seniors, provides them choice.

A study was just done. They claim that all these private plans will not work. Our own plan, FEHBP, has been growing at a slower rate than the Medicare plan. That ought to tell Members something, when there is competitiveness in the process, costs are held down and quality is increased.

Let me tell Members, this is the beginning of something that we can be proud of. It may not be the end. We may have to change it down the line, but we need the opportunity to move this forward so we can provide a future for our children that brings sanity to this process. That is why we came here, to bring sanity to this process. I urge all Members on both sides of the aisle to join us because Medicare is too important for partisan politics.

Mr. Speaker, the American people have asked us for this. They sent us here to do this, and they deserve this approach. It is the right thing to do. It is the right time to do it, and if we fail to act now, we may never have another chance to make it right. The American people have given us this opportunity to lead; and in leadership, responsibility has to be there. We are ready to stand up and lead, and it is our job to seize that opportunity today. I just ask Members, I implore Members to vote yes for Medicare, vote yes for our seniors, vote yes for this bill.

Mr. STARK. Mr. Speaker, I yield the balance of my time to the gentlewoman from California (Ms. PELOSI), the minority leader.

Ms. PELOSI. Mr. Speaker, the distinguished majority leader who just spoke said something that I agree with. He said that this issue that we are voting on tonight is probably one of the most important issues we will vote on in our career. Mr. Leader, I quite agree.

Mr. Speaker, that is why it is hard to understand why we are taking up this debate in the dark of night when the Senate has taken up the bill for 2 weeks with the consideration of 30 amendments, to have a free and open exchange of ideas about this most important issue in our careers. And when the bill was sent to the floor in this House of Representatives for this most important issue, no amendments were allowed. Why were they not allowed, because of the fear that they might have passed and improved this Republican bill on the floor which dishonors the seniors that it pretends to support and dishonors the people who sent us to this House of Representatives by not allowing their amendments to be heard on this floor.

My leadership role afforded me the opportunity to speak at some length earlier about my concerns about the Republican bill and my preference for the Democratic bill. I had only intended to take one moment to close, but after hearing my colleagues talk about fiscal responsibility, I cannot resist the opportunity to state the facts because it is one of the mysteries of this floor, that Members can come to the floor and misrepresent the facts, and that is in order, but to call them on it is out of order. But I am going to take that risk.

The fact is that under the Clinton administration and the legislation passed in this House with 100 percent of the Democratic votes and not one Republican vote, coming out of the Clinton years we were on a path of $5.6 trillion in surplus, in surplus. In the 2½ years in the Bush administration, we are now on a path going to $3 trillion in deficit, a swing of over $8 trillion onto the national debt, and they call that fiscally sound, as they give away huge tax cuts to the 200,000 wealthiest families in America, and many of us in this room are part of that and would benefit, but not in the enlightened self-interest of this country. But for that same money,

every senior citizen in America could have a real, guaranteed, defined prescription drug benefit.

Mr. Speaker, I want to make two more points. We have had some debate; unfortunately, none of our amendments were we allowed to bring to the floor. It is late, and we usually do these things in the dark of night so the American people cannot see and cannot have the bright light of day on the debate on this floor to see what is happening to them and to their futures.

□ 0045

But I want to make just two points about the bills. The Democratic bill is a defined guaranteed benefit under Medicare. The Republican bill is not. I heard the distinguished chairman of the Committee on the Budget speak about the cost of the Democratic bill. The Democratic bill cost would be in half if the Republicans would allow the Secretary of HHS to negotiate for best prices. That provision is in the Democratic bill. It makes sense, right? Forty million seniors, lots of purchasing power, lots of leverage. It makes sense. Not to the Republicans. Their bill has a prohibition on the Secretary negotiating for best prices. A prohibition.

I think there are many questions about the Republican bill. It is very complex. But as seniors look at it and they ask those questions, I think there is one question that every American should have: Why do the Republicans have a prohibition on the Secretary negotiating for the best possible price, reducing the cost of prescription drugs to seniors and to the American taxpayer? Why? I will tell you why. Because tonight we have a debate between the special interests and the public interest. The Democrats have come to this floor as servants of the people. The Republicans have come to this floor as handmaidens of the prescription drug industry.

I urge my colleagues to support this amendment and oppose the Republican bill.

Mr. TAUZIN. Mr. Speaker, in order to close this historic debate, I yield the balance of my time to the gentleman from Illinois (Mr. HASTERT), the distinguished Speaker of our whole House.

Mr. HASTERT. Mr. Speaker, the hour is late. We have had a lot of rhetoric. We have had a lot of flailing of arms and pointing fingers across the aisle. It is time for us to come to a reasoned decision. It is time for us to look at all the debate that we have had, to look at the facts. I guess I could be suckered into a debate about fiscal responsibility over the past years, votes we have had and votes we did not have. But the fact is we have a very important bill on the floor of this House tonight, a bill that probably will reach into every American household and give people decisions and benefits on how they are going to take care of their mothers and their fathers and the elderly people that they hold dear.

I want to salute those folks who worked hard on both sides of the aisle to carry on this debate. I thank the gentleman from California (Mr. THOMAS) and the gentleman from Louisiana (Mr. TAUZIN). I am grateful for their hard work. I have worked on health care issues in this Congress for more than a decade. When you compare me to the great gentleman from Michigan, that is probably not very much time. But Bob Michel put me on Mrs. CLINTON's health care task force back in 1993 and Newt Gingrich asked me to deal with the issue of health insurance portability in 1995 and we did that. In every Congress that I have presided as Speaker, this House has passed a prescription drug benefit as part of an effort to modernize Medicare. Today, we have a chance to take a most dramatic step in health care reform, the most dramatic step we have taken in 25 years.

Some of my friends on the other side of the aisle say that we do not spend enough. That is not surprising, because they think that $1 trillion over $400 billion is better over a 10-year period of time. Some of my friends on this side of the aisle believe we spend too much. That is not surprising, either, given their philosophical beliefs. But this bill spends what we can afford to spend. We cannot afford to ignore this issue this year. We on both sides of the aisle have held out a promise to America's seniors that we will give them an opportunity to have a prescription drug benefit and a new modern Medicare. Ladies and gentlemen, we hold out this promise. Tonight is the night that we have an opportunity to fulfill that promise.

In a sense, this is the best of times and the worst of times when it comes to health care in this country. We have the finest doctors. We have the best hospitals. We have people who are uninsured. But we also have the cutting-edge issues and lifesaving prescription drugs. We also have skyrocketing costs. And we have too many people who are uninsured. And we have drugs that for some folks are just too expensive. Last week, we passed legislation to deal with the uninsured when we passed association health plans. Today we deal with the cost issues of health care. Earlier today we passed a health savings account bill which puts the consumer in the driver's seat in driving down costs. And now, in this bill, we make Medicare work better for senior citizens. A Medicare program that does not include a prescription drug benefit is not serving America's seniors well.

When Medicare was first conceived in the 1960s, it was at its heart a program with the costs of going to hospitals and going to doctors. Back then, prescription drugs were not used to the extent they are today. You got an aspirin once in a while, but they just did not play the role they play today. Today because of advancements made over the last 30 years and the R&D we have done in this country, we have drugs that help us stay out of the hospital, we have drugs to help with cholesterol, we have drugs that help us with diabetes, with arthritis, with high blood pressure, on and on and on. And there are lifesaving drugs.

Seniors should have better access at a better price to these drugs through the Medicare system. This bill makes that happen. It will cut drug costs by an average of 37 percent for the average senior. It also includes catastrophic coverage so that no senior with high drug costs will be forced into bankruptcy. This is a compassionate program for senior citizens.

This bill also includes conservative reforms to make sure that Medicare stays solvent. We cannot allow the Medicare system to continue to grow so large that it actually bankrupts this country. We must introduce market-based reforms that lead to greater choices for seniors and greater competition among providers. I agree with the proposition that an 80-year-old grandmother should not be forced into a PPO simply because she gets a prescription drug benefit. But I also agree that a 50-year-old father who has health care choices throughout his whole working career will feel comfortable shopping around for the best health care plan for his individual needs when he qualifies for Medicare. Competition, choice, the marketplace, these are the concepts which will save Medicare for the coming decades.

Mr. Speaker, I urge my colleagues on both sides of the aisle to support this bill. This is a defining moment for this Congress. It is too late for obstruction. It is too late for nit-picking. It is too late for all the lame excuses that we often hear. Senior citizens will long remember if you voted for them today, but they will never forget if you voted against them.

Ladies and gentlemen, not many times in this great hall do we have a piece of legislation when all the forces come together and we have an opportunity to make real change. We have that opportunity tonight. I ask you to vote to provide senior citizens with a better Medicare system and a real prescription drug benefit.

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

Pursuant to House Resolution 299, the previous question is ordered on the bill and on the amendment in the nature of a substitute offered by the gentleman from New York (Mr. RANGEL).

The question is on the amendment in the nature of a substitute offered by the gentleman from New York (Mr. RANGEL).

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

RECORDED VOTE

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

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 175, noes 255, answered ''present'' 1, not voting 4, as follows:

[Roll No. 330]

AYES—175

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

NOES—255

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

ANSWERED ''PRESENT''—1

Baird

NOT VOTING—4

LaTourette
McInnis
Smith (WA)
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

□ 0112

Messrs. BACHUS, COSTELLO, and LIPINSKI changed their vote from ''aye'' to ''no.''

So the amendment in the nature of a substitute was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the 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. THOMPSON OF CALIFORNIA

Mr. THOMPSON of California. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. THOMPSON of California. Yes, I am, Mr. Speaker, in its present form.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

MOTION TO RECOMMIT WITH INSTRUCTIONS

Mr. THOMPSON of California moves to recommit the bill H.R. 1 jointly to the Committee on Ways and Means and the Committee on Energy and Commerce with instructions to report the same back to the House promptly with the following amendments:

Strike all after the enacting clause and insert the following:

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

(a) SHORT TITLE.—This Act may be cited as the ''Prescription Drug and Medicare Improvement Act of 2003''.

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

(c) BIPA; SECRETARY.—In this Act:

(1) BIPA.—The term ''BIPA'' means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 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

Subtitle A—Medicare Voluntary Prescription Drug Delivery Program

Sec. 101. Medicare voluntary prescription drug delivery program.

''PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

''Sec. 1860D. Definitions; treatment of references to provisions in MedicareAdvantage program.

''Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

''Sec. 1860D–1. Establishment of voluntary prescription drug delivery program.

''Sec. 1860D–2. Enrollment under program.

''Sec. 1860D–3. Election of a Medicare Prescription Drug plan.

''Sec. 1860D–4. Providing information to beneficiaries.

''Sec. 1860D–5. Beneficiary protections.

''Sec. 1860D–6. Prescription drug benefits.

''Sec. 1860D–7. Requirements for entities offering Medicare Prescription Drug plans; establishment of standards.

''Subpart 2—Prescription Drug Delivery System

''Sec. 1860D–10. Establishment of service areas.

''Sec. 1860D–11. Publication of risk adjusters.

''Sec. 1860D–12. Submission of bids for proposed Medicare Prescription Drug plans.

''Sec. 1860D–13. Approval of proposed Medicare Prescription Drug plans.

''Sec. 1860D–14. Computation of monthly standard prescription drug coverage premiums.

''Sec. 1860D–15. Computation of monthly national average premium.
''Sec. 1860D–16. Payments to eligible entities.
''Sec. 1860D–17. Computation of monthly beneficiary obligation.
''Sec. 1860D–18. Collection of monthly beneficiary obligation.
''Sec. 1860D–19. Premium and cost-sharing subsidies for low-income individuals.
''Sec. 1860D–20. Reinsurance payments for expenses incurred in providing prescription drug coverage above the annual out-of-pocket threshold.
''Sec. 1860D–21. Direct subsidy for sponsor of a qualified retiree prescription drug plan for plan enrollees eligible for, but not enrolled in, this part.
''Subpart 3—Miscellaneous Provisions
''Sec. 1860D–25. Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund.
''Sec. 1860D–26. Other related provisions.
Sec. 102. Study and report on permitting part B only individuals to enroll in medicare voluntary prescription drug delivery program.
Sec. 103. Rules relating to medigap policies that provide prescription drug coverage.
Sec. 104. Medicaid and other amendments related to low-income beneficiaries.
Sec. 105. Expansion of membership and duties of Medicare Payment Advisory Commission (MedPAC).
Sec. 106. Study regarding variations in spending and drug utilization.
Subtitle B—Medicare Prescription Drug Discount Card and Transitional Assistance for Low-Income Beneficiaries
Sec. 111. Medicare prescription drug discount card and transitional assistance for low-income beneficiaries.
Subtitle C—Standards for Electronic Prescribing
Sec. 121. Standards for electronic prescribing.
TITLE II—MEDICAREADVANTAGE
Subtitle A—MedicareAdvantage Competition
Sec. 201. Eligibility, election, and enrollment.
Sec. 202. Benefits and beneficiary protections.
Sec. 203. Payments to MedicareAdvantage organizations.
Sec. 204. Submission of bids; premiums.
Sec. 205. Special rules for prescription drug benefits.
Sec. 206. Facilitating employer participation.
Sec. 207. Administration by the Center for Medicare Choices.
Sec. 208. Conforming amendments.
Sec. 209. Effective date.
Subtitle B—Preferred Provider Organizations
Sec. 211. Establishment of MedicareAdvantage preferred provider program option.
Subtitle C—Other Managed Care Reforms
Sec. 221. Extension of reasonable cost contracts.
Sec. 222. Specialized Medicare+Choice plans for special needs beneficiaries.
Sec. 223. Payment by PACE providers for medicare and medicaid services furnished by noncontract providers.
Sec. 224. Institute of Medicine evaluation and report on health care performance measures.
Sec. 225. Expanding the work of medicare quality improvement organizations to include parts C and D.
TITLE III—CENTER FOR MEDICARE CHOICES
Sec. 301. Establishment of the Center for Medicare Choices.
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TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

Subtitle A—Medicare Voluntary Prescription Drug Delivery Program

SEC. 101. MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.

(a) ESTABLISHMENT.—Title XVIII (42 U.S.C. 1395 et seq.) is amended by redesignating part D as part E and by inserting after part C the following new part:

''PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

''DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN MEDICAREADVANTAGE PROGRAM

''SEC. 1860D. (a) DEFINITIONS.—In this part:

''(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Center for Medicare Choices as established under section 1808.

''(2) COVERED DRUG.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), and (D), the term 'covered drug' means—

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

''(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section; or

''(iii) 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 drug for a medically accepted indication (as defined in section 1927(k)(6)).

''(B) EXCLUSIONS.—

''(i) IN GENERAL.—The term 'covered drug' 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).

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B, but shall be so considered if such payment is not available under part A or B or because benefits under such parts have been exhausted.

''(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered 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 resolved under subsection (d) or (e)(2) of section 1860D–5.

''(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A Medicare Prescription Drug plan or a MedicareAdvantage plan may exclude from qualified prescription drug coverage any covered drug—

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

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

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860D–5(e).

''(3) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A and enrolled under part B.

''(4) ELIGIBLE ENTITY.—The term 'eligible entity' means any risk-bearing entity that the Administrator determines to be appropriate to provide eligible beneficiaries with the benefits under a Medicare Prescription Drug plan, including—

''(A) a pharmaceutical benefit management company;

''(B) a wholesale or retail pharmacist delivery system;

''(C) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

''(D) any other risk-bearing entity; or

''(E) any combination of the entities described in subparagraphs (A) through (D).

''(5) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means the limit as established under section 1860D–6(c)(3), or, in the case of coverage that is not standard prescription drug coverage, the comparable limit (if any) established under the coverage.

''(6) MEDICAREADVANTAGE ORGANIZATION; MEDICAREADVANTAGE PLAN.—The terms 'MedicareAdvantage organization' and 'MedicareAdvantage plan' have the meanings given such terms in subsections (a)(1) and (b)(1), respectively, of section 1859 (relating to definitions relating to MedicareAdvantage organizations).

''(7) MEDICARE PRESCRIPTION DRUG PLAN.—The term 'Medicare Prescription Drug plan' means prescription drug coverage that is offered under a policy, contract, or plan—

''(A) that has been approved under section 1860D–13; and

''(B) by an eligible entity pursuant to, and in accordance with, a contract between the Administrator and the entity under section 1860D–7(b).

''(8) PRESCRIPTION DRUG ACCOUNT.—The term 'Prescription Drug Account' means the Prescription Drug Account (as established under section 1860D–25) in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(9) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' means the coverage described in section 1860D–6(a)(1).

''(10) STANDARD PRESCRIPTION DRUG COVERAGE.—The term 'standard prescription drug coverage' means the coverage described in section 1860D–6(c).

''(b) APPLICATION OF MEDICARE ADVANTAGE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a Medicare Prescription Drug plan and an eligible entity, unless otherwise provided in this part such provisions shall be applied as if—

''(1) any reference to a MedicareAdvantage plan included a reference to a Medicare Prescription Drug plan;

''(2) any reference to a provider-sponsored organization included a reference to an eligible entity;

''(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D–7(b); and

''(4) any reference to part C included a reference to this part.

''Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

''ESTABLISHMENT OF VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

''SEC. 1860D–1. (a) PROVISION OF BENEFIT.—

''(1) IN GENERAL.—The Administrator shall provide for and administer a voluntary prescription drug delivery program under which

each eligible beneficiary enrolled under this part shall be provided with access to qualified prescription drug coverage as follows:

''(A) MEDICAREADVANTAGE ENROLLEES RECEIVE COVERAGE THROUGH MEDICAREADVANTAGE PLAN.—

''(i) IN GENERAL.—Except as provided in clause (ii), an eligible beneficiary who is enrolled under this part and enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization shall receive coverage of benefits under this part through such plan.

''(ii) EXCEPTION FOR ENROLLEES IN MEDICAREADVANTAGE MSA PLANS.—An eligible beneficiary who is enrolled under this part and enrolled in an MSA plan under part C shall receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides. For purposes of this part, the term 'MSA plan' has the meaning given such term in section 1859(b)(3).

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

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

''(ii) if the plan does not provide qualified prescription drug coverage, receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides. For purposes of this part, the term 'private fee-for-service plan' has the meaning given such term in section 1859(b)(2).

''(B) FEE-FOR-SERVICE ENROLLEES RECEIVE COVERAGE THROUGH A MEDICARE PRESCRIPTION DRUG PLAN.—An eligible beneficiary who is enrolled under this part but is not enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) shall receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides.

''(2) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

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

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

''(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG COVERAGE.—In the case of an eligible beneficiary who has creditable prescription drug coverage (as defined in section 1860D–2(b)(1)(F)), such beneficiary—

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

''(2) pursuant to section 1860D–2(b)(1)(C), is permitted to subsequently enroll under this part without any penalty and obtain access to qualified prescription drug coverage in the manner described in subsection (a) if the beneficiary involuntarily loses such coverage.

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

''ENROLLMENT UNDER PROGRAM

''SEC. 1860D–2. (a) ESTABLISHMENT OF ENROLLMENT PROCESS.—

''(1) PROCESS SIMILAR TO PART B ENROLLMENT.—The Administrator shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization) may make an election to enroll under this part. Such process shall be similar to the process for enrollment in part B under section 1837, including the deeming provisions of such section.

''(2) CONDITION OF ENROLLMENT.—An eligible beneficiary must be enrolled under this part in order to be eligible to receive access to qualified prescription drug coverage.

''(b) SPECIAL ENROLLMENT PROCEDURES.—

''(1) LATE ENROLLMENT PENALTY.—

''(A) INCREASE IN MONTHLY BENEFICIARY OBLIGATION.—Subject to the succeeding provisions of this paragraph, in the case of an eligible beneficiary whose coverage period under this part began pursuant to an enrollment after the beneficiary's initial enrollment period under part B (determined pursuant to section 1837(d)) and not pursuant to the open enrollment period described in paragraph (2), the Administrator shall establish procedures for increasing the amount of the monthly beneficiary obligation under section 1860D–17 applicable to such beneficiary by an amount that the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under this part but was not so enrolled.

''(B) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under subparagraph (A), there shall be taken into account—

''(i) the months which elapsed between the close of the eligible beneficiary's initial enrollment period and the close of the enrollment period in which the beneficiary enrolled; and

''(ii) in the case of an eligible beneficiary who reenrolls under this part, the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which the beneficiary reenrolled.

''(C) PERIODS NOT TAKEN INTO ACCOUNT.—

''(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 eligible beneficiary can demonstrate that the beneficiary had creditable prescription drug coverage (as defined in subparagraph (F)).

''(ii) BENEFICIARY MUST INVOLUNTARILY LOSE COVERAGE.—Clause (i) shall only apply with respect to coverage—

''(I) in the case of coverage described in clause (ii) of subparagraph (F), if the plan terminates, ceases to provide, or reduces the value of the prescription drug coverage under such plan to below the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f));

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

''(III) in the case of a beneficiary with coverage described in clause (v) of subparagraph (F), if the issuer of the policy terminates coverage under the policy.

''(D) PERIODS TREATED SEPARATELY.—Any increase in an eligible beneficiary's monthly beneficiary obligation under subparagraph (A) with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which the beneficiary may have.

''(E) CONTINUOUS PERIOD OF ELIGIBILITY.—

''(i) IN GENERAL.—Subject to clause (ii), for purposes of this paragraph, an eligible beneficiary's 'continuous period of eligibility' is the period that begins with the first day on which the beneficiary is eligible to enroll under section 1836 and ends with the beneficiary's death.

''(ii) SEPARATE PERIOD.—Any period during all of which an eligible beneficiary satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which the beneficiary attained age 65 shall be a separate 'continuous period of eligibility' with respect to the beneficiary (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this paragraph).

''(F) CREDITABLE PRESCRIPTION DRUG COVERAGE DEFINED.—Subject to subparagraph (G), for purposes of this part, the term 'creditable prescription drug coverage' means any of the following:

''(i) DRUG-ONLY COVERAGE UNDER MEDICAID.—Coverage of covered outpatient drugs (as defined in section 1927) under title XIX through a waiver under 1115 where covered outpatient drugs are the sole medical assistance benefit.

''(ii) PRESCRIPTION DRUG COVERAGE UNDER A GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under chapter 89 of title 5, United States Code (commonly known as the Federal employees health benefits program), and a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)).

''(iii) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program.

''(iv) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans, and survivors and dependents of veterans, under chapter 17 of title 38, United States Code.

''(v) PRESCRIPTION DRUG COVERAGE UNDER 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)).

''(G) REQUIREMENT FOR CREDITABLE COVERAGE.—Coverage described in clauses (i) through (v) of subparagraph (F) shall not be considered to be creditable coverage under this part unless the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)).

''(H) DISCLOSURE.—

''(i) IN GENERAL.—Each entity that offers coverage of the type described in clause (ii) (iii), (iv), or (v) of subparagraph (F) shall provide for disclosure, consistent with standards established by the Administrator, of whether the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)).

''(ii) WAIVER OF LIMITATIONS.—An individual may apply to the Administrator to waive the application of subparagraph (G) if the individual establishes that the individual was not adequately informed that the coverage the beneficiary was enrolled in did not provide the level of benefits required in order for the coverage to be considered creditable coverage under subparagraph (F).

''(2) INITIAL ELECTION PERIODS.—

''(A) OPEN ENROLLMENT PERIOD FOR CURRENT BENEFICIARIES IN WHICH LATE ENROLLMENT PROCEDURES DO NOT APPLY.—In the case of an individual who is an eligible beneficiary as of November 1, 2005, there shall be an open enrollment period of 6 months beginning on that date under which such beneficiary may enroll under this part without the application of the late enrollment procedures established under paragraph (1)(A).

''(B) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who becomes an eligible beneficiary after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

''(3) SPECIAL ENROLLMENT PERIOD FOR BENEFICIARIES WHO INVOLUNTARILY LOSE CREDITABLE PRESCRIPTION DRUG COVERAGE.—

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

''(B) SPECIAL OPEN ENROLLMENT PERIOD.—The special open enrollment period described in this subparagraph is the 63-day period that begins on—

''(i) in the case of a beneficiary with coverage described in clause (ii) of paragraph (1)(F), the later of the date on which the plan terminates, ceases to provide, or substantially reduces (as defined by the Administrator) the value of the prescription drug coverage under such plan or the date the beneficiary is provided with notice of such termination or reduction;

''(ii) in the case of a beneficiary with coverage described in clause (i), (iii), or (iv) of paragraph (1)(F), the later of the date on which the beneficiary is involuntarily disenrolled or becomes ineligible for such coverage or the date the beneficiary is provided with notice of such loss of eligibility; or

''(iii) in the case of a beneficiary with coverage described in clause (v) of paragraph (1)(F), the latter of the date on which the issuer of the policy terminates coverage under the policy or the date the beneficiary is provided with notice of such termination.

''(c) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as provided in paragraph (2) and subject to paragraph (3), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

''(2) OPEN AND SPECIAL ENROLLMENT.—

''(A) OPEN ENROLLMENT.—An eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(2) shall be entitled to the benefits under this part beginning on January 1, 2006.

''(B) SPECIAL ENROLLMENT.—Subject to paragraph (3), an eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(3) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

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

''(d) TERMINATION.—

''(1) IN GENERAL.—The causes of termination specified in section 1838 shall apply to this part in the same manner as such causes apply to part B.

''(2) COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PART A OR B.—

''(A) IN GENERAL.—In addition to the causes of termination specified in paragraph (1), the Administrator shall terminate an individual's coverage under this part if the individual is no longer enrolled in both parts A and B.

''(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of termination of coverage under part A or (if earlier) under part B.

''(3) PROCEDURES REGARDING TERMINATION OF A BENEFICIARY UNDER A PLAN.—The Administrator shall establish procedures for determining the status of an eligible beneficiary's enrollment under this part if the beneficiary's enrollment in a Medicare Prescription Drug plan offered by an eligible entity under this part is terminated by the entity for cause (pursuant to procedures established by the Administrator under section 1860D–3(a)(1)).

''ELECTION OF A MEDICARE PRESCRIPTION DRUG PLAN

''SEC. 1860D–3. (a) IN GENERAL.—

''(1) PROCESS.—

''(A) ELECTION.—

''(i) IN GENERAL.—The Administrator shall establish a process through which an eligible beneficiary who is enrolled under this part but not enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) offered by a MedicareAdvantage organization—

''(I) shall make an election to enroll in any Medicare Prescription Drug plan that is offered by an eligible entity and that serves the geographic area in which the beneficiary resides; and

''(II) may make an annual election to change the election under this clause.

''(ii) CLARIFICATION REGARDING ENROLLMENT.—The process established under clause (i) shall include, in the case of an eligible beneficiary who is enrolled under this part but who has failed to make an election of a Medicare Prescription Drug plan in an area, for the enrollment in any Medicare Prescription Drug plan that has been designated by the Administrator in the area. The Administrator shall establish a process for designating a plan or plans in order to carry out the preceding sentence.

''(B) REQUIREMENTS FOR PROCESS.—In establishing the process under subparagraph (A), the Administrator shall—

''(i) use rules similar to the rules for enrollment, disenrollment, and termination of enrollment with a MedicareAdvantage plan under section 1851, including—

''(I) the establishment of special election periods under subsection (e)(4) of such section; and

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

''(ii) coordinate enrollments, disenrollments, and terminations of enrollment under part C with enrollments, disenrollments, and terminations of enrollment under this part.

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

''(b) ENROLLMENT IN A MEDICAREADVANTAGE PLAN.—

''(1) IN GENERAL.—An eligible beneficiary who is enrolled under this part and enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) offered by a MedicareAdvantage organization shall receive access to such coverage under this part through such plan.

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

''(c) INFORMATION TO ENTITIES TO FACILITATE ENROLLMENT.—Notwithstanding any other provision of law, the Administrator may provide to each eligible entity with a contract under this part such information about eligible beneficiaries as the Administrator determines to be necessary to facilitate efficient enrollment by such beneficiaries with such entities. The Administrator may provide such information only so long as and to the extent necessary to carry out such objective.

''PROVIDING INFORMATION TO BENEFICIARIES

''SEC. 1860D–4. (a) ACTIVITIES.—

''(1) IN GENERAL.—The Administrator shall conduct activities that are designed to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding the coverage provided under this part.

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

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—The activities described in subsection (a) shall—

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

''(B) be coordinated with the activities performed by—

''(i) the Administrator under such section; and

''(ii) the Secretary under section 1804; and

''(C) provide for the dissemination of information comparing the plans offered by eligible entities under this part that are available to eligible beneficiaries residing in an area.

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

''(A) BENEFITS.—The benefits provided under the plan and the formularies and grievance and appeals processes under the plan.

''(B) MONTHLY BENEFICIARY OBLIGATION.—The monthly beneficiary obligation under the plan.

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

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

''(E) CONSUMER SATISFACTION SURVEYS.—The results of consumer satisfaction surveys regarding the plan and the eligible entity offering such plan (conducted pursuant to section 1860D–5(h).

''(F) ADDITIONAL INFORMATION.—Such additional information as the Administrator may prescribe.

''BENEFICIARY PROTECTIONS

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

''(1) GENERAL INFORMATION.—An eligible entity offering a Medicare Prescription Drug plan shall disclose, in a clear, accurate, and standardized form to each enrollee 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 drugs, including access through pharmacy networks.

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

''(C) Copayments, coinsurance, and deductible requirements.

''(D) Grievance and appeals processes.

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

''(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll in a Medicare Prescription Drug plan, the eligible entity offering such plan shall provide information similar (as determined by the Administrator) to the information described in subparagraphs (A), (B), and (C) of section 1852(c)(2) to such individual.

''(3) RESPONSE TO BENEFICIARY QUESTIONS.—An eligible entity offering a Medicare Prescription Drug plan shall have a mechanism for providing on a timely basis specific information to enrollees upon request, including information on the coverage of specific drugs and changes in its formulary.

''(4) CLAIMS INFORMATION.—An eligible entity offering a Medicare Prescription Drug plan must furnish to enrolled individuals in a form easily understandable to such individuals—

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

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

''(5) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The provisions of section 1851(h) shall apply to marketing material and application forms under this part in the same manner as such provisions apply to marketing material and application forms under part C.

''(b) ACCESS TO COVERED DRUGS.—

''(1) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—An eligible entity offering a Medicare Prescription Drug plan shall have in place procedures to ensure that beneficiaries are not charged more than the negotiated price of a covered drug. Such procedures shall include the issuance of a card (or other technology) that may be used by an enrolled beneficiary for the purchase of prescription drugs for which coverage is not otherwise provided under the Medicare Prescription Drug plan.

''(2) ASSURING PHARMACY ACCESS.—

''(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Administrator and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established by the Administrator under section 1860D–7(g) that ensure such convenient access. Such standards shall take into account reasonable distances to pharmacy services in both urban and rural areas.

''(B) USE OF POINT-OF-SERVICE SYSTEM.—An eligible entity offering a Medicare Prescription Drug plan shall establish an optional point-of-service method of operation under which—

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

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

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

''(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity offering a Medicare Prescription Drug plan uses a formulary, the following requirements must be met:

''(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

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

''(ii) COMPOSITION.—A pharmacy and therapeutic committee shall include at least 1 academic expert, at least 1 practicing physician, and at least 1 practicing pharmacist, all of whom have expertise in the care of elderly or disabled persons, and a majority of the members of such committee shall consist of individuals who are 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 on such other information as the committee determines to be appropriate.

''(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES AND CLASSES.—

''(i) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered drugs (as defined by the Administrator), although not necessarily for all drugs within such categories and classes.

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

''(I) the compendia referred to section 1927(g)(1)(B)(i); and

''(II) other recognized sources of drug classifications and categorizations determined appropriate by the Administrator.

''(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, physicians, and pharmacists.

''(F) APPEALS AND EXCEPTIONS TO APPLICATION.—The eligible entity must have, as part of the appeals process under subsection (e), a process for timely appeals for denials of coverage based on such application of the formulary.

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

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

''(A) A cost-effective drug utilization management program, including incentives to reduce costs when appropriate.

''(B) Quality assurance measures to reduce medical errors and adverse drug interactions and to improve medication use, which—

''(i) shall include a medication therapy management program described in paragraph (2); and

''(ii) may include beneficiary education programs, counseling, medication refill reminders, and special packaging.

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

Nothing in this section shall be construed as impairing an eligible entity 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, hyperlipidemia, and congestive heart failure) or multiple prescriptions, that covered drugs under the Medicare Prescription Drug plan are appropriately used to optimize therapeutic outcomes through improved medication use and 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 eligible entity offering a Medicare Prescription Drug plan 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) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—The eligible entity offering a Medicare Prescription Drug plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

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

''(1) IN GENERAL.—An eligible entity shall provide meaningful procedures for hearing and resolving grievances between the eligible entity (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with Medicare Prescription Drug plans of the eligible entity under this part in accordance with section 1852(f).

''(2) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—The requirements of paragraphs (1) through (3) of section 1852(g) shall apply to an eligible entity with respect to covered benefits under the Medicare Prescription Drug plan it offers under this part in the same manner as such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

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

''(e) APPEALS.—

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

''(2) FORMULARY DETERMINATIONS.—An individual who is enrolled in a Medicare Prescription Drug plan offered by an eligible entity may appeal to obtain coverage for a covered drug that is not on a formulary of the entity under the terms applicable for a formulary drug 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.

''(f) PRIVACY, CONFIDENTIALITY, AND ACCURACY OF ENROLLEE RECORDS.—Insofar as an eligible entity maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in the Medicare Prescription Drug plan offered by the entity, the entity shall have in place procedures to—

''(1) safeguard the privacy of any individually identifiable beneficiary information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996;

''(2) maintain such records and information in a manner that is accurate and timely;

''(3) ensure timely access by such beneficiaries to such records and information; and

''(4) otherwise comply with applicable laws relating to patient privacy and confidentiality.

''(g) UNIFORM MONTHLY PLAN PREMIUM.—An eligible entity shall ensure that the monthly plan premium for a Medicare Prescription Drug plan charged under this part is the same for all eligible beneficiaries enrolled in the plan.

''(h) CONSUMER SATISFACTION SURVEYS.—An eligible entity shall conduct consumer satisfaction surveys with respect to the plan and the entity. The Administrator shall establish uniform requirements for such surveys.

''PRESCRIPTION DRUG BENEFITS

''SEC. 1860D–6. (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 PRESCRIPTION DRUG COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard prescription drug coverage (as defined in subsection (c)) and access to negotiated prices under subsection (e).

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

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

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

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

''(3) COST CONTROL MECHANISMS.—In providing qualified prescription drug coverage, the entity offering the Medicare Prescription Drug plan or the MedicareAdvantage plan may use a variety of cost control mechanisms, including the use of formularies, tiered copayments, selective contracting with providers of prescription drugs, and mail order pharmacies.

''(b) 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.

''(c) STANDARD PRESCRIPTION DRUG COVERAGE.—For purposes of this part and part C, the term 'standard prescription drug coverage' means coverage of covered drugs that meets the following requirements:

''(1) DEDUCTIBLE.—

''(A) IN GENERAL.—The coverage has an annual deductible—

''(i) for 2006, that is equal to $275; or

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

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

''(2) LIMITS ON COST-SHARING.—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)) that is equal to 50 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 50 percent of such costs.

''(3) INITIAL COVERAGE LIMIT.—

''(A) IN GENERAL.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (including the annual deductible)—

''(i) for 2006, that is equal to $4,500; or

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

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

''(4) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARY.—

''(A) IN GENERAL.—The coverage provides benefits with cost-sharing that is equal to 20 percent after the individual has incurred costs (as described in subparagraph (C)) for covered drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET LIMIT.—

''(i) IN GENERAL.—For purposes of this part, the 'annual out-of-pocket limit' specified in this subparagraph—

''(I) for 2006, 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.

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

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

''(i) incurred costs shall only include costs incurred, with respect to covered drugs, 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) (including costs incurred for covered drugs described in section 1860D(a)(2)(C)); and

''(ii) such costs shall be treated as incurred without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such costs, except that only the applicable percent (specified in subparagraph (D)) of the amount of portion of such costs that are paid or reimbursed through insurance, a group health plan, or other third-party payment arrangement for such costs shall not be counted.

''(D) APPLICABLE PERCENT DEFINED.—

''(i) IN GENERAL.—For purposes of subparagraph (C)(ii), but subject to clause (ii), the applicable percent specified in this subparagraph is—

''(I) for years before 2010, 20 percent;

''(II) for 2011, 2012, 2013, 2014, and 2015, 40 percent; and

''(III) for any year thereafter, 100 percent.

''(ii) SECRETARIAL LIMITATION ON TOTAL EXPENDITURES.—The Secretary, in consultation with the Office of Management and Budget, shall estimate at the time of enactment of this part, the aggregate budget outlays that will result during the 10-fiscal-year period beginning with fiscal year 2004 from the enactment of the Prescription Drug and Medicare Improvement Act of 2003. If such estimate exceeds $393,000,000,000, the Secretary shall provide for such proportional reductions in the percentages specified in clause (i) as the Secretary determines to be necessary to assure that such aggregate budget outlays during such period do not exceed such amount.

''(E) INFORMATION REGARDING THIRD-PARTY REIMBURSEMENT.—In order to ensure compliance with the requirements of subparagraph (C)(ii), the Administrator is authorized to establish procedures, in coordination with the Secretary of Treasury and the Secretary of Labor, for determining whether costs for individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement, and for alerting the entities in which such individuals are enrolled about such reimbursement arrangements. An entity with a contract under this part may also periodically ask individuals enrolled in a plan offered by the entity whether the individuals have or expect to receive such third-party reimbursement. A material misrepresentation of the information described in the preceding sentence by an individual (as defined in standards set by the Administrator and determined through a process established by the Administrator) shall constitute grounds for termination of enrollment under section 1860D–2(d).

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

''(d) ALTERNATIVE COVERAGE REQUIREMENTS.—A Medicare Prescription Drug plan or MedicareAdvantage plan may provide a different prescription drug benefit design from the standard prescription drug coverage described in subsection (c) 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 PRESCRIPTION DRUG COVERAGE.—

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

''(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard prescription drug coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (f)) exceeds the actuarial value of the amounts associated with the application of section 1860D–17(c) and reinsurance payments under section 1860D–20 with respect to such coverage.

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

''(i) such initial coverage limit minus the deductible under subsection (c)(1); and

''(ii) the percentage specified in subsection (c)(2).

Benefits other than qualified prescription drug coverage shall not be taken into account for purposes of this paragraph.

''(2) DEDUCTIBLE AND LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARIES MAY NOT VARY.—The coverage may not vary the deductible under subsection (c)(1) for the year or the limitation on out-of-pocket expenditures by beneficiaries described in subsection (c)(4) for the year.

''(e) ACCESS TO NEGOTIATED PRICES.—

''(1) ACCESS.—

''(A) IN GENERAL.—Under qualified prescription drug coverage offered by an eligible entity or a MedicareAdvantage organization, the entity or organization shall provide beneficiaries with access to negotiated prices used for payment for covered drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of the deductible, any cost-sharing, or an initial coverage limit (described in subsection (c)(3)). For purposes of this part, the term 'negotiated prices' includes all discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations and shall reflect prices that are no higher than the prices negotiated by the Secretary under subparagraph (B).

''(B) SECRETARIAL NEGOTIATED PRICE.—Notwithstanding any other provision of this part, 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 drugs that provide for the maximum prices that may be charged to individuals enrolled under this part by participating pharmacies for dispensing such drugs to such individuals.

''(C) MEDICAID RELATED PROVISIONS.—Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated under a Medicare Prescription Drug plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated under a Medicare Prescription Drug plan with respect to covered drugs, under a MedicareAdvantage plan with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)) with respect to such drugs, on behalf of eligible beneficiaries, 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) CARDS OR OTHER TECHNOLOGY.—

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

''(B) NATIONAL STANDARDS.—

''(i) DEVELOPMENT.—The Administrator shall provide for the development of national standards relating to a standardized format for the card or other technology required under subparagraph (A). Such standards shall be compatible with parts C and D of title XI and may be based on standards developed by an appropriate standard setting organization.

''(ii) CONSULTATION.—In developing the standards under clause (i), the Administrator shall consult with the National Council for Prescription Drug Programs and other standard-setting organizations determined appropriate by the Administrator.

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

''(3) DISCLOSURE.—The eligible entity offering a Medicare Prescription Drug plan and the MedicareAdvantage organization offering a MedicareAdvantage plan shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made available to the entity 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.

''(4) AUDITS AND REPORTS.—To protect against fraud and abuse and to ensure proper disclosures and accounting under this part, in addition to any protections against fraud and abuse provided under section 1860D–7(f)(1), the Administrator may periodically audit the financial statements and records of an eligible entity offering a Medicare Prescription Drug plan and a MedicareAdvantage organization offering a MedicareAdvantage plan.

''(f) 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 prescription drug coverage and of the reinsurance payments under section 1860D–20;

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

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

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

Such processes shall take into account any effect that providing actuarially equivalent prescription drug coverage rather than standard prescription drug coverage has on drug utilization.

''(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), eligible entities and MedicareAdvantage 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).

''REQUIREMENTS FOR ENTITIES OFFERING MEDICARE PRESCRIPTION DRUG PLANS; ESTABLISHMENT OF STANDARDS

''SEC. 1860D–7. (a) GENERAL REQUIREMENTS.—An eligible entity offering a Medicare Prescription Drug plan shall meet the following requirements:

''(1) LICENSURE.—Subject to subsection (c), the entity 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 Medicare Prescription Drug plan.

''(2) ASSUMPTION OF FINANCIAL RISK.—

''(A) IN GENERAL.—Subject to subparagraph (B) and subsections (d)(2) and (e) of section 1860D–13, to the extent that the entity is at risk pursuant to such section 1860D–16, the entity assumes financial risk on a prospective basis for the benefits that it offers under a Medicare Prescription Drug plan and that is not covered under section 1860D–20.

''(B) REINSURANCE PERMITTED.—To the extent that the entity is at risk pursuant to section 1860D–16, 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 ENTITIES.—In the case of an eligible entity that is not described in paragraph (1) and for which a waiver has been approved under subsection (c), such entity shall meet solvency standards established by the Administrator under subsection (d).

''(b) CONTRACT REQUIREMENTS.—The Administrator shall not permit an eligible beneficiary to elect a Medicare Prescription Drug plan offered by an eligible entity under this part, and the entity shall not be eligible for payments under section 1860D–16 or 1860D–20, unless the Administrator has entered into a contract under this subsection with the entity with respect to the offering of such plan. Such a contract with an entity may cover more than 1 Medicare Prescription Drug plan. Such contract shall provide that the entity 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.

''(c) WAIVER OF CERTAIN REQUIREMENTS IN ORDER TO ENSURE BENEFICIARY CHOICE.—

''(1) IN GENERAL.—In the case of an eligible entity that seeks to offer a Medicare 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) have been met.

''(2) GROUNDS FOR APPROVAL.—The grounds for approval under this paragraph are the grounds for approval described in subparagraphs (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) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying the provisions of section 1855(a)(2) under this

subsection to Medicare Prescription Drug plans and eligible entities—

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

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

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

''(1) ESTABLISHMENT AND PUBLICATION.—The Administrator, in consultation with the National Association of Insurance Commissioners, shall establish and publish, by not later than January 1, 2005, financial solvency and capital adequacy standards for entities described in paragraph (2).

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

''(e) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) or has a waiver application approved under subsection (c) does not deem the eligible entity to meet other requirements imposed under this part for an eligible entity.

''(f) INCORPORATION OF CERTAIN MEDICAREADVANTAGE CONTRACT REQUIREMENTS.—The following provisions of section 1857 shall apply, subject to subsection (c)(4), to contracts under this section in the same manner as they apply to contracts under section 1857(a):

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

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

''(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.

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

''(g) OTHER STANDARDS.—The Administrator shall establish by regulation other standards (not described in subsection (d)) for eligible entities and Medicare Prescription Drug plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by January 1, 2005.

''(h) PERIODIC REVIEW AND REVISION OF STANDARDS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Administrator shall periodically review the standards established under this section and, based on such review, may revise such standards if the Administrator determines such revision to be appropriate.

''(2) PROHIBITION OF MIDYEAR IMPLEMENTATION OF SIGNIFICANT NEW REGULATORY REQUIREMENTS.—The Administrator may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on an eligible entity or a Medicare Prescription Drug plan.

''(i) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—The standards established under this part shall supersede any State law or regulation (including standards described in paragraph (2)) with respect to Medicare Prescription Drug plans which are offered by eligible entities under this part—

''(A) to the extent such law or regulation is inconsistent with such standards; and

''(B) in the same manner as such laws and regulations are superseded under section 1856(b)(3).

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

''(A) Benefit requirements, including requirements relating to cost-sharing and the structure of formularies.

''(B) Premiums.

''(C) Requirements relating to inclusion or treatment of providers.

''(D) Coverage determinations (including related appeals and grievance processes).

''(E) Requirements relating to marketing materials and summaries and schedules of benefits regarding a Medicare Prescription Drug plan.

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

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

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

''Subpart 2—Prescription Drug Delivery System

''ESTABLISHMENT OF SERVICE AREAS

''SEC. 1860D–10. (a) ESTABLISHMENT.—

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

''(2) PERIODIC REVIEW AND REVISION OF SERVICE AREAS.—The Administrator shall periodically review the service areas applicable under this section and, based on such review, may revise such service areas if the Administrator determines such revision to be appropriate.

''(b) REQUIREMENTS FOR ESTABLISHMENT OF SERVICE AREAS.—

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

''(A) maximizes the availability of Medicare Prescription Drug plans to eligible beneficiaries; and

''(B) minimizes the ability of eligible entities offering such plans to favorably select eligible beneficiaries.

''(2) ADDITIONAL REQUIREMENTS.—The Administrator shall establish the service areas under subsection (a) consistent with the following requirements:

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

''(B) Each service area must include at least 1 State.

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

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

''(3) MAY CONFORM TO MEDICAREADVANTAGE PREFERRED PROVIDER REGIONS.—The Administrator may conform the service areas established under this section to the preferred provider regions established under section 1858(a)(3).

''PUBLICATION OF RISK ADJUSTERS

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

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

''(2) the amount of payment to MedicareAdvantage plans in the subsequent year under section 1858A(c), insofar as it is attributable to standard prescription drug coverage (or actuarially equivalent prescription drug coverage).

''(b) ESTABLISHMENT OF RISK ADJUSTERS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Administrator shall establish an appropriate methodology for adjusting the amount of payment to plans referred to in subsection (a) to take into account variation in costs based on the differences in actuarial risk of different enrollees being served. Any such risk adjustment shall be designed in a manner as to not result in a change in the aggregate payments described in paragraphs (1) and (2) of subsection (a).

''(2) CONSIDERATIONS.—In establishing the methodology under paragraph (1), the Administrator may take into account the similar methodologies used under section 1853(a)(3) to adjust payments to MedicareAdvantage organizations.

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

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

''(B) MedicareAdvantage organizations (except MSA plans or a private fee-for-service plan that does not provide qualified prescription drug coverage) to submit data regarding drug claims that can be linked to other data that such organizations are required to submit to the Administrator and such other information as the Administrator determines necessary.

''SUBMISSION OF BIDS FOR PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

''SEC. 1860D–12. (a) SUBMISSION.—

''(1) IN GENERAL.—Each eligible entity that intends to offer a Medicare Prescription Drug plan in an area in a year (beginning with 2006) shall submit to the Administrator, at such time in the previous year and in such manner as the Administrator may specify, such information as the Administrator may require, including the information described in subsection (b).

''(2) ANNUAL SUBMISSION.—An eligible entity shall submit the information required under paragraph (1) with respect to a Medicare Prescription Drug plan that the entity intends to offer on an annual basis.

''(b) INFORMATION DESCRIBED.—The information described in this subsection includes information on each of the following:

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

''(2) The actuarial value of the qualified prescription drug coverage.

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

''(A) the actuarial basis for such monthly plan premium;

''(B) the portion of such monthly plan premium attributable to standard prescription drug coverage or actuarially equivalent prescription drug coverage and, if applicable, to benefits that are in addition to such coverage; and

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

''(4) The service area for the plan.

''(5) Whether the entity plans to use any funds in the plan stabilization reserve fund in the Prescription Drug Account that are

available to the entity to stabilize or reduce the monthly plan premium submitted under paragraph (3), and if so, the amount in such reserve fund that is to be used.

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

''(c) OPTIONS REGARDING SERVICE AREAS.—

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

''(A) the entire area of 1 of the service areas established by the Administrator under section 1860D–10; or

''(B) the entire area covered by the medicare program.

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

''APPROVAL OF PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

''SEC. 1860D–13. (a) APPROVAL.—

''(1) IN GENERAL.—The Administrator shall review the information filed under section 1860D–12 and shall approve or disapprove the Medicare Prescription Drug plan.

''(2) REQUIREMENTS FOR APPROVAL.—The Administrator may not approve a Medicare Prescription Drug plan unless the following requirements are met:

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

''(B) APPLICATION OF FEHBP STANDARD.—(i) The portion of the monthly plan premium submitted under section 1860D–12(b) that is attributable to standard prescription drug coverage reasonably and equitably reflects the actuarial value of the standard prescription drug coverage less the actuarial value of the reinsurance payments under section 1860D–20 and the amount of any funds in the plan stabilization reserve fund in the Prescription Drug Account used to stabilize or reduce the monthly plan premium.

''(ii) If the plan provides additional prescription drug coverage pursuant to section 1860D–6(a)(2), the monthly plan premium reasonably and equitably reflects the actuarial value of the coverage provided less the actuarial value of the reinsurance payments under section 1860D–20 and the amount of any funds in the plan stabilization reserve fund in the Prescription Drug Account used to stabilize or reduce the monthly plan premium.

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

''(1) negotiate the terms and conditions of the proposed monthly plan premiums submitted and other terms and conditions of a proposed plan; and

''(2) disapprove, or limit enrollment in, a proposed plan based on—

''(A) the costs to beneficiaries under the plan;

''(B) the quality of the coverage and benefits under the plan;

''(C) the adequacy of the network under the plan; or

''(D) other factors determined appropriate by the Administrator.

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

''(1) include the required benefits under section 1860D–6(a)(1); and

''(2) are not designed in such a manner that the Administrator finds is likely to result in favorable selection of eligible beneficiaries.

''(d) ACCESS TO COMPETITIVE COVERAGE.—

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

''(2) AUTHORITY TO REDUCE RISK TO ENSURE ACCESS.—

''(A) IN GENERAL.—Subject to subparagraph (B), if the Administrator determines, with respect to an area, that the access required under paragraph (1) is not going to be provided in the area during the subsequent year, the Administrator shall—

''(i) adjust the percents specified in paragraphs (2) and (4) of section 1860D–16(b) in an area in a year; or

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

The administrator shall exercise the authority under the preceding sentence only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

''(B) REQUIREMENTS FOR USE OF AUTHORITY.—In exercising authority under subparagraph (A), the Administrator—

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

''(ii) shall not provide for any underwriting of financial risk for a public eligible entity with respect to the offering of a nationwide Medicare Prescription Drug plan; and

''(iii) shall seek to maximize the assumption of financial risk by eligible entities to ensure fair competition among Medicare Prescription Drug plans.

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

''(D) REPORTS.—The Administrator, in each annual report to Congress under section 1808(c)(1)(D), shall include information on the exercise of authority under subparagraph (A). The Administrator also shall include such recommendations as may be appropriate to limit the exercise of such authority.

''(e) GUARANTEED ACCESS.—

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

''(A) DETERMINATION.—Not later than September 1 of each year (beginning in 2005) and for each area (established under section 1860D–10), the Administrator shall make a determination as to whether the access required under subsection (d)(1) is going to be provided in the area during the subsequent year. Such determination shall be made after the Administrator has exercised the authority under subsection (d)(2).

''(B) CONTRACT WITH AN ENTITY TO PROVIDE COVERAGE IN AN AREA.—Subject to paragraph (3), if the Administrator makes a determination under subparagraph (A) that the access required under subsection (d)(1) is not going to be provided in an area during the subsequent year, the Administrator shall enter into a contract with an entity to provide eligible beneficiaries enrolled under this part (and not, except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage enrolled in a MedicareAdvantage plan) and residing in the area with standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) during the subsequent year. An entity may be awarded a contract for more than 1 of the areas for which the Administrator is required to enter into a contract under this paragraph but the Administrator may enter into only 1 such contract in each such area. An entity with a contract under this part shall meet the requirements described in section 1860D–5 and such other requirements determined appropriate by the Administrator.

''(C) REQUIREMENT TO ACCEPT 2 REDUCED-RISK QUALIFIED BIDS BEFORE ENTERING INTO CONTRACT.—The Administrator may not enter into a contract under subparagraph (B) with respect to an area and year if 2 or more qualified bids are submitted by eligible entities to offer a Medicare Prescription Drug plan in the area for the year after the Administrator has exercised the authority under subsection (d)(2) in the area for the year.

''(D) ENTITY REQUIRED TO MEET BENEFICIARY PROTECTION AND OTHER REQUIREMENTS.—An entity with a contract under subparagraph (B) shall meet the requirements described in section 1860D–5 and such other requirements determined appropriate by the Administrator.

''(E) 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 a contract under subparagraph (B).

''(2) MONTHLY BENEFICIARY OBLIGATION FOR ENROLLMENT.—

''(A) IN GENERAL.—In the case of an eligible beneficiary receiving access to qualified prescription drug coverage through enrollment with an entity with a contract under paragraph (1)(B), the monthly beneficiary obligation of such beneficiary for such enrollment shall be an amount equal to the applicable percent (as determined under section 1860D–17(c)) of the monthly national average premium (as computed under section 1860D–15) for the area for the year, as adjusted using the geographic adjuster under subparagraph (B).

''(B) ESTABLISHMENT OF GEOGRAPHIC ADJUSTER.—The Administrator shall establish an appropriate methodology for adjusting the monthly beneficiary obligation (as computed under subparagraph (A)) for the year in an area to take into account differences in drug prices among areas. In establishing such methodology, the Administrator may take into account differences in drug utilization between eligible beneficiaries in an area and eligible beneficiaries in other areas and the results of the ongoing study required under section 106 of the Prescription Drug and Medicare Improvement Act of 2003. Any such adjustment shall be applied in a manner so as to not result in a change in the aggregate payments made under this part that would have been made if the Administrator had not applied such adjustment.

''(3) PAYMENTS UNDER THE CONTRACT.—

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

''(i) payment for the negotiated costs of covered drugs provided to eligible beneficiaries enrolled with the entity; and

''(ii) payment of prescription management fees that are tied to performance requirements established by the Administrator for the management, administration, and delivery of the benefits under the contract.

''(B) PERFORMANCE REQUIREMENTS.—The performance requirements established by the Administrator pursuant to subparagraph (A)(ii) shall include the following:

''(i) The entity contains costs to the Prescription Drug Account and to eligible beneficiaries enrolled under this part and with the entity.

''(ii) The entity provides such beneficiaries with quality clinical care.

''(iii) The entity provides such beneficiaries with quality services.

''(C) ENTITY ONLY AT RISK TO THE EXTENT OF THE FEES TIED TO PERFORMANCE REQUIREMENTS.—An entity with a contract under paragraph (1)(B) shall only be at risk for the provision of benefits under the contract to the extent that the management fees paid to the entity are tied to performance requirements under subparagraph (A)(ii).

''(4) ELIGIBLE ENTITY THAT SUBMITTED A BID FOR THE AREA NOT ELIGIBLE TO BE AWARDED THE CONTRACT.—An eligible entity that submitted a bid to offer a Medicare Prescription Drug plan for an area for a year under section 1860D–12, including a bid submitted after the Administrator has exercised the authority under subsection (d)(2), may not be awarded a contract under paragraph (1)(B) for that area and year. The previous sentence shall apply to an entity that was awarded a contract under paragraph (1)(B) for the area in the previous year and submitted such a bid under section 1860D–12 for the year.

''(5) CONTRACT TO BE AVAILABLE IN DESIGNATED AREA FOR 2 YEARS.—Notwithstanding paragraph (1), if the Administrator enters into a contract with an entity with respect to an area designated under subparagraph (B) of such paragraph for a year, the following rules shall apply:

''(A) The contract shall be for a 2-year period.

''(B) The Secretary is not required to make the determination under paragraph (1)(A) with respect to the second year of the contract for the area.

''(C) During the second year of the contract, an eligible beneficiary residing in the area may continue to receive standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D-6(e)) under such contract or through any Medicare Prescription Drug plan that is available in the area.

''(6) ENTITY NOT PERMITTED TO MARKET OR BRAND THE CONTRACT.—An entity with a contract under paragraph (1)(B) may not engage in any marketing or branding of such contract.

''(7) RULES FOR AREAS WHERE ONLY 1 COMPETITIVELY BID PLAN WAS APPROVED.—In the case of an area where (before the application of this subsection) only 1 Medicare Prescription Drug plan was approved for a year—

''(A) the plan may (at the option of the plan) be offered in the area for the year (under rules applicable to such plans under this part and not under this subsection);

''(B) eligible beneficiaries described in paragraph (1)(B) may receive access to qualified prescription drug coverage through enrollment in the plan or with an entity with a contract under paragraph (1)(B); and

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

''(f) TWO-YEAR CONTRACTS.—Except for a contract entered into under subsection (e)(1)(B), a contract approved under this part (including a contract under) shall be for a 2-year period.

''COMPUTATION OF MONTHLY STANDARD PRESCRIPTION DRUG COVERAGE PREMIUMS

''SEC. 1860D–14. (a) IN GENERAL.—For each year (beginning with 2006), the Administrator shall compute a monthly standard prescription drug coverage premium for each Medicare Prescription Drug plan approved under section 1860D–13 and for each MedicareAdvantage plan.

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

''(1) in the case of a plan offered by an eligible entity or MedicareAdvantage organization that provides standard prescription drug coverage or an actuarially equivalent prescription drug coverage and does not provide additional prescription drug coverage pursuant to section 1860D–6(a)(2), the monthly plan premium approved for the plan under section 1860D–13 for the year; and

''(2) in the case of a plan offered by an eligible entity or MedicareAdvantage organization that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2)—

''(A) an amount that reflects only the actuarial value of the standard prescription drug coverage offered under the plan; or

''(B) if determined appropriate by the Administrator, the monthly plan premium approved under section 1860D–13 for the year for the Medicare Prescription Drug plan (or, if applicable, the MedicareAdvantage plan) that, as required under section 1860D–6(a)(2)(B) for a Medicare Prescription Drug plans and a MedicareAdvantage plan—

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

''(ii) does not provide additional prescription drug coverage pursuant to such section.

''COMPUTATION OF MONTHLY NATIONAL AVERAGE PREMIUM

''SEC. 1860D–15. (a) COMPUTATION.—

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

''(2) WEIGHTED AVERAGE.—The monthly national average premium computed under paragraph (1) shall be a weighted average, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the previous year.

''(b) GEOGRAPHIC ADJUSTMENT.—The Administrator shall establish an appropriate methodology for adjusting the monthly national average premium (as computed under subsection (a)) for the year in an area to take into account differences in prices for covered drugs among different areas. In establishing such methodology, the Administrator may take into account differences in drug utilization between eligible beneficiaries in that area and other eligible beneficiaries and the results of the ongoing study required under section 106 of the Prescription Drug and Medicare Improvement Act of 2003. Any such adjustment shall be applied in a manner as to not result in a change in aggregate payments made under this part than would have been made if the Administrator had not applied such adjustment.

''(c) SPECIAL RULE FOR 2006.—For purposes of applying this section for 2006, the Administrator shall establish procedures for determining the weighted average under subsection (a)(2) for 2005.

''PAYMENTS TO ELIGIBLE ENTITIES

''SEC. 1860D–16. (a) PAYMENT OF MONTHLY PLAN PREMIUMS.—For each year (beginning with 2006), the Administrator shall pay to each entity offering a Medicare Prescription Drug plan in which an eligible beneficiary is enrolled an amount equal to the full amount of the monthly plan premium approved for the plan under section 1860D–13 on behalf of each eligible beneficiary enrolled in such plan for the year, as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

''(b) PORTION OF TOTAL PAYMENTS OF MONTHLY PLAN PREMIUMS SUBJECT TO RISK.—

''(1) NOTIFICATION OF SPENDING UNDER THE PLAN.—

''(A) IN GENERAL.—For each year (beginning in 2007), the eligible entity offering a Medicare Prescription Drug plan shall notify the Administrator of the following:

''(i) TOTAL ACTUAL COSTS.—The total amount of costs that the entity incurred in providing standard prescription drug coverage (or prescription drug coverage that is actuarially equivalent pursuant to section 1860D–6(a)(1)(B)) for all enrollees under the plan in the previous year.

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

''(I) each covered drug that constitutes a portion of such amount;

''(II) the negotiated price for the eligible entity for each such drug;

''(III) the number of prescriptions; and

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

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

''(i) administrative expenses incurred in providing the coverage described in subparagraph (A)(i);

''(ii) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2); or

''(iii) amounts expended for which the entity is subsequently provided with reinsurance payments under section 1860D–20.

''(2) ADJUSTMENT OF PAYMENT.—

''(A) NO ADJUSTMENT IF ALLOWABLE COSTS WITHIN RISK CORRIDOR.—If the allowable costs (specified in paragraph (3)) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (4)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (4)(A)(i)) for the plan for the year, then no additional payments shall be made by the Administrator and no payments shall be made by (or collected from) the eligible entity offering the plan.

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

''(i) IN GENERAL.—If the allowable costs for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Administrator shall increase the total of the monthly payments made to the entity offering the plan for the year under subsection (a) by an amount equal to the sum of—

''(I) the applicable percent (as defined in subparagraph (D)) of such allowable costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (4)(A)(iv)); and

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

''(ii) SPECIAL TRANSITIONAL CORRIDOR FOR 2006 AND 2007.—If the Administrator determines with respect to 2006 or 2007 that at least 60 percent of Medicare Prescription Drug plans and MedicareAdvantage Plans (excluding MSA plans or private fee-for-service plans that do not provide qualified prescription drug coverage) have allowable costs for the plan for the year that are more than the first threshold upper limit of the risk corridor for the plan for the year and that such plans represent at least 60 percent of eligible beneficiaries enrolled under this part, clause (i)(I) shall be applied by substituting '90 percent' for 'applicable percent'.

''(C) PLAN PAYMENT IF ALLOWABLE COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the allowable costs for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the entity offering the plan shall a make a payment to the Administrator of an amount (or the Administrator shall otherwise recover from the plan an amount) equal to—

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

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

''(D) APPLICABLE PERCENT DEFINED.—For purposes of this paragraph, the term 'applicable percent' means—

''(i) for 2006 and 2007, 75 percent; and

''(ii) for 2008 and subsequent years, 50 percent.

''(3) ESTABLISHMENT OF ALLOWABLE COSTS.—

''(A) IN GENERAL.—For each year, the Administrator shall establish the allowable costs for each Medicare Prescription Drug plan for the year. The allowable costs for a plan for a year shall be equal to the amount described in paragraph (1)(A)(i) for the plan for the year, adjusted under subparagraph (B)(ii).

''(B) REPRICING OF COSTS.—

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

''(ii) ADJUSTMENT IF ACTUAL COSTS EXCEED AVERAGE COSTS.—With respect to a Medicare Prescription Drug plan for a year, the Administrator shall reduce the amount described in paragraph (1)(A)(i) for the plan for the year to the extent such amount is based on costs of specific covered drugs furnished under the plan in the year (as specified under paragraph (1)(A)(ii)) for which the negotiated prices are greater than the average negotiated price for the covered drug for the year (as determined under clause (i)).

''(4) ESTABLISHMENT OF RISK CORRIDORS.—

''(A) IN GENERAL.—For each year (beginning with 2006), the Administrator shall establish a risk corridor for each Medicare Prescription Drug plan. The risk corridor for a plan for a year shall be equal to a range as follows:

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

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to the first threshold risk percentage for the plan (as determined under subparagraph (C)(i)) of such target amount.

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

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to the second threshold risk percentage for the plan (as determined under subparagraph (C)(ii)) of such target amount.

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

''(I) such target amount; and

''(II) the amount described in clause (i)(II).

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

''(I) such target amount; and

''(II) the amount described in clause (ii)(II).

''(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a Medicare Prescription Drug plan offered by an eligible entity in a year—

''(i) in the case of a plan offered by an eligible entity that provides standard prescription drug coverage or actuarially equivalent prescription drug coverage and does not provide additional prescription drug coverage pursuant to section 1860D–6(a)(2), an amount equal to the total of the monthly plan premiums paid to such entity for such plan for the year pursuant to subsection (a), reduced by the percentage specified in subparagraph (D); and

''(ii) in the case of a plan offered by an eligible entity that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2), an amount equal to the total of the monthly plan premiums paid to such entity for such plan for the year pursuant to subsection (a) that are related to standard prescription drug coverage (determined using the rules under section 1860D–14(b)), reduced by the percentage specified in subparagraph (D).

''(C) FIRST AND SECOND THRESHOLD RISK PERCENTAGE DEFINED.—

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

''(I) for 2006 and 2007, and 2.5 percent;

''(II) for 2008 through 2011, 5 percent; and

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

''(ii) SECOND THRESHOLD RISK PERCENTAGE.—Subject to clause (iii), for purposes of this section, the second threshold risk percentage is—

''(I) for 2006 and 2007, 5.0 percent;

''(II) for 2008 through 2011, 10 percent

''(III) for 2012 and subsequent years, a percentage established by the Administrator that is greater than the percent established for the year under clause (i)(III), but in no case less than 10 percent.

''(iii) REDUCTION OF RISK PERCENTAGE TO ENSURE 2 PLANS IN AN AREA.—Pursuant to paragraph (2) of section 1860D–13(d), the Administrator may reduce the applicable first or second threshold risk percentage in an area in a year in order to ensure the access to plans required under paragraph (1) of such section.

''(D) TARGET AMOUNT NOT TO INCLUDE ADMINISTRATIVE EXPENSES NEGOTIATED BETWEEN THE ADMINISTRATOR AND THE ENTITY OFFERING THE PLAN.—For each year (beginning in 2006), the Administrator and the entity offering a Medicare Prescription Drug plan shall negotiate, as part of the negotiation process described in section 1860D–13(b) during the previous year, the percentage of the payments to the entity under subsection (a) with respect to the plan that are attributable and reasonably incurred for administrative expenses for providing standard prescription drug coverage or actuarially equivalent prescription drug coverage in the year.

''(5) PLANS AT RISK FOR ENTIRE AMOUNT OF ADDITIONAL PRESCRIPTION DRUG COVERAGE.—An eligible entity that offers a Medicare Prescription Drug plan that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2) shall be at full financial risk for the provision of such additional coverage.

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

''(7) DISCLOSURE OF INFORMATION.—

''(A) IN GENERAL.—Each contract under this part shall provide that—

''(i) the entity offering a Medicare Prescription Drug plan shall provide the Administrator with such information as the Administrator determines is necessary to carry out this section; and

''(ii) the Administrator shall have the right to inspect and audit any books and records of the eligible entity that pertain to the information regarding costs provided to the Administrator under paragraph (1).

''(B) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this section may be used by officers and employees of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

''(c) STABILIZATION RESERVE FUND.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—There is established, within the Prescription Drug Account, a stabilization reserve fund in which the Administrator shall deposit amounts on behalf of eligible entities in accordance with paragraph (2) and such amounts shall be made available by the Secretary for the use of eligible entities in contract year 2008 and subsequent contract years in accordance with paragraph (3).

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

''(2) DEPOSIT OF AMOUNTS FOR 5 YEARS.—

''(A) IN GENERAL.—If the target amount for a Medicare Prescription Drug plan for 2006, 2007, 2008, 2009, or 2010 (as determined under subsection (b)(4)(B)) exceeds the applicable costs for the plan for the year by more than 3 percent, then—

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

''(ii) the Administrator shall deposit an amount equal to the amount collected or otherwise recovered under clause (i) in the stabilization reserve fund on behalf of the eligible entity offering such plan.

''(B) APPLICABLE COSTS.—For purposes of subparagraph (A), the term 'applicable costs' means, with respect to a Medicare Prescription Drug plan and year, an amount equal the sum of—

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

''(ii) the total amount by which monthly payments to the plan were reduced (or otherwise recovered from the plan) for the year under subsection (b)(2)(C).

''(3) USE OF RESERVE FUND TO STABILIZE OR REDUCE MONTHLY PLAN PREMIUMS.—

''(A) IN GENERAL.—For any contract year beginning after 2007, an eligible entity offering a Medicare Prescription Drug plan may use funds in the stabilization reserve fund in the Prescription Drug Account that were deposited in such fund on behalf of the entity to stabilize or reduce monthly plan premiums submitted under section 1860D–12(b)(3).

''(B) PROCEDURES.—The Administrator shall establish procedures for—

''(i) reducing monthly plan premiums submitted under section 1860D–12(b)(3) pursuant to subparagraph (A); and

''(ii) making payments from the plan stabilization reserve fund in the Prescription Drug Account to eligible entities that inform the Secretary under section 1860D–12(b)(5) of the entity's intent to use funds in such reserve fund to reduce such premiums.

''(d) PORTION OF PAYMENTS OF MONTHLY PLAN PREMIUMS ATTRIBUTABLE TO ADMINISTRATIVE EXPENSES TIED TO PERFORMANCE REQUIREMENTS.—

''(1) IN GENERAL.—The Administrator shall establish procedures to adjust the portion of the payments made to an entity under subsection (a) that are attributable to administrative expenses (as determined pursuant to subsection (b)(4)(D)) to ensure that the entity meets the performance requirements described in clauses (ii) and (iii) of section 1860D–13(e)(4)(B).

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

''(e) PAYMENT TERMS.—

''(1) ADMINISTRATOR PAYMENTS.—Payments to an entity offering a Medicare Prescription Drug plan under this section shall be made in a manner determined by the Administrator and based upon the manner in which payments are made under section 1853(a) (relating to payments to MedicareAdvantage organizations).

''(2) PLAN PAYMENTS.—The Administrator shall establish a process for collecting (or other otherwise recovering) amounts that an entity offering a Medicare Prescription Drug plan is required to make to the Administrator under this section.

''(f) PAYMENTS TO MEDICAREADVANTAGE PLANS.—For provisions related to payments to MedicareAdvantage organizations offering MedicareAdvantage plans for qualified prescription drug coverage made available under the plan, see section 1858A(c).

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

''COMPUTATION OF MONTHLY BENEFICIARY OBLIGATION

''SEC. 1860D–17. (a) BENEFICIARIES ENROLLED IN A MEDICARE PRESCRIPTION DRUG PLAN.—In the case of an eligible beneficiary enrolled under this part and in a Medicare Prescription Drug plan, the monthly beneficiary obligation for enrollment in such plan in a year shall be determined as follows:

''(1) MONTHLY PLAN PREMIUM EQUALS MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year is equal to the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to the applicable percent (as determined in subsection (c)) of the amount of such monthly national average premium.

''(2) MONTHLY PLAN PREMIUM LESS THAN MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for the Medicare Prescription Drug plan for the year is less than the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to—

''(A) the applicable percent of the amount of such monthly national average premium; minus

''(B) the amount by which such monthly national average premium exceeds the amount of the monthly plan premium approved by the Administrator for the plan.

''(3) MONTHLY PLAN PREMIUM EXCEEDS MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year exceeds the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to the sum of—

''(A) the applicable percent of the amount of such monthly national average premium; plus

''(B) the amount by which the monthly plan premium approved by the Administrator for the plan exceeds the amount of such monthly national average premium.

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

''(c) APPLICABLE PERCENT.—For purposes of this section, except as provided in section 1860D–19 (relating to premium subsidies for low-income individuals), the applicable percent for any year is the percentage equal to a fraction—

''(1) the numerator of which is 27.5 percent; and

''(2) the denominator of which is 100 percent minus a percentage equal to—

''(A) the total reinsurance payments which the Administrator estimates will be made under section 1860D–20 to qualifying entities described in subsection (e)(3) of such section during the year; divided by

''(B) the sum of—

''(i) the amount estimated under subparagraph (A) for the year; and

''(ii) the total payments which the Administrator estimates will be made under sections 1860D–16 and 1858A(c) during the year that relate to standard prescription drug coverage (or actuarially equivalent prescription drug coverage).

''COLLECTION OF MONTHLY BENEFICIARY OBLIGATION

''SEC. 1860D–18. (a) COLLECTION OF AMOUNT IN SAME MANNER AS PART B PREMIUM.—

''(1) IN GENERAL.—Subject to paragraph (2), the amount of the monthly beneficiary obligation (determined under section 1860D–17) applicable to an eligible beneficiary under this part (after application of any increase under section 1860D–2(b)(1)(A)) shall be collected and credited to the Prescription Drug Account in the same manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supplementary Medical Insurance Trust Fund under section 1840.

''(2) PROCEDURES FOR SPONSOR TO PAY OBLIGATION ON BEHALF OF RETIREE.—The Administrator shall establish procedures under which an eligible beneficiary enrolled in a Medicare Prescription Drug plan may elect to have the sponsor (as defined in paragraph (5) of section 1860D–20(e)) of employment-based retiree health coverage (as defined in paragraph (4)(B) of such section) in which the beneficiary is enrolled pay the amount of the monthly beneficiary obligation applicable to the beneficiary under this part directly to the Administrator.

''(b) INFORMATION NECESSARY FOR COLLECTION.—In order to carry out subsection (a), the Administrator shall transmit to the Commissioner of Social Security—

''(1) by the beginning of each year, the name, social security account number, monthly beneficiary obligation owed by each individual enrolled in a Medicare Prescription Drug plan for each month during the year, and other information determined appropriate by the Administrator; and

''(2) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

''(c) COLLECTION FOR BENEFICIARIES ENROLLED IN A MEDICAREADVANTAGE PLAN.—For provisions related to the collection of the monthly beneficiary obligation for qualified prescription drug coverage under a MedicareAdvantage plan, see section 1858A(e).

''PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS

''SEC. 1860D–19. (a) AMOUNT OF SUBSIDIES.—

''(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR QUALIFIED MEDICARE BENEFICIARIES.—In the case of a qualified medicare beneficiary (as defined in paragraph (4)(A))—

''(A) section 1860D–17 shall be applied—

''(i) in subsection (c), by substituting '0 percent' for the applicable percent that would otherwise apply under such subsection; and

''(ii) in subsection (a)(3)(B), by substituting 'the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides' for 'the amount of such monthly national average premium', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year;

''(B) the annual deductible applicable under section 1860D–6(c)(1) in a year shall be reduced to $0;

''(C) section 1860D–6(c)(2) shall be applied by substituting '2.5 percent' for '50 percent' each place it appears;

''(D) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 5.0 percent; and

''(E) section 1860D–6(c)(4)(A) shall be applied by substituting '2.5 percent' for '10 percent'.

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

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

''(A) section 1860D–17 shall be applied—

''(i) in subsection (c), by substituting '0 percent' for the applicable percent that would otherwise apply under such subsection; and

''(ii) in subsection (a)(3)(B), by substituting 'the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides' for 'the amount of such monthly national average premium', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a

monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year;

''(B) the annual deductible applicable under section 1860D–6(c)(1) in a year shall be reduced to $0;

''(C) section 1860D–6(c)(2) shall be applied by substituting '5.0 percent' for '50 percent' each place it appears;

''(D) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 10.0 percent; and

''(E) section 1860D–6(c)(4)(A) shall be applied by substituting '2.5 percent' for '10 percent'.

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

''(3) SLIDING SCALE PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR SUBSIDY-ELIGIBLE INDIVIDUALS.—

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

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

''(I) in subsection (c), by substituting 'subsidy percent' for the applicable percentage that would otherwise apply under such subsection; and

''(II) in subparagraphs (A) and (B) of subsection (a)(3), by substituting 'the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides' for 'the amount of such monthly national average premium', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year; and

''(ii) the annual deductible applicable under section 1860D–6(c)(1)—

''(I) for 2006, shall be reduced to $50; and

''(II) for a subsequent year, shall be reduced to the amount specified under this clause for the previous year increased by the percentage specified in section 1860D–6(c)(5) for the year involved;

''(iii) section 1860D–6(c)(2) shall be applied by substituting '10.0 percent' for '50 percent' each place it appears;

''(iv) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 20.0 percent; and

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

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

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

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

''(ii) the highest percentage that would otherwise apply under section 1860D–17 in the service area in which the subsidy-eligible individual resides, in the case of a subsidy-eligible individual residing in the State whose income equals 160 percent of the poverty line.

''(4) DEFINITIONS.—In this part:

''(A) QUALIFIED MEDICARE BENEFICIARY.—Subject to subparagraph (H), the term 'qualified medicare beneficiary' means an individual who—

''(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan; and

''(ii) is described in section 1905(p)(1).

''(B) SPECIFIED LOW INCOME MEDICARE BENEFICIARY.—Subject to subparagraph (H), the term 'specified low income medicare beneficiary' means an individual who—

''(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan; and

''(ii) is described in section 1902(a)(10)(E)(iii).

''(C) QUALIFYING INDIVIDUAL.—Subject to subparagraph (H), the term 'qualifying individual' means an individual who—

''(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan; and

''(ii) is described in section 1902(a)(10)(E)(iv) (without regard to any termination of the application of such section under title XIX).

''(D) SUBSIDY-ELIGIBLE INDIVIDUAL.—Subject to subparagraph (H), the term 'subsidy-eligible individual' means an individual—

''(i) who is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan; and

''(ii) whose income is less than 160 percent of the poverty line; and

''(iii) who is not—

''(I) a qualified medicare beneficiary;

''(II) a specified low-income medicare beneficiary; or

''(III) a qualifying individual. *

''(E) POVERTY LINE.—The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(F) ELIGIBILITY DETERMINATIONS.—Beginning on November 1, 2005, the determination of whether an individual residing in a State is an individual described in subparagraph (A), (B), (C), or (D) and, for purposes of paragraph (3), the amount of an 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.

''(G) NONAPPLICATION TO TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of the 50 States or the District of Columbia—

''(i) the subsidies provided under this section shall not apply; and

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

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

''(c) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator shall establish a process whereby, in the case of an individual eligible for a cost-sharing subsidy under subsection (a) who is enrolled in a Medicare Prescription Drug plan or a MedicareAdvantage plan—

''(1) the Administrator provides for a notification of the eligible entity or MedicareAdvantage organization involved that the individual is eligible for a cost-sharing subsidy and the amount of the subsidy under such subsection;

''(2) the entity or organization involved reduces the 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 entity or organization for the amount of such reductions.

The reimbursement under paragraph (3) 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.

''(d) RELATION TO MEDICAID PROGRAM.—For provisions providing for eligibility determinations and additional Federal payments for expenditures related to providing prescription drug coverage for territorial residents under the medicaid program, see section 1935.

''REINSURANCE PAYMENTS FOR EXPENSES INCURRED IN PROVIDING PRESCRIPTION DRUG COVERAGE ABOVE THE ANNUAL OUT-OF-POCKET THRESHOLD

''SEC. 1860D–20. (a) REINSURANCE PAYMENTS.—

''(1) IN GENERAL.—Subject to section 1860D–21(b), the Administrator shall provide in accordance with this section for payment to a qualifying entity of the reinsurance payment amount (as specified in subsection (c)(1)) for costs incurred by the entity in providing prescription drug coverage for a qualifying covered individual after the individual has reached the annual out-of-pocket threshold specified in section 1860D–6(c)(4)(B) for the year.

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

''(b) NOTIFICATION OF SPENDING UNDER THE PLAN FOR COSTS INCURRED IN PROVIDING PRESCRIPTION DRUG COVERAGE ABOVE THE ANNUAL OUT-OF-POCKET THRESHOLD.—

''(1) IN GENERAL.—Each qualifying entity shall notify the Administrator of the following with respect to a qualifying covered individual for a coverage year:

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

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

''(i) each covered drug that constitutes a portion of such amount;

''(ii) the negotiated price for the qualifying entity for each such drug;

''(iii) the number of prescriptions; and

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

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

''(A) administrative expenses incurred in providing the coverage described in paragraph (1)(A); or

''(B) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2).

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

''(c) REINSURANCE PAYMENT AMOUNT.—

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

''(2) ALLOWABLE COSTS.—*

''(A) IN GENERAL.—In the case of a qualifying entity that has incurred costs described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year, the Administrator shall establish the allowable costs for the individual and year. Such allowable costs shall be equal to the amount described in such subsection for the individual and year, adjusted under subparagraph (B).

''(B) REPRICING OF COSTS IF ACTUAL COSTS EXCEED AVERAGE COSTS.—The Administrator shall reduce the amount described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year to the extent such amount is based on costs of specific covered drugs furnished under the plan in the year (as specified under subsection (b)(1)(B)) that are greater than the average cost for the covered drug for the year (as determined under section 1860D–16(b)(3)(A)).

''(d) PAYMENT METHODS.—

''(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 Prescription Drug Account.

''(e) DEFINITIONS.—In this section:

''(1) COVERAGE YEAR.—The term 'coverage year' means a calendar year in which covered drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

''(2) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

''(A) is enrolled in this part and in a Medicare Prescription Drug plan;

''(B) is enrolled in this part and in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage); or

''(C) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified retiree prescription drug plan.

''(3) QUALIFYING ENTITY.—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:

''(A) An eligible entity offering a Medicare Prescription Drug plan under this part.

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

''(C) The sponsor of a qualified retiree prescription drug plan.

''(4) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—

''(A) IN GENERAL.—The term 'qualified retiree prescription drug plan' means employment-based retiree health coverage if, with respect to a qualifying covered individual who is covered under the plan, the following requirements are met:

''(i) 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.

''(ii) DISCLOSURE OF INFORMATION.—The sponsor complies with the requirements described in clauses (i) and (ii) of section 1860D–16(b)(7)(A).

''(B) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage, whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation, of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

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

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

''SEC. 1860D–21. (a) DIRECT SUBSIDY.—

''(1) IN GENERAL.—The Administrator shall provide for the payment to a sponsor of a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)) for each qualifying covered individual (described in subparagraph (C) of section 1860D–20(e)(2)) enrolled in the plan for each month for which such individual is so enrolled.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—The amount of the payment under paragraph (1) shall be an amount equal to the direct subsidy percent determined for the year of the monthly national average premium for the area for the year (determined under section 1860D–15), as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

''(B) DIRECT SUBSIDY PERCENT.—For purposes of subparagraph (A), the term 'direct subsidy percent' means the percentage equal to—

''(i) 100 percent; minus

''(ii) the applicable percent for the year (as determined under section 1860D–17(c).

''(b) 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 Prescription Drug Account.

''Subpart 3—Miscellaneous Provisions

''PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

''SEC. 1860D–25. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Account' (in this section referred to as the 'Account').

''(2) FUNDS.—The Account 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, the Account as provided in this part.

''(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

''(b) PAYMENTS FROM ACCOUNT.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including—

''(A) payments to eligible entities under section 1860D–16;

''(B) payments under 1860D–19 for low-income subsidy payments for cost-sharing;

''(C) reinsurance payments under section 1860D–20;

''(D) payments to sponsors of qualified retiree prescription drug plans under section 1860D–21;

''(E) payments to MedicareAdvantage organizations for the provision of qualified prescription drug coverage under section 1858A(c); and

''(F) payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

''(c) APPROPRIATIONS TO COVER BENEFITS AND ADMINISTRATIVE COSTS.—There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the payments and transfers made from the Account in the year.

''OTHER RELATED PROVISIONS

''SEC. 1860D–26. (a) RESTRICTION ON ENROLLMENT IN A MEDICARE PRESCRIPTION DRUG PLAN OFFERED BY A SPONSOR OF EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—

''(1) IN GENERAL.—In the case of a Medicare Prescription Drug plan offered by an eligible entity that is a sponsor (as defined in paragraph (5) of section 1860D–20(e)) of employment-based retiree health coverage (as defined in paragraph (4)(B) of such section), notwithstanding any other provision of this part and in accordance with regulations of the Administrator, the entity offering the plan may restrict the enrollment of eligible beneficiaries enrolled under this part to eligible beneficiaries who are enrolled in such coverage.

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

''(b) COORDINATION WITH STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

''(1) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan, or a MedicareAdvantage organization offering a MedicareAdvantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), may enter into an agreement with a State pharmaceutical assistance program described in paragraph (2) to coordinate the coverage provided under the plan with the assistance provided under the State pharmaceutical assistance program.

''(2) STATE PHARMACEUTICAL ASSISTANCE PROGRAM DESCRIBED.—For purposes of paragraph (1), a State pharmaceutical assistance program described in this paragraph is a program that has been established pursuant to a waiver under section 1115 or otherwise.

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

''(1) AUTHORITY FOR INTERIM FINAL REGULATIONS.—The Secretary may promulgate initial regulations implementing this part in interim final form without prior opportunity for public comment.

''(2) FINAL REGULATIONS.—A final regulation reflecting public comments must be published within 1 year of the interim final regulation promulgated under paragraph (1).''.

(b) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 (42 U.S.C. 1395t) is amended—

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

(A) by striking ''and'' before ''such amounts''; and

(B) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Prescription Drug Account established by section 1860D–25'';

(2) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),'';

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

(4) in subsection (i), by inserting after ''section 1840(b)(1)'' the following: '', sections 1860D–18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),''.

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

(d) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this Act.

SEC. 102. STUDY AND REPORT ON PERMITTING PART B ONLY INDIVIDUALS TO ENROLL IN MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.

(a) STUDY.—The Administrator of the Center for Medicare Choices (as established under section 1808 of the Social Security Act, as added by section 301(a)) shall conduct a study on the need for rules relating to permitting individuals who are enrolled under part B of title XVIII of the Social Security Act but are not entitled to benefits under part A of such title to buy into the medicare voluntary prescription drug delivery program under part D of such title (as so added).

(b) REPORT.—Not later than January 1, 2005, the Administrator of the Center for Medicare Choices shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that the Administrator determines to be appropriate as a result of such study.

SEC. 103. RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.

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

''(v) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

''(1) PROHIBITION ON SALE, ISSUANCE, AND RENEWAL OF POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE TO PART D ENROLLEES.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, on or after January 1, 2006, no medicare supplemental policy that provides coverage of expenses for prescription drugs may be sold, issued, or renewed under this section to an individual who is enrolled under part D.

''(B) PENALTIES.—The penalties described in subsection (d)(3)(A)(ii) shall apply with respect to a violation of subparagraph (A).

''(2) ISSUANCE OF SUBSTITUTE POLICIES IF THE POLICYHOLDER OBTAINS 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' (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)), 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 during the open enrollment period established under section 1860D–2(b)(2) and who submits evidence that they meet the requirements under subparagraph (B) along with the application for such medicare supplemental policy.

''(B) INDIVIDUAL DESCRIBED.—An individual described in this subparagraph is an individual who—

''(i) enrolls in the medicare prescription drug delivery program 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' (including the benefit package classified as 'J' with a high deductible feature, as described in section 1882(p)(11)) 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 subparagraph (A) shall be enforced as though they were included in subsection (s).

''(3) NOTICE REQUIRED TO BE PROVIDED TO CURRENT POLICYHOLDERS WITH PRESCRIPTION DRUG COVERAGE.—No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer provides written notice during the 60-day period immediately preceding the period established for the open enrollment period established under section 1860D–2(b)(2), to each individual who is a policyholder or certificate holder of a medicare supplemental policy issued by that issuer that provides some coverage of expenses for prescription drugs (at the most recent available address of that individual) of—

''(A) the ability to enroll in a new medicare supplemental policy pursuant to paragraph (2); and

''(B) the fact that, so long as such individual retains coverage under such policy, the individual shall be ineligible for coverage of prescription drugs under part D.''.

(b) RULE OF CONSTRUCTION.—

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

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

SEC. 104. MEDICAID AND OTHER AMENDMENTS RELATED TO LOW-INCOME BENEFICIARIES.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

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

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

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

''(66) provide for making eligibility determinations under section 1935(a).''.

(b) NEW SECTION.—

(1) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is 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 satisfy the following:

''(1) DETERMINATION OF ELIGIBILITY FOR TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE CARD PROGRAM FOR ELIGIBLE LOW-INCOME BENEFICIARIES.—For purposes of section 1807A, submit to the Secretary an eligibility plan under which the State—

''(A) establishes eligibility standards consistent with the provisions of that section;

''(B) establishes procedures for providing presumptive eligibility for eligible low-income beneficiaries (as defined in section 1807A(i)(2)) under that section in a manner that is similar to the manner in which presumptive eligibility is provided to children and pregnant women under this title;

''(C) makes determinations of eligibility and income for purposes of identifying eligible low-income beneficiaries (as so defined) under that section; and

''(D) communicates to the Secretary determinations of eligibility or discontinuation of eligibility under that section for purposes of notifying prescription drug card sponsors under that section of the identity of eligible medicare low-income beneficiaries.

''(2) DETERMINATION OF ELIGIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES UNDER PART D OF TITLE XVIII FOR LOW-INCOME INDIVIDUALS.—Beginning November 1, 2005, for purposes of section 1860D–19—

''(A) make determinations of eligibility for premium and cost-sharing subsidies under and in accordance with such section;

''(B) establish procedures for providing presumptive eligibility for individuals eligible for subsidies under that section in a manner that is similar to the manner in which presumptive eligibility is provided to children and pregnant women under this title;

''(C) inform the Administrator of the Center for Medicare Choices of such determinations in cases in which such eligibility is established; and

''(D) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860D–19).

''(3) AGREEMENT TO ESTABLISH INFORMATION AND ENROLLMENT SITES AT SOCIAL SECURITY

FIELD OFFICES.—Enter into an agreement with the Commissioner of Social Security to use all Social Security field offices located in the State as information and enrollment sites for making the eligibility determinations required under paragraphs (1) and (2).

''(b) FEDERAL SUBSIDY OF ADMINISTRATIVE COSTS.—

''(1) ENHANCED MATCH FOR ELIGIBILITY DETERMINATIONS.—Subject to paragraphs (2) and (4), with respect to calendar quarters beginning on or after January 1, 2004, the amounts expended by a State in carrying out subsection (a) are expenditures reimbursable under section 1903(a)(7) except that, in applying such section with respect to such expenditures incurred for—

''(A) such calendar quarters occurring in fiscal year 2004 or 2005, '75 percent' shall be substituted for '50 per centum';

''(B) calendar quarters occurring in fiscal year 2006, '70 percent' shall be substituted for '50 per centum';

''(C) calendar quarters occurring in fiscal year 2007, '65 percent' shall be substituted for '50 per centum'; and

''(D) calendar quarters occurring in fiscal year 2008 or any fiscal year thereafter, '60 percent' shall be substituted for '50 per centum'.

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

''(3) ENHANCED MATCH FOR UPDATES OR IMPROVEMENTS TO ELIGIBILITY DETERMINATION SYSTEMS.—With respect to calendar quarters occurring in fiscal year 2004, 2005, or 2006, the Secretary, in addition to amounts otherwise paid under section 1903(a), shall pay to each State which has a plan approved under this title, for each such quarter an amount equal to 90 percent of so much of the sums expended during such quarter as are attributable to the design, development, acquisition, or installation of improved eligibility determination systems (including hardware and software for such systems) in order to carry out the requirements of subsection (a) and section 1807A(h)(1) and to the design, development, acquisition or installation of improved data systems necessary to track prescription drug spending for purposes of implementing section 1935(c). No payment shall be made to a State under the preceding sentence unless the State's improved eligibility determination system—

''(A) satisfies such standards for improvement as the Secretary may establish; and

''(B) complies, and is compatible, with the standards established under part C of title XI and any regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

''(4) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate expenditures described in paragraph (1), (2), or (3) that may otherwise be made for similar eligibility determinations or expenditures.

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

''(1) IN GENERAL.—For purpose of section 1903(a)(1) for a State for a calendar quarter in a year (beginning with 2006) the amount computed under this subsection is equal to the product of the following:

''(A) STANDARD PRESCRIPTION DRUG COVERAGE UNDER MEDICARE.—With respect to individuals who are residents of the State, who are entitled to, or enrolled for, benefits under part A of title XVIII, or are enrolled under part B of title XVIII and are receiving medical assistance under subparagraph (A)(i), (A)(ii), or (C) of section 1902(a)(10) (or as the result of the application of section 1902(f)) that includes covered outpatient drugs (as defined for purposes of section 1927) under the State plan under this title (including such a plan operated under a waiver under section 1115)—

''(i) the total amounts attributable to such individuals in the quarter under section 1860D–19 (relating to premium and cost-sharing subsidies for low-income medicare beneficiaries); and

''(ii) the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)) provided to such individuals in the quarter.

''(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.—Subject to subparagraph (D), the phase-out proportion for a quarter in—

''(i) 2006 is 100 percent;

''(ii) 2007 is 95 percent;

''(iii) 2008 or 2009, is 90 percent;

''(iv) 2010 is 85 percent; or

''(v) 2011, 2012, or 2013 is 80 percent.

''(d) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to a Medicare Prescription Drug plan under part D or drug coverage under a MedicareAdvantage plan, and medical assistance including covered outpatient drugs under this title, medical assistance shall continue to be provided under this title for covered outpatient drugs to the extent payment is not made under the Medicare Prescription Drug plan or a MedicareAdvantage plan.

''(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), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be further 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 drugs (as defined in section 1860D(a)(2)) to individuals described in subparagraph (A), (B), (C), or (D) of section 1860D–19(a)(3); and

''(B) ensures 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 fiscal 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) the last 3 quarters of fiscal year 2006, is equal to $22,500,000;

''(ii) fiscal year 2007, is equal to $30,000,000; and

''(iii) any subsequent fiscal year, is equal to the aggregate amount specified in this subparagraph for the previous fiscal year increased by the annual percentage increase specified in section 1860D–6(c)(5) for the calendar year beginning in such fiscal year.

''(4) NONAPPLICATION.—Section 1927(d)(2)(E) shall not apply to a State described in paragraph (1) for purposes of providing medical assistance described in paragraph (2)(A).

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

''(f) DEFINITION.—For purposes of this section, the term 'subsidy-eligible individual' has the meaning given that term in subparagraph (D) of section 1860D–19(a)(4).''.

(C) CONFORMING AMENDMENTS.—

(1) Section 1903(a)(1) (42 U.S.C. 1396a(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) Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting ''and section 1935(e)(1)(B)'' after ''Subject to subsection (g)''.

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

(A) by striking ''and'' at the end of subclause (IV);

(B) by striking the period at the end of subclause (V) and inserting ''; and''; and

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

''(VI) any prices charged which are negotiated under a Medicare Prescription Drug plan under part D of title XVIII with respect to covered drugs, under a MedicareAdvantage plan under part C of such title with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(f)(1)) with respect to such drugs, on behalf of eligible beneficiaries (as defined in section 1860D(a)(3).''.

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

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

''(iv) subject to sections 1933 and 1905(p)(4), for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2008) for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;''.

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

(A) in paragraph (1)—

(i) in subparagraph (D), by striking ''and'' at the end;

(ii) in subparagraph (E)—

(I) by striking ''fiscal year 2002'' and inserting ''each of fiscal years 2002 through 2008''; and

(II) by striking the period and inserting ''; and''; and

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

''(F) the first quarter of fiscal year 2009, $100,000,000.''; and

(B) in paragraph (2)(A), by striking ''the sum of'' and all that follows through ''1902(a)(10)(E)(iv)(II) in the State; to'' and

inserting ''twice the total number of individuals described in section 1902(a)(10)(E)(iv) in the State; to''.

(d) OUTREACH BY THE COMMISSIONER OF SOCIAL SECURITY.—Section 1144 (42 U.S.C. 1320b–14) is amended—

(1) in the section heading, by inserting ''AND SUBSIDIES FOR LOW-INCOME INDIVIDUALS UNDER TITLE XVIII'' after ''COST-SHARING'';

(2) in subsection (a)—

(A) in paragraph (1)—

(i) in subparagraph (A), by inserting ''for the transitional prescription drug assistance card program under section 1807A, or for premium and cost-sharing subsidies under section 1860D–19'' before the semicolon; and

(ii) in subparagraph (B), by inserting '', program, and subsidies'' after ''medical assistance''; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting '', the transitional prescription drug assistance card program under section 1807A, or premium and cost-sharing subsidies under section 1860D–19'' after ''assistance''; and

(ii) in subparagraph (A), by striking ''such eligibility'' and inserting ''eligibility for medicare cost-sharing under the medicaid program''; and

(3) in subsection (b)—

(A) in paragraph (1)(A), by inserting '', for the transitional prescription drug assistance card program under section 1807A, or for premium and cost-sharing subsidies for low-income individuals under section 1860D–19'' after ''1933''; and

(B) in paragraph (2), by inserting '', program, and subsidies'' after ''medical assistance''.

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 drug benefit programs,'' after ''other health professionals,''.

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(A) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (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, 2005.

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

''(D) VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.—Specifically, the Commission shall review, with respect to the voluntary prescription drug delivery program under part D, competition among eligible entities offering Medicare Prescription Drug plans and beneficiary access to such plans and covered drugs, particularly in rural areas.''.

SEC. 106. STUDY REGARDING VARIATIONS IN SPENDING AND DRUG UTILIZATION.

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

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

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

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

Subtitle B—Medicare Prescription Drug Discount Card and Transitional Assistance for Low-Income Beneficiaries

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

(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) ESTABLISHMENT.—There is established a medicare prescription drug discount card endorsement program under which the Secretary shall—

''(1) endorse prescription drug discount card programs offered by prescription drug card sponsors that meet the requirements of this section; and

''(2) make available to eligible beneficiaries information regarding such endorsed programs.

''(b) ELIGIBILITY, ELECTION OF PROGRAM, AND ENROLLMENT FEES.—

''(1) ELIGIBILITY AND ELECTION OF PROGRAM.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall establish procedures—

''(i) for identifying eligible beneficiaries; and

''(ii) under which such beneficiaries may make an election to enroll in any prescription drug discount card program endorsed under this section and disenroll from such a program.

''(B) LIMITATION.—An eligible beneficiary may not be enrolled in more than 1 prescription drug discount card program at any time.

''(2) ENROLLMENT FEES.—

''(A) IN GENERAL.—A prescription drug card sponsor may charge an annual enrollment fee to each eligible beneficiary enrolled in a prescription drug discount card program offered by such sponsor.

''(B) AMOUNT.—No enrollment fee charged under subparagraph (A) may exceed $25.

''(C) UNIFORM ENROLLMENT FEE.—A prescription drug card sponsor shall ensure that the enrollment fee for a prescription drug discount card program endorsed under this section is the same for all eligible medicare beneficiaries enrolled in the program.

''(D) COLLECTION.—Any enrollment fee shall be collected by the prescription drug card sponsor.

''(c) PROVIDING INFORMATION TO ELIGIBLE BENEFICIARIES.—

''(1) PROMOTION OF INFORMED CHOICE.—

''(A) BY THE SECRETARY.—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. Such dissemination shall be coordinated with the dissemination of educational information on other medicare options.

''(B) BY PRESCRIPTION DRUG CARD SPONSORS.—Each prescription drug card sponsor shall make available to each eligible beneficiary (through the Internet and otherwise) information—

''(i) that the Secretary identifies as being necessary to promote informed choice among endorsed prescription drug discount card programs by eligible beneficiaries, including information on enrollment fees, negotiated prices for prescription drugs charged to beneficiaries, and services relating to prescription drugs offered under the program;

''(ii) on how any formulary used by such sponsor functions.

''(2) 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 medicare prescription drug discount card endorsement program established under this section and prescription drug discount card programs endorsed under such program.

''(d) BENEFICIARY PROTECTIONS.—

''(1) IN GENERAL.—Each prescription drug discount card program endorsed under this section shall meet such requirements as the Secretary identifies to protect and promote the interest of eligible beneficiaries, including requirements that—

''(A) relate to appeals by eligible beneficiaries and marketing practices; and

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

''(2) ENSURING PHARMACY ACCESS.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section 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 Secretary and including adequate emergency access) for enrolled beneficiaries. Such standards shall take into account reasonable distances to pharmacy services in both urban and rural areas.

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

''(4) CONFIDENTIALITY OF ENROLLEE RECORDS.—Insofar as a prescription drug card sponsor maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in a prescription drug discount card program endorsed under this section, the prescription drug card sponsor shall have in place procedures to safeguard the privacy of any individually identifiable beneficiary information in a manner that the Secretary determines is consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(5) NO OTHER FEES.—A prescription drug card sponsor may not charge any fee to an eligible beneficiary under a prescription drug discount card program endorsed under this section other than an enrollment fee charged under subsection (b)(2)(A).

''(6) PRICES.—

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

''(B) PRICE STABILITY.—Negotiated prices charged for prescription drugs covered under

a prescription drug discount card program endorsed under this section may not change more frequently than once every 60 days.

''(e) PRESCRIPTION DRUG BENEFITS.—

''(1) IN GENERAL.—Each prescription drug card sponsor may only provide benefits that relate to prescription drugs (as defined in subsection (i)(2)) under a prescription drug discount card program endorsed under this section.

''(2) SAVINGS TO ELIGIBLE BENEFICIARIES.—

''(A) IN GENERAL.—Subject to subparagraph (D), each prescription drug card sponsor shall provide eligible beneficiaries who enroll in a prescription drug discount card program offered by such sponsor that is endorsed under this section with access to negotiated prices used by the sponsor with respect to prescription drugs dispensed to eligible beneficiaries.

''(B) INAPPLICABILITY OF MEDICAID BEST PRICE RULES.—The requirements of section 1927 relating to manufacturer best price shall not apply to the negotiated prices for prescription drugs made available under a prescription drug discount card program endorsed under this section.

''(C) GUARANTEED ACCESS TO NEGOTIATED PRICES.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures to ensure that eligible beneficiaries have access to the negotiated prices for prescription drugs provided under subparagraph (A).

''(D) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug discount card program if the program excludes the drug under a formulary.

''(3) BENEFICIARY SERVICES.—Each prescription drug discount card program endorsed under this section shall provide pharmaceutical support services, such as education, counseling, and services to prevent adverse drug interactions.

''(4) DISCOUNT CARDS.—Each prescription drug card sponsor shall issue a card to eligible beneficiaries enrolled in a prescription drug discount card program offered by such sponsor that the beneficiary may use to obtain benefits under the program.

''(f) SUBMISSION OF APPLICATIONS FOR ENDORSEMENT AND APPROVAL.—

''(1) SUBMISSION OF APPLICATIONS FOR ENDORSEMENT.—Each prescription drug card sponsor that seeks endorsement of a prescription drug discount card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, such information as the Secretary may require.

''(2) APPROVAL.—The Secretary shall review the information submitted under paragraph (1) and shall determine whether to endorse the prescription drug discount card program to which such information relates. The Secretary may not approve a program unless the program and prescription drug card sponsor offering the program comply with the requirements under this section.

''(g) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a prescription drug card sponsor offering a prescription drug discount card program uses a formulary, the following requirements must be met:

''(1) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

''(A) IN GENERAL.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary.

''(B) COMPOSITION.—A pharmacy and therapeutic committee shall include at least 1 academic expert, at least 1 practicing physician, and at least 1 practicing pharmacist, all of whom have expertise in the care of elderly or disabled persons, and a majority of the members of such committee shall consist of individuals who are a practicing physician or a practicing pharmacist (or both).

''(2) 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.

''(3) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES AND CLASSES.—

''(A) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs (as defined by the Secretary), although not necessarily for all drugs within such categories and classes.

''(B) REQUIREMENT.—In defining therapeutic categories and classes of covered outpatient drugs pursuant to subparagraph (A), the Secretary shall use the compendia referred to section 1927(g)(1)(B)(i) or other recognized sources for categorizing drug therapeutic categories and classes.

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

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

''(h) FRAUD AND ABUSE PREVENTION.—

''(1) IN GENERAL.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed programs with the requirements of this section, including verification of the negotiated prices and services provided.

''(2) DISQUALIFICATION FOR ABUSIVE PRACTICES.—The Secretary may implement intermediate sanctions and may 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.

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

''(4) REPORTING TO SECRETARY.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall report information relating to program performance, use of prescription drugs by eligible beneficiaries enrolled in the program, financial information of the sponsor, and such other information as the Secretary may specify. The Secretary may not disclose any proprietary data reported under this paragraph.

''(5) DRUG UTILIZATION REVIEW.—The Secretary may use claims data from parts A and B for purposes of conducting a drug utilization review program.

''(i) DEFINITIONS.—In this section:

''(1) ELIGIBLE BENEFICIARY.—

''(A) IN GENERAL.—The term 'eligible beneficiary' means an individual who—

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

''(ii) is not a dual eligible individual (as defined in subparagraph (B)).

''(B) DUAL ELIGIBLE INDIVIDUAL.—

''(i) IN GENERAL.—The term 'dual eligible individual' means an individual who is—

''(I) enrolled under title XIX or under a waiver under section 1115 of the requirements of such title for medical assistance that includes but is limited solely to covered outpatient drugs (as such term is defined for purposes of section 1927); and

''(II) entitled to benefits under part A and enrolled under part B.

''(ii) INCLUSION OF MEDICALLY NEEDY.—Such term includes an individual described in section 1902(a)(10)(C).

''(2) PRESCRIPTION DRUG.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'prescription drug' means—

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

''(ii) a biological product or insulin described in subparagraph (B) or (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)).

''(B) EXCLUSIONS.—The term 'prescription drug' 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).

''(3) NEGOTIATED PRICE.—The term 'negotiated price' includes all discounts, direct or indirect subsidies, rebates, price concessions, and direct or indirect remunerations.

''(4) PRESCRIPTION DRUG CARD SPONSOR.—The term 'prescription drug card sponsor' means any entity with demonstrated experience and expertise in operating a prescription drug discount card program, an insurance program that provides coverage for prescription drugs, or a similar program that the Secretary determines to be appropriate to provide eligible beneficiaries with the benefits under a prescription drug discount card program endorsed by the Secretary under this section, including—

''(A) a pharmaceutical benefit management company;

''(B) a wholesale or retail pharmacist delivery system;

''(C) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

''(D) any other entity; or

''(E) any combination of the entities described in subparagraphs (A) through (D).

''TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE CARD PROGRAM FOR ELIGIBLE LOW-INCOME BENEFICIARIES

''SEC. 1807A. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is established a program under which the Secretary shall award contracts to prescription drug card sponsors offering a prescription drug discount card that has been endorsed by the Secretary under section 1807 under which such sponsors shall offer a prescription drug assistance card program to eligible low-income beneficiaries in accordance with the requirements of this section.

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

''(b) ELIGIBILITY, ELECTION OF PROGRAM, AND ENROLLMENT FEES.—

''(1) ELIGIBILITY AND ELECTION OF PROGRAM.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, the enrollment procedures established under section 1807(b)(1)(A)(ii) shall apply for purposes of this section.

''(B) ENROLLMENT OF ANY ELIGIBLE LOW-INCOME BENEFICIARY.—Each prescription drug card sponsor offering a prescription drug assistance card program under this section shall permit any eligible low-income beneficiary to enroll in such program if it serves the geographic area in which the beneficiary resides.

''(C) SIMULTANEOUS ENROLLMENT IN PRESCRIPTION DRUG DISCOUNT CARD PROGRAM.—An eligible low-income beneficiary who enrolls in a prescription drug assistance card program offered by a prescription drug card sponsor under this section shall be simultaneously enrolled in a prescription drug discount card program offered by such sponsor.

''(2) WAIVER OF ENROLLMENT FEES.—

''(A) IN GENERAL.—A prescription drug card sponsor may not charge an enrollment fee to any eligible low-income beneficiary enrolled in a prescription drug discount card program offered by such sponsor.

''(B) PAYMENT BY SECRETARY.—Under a contract awarded under subsection (f)(2), the Secretary shall pay to each prescription drug card sponsor an amount equal to any enrollment fee charged under section 1807(b)(2)(A) on behalf of each eligible low-income beneficiary enrolled in a prescription drug discount card program under paragraph (1)(C) offered by such sponsor.

''(c) ADDITIONAL BENEFICIARY PROTECTIONS.—

''(1) PROVIDING INFORMATION TO ELIGIBLE LOW-INCOME BENEFICIARIES.—In addition to the information provided to eligible beneficiaries under section 1807(c), the prescription drug card sponsor shall—

''(A) periodically notify each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor of the amount of coverage for prescription drugs remaining under subsection (d)(2)(A); and

''(B) notify each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor of the grievance and appeals processes under the program.

''(2) CONVENIENT ACCESS IN LONG-TERM CARE FACILITIES.—For purposes of determining whether convenient access has been provided under section 1807(d)(2) with respect to eligible low-income beneficiaries enrolled in a prescription drug assistance card program, the Secretary may only make a determination that such access has been provided if an appropriate arrangement is in place for eligible low-income beneficiaries who are in a long-term care facility (as defined by the Secretary) to receive prescription drug benefits under the program.

''(3) COORDINATION OF BENEFITS.—

''(A) IN GENERAL.—The Secretary shall establish procedures under which eligible low-income beneficiaries who are enrolled for coverage described in subparagraph (B) and enrolled in a prescription drug assistance card program have access to the prescription drug benefits available under such program.

''(B) COVERAGE DESCRIBED.—Coverage described in this subparagraph is as follows:

''(i) Coverage of prescription drugs under a State pharmaceutical assistance program.

''(ii) Enrollment in a Medicare+Choice plan under part C.

''(4) GRIEVANCE MECHANISM.—Each prescription drug card sponsor with a contract under this section shall provide in accordance with section 1852(f) meaningful procedures for hearing and resolving grievances between the prescription drug card sponsor (including any entity or individual through which the prescription drug card sponsor provides covered benefits) and enrollees in a prescription drug assistance card program offered by such sponsor.

''(5) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—

''(A) IN GENERAL.—The requirements of paragraphs (1) through (3) of section 1852(g) shall apply with respect to covered benefits under a prescription drug assistance card program under this section 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.

''(B) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug assistance card program offered by a prescription drug card sponsor that provides for tiered pricing for drugs included within a formulary and provides lower prices for preferred drugs included within the formulary, an eligible low-income beneficiary who is enrolled in the program 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 eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

''(C) FORMULARY DETERMINATIONS.—An eligible low-income beneficiary who is enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor may appeal to obtain coverage for a covered drug that is not on a formulary of the entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

''(6) APPEALS.—

''(A) IN GENERAL.—Subject to subparagraph (B), a prescription drug card sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in a similar manner (as determined by the Secretary) as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(B) FORMULARY DETERMINATIONS.—An eligible low-income beneficiary who is enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor may appeal to obtain coverage for a covered drug that is not on a formulary of the entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

''(C) APPEALS AND EXCEPTIONS TO APPLICATION.—The prescription drug card sponsor must have, as part of the appeals process under this paragraph, a process for timely appeals for denials of coverage based on the application of the formulary.

''(d) PRESCRIPTION DRUG BENEFITS.—

''(1) IN GENERAL.—Subject to paragraph (5), all the benefits available under a prescription drug discount card program offered by a prescription drug card sponsor and endorsed under section 1807 shall be available to eligible low-income beneficiaries enrolled in a prescription drug assistance card program offered by such sponsor.

''(2) ASSISTANCE FOR ELIGIBLE LOW-INCOME BENEFICIARIES.—

''(A) $600 ANNUAL ASSISTANCE.—Subject to subparagraphs (B) and (C) and paragraph (5), each prescription drug card sponsor with a contract under this section shall provide coverage for the first $600 of expenses for prescription drugs incurred during each calendar year by an eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor.

''(B) COINSURANCE.—

''(i) IN GENERAL.—The prescription drug card sponsor shall determine an amount of coinsurance to collect from each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor for which coverage is available under subparagraph (A).

''(ii) AMOUNT.—The amount of coinsurance collected under clause (i) shall be at least 10 percent of the negotiated price of each prescription drug dispensed to an eligible low-income beneficiary.

''(iii) CONSTRUCTION.—Amounts collected under clause (i) shall not be counted against the total amount of coverage available under subparagraph (A).

''(C) REDUCTION FOR LATE ENROLLMENT.—For each month during a calendar quarter in which an eligible low-income beneficiary is not enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor with a contract under this section, the amount of assistance available under subparagraph (A) shall be reduced by $50.

''(D) CREDITING OF UNUSED BENEFITS TOWARD FUTURE YEARS.—The dollar amount of coverage described in subparagraph (A) shall be increased by any amount of coverage described in such subparagraph that was not used during the previous calendar year.

''(E) WAIVER TO ENSURE PROVISION OF BENEFIT.—The Secretary may waive such requirements of this section and section 1807 as may be necessary to ensure that each eligible low-income beneficiaries has access to the assistance described in subparagraph (A).

''(3) ADDITIONAL DISCOUNTS.—A prescription drug card sponsor with a contract under this section shall provide each eligible low-income beneficiary enrolled in a prescription drug assistance program offered by the sponsor with access to negotiated prices that reflect a minimum average discount of at least 20 percent of the average wholesale price for prescription drugs covered under that program.

''(4) ASSISTANCE CARDS.—Each prescription drug card sponsor shall permit eligible low-income beneficiaries enrolled in a prescription drug assistance card program offered by such sponsor to use the discount card issued under section 1807(e)(4) to obtain benefits under the program.

''(5) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible low-income beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug assistance card program if the program excludes the drug under a formulary and such exclusion is not successfully resolved under paragraph (4), (5), or (6) of subsection (c).

''(e) REQUIREMENTS FOR PRESCRIPTION DRUG CARD SPONSORS THAT OFFER PRESCRIPTION DRUG ASSISTANCE CARD PROGRAMS.—

''(1) IN GENERAL.—Each prescription drug card sponsor shall—

''(A) process claims made by eligible low-income beneficiaries;

''(B) negotiate with brand name and generic prescription drug manufacturers and others for low prices on prescription drugs;

''(C) track individual beneficiary expenditures in a format and periodicity specified by the Secretary; and

''(D) perform such other functions as the Secretary may assign.

''(2) DATA EXCHANGES.—Each prescription drug card sponsor shall receive data exchanges in a format specified by the Secretary and shall maintain real-time beneficiary files.

''(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—The prescription drug card sponsor offering the prescription drug assistance card program shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the eligible low-income 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 priced generic drug covered under the plan that is therapeutically equivalent and bioequivalent and available at such pharmacy or other dispenser.

''(f) SUBMISSION OF BIDS AND AWARDING OF CONTRACTS.—

''(1) SUBMISSION OF BIDS.—Each prescription drug card sponsor that seeks to offer a prescription drug assistance card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, such information as the Secretary may require.

''(2) AWARDING OF CONTRACTS.—The Secretary shall review the information submitted under paragraph (1) and shall determine whether to award a contract to the prescription drug card sponsor offering the program to which such information relates. The Secretary may not approve a program unless the program and prescription drug card sponsor offering the program comply with the requirements under this section.

''(3) NUMBER OF CONTRACTS.—There shall be no limit on the number of prescription drug card sponsors that may be awarded contracts under paragraph (2).

''(4) CONTRACT PROVISIONS.—

''(A) DURATION.—A contract awarded under paragraph (2) shall be for the lifetime of the program under this section.

''(B) WITHDRAWAL.—A prescription drug card sponsor that desires to terminate the contract awarded under paragraph (2) may terminate such contract without penalty if such sponsor gives notice—

''(i) to the Secretary 90 days prior to the termination of such contract; and

''(ii) to each eligible low-income beneficiary that is enrolled in a prescription drug assistance card program offered by such sponsor 60 days prior to such termination.

''(C) SERVICE AREA.—The service area under the contract shall be the same as the area served by the prescription drug card sponsor under section 1807.

''(5) SIMULTANEOUS APPROVAL OF DISCOUNT CARD AND ASSISTANCE PROGRAMS.—A prescription drug card sponsor may submit an application for endorsement under section 1807 as part of the bid submitted under paragraph (1) and the Secretary may approve such application at the same time as the Secretary awards a contract under this section.

''(g) PAYMENTS TO PRESCRIPTION DRUG CARD SPONSORS.—

''(1) IN GENERAL.—The Secretary shall pay to each prescription drug card sponsor offering a prescription drug assistance card program in which an eligible low-income beneficiary is enrolled an amount equal to the amount agreed to by the Secretary and the sponsor in the contract awarded under subsection (f)(2).

''(2) PAYMENT FROM PART B TRUST FUND.—The costs of providing benefits under this section shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

''(h) ELIGIBILITY DETERMINATIONS MADE BY STATES; PRESUMPTIVE ELIGIBILITY.—States shall perform the functions described in section 1935(a)(1).

''(i) APPROPRIATIONS.—There are appropriated from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 such sums as may be necessary to carry out the program under this section.

''(j) DEFINITIONS.—In this section:

''(1) ELIGIBLE BENEFICIARY; NEGOTIATED PRICE; PRESCRIPTION DRUG.—The terms 'eligible beneficiary', 'negotiated price', and 'prescription drug' have the meanings given those terms in section 1807(i).

''(2) ELIGIBLE LOW-INCOME BENEFICIARY.—The term 'eligible low-income beneficiary' means an individual who—

''(A) is an eligible beneficiary (as defined in section 1807(i));

''(B) is not a dual eligible beneficiary as defined under section 1807(i)(1)(B); and

''(C) is described in clause (iii) or (iv) of section 1902(a)(10)(E) or in section 1905(p)(1).

''(3) PRESCRIPTION DRUG CARD SPONSOR.—The term 'prescription drug card sponsor' has the meaning given that term in section 1807(i), except that such sponsor shall also be an entity that the Secretary determines is—

''(A) is appropriate to provide eligible low-income beneficiaries with the benefits under a prescription drug assistance card program under this section; and

''(B) is able to manage the monetary assistance made available under subsection (d)(2);

''(C) agrees to submit to audits by the Secretary; and

''(D) provides such other assurances as the Secretary may require.

''(4) STATE.—The term 'State' has the meaning given such term for purposes of title XIX.''.

(b) EXCLUSION OF PRICES FROM DETERMINATION OF 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 negotiated prices charged under the medicare prescription drug discount card endorsement program under section 1807 or under the transitional prescription drug assistance card program for eligible low-income beneficiaries under section 1807A.''.

(c) EXCLUSION OF PRESCRIPTION DRUG ASSISTANCE CARD COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(g) of the Social Security Act (42 U.S.C. 1395r(g)) is amended—

(1) by striking ''attributable to the application of section'' and inserting ''attributable to—

''(1) the application of section'';

(2) by striking the period and inserting ''; and''; and

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

''(2) the prescription drug assistance card program under section 1807A.''.

(d) REGULATIONS.—

(1) AUTHORITY FOR INTERIM FINAL REGULATIONS.—The Secretary may promulgate initial regulations implementing sections 1807 and 1807A of the Social Security Act (as added by this section) in interim final form without prior opportunity for public comment.

(2) FINAL REGULATIONS.—A final regulation reflecting public comments must be published within 1 year of the interim final regulation promulgated under paragraph (1).

(3) EXEMPTION FROM THE PAPERWORK REDUCTION ACT.—The promulgation of the regulations under this subsection and the administration the programs established by sections 1807 and 1807A of the Social Security Act (as added by this section) shall be made without regard to chapter 35 of title 44, United States Code (commonly known as the ''Paperwork Reduction Act'').

(e) IMPLEMENTATION; TRANSITION.—

(1) IMPLEMENTATION.—The Secretary shall implement the amendments made by this section in a manner that discounts are available to eligible beneficiaries under section 1807 of the Social Security Act and assistance is available to eligible low-income beneficiaries under section 1807A of such Act not later than January 1, 2004.

(2) TRANSITION.—The Secretary shall provide for an appropriate transition and discontinuation of the programs under section 1807 and 1807A of the Social Security Act. Such transition and discontinuation shall ensure that such programs continue to operate until the date on which the first enrollment period under part D ends.

Subtitle C—Standards for Electronic Prescribing

SEC. 121. STANDARDS FOR ELECTRONIC PRESCRIBING.

Title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

''PART D—ELECTRONIC PRESCRIBING

''STANDARDS FOR ELECTRONIC PRESCRIBING

''SEC. 1180. (a) STANDARDS.—

''(1) DEVELOPMENT AND ADOPTION.—

''(A) IN GENERAL.—The Secretary shall develop or adopt standards for transactions and data elements for such transactions (in this section referred to as 'standards') to enable the electronic transmission of medication history, eligibility, benefit, and other prescription information.

''(B) CONSULTATION.—In developing and adopting the standards under subparagraph (A), the Secretary shall consult with representatives of physicians, hospitals, pharmacists, standard setting organizations, pharmacy benefit managers, beneficiary information exchange networks, technology experts, and representatives of the Departments of Veterans Affairs and Defense and other interested parties.

''(2) OBJECTIVE.—Any standards developed or adopted under this part shall be consistent with the objectives of improving—

''(A) patient safety; and

''(B) the quality of care provided to patients.

''(3) REQUIREMENTS.—Any standards developed or adopted under this part shall comply with the following:

''(A) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—

''(i) IN GENERAL.—Except as provided in clause (ii), the standards require that prescriptions be written and transmitted electronically.

''(ii) EXCEPTIONS.—The standards shall not require a prescription to be written and transmitted electronically—

''(I) in emergency cases and other exceptional circumstances recognized by the Administrator; or

''(II) if the patient requests that the prescription not be transmitted electronically.

If a patient makes a request under subclause (II), no additional charges may be imposed on the patient for making such request.

''(B) PATIENT-SPECIFIC MEDICATION HISTORY, ELIGIBILITY, BENEFIT, AND OTHER PRESCRIPTION INFORMATION.—

''(i) IN GENERAL.—The standards shall accommodate electronic transmittal of patient-specific medication history, eligibility, benefit, and other prescription information among prescribing and dispensing professionals at the point of care.

''(ii) REQUIRED INFORMATION.—The information described in clause (i) shall include the following:

''(I) Information (to the extent available and feasible) on the drugs being prescribed for that patient and other information relating to the medication history of the patient that may be relevant to the appropriate prescription for that patient.

''(II) Cost-effective alternatives (if any) to the drug prescribed.

''(III) Information on eligibility and benefits, including the drugs included in the applicable formulary and any requirements for prior authorization.

''(IV) Information on potential interactions with drugs listed on the medication history, graded by severity of the potential interaction.

''(V) Other information to improve the quality of patient care and to reduce medical errors.

''(C) UNDUE BURDEN.—The standards shall be designed so that, to the extent practicable, the standards do not impose an undue administrative burden on the practice of medicine, pharmacy, or other health professions.

''(D) COMPATIBILITY WITH ADMINISTRATIVE SIMPLIFICATION AND PRIVACY LAWS.—The standards shall be—

''(i) 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; and

''(ii) compatible with the standards adopted under part C.

''(4) TRANSFER OF INFORMATION.—The Secretary shall develop and adopt standards for transferring among prescribing and insurance entities and other necessary entities appropriate standard data elements needed for the electronic exchange of medication history, eligibility, benefit, and other prescription drug information and other health information determined appropriate in compliance with the standards adopted or modified under this part.

''(b) TIMETABLE FOR ADOPTION OF STANDARDS.—

''(1) IN GENERAL.—The Secretary shall adopt the standards under this part by January 1, 2006.

''(2) ADDITIONS AND MODIFICATIONS TO STANDARDS.—The Secretary shall, in consultation with appropriate representatives of interested parties, review the standards developed or adopted under this part and adopt modifications to the standards (including additions to the standards), as determined appropriate. Any addition or modification to such standards shall be completed in a manner which minimizes the disruption and cost of compliance.

''(c) COMPLIANCE WITH STANDARDS.—

''(1) REQUIREMENT FOR ALL INDIVIDUALS AND ENTITIES THAT TRANSMIT OR RECEIVE PRESCRIPTIONS ELECTRONICALLY.—

''(A) IN GENERAL.—Individuals or entities that transmit or receive electronic medication history, eligibility, benefit and prescription information, shall comply with the standards adopted or modified under this part.

''(B) RELATION TO STATE LAWS.—The standards adopted or modified under this part shall supersede any State law or regulations pertaining to the electronic transmission of medication history, eligibility, benefit and prescription information.

''(2) TIMETABLE FOR COMPLIANCE.—

''(A) INITIAL COMPLIANCE.—

''(i) IN GENERAL.—Not later than 24 months after the date on which an initial standard is adopted under this part, each individual or entity to whom the standard applies shall comply with the standard.

''(ii) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, as defined by the Secretary for purposes of section 1175(b)(1)(B), clause (i) shall be applied by substituting '36 months' for '24 months'.

''(d) CONSULTATION WITH ATTORNEY GENERAL.—The Secretary shall consult with the Attorney General before developing, adopting, or modifying a standard under this part to ensure that the standard accommodates secure electronic transmission of prescriptions for controlled substances in a manner that minimizes the possibility of violations under the Comprehensive Drug Abuse Prevention and Control Act of 1970 and related Federal laws.

''GRANTS TO HEALTH CARE PROVIDERS TO IMPLEMENT ELECTRONIC PRESCRIPTION PROGRAMS

''SEC. 1180A. (a) IN GENERAL.—The Secretary is authorized to make grants to health care providers for the purpose of assisting such entities to implement electronic prescription programs that comply with the standards adopted or modified under this part.

''(b) APPLICATION.—No grant may be made under this section except pursuant to a grant application that is submitted in a time, manner, and form approved by the Secretary.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of fiscal years 2006, 2007, and 2008, such sums as may be necessary to carry out this section.''.

TITLE II—MEDICAREADVANTAGE

Subtitle A—MedicareAdvantage Competition

SEC. 201. ELIGIBILITY, ELECTION, AND ENROLLMENT.

Section 1851 (42 U.S.C. 1395w–21) is amended to read as follows:

''ELIGIBILITY, ELECTION, AND ENROLLMENT

''SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICAREADVANTAGE PLANS.—

''(1) IN GENERAL.—Subject to the provisions of this section, each MedicareAdvantage eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

''(A) through—

''(i) the original Medicare fee-for-service program under parts A and B; and

''(ii) the voluntary prescription drug delivery program under part D; or

''(B) through enrollment in a MedicareAdvantage plan under this part.

''(2) TYPES OF MEDICAREADVANTAGE PLANS THAT MAY BE AVAILABLE.—A MedicareAdvantage plan may be any of the following types of plans of health insurance:

''(A) COORDINATED CARE PLANS.—Coordinated care plans which provide health care services, including health maintenance organization plans (with or without point of service options) and plans offered by provider-sponsored organizations (as defined in section 1855(d)).

''(B) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICAREADVANTAGE MSA.—An MSA plan, as defined in section 1859(b)(3), and a contribution into a MedicareAdvantage medical savings account (MSA).

''(C) PRIVATE FEE-FOR-SERVICE PLANS.—A MedicareAdvantage private fee-for-service plan, as defined in section 1859(b)(2).

''(3) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—Subject to subparagraph (B), in this title, the term 'MedicareAdvantage eligible individual' means an individual who is entitled to (or enrolled for) benefits under part A, enrolled under part B, and enrolled under part D.

''(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that—

''(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice or a MedicareAdvantage plan may continue to be enrolled in that plan; and

''(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan or a MedicareAdvantage plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in section 1851(e)(4)(A), then the individual will be treated as a 'MedicareAdvantage eligible individual' for purposes of electing to continue enrollment in another MedicareAdvantage plan.

''(b) SPECIAL RULES.—

''(1) RESIDENCE REQUIREMENT.—

''(A) IN GENERAL.—Except as the Secretary may otherwise provide and except as provided in subparagraph (C), an individual is eligible to elect a MedicareAdvantage plan offered by a MedicareAdvantage organization only if the plan serves the geographic area in which the individual resides.

''(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that a plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the basic benefits described in section 1852(a)(1)(A), reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost-sharing liability in obtaining such benefits.

''(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a MedicareAdvantage organization eliminates from its service area a MedicareAdvantage payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in a MedicareAdvantage plan it offers so long as—

''(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

''(ii) there is no other MedicareAdvantage plan offered in the area in which the enrollee resides at the time of the organization's election.

''(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS.—

''(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

''(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

''(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working

individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

''(4) COVERAGE UNDER MSA PLANS ON A DEMONSTRATION BASIS.—

''(A) IN GENERAL.—An individual is not eligible to enroll in an MSA plan under this part—

''(i) on or after January 1, 2004, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

''(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000.

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

''(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

''(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B).

''(c) PROCESS FOR EXERCISING CHOICE.—

''(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

''(2) COORDINATION THROUGH MEDICAREADVANTAGE ORGANIZATIONS.—

''(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a MedicareAdvantage plan offered by a MedicareAdvantage organization to make such election through the filing of an appropriate election form with the organization.

''(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a MedicareAdvantage plan offered by a MedicareAdvantage organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

''(3) DEFAULT.—

''(A) INITIAL ELECTION.—

''(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the original medicare fee-for-service program option.

''(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a Medicare+Choice plan or another health plan (other than a MedicareAdvantage plan) offered by a MedicareAdvantage organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the MedicareAdvantage plan offered by the organization (or, if the organization offers more than 1 such plan, such plan or plans as the Secretary identifies under such procedures).

''(B) CONTINUING PERIODS.—An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

''(i) the individual changes the election under this section; or

''(ii) the MedicareAdvantage plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B), no longer serves the area in which the individual resides.

''(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

''(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

''(2) PROVISION OF NOTICE.—

''(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each MedicareAdvantage eligible individual residing in an area the following:

''(i) GENERAL INFORMATION.—The general information described in paragraph (3).

''(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the MedicareAdvantage plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

''(iii) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated, to the extent practicable, with the mailing of any annual notice under section 1804.

''(B) NOTIFICATION TO NEWLY ELIGIBLE MEDICAREADVANTAGE ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial MedicareAdvantage enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

''(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

''(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of MedicareAdvantage plans, the benefits under such plans, and the MedicareAdvantage monthly basic beneficiary premium, MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, and MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage for such plans.

''(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

''(A) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered under parts A and B of the original medicare fee-for-service program, including—

''(i) covered items and services;

''(ii) beneficiary cost-sharing, such as deductibles, coinsurance, and copayment amounts; and

''(iii) any beneficiary liability for balance billing.

''(B) CATASTROPHIC COVERAGE AND COMBINED DEDUCTIBLE.—A description of the catastrophic coverage and unified deductible applicable under the plan.

''(C) OUTPATIENT PRESCRIPTION DRUG COVERAGE BENEFITS.—The information required under section 1860D–4 with respect to coverage for prescription drugs under the plan.

''(D) ELECTION PROCEDURES.—Information and instructions on how to exercise election options under this section.

''(E) RIGHTS.—A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program (including such rights under part D) and the MedicareAdvantage program and the right to be protected against discrimination based on health status-related factors under section 1852(b).

''(F) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

''(G) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a MedicareAdvantage organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the MedicareAdvantage plan under this part.

''(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a MedicareAdvantage plan for a year, shall include the following:

''(A) BENEFITS.—The benefits covered under the plan, including the following:

''(i) Covered items and services beyond those provided under the original medicare fee-for-service program option.

''(ii) Beneficiary cost-sharing for any items and services described in clause (i) and paragraph (3)(A)(i), including information on the unified deductible under section 1852(a)(1)(C).

''(iii) The maximum limitations on out-of-pocket expenses under section 1852(a)(1)(C).

''(iv) In the case of an MSA plan, differences in cost-sharing, premiums, and balance billing under such a plan compared to under other MedicareAdvantage plans.

''(v) In the case of a MedicareAdvantage private fee-for-service plan, differences in cost-sharing, premiums, and balance billing under such a plan compared to under other MedicareAdvantage plans.

''(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

''(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

''(viii) The organization's coverage of emergency and urgently needed care.

''(ix) The comparative information described in section 1860D–4(b)(2) relating to prescription drug coverage under the plan.

''(B) PREMIUMS.—

''(i) IN GENERAL.—The MedicareAdvantage monthly basic beneficiary premium and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, if any, for the plan or, in the case of an MSA plan, the MedicareAdvantage monthly MSA premium.

''(ii) REDUCTIONS.—The reduction in part B premiums, if any.

''(iii) NATURE OF THE PREMIUM FOR ENHANCED MEDICAL BENEFITS.—Whether the MedicareAdvantage monthly premium for enhanced benefits is optional or mandatory.

''(C) SERVICE AREA.—The service area of the plan.

''(D) QUALITY AND PERFORMANCE.—Plan quality and performance indicators for the

benefits under the plan (and how such indicators compare to quality and performance indicators under the original medicare fee-for-service program under parts A and B and under the voluntary prescription drug delivery program under part D in the area involved), including—

''(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area);

''(ii) information on medicare enrollee satisfaction;

''(iii) information on health outcomes; and

''(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

''(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding MedicareAdvantage options and the operation of this part in all areas in which MedicareAdvantage plans are offered and an Internet site through which individuals may electronically obtain information on such options and MedicareAdvantage plans.

''(6) USE OF NON-FEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

''(7) PROVISION OF INFORMATION.—A MedicareAdvantage organization shall provide the Secretary with such information on the organization and each MedicareAdvantage plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

''(e) COVERAGE ELECTION PERIODS.—

''(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICAREADVANTAGE PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes eligible to elect to receive benefits under part B or D (whichever is later), there is 1 or more MedicareAdvantage plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a MedicareAdvantage plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

''(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5), the following rules shall apply:

''(A) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005.—At any time during the period beginning January 1, 1998, and ending on December 31, 2005, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

''(B) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2006.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), at any time during the first 6 months of 2006, or, if the individual first becomes a MedicareAdvantage eligible individual during 2006, during the first 6 months during 2006 in which the individual is a MedicareAdvantage eligible individual, a MedicareAdvantage eligible individual may change the election under subsection (a)(1).

''(ii) LIMITATION OF 1 CHANGE.—An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

''(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), at any time during the first 3 months of 2007 and each subsequent year, or, if the individual first becomes a MedicareAdvantage eligible individual during 2007 or any subsequent year, during the first 3 months of such year in which the individual is a MedicareAdvantage eligible individual, a MedicareAdvantage eligible individual may change the election under subsection (a)(1).

''(ii) LIMITATION OF 1 CHANGE DURING OPEN ENROLLMENT PERIOD EACH YEAR.—An individual may exercise the right under clause (i) only once during the applicable 3-month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

''(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time during 2006 or any subsequent year, in the case of a MedicareAdvantage eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

''(i) to enroll in a MedicareAdvantage plan; or

''(ii) to change the MedicareAdvantage plan in which the individual is enrolled.

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—

''(A) IN GENERAL.—Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

''(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a year before 2003 and after 2006, the month of November before such year and with respect to 2003, 2004, 2005, and 2006, the period beginning on November 15 and ending on December 31 of the year before such year.

''(C) MEDICAREADVANTAGE HEALTH INFORMATION FAIRS.—During the fall season of each year (beginning with 2006), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform MedicareAdvantage eligible individuals about MedicareAdvantage plans and the election process provided under this section.

''(D) SPECIAL INFORMATION CAMPAIGN IN 2005.—During the period beginning on November 15, 2005, and ending on December 31, 2005, the Secretary shall provide for an educational and publicity campaign to inform MedicareAdvantage eligible individuals about the availability of MedicareAdvantage plans, and eligible organizations with risk-sharing contracts under section 1876, offered in different areas and the election process provided under this section.

''(4) SPECIAL ELECTION PERIODS.—Effective on and after January 1, 2006, an individual may discontinue an election of a MedicareAdvantage plan offered by a MedicareAdvantage organization other than during an annual, coordinated election period and make a new election under this section if—

''(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

''(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

''(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

''(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

''(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

''(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

''(D) the individual meets such other exceptional conditions as the Secretary may provide.

Effective on and after January 1, 2006, an individual who, upon first becoming eligible for benefits under part A at age 65, enrolls in a MedicareAdvantage plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

''(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

''(A) may elect an MSA plan only during—

''(i) an initial open enrollment period described in paragraph (1);

''(ii) an annual, coordinated election period described in paragraph (3)(B); or

''(iii) the month of November 1998;

''(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under the first sentence of paragraph (4); and

''(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by the Secretary, by not later than December 15 following the date of the election.

''(6) OPEN ENROLLMENT PERIODS.—Subject to paragraph (5), a MedicareAdvantage organization—

''(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the period beginning on November 15, 2005, and ending on December 31, 2005, and during the annual, coordinated election period under paragraph (3) for each subsequent year, and during special election periods described in the first sentence of paragraph (4); and

''(B) may accept other changes to elections at such other times as the organization provides.

''(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

''(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to (or enrolled for) benefits under part A, enrolled under part B, and enrolled under part D, except as the Secretary may provide (consistent with sections 1838 and 1860D–2)) in order to prevent retroactive coverage.

''(2) DURING CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election or change is made.

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B)) in a year shall take effect as of the first day of the following year.

''(4) OTHER PERIODS.—An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

''(g) GUARANTEED ISSUE AND RENEWAL.—

''(1) IN GENERAL.—Except as provided in this subsection, a MedicareAdvantage organization shall provide that at any time during which elections are accepted under this section with respect to a MedicareAdvantage plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

''(2) PRIORITY.—If the Secretary determines that a MedicareAdvantage organization, in relation to a MedicareAdvantage plan it offers, has a capacity limit and the number of MedicareAdvantage eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

''(A) first to such individuals as have elected the plan at the time of the determination; and

''(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

''(3) LIMITATION ON TERMINATION OF ELECTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), a MedicareAdvantage organization may not for any reason terminate the election of any individual under this section for a MedicareAdvantage plan it offers.

''(B) BASIS FOR TERMINATION OF ELECTION.—A MedicareAdvantage organization may terminate an individual's election under this section with respect to a MedicareAdvantage plan it offers if—

''(i) any MedicareAdvantage monthly basic beneficiary premium, MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, or MedicareAdvantage monthly beneficiary premium for required or optional enhanced medical benefits required with respect to such plan are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of such premiums);

''(ii) the individual has engaged in disruptive behavior (as specified in such standards); or

''(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

''(C) CONSEQUENCE OF TERMINATION.—

''(i) TERMINATIONS FOR CAUSE.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected to receive benefits under the original medicare fee-for-service program option.

''(ii) TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another MedicareAdvantage plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the original medicare fee-for-service program option.

''(D) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1857858., each MedicareAdvantage organization receiving an election form under subsection (c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

''(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

''(1) SUBMISSION.—No marketing material or application form may be distributed by a MedicareAdvantage organization to (or for the use of) MedicareAdvantage eligible individuals unless—

''(A) at least 45 days (or 10 days in the case described in paragraph (5)) before the date of distribution the organization has submitted the material or form to the Secretary for review; and

''(B) the Secretary has not disapproved the distribution of such material or form.

''(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

''(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a MedicareAdvantage plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except with regard to that portion of such material or form that is specific only to an area involved.

''(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each MedicareAdvantage organization shall conform to fair marketing standards, in relation to MedicareAdvantage plans offered under this part, included in the standards established under section 1856. Such standards—

''(A) shall not permit a MedicareAdvantage organization to provide for cash or other monetary rebates as an inducement for enrollment or otherwise (other than as an additional benefit described in section 1854(g)(1)(C)(i)); and

''(B) may include a prohibition against a MedicareAdvantage organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual.

''(5) SPECIAL TREATMENT OF MARKETING MATERIAL FOLLOWING MODEL MARKETING LANGUAGE.—In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

''(i) EFFECT OF ELECTION OF MEDICAREADVANTAGE PLAN OPTION.—

''(1) PAYMENTS TO ORGANIZATIONS.—Subject to sections 1852(a)(5), 1853(h), 1853(i), 1886(d)(11), and 1886(h)(3)(D), payments under a contract with a MedicareAdvantage organization under section 1853(a) with respect to an individual electing a MedicareAdvantage plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable under parts A, B, and D for items and services furnished to the individual.

''(2) ONLY ORGANIZATION ENTITLED TO PAYMENT.—Subject to sections 1853(f), 1853(h), 1853(i), 1857(f)(2), 1886(d)(11), and 1886(h)(3)(D), only the MedicareAdvantage organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.''.

SEC. 202. BENEFITS AND BENEFICIARY PROTECTIONS.

Section 1852 (42 U.S.C. 1395w–22) is amended to read as follows:

''BENEFITS AND BENEFICIARY PROTECTIONS

''SEC. 1852. (a) BASIC BENEFITS.—

''(1) IN GENERAL.—Except as provided in section 1859(b)(3) for MSA plans, each MedicareAdvantage plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

''(A) those items and services (other than hospice care) for which benefits are available under parts A and B to individuals residing in the area served by the plan;

''(B) except as provided in paragraph (2)(D), qualified prescription drug coverage under part D to individuals residing in the area served by the plan;

''(C) a maximum limitation on out-of-pocket expenses and a unified deductible; and

''(D) additional benefits required under section 1854(d)(1).

''(2) SATISFACTION OF REQUIREMENT.—

''(A) IN GENERAL.—A MedicareAdvantage plan (other than an MSA plan) offered by a MedicareAdvantage organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

''(i) the sum of such payment amount and any cost-sharing provided for under the plan; is equal to at least

''(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

''(B) REFERENCE TO RELATED PROVISIONS.—For provisions relating to—

''(i) limitations on balance billing against MedicareAdvantage organizations for non-contract providers, see sections 1852(k) and 1866(a)(1)(O); and

''(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1854(f).

''(C) ELECTION OF UNIFORM COVERAGE POLICY.—In the case of a MedicareAdvantage organization that offers a MedicareAdvantage plan in an area in which more than 1 local coverage policy is applied with respect to different parts of the area, the organization may elect to have the local coverage policy for the part of the area that is most beneficial to MedicareAdvantage enrollees (as identified by the Secretary) apply with respect to all MedicareAdvantage enrollees enrolled in the plan.

''(D) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE PLANS.—

''(i) IN GENERAL.—A private fee-for-service plan may elect not to provide qualified prescription drug coverage under part D to individuals residing in the area served by the plan.

''(ii) AVAILABILITY OF DRUG COVERAGE FOR ENROLLEES.—If a beneficiary enrolls in a plan making the election described in clause (i),

the beneficiary may enroll for drug coverage under part D with an eligible entity under such part.

''(3) ENHANCED MEDICAL BENEFITS.—

''(A) BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.—Each MedicareAdvantage organization may provide to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), enhanced medical benefits that the Secretary may approve. The Secretary shall approve any such enhanced medical benefits unless the Secretary determines that including such enhanced medical benefits would substantially discourage enrollment by MedicareAdvantage eligible individuals with the organization.

''(B) AT ENROLLEES' OPTION.—A MedicareAdvantage organization may not provide, under an MSA plan, enhanced medical benefits that cover the deductible described in section 1859(b)(2)(B). In applying the previous sentence, health benefits described in section 1882(u)(2)(B) shall not be treated as covering such deductible.

''(C) APPLICATION TO MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—Nothing in this paragraph shall be construed as preventing a MedicareAdvantage private fee-for-service plan from offering enhanced medical benefits that include payment for some or all of the balance billing amounts permitted consistent with section 1852(k) and coverage of additional services that the plan finds to be medically necessary.

''(D) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—Notwithstanding the preceding provisions of this paragraph, the Secretary may not approve any enhanced medical benefit that provides for the coverage of any prescription drug (other than that relating to prescription drugs covered under the original medicare fee-for-service program option).

''(4) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicareAdvantage organization may (in the case of the provision of items and services to an individual under a MedicareAdvantage plan under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

''(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services; or

''(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

''(5) NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a MedicareAdvantage organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the benchmark amount announced under section 1853(b)(1)(A) at the beginning of such period, then, unless otherwise required by law—

''(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period; and

''(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i)(1) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based on an analysis by the Secretary of the actuarial costs associated with the coverage determination or legislative change in benefits.

''(6) AUTHORITY TO PROHIBIT RISK SELECTION.—The Secretary shall have the authority to disapprove any MedicareAdvantage plan that the Secretary determines is designed to attract a population that is healthier than the average population residing in the service area of the plan.

''(7) UNIFIED DEDUCTIBLE DEFINED.—In this part, the term 'unified deductible' means an annual deductible amount that is applied in lieu of the inpatient hospital deductible under section 1813(b)(1) and the deductible under section 1833(b). Nothing in this part shall be construed as preventing a MedicareAdvantage organization from requiring coinsurance or a copayment for inpatient hospital services after the unified deductible is satisfied, subject to the limitation on enrollee liability under section 1854(f).

''(b) ANTIDISCRIMINATION.—

''(1) BENEFICIARIES.—

''(A) IN GENERAL.—A MedicareAdvantage organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(B) CONSTRUCTION.—Except as provided under section 1851(a)(3)(B), subparagraph (A) shall not be construed as requiring a MedicareAdvantage organization to enroll individuals who are determined to have end-stage renal disease.

''(2) PROVIDERS.—A MedicareAdvantage organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

''(c) DISCLOSURE REQUIREMENTS.—

''(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A MedicareAdvantage organization shall disclose, in clear, accurate, and standardized form to each enrollee with a MedicareAdvantage plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

''(A) SERVICE AREA.—The plan's service area.

''(B) BENEFITS.—Benefits offered under the plan, including information described section 1852(a)(1) (relating to benefits under the original medicare fee-for-service program option, the maximum limitation in out-of-pocket expenses and the unified deductible, and qualified prescription drug coverage under part D, respectively) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other MedicareAdvantage plans.

''(C) ACCESS.—The number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and any point-of-service option (including the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits for such option).

''(D) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

''(E) EMERGENCY COVERAGE.—Coverage of emergency services, including—

''(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

''(ii) the process and procedures of the plan for obtaining emergency services; and

''(iii) the locations of—

''(I) emergency departments; and

''(II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

''(F) ENHANCED MEDICAL BENEFITS.—Enhanced medical benefits available from the organization offering the plan, including—

''(i) whether the enhanced medical benefits are optional;

''(ii) the enhanced medical benefits covered; and

''(iii) the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits.

''(G) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in nonpayment.

''(H) PLAN GRIEVANCE AND APPEALS PROCEDURES.—All plan appeal or grievance rights and procedures.

''(I) QUALITY ASSURANCE PROGRAM.—A description of the organization's quality assurance program under subsection (e).

''(2) DISCLOSURE UPON REQUEST.—Upon request of a MedicareAdvantage eligible individual, a MedicareAdvantage organization must provide the following information to such individual:

''(A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1851(d)(2)(A).

''(B) Information on procedures used by the organization to control utilization of services and expenditures.

''(C) Information on the number of grievances, reconsiderations, and appeals and on the disposition in the aggregate of such matters.

''(D) An overall summary description as to the method of compensation of participating physicians.

''(E) The information described in subparagraphs (A) through (C) in relation to the qualified prescription drug coverage provided by the organization.

''(d) ACCESS TO SERVICES.—

''(1) IN GENERAL.—A MedicareAdvantage organization offering a MedicareAdvantage plan may select the providers from whom the benefits under the plan are provided so long as—

''(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

''(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

''(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

''(i) the services were not emergency services (as defined in paragraph (3)), but—

''(I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition; and

''(II) it was not reasonable given the circumstances to obtain the services through the organization;

''(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area; or

''(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

''(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

''(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

''(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—A MedicareAdvantage plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

''(3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

''(A) IN GENERAL.—The term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

''(i) are furnished by a provider that is qualified to furnish such services under this title; and

''(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

''(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

''(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

''(ii) serious impairment to bodily functions; or

''(iii) serious dysfunction of any bodily organ or part.

''(4) ASSURING ACCESS TO SERVICES IN MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—In addition to any other requirements under this part, in the case of a MedicareAdvantage private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. The Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

''(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A, B, or D for such services; or

''(B) the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan,

or a combination of both. The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.

''(e) QUALITY ASSURANCE PROGRAM.—

''(1) IN GENERAL.—Each MedicareAdvantage organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with MedicareAdvantage plans of the organization.

''(2) ELEMENTS OF PROGRAM.—

''(A) IN GENERAL.—The quality assurance program of an organization with respect to a MedicareAdvantage plan (other than a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan) it offers shall—

''(i) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will permit measurement of outcomes and other indices of the quality of MedicareAdvantage plans and organizations;

''(ii) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

''(iii) provide access to disease management and chronic care services;

''(iv) provide access to preventive benefits and information for enrollees on such benefits;

''(v) evaluate the continuity and coordination of care that enrollees receive;

''(vi) be evaluated on an ongoing basis as to its effectiveness;

''(vii) include measures of consumer satisfaction;

''(viii) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part;

''(ix) provide review by physicians and other health care professionals of the process followed in the provision of such health care services;

''(x) provide for the establishment of written protocols for utilization review, based on current standards of medical practice;

''(xi) have mechanisms to detect both underutilization and overutilization of services;

''(xii) after identifying areas for improvement, establish or alter practice parameters;

''(xiii) take action to improve quality and assesses the effectiveness of such action through systematic followup; and

''(xiv) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate).

Such program shall include a separate focus (with respect to all the elements described in this subparagraph) on racial and ethnic minorities.

''(B) ELEMENTS OF PROGRAM FOR ORGANIZATIONS OFFERING MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS, AND NONNETWORK MSA PLANS.—The quality assurance program of an organization with respect to a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan it offers shall—

''(i) meet the requirements of clauses (i) through (viii) of subparagraph (A);

''(ii) insofar as it provides for the establishment of written protocols for utilization review, base such protocols on current standards of medical practice; and

''(iii) have mechanisms to evaluate utilization of services and inform providers and enrollees of the results of such evaluation.

Such program shall include a separate focus (with respect to all the elements described in this subparagraph) on racial and ethnic minorities.

''(C) DEFINITION OF NONNETWORK MSA PLAN.—In this subsection, the term 'nonnetwork MSA plan' means an MSA plan offered by a MedicareAdvantage organization that does not provide benefits required to be provided by this part, in whole or in part, through a defined set of providers under contract, or under another arrangement, with the organization.

''(3) EXTERNAL REVIEW.—

''(A) IN GENERAL.—Each MedicareAdvantage organization shall, for each MedicareAdvantage plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in paragraphs (4)(B) and (14) of section 1154(a) with respect to services furnished by MedicareAdvantage plans for which payment is made under this title. The previous sentence shall not apply to a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan that does not employ utilization review.

''(B) NONDUPLICATION OF ACCREDITATION.—Except in the case of the review of quality complaints, and consistent with subparagraph (C), the Secretary shall ensure that the external review activities conducted under subparagraph (A) are not duplicative of review activities conducted as part of the accreditation process.

''(C) WAIVER AUTHORITY.—The Secretary may waive the requirement described in subparagraph (A) in the case of an organization if the Secretary determines that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

''(4) TREATMENT OF ACCREDITATION.—

''(A) IN GENERAL.—The Secretary shall provide that a MedicareAdvantage organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1856 to carry out the requirements in such clause.

''(B) REQUIREMENTS DESCRIBED.—The provisions described in this subparagraph are the following:

''(i) Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).

''(ii) Subsection (b) (relating to antidiscrimination).

''(iii) Subsection (d) (relating to access to services).

''(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

''(v) Subsection (i) (relating to information on advance directives).

''(vi) Subsection (j) (relating to provider participation rules).

''(C) TIMELY ACTION ON APPLICATIONS.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1865(b)(2), whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

''(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1857,

including the authority to terminate contracts with MedicareAdvantage organizations under subsection (c)(2) of such section.

''(5) REPORT TO CONGRESS.—

''(A) IN GENERAL.—The Secretary shall submit to Congress a biennial report regarding how quality assurance programs conducted under this subsection focus on racial and ethnic minorities.

''(B) CONTENTS OF REPORT.—Each such report shall include the following:

''(i) A description of the means by which such programs focus on such racial and ethnic minorities.

''(ii) An evaluation of the impact of such programs on eliminating health disparities and on improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction.

''(iii) Recommendations on ways to reduce clinical outcome disparities among racial and ethnic minorities.

''(f) GRIEVANCE MECHANISM.—Each MedicareAdvantage organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with MedicareAdvantage plans of the organization under this part.

''(g) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

''(1) DETERMINATIONS BY ORGANIZATION.—

''(A) IN GENERAL.—A MedicareAdvantage organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

''(B) EXPLANATION OF DETERMINATION.—Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

''(2) RECONSIDERATIONS.—

''(A) IN GENERAL.—The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

''(B) PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

''(3) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

''(A) RECEIPT OF REQUESTS.—

''(i) ENROLLEE REQUESTS.—An enrollee in a MedicareAdvantage plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the MedicareAdvantage organization.

''(ii) PHYSICIAN REQUESTS.—A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

''(B) ORGANIZATION PROCEDURES.—

''(i) IN GENERAL.—The MedicareAdvantage organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal timeframe for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

''(ii) EXPEDITION REQUIRED FOR PHYSICIAN REQUESTS.—In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal timeframe for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

''(iii) TIMELY RESPONSE.—In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

''(4) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.

''(5) APPEALS.—An enrollee with a MedicareAdvantage plan of a MedicareAdvantage organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 205 as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

''(h) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Insofar as a MedicareAdvantage organization maintains medical records or other health information regarding enrollees under this part, the MedicareAdvantage organization shall establish procedures—

''(1) to safeguard the privacy of any individually identifiable enrollee information;

''(2) to maintain such records and information in a manner that is accurate and timely; and

''(3) to assure timely access of enrollees to such records and information.

''(i) INFORMATION ON ADVANCE DIRECTIVES.—Each MedicareAdvantage organization shall meet the requirement of section 1866(f) (relating to maintaining written policies and procedures respecting advance directives).

''(j) RULES REGARDING PROVIDER PARTICIPATION.—

''(1) PROCEDURES.—Insofar as a MedicareAdvantage organization offers benefits under a MedicareAdvantage plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

''(A) providing notice of the rules regarding participation;

''(B) providing written notice of participation decisions that are adverse to physicians; and

''(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

''(2) CONSULTATION IN MEDICAL POLICIES.—A MedicareAdvantage organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

''(3) PROHIBITING INTERFERENCE WITH PROVIDER ADVICE TO ENROLLEES.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a MedicareAdvantage organization (in relation to an individual enrolled under a MedicareAdvantage plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

''(B) CONSCIENCE PROTECTION.—Subparagraph (A) shall not be construed as requiring a MedicareAdvantage plan to provide, reimburse for, or provide coverage of a counseling or referral service if the MedicareAdvantage organization offering the plan—

''(i) objects to the provision of such service on moral or religious grounds; and

''(ii) in the manner and through the written instrumentalities such MedicareAdvantage organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

''(C) CONSTRUCTION.—Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

''(D) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term 'health care professional' means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the MedicareAdvantage plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, licensed pharmacist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social

worker, registered respiratory therapist, and certified respiratory therapy technician.

''(4) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

''(A) IN GENERAL.—No MedicareAdvantage organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

''(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

''(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

''(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group; and

''(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

''(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

''(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term 'physician incentive plan' means any compensation arrangement between a MedicareAdvantage organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

''(5) LIMITATION ON PROVIDER INDEMNIFICATION.—A MedicareAdvantage organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a MedicareAdvantage plan of the organization under this part by the organization's denial of medically necessary care.

''(6) SPECIAL RULES FOR MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—For purposes of applying this part (including subsection (k)(1)) and section 1866(a)(1)(O), a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a MedicareAdvantage organization (with respect to an individual enrolled in a MedicareAdvantage private fee-for-service plan it offers), if—

''(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

''(B) before providing such services, the provider, professional, or other entity —

''(i) has been informed of the individual's enrollment under the plan; and

''(ii) either—

''(I) has been informed of the terms and conditions of payment for such services under the plan; or

''(II) is given a reasonable opportunity to obtain information concerning such terms and conditions,

in a manner reasonably designed to effect informed agreement by a provider.

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the MedicareAdvantage organization.

''(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a MedicareAdvantage organization described in section 1851(a)(2)(A) shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a MedicareAdvantage organization under this part) also applies with respect to an individual so enrolled.

''(2) APPLICATION TO MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—

''(A) BALANCE BILLING LIMITS UNDER MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS IN CASE OF CONTRACT PROVIDERS.—

''(i) IN GENERAL.—In the case of an individual enrolled in a MedicareAdvantage private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6)) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this title that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

''(ii) PROCEDURES TO ENFORCE LIMITS.—The MedicareAdvantage organization that offers such a plan shall establish procedures, similar to the procedures described in section 1848(g)(1)(A), in order to carry out clause (i).

''(iii) ASSURING ENFORCEMENT.—If the MedicareAdvantage organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1857(g).

''(B) ENROLLEE LIABILITY FOR NONCONTRACT PROVIDERS.—For provisions—

''(i) establishing a minimum payment rate in the case of noncontract providers under a MedicareAdvantage private fee-for-service plan, see section 1852(a)(2); or

''(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1866(a)(1)(O).

''(C) INFORMATION ON BENEFICIARY LIABILITY.—

''(i) IN GENERAL.—Each MedicareAdvantage organization that offers a MedicareAdvantage private fee-for-service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A, B, and D, and, if applicable, under medicare supplemental policies) that includes a clear statement of the amount of the enrollee's liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

''(ii) ADVANCE NOTICE BEFORE RECEIPT OF INPATIENT HOSPITAL SERVICES AND CERTAIN OTHER SERVICES.—In addition, such organization shall, in its terms and conditions of payments to hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balance billing under subparagraph (A) could be substantial, require the hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)—

''(I) notice of the fact that balance billing is permitted under such subparagraph for such services; and

''(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

''(l) RETURN TO HOME SKILLED NURSING FACILITIES FOR COVERED POST-HOSPITAL EXTENDED CARE SERVICES.—

''(1) ENSURING RETURN TO HOME SNF.—

''(A) IN GENERAL.—In providing coverage of post-hospital extended care services, a MedicareAdvantage plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

''(i) ENROLLEE ELECTION.—The enrollee elects to receive such coverage through such facility.

''(ii) SNF AGREEMENT.—The facility has a contract with the MedicareAdvantage organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the MedicareAdvantage organization for the provision of such services and through which the enrollee would otherwise receive such services.

''(B) MANNER OF PAYMENT TO HOME SNF.—The organization shall provide payment to the home skilled nursing facility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

''(2) NO LESS FAVORABLE COVERAGE.—The coverage provided under paragraph (1) (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the MedicareAdvantage plan.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to do the following:

''(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for medicare beneficiaries not enrolled in a MedicareAdvantage plan.

''(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

''(4) DEFINITIONS.—In this subsection:

''(A) HOME SKILLED NURSING FACILITY.—The term 'home skilled nursing facility' means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a MedicareAdvantage plan, any of the following skilled nursing facilities:

''(i) SNF RESIDENCE AT TIME OF ADMISSION.—The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

''(ii) SNF IN CONTINUING CARE RETIREMENT COMMUNITY.—A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

''(iii) SNF RESIDENCE OF SPOUSE AT TIME OF DISCHARGE.—The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

''(B) CONTINUING CARE RETIREMENT COMMUNITY.—The term 'continuing care retirement community' means, with respect to an enrollee in a MedicareAdvantage plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.''.

SEC. 203. PAYMENTS TO MEDICAREADVANTAGE ORGANIZATIONS.

Section 1853 (42 U.S.C. 1395w–23) is amended to read as follows:

''PAYMENTS TO MEDICAREADVANTAGE ORGANIZATIONS

''SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

''(1) MONTHLY PAYMENTS.—

''(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (f), (h), and (j) and section 1859(e)(4), the Secretary shall make, to each MedicareAdvantage organization, with respect to coverage of an individual for a month under this part in a MedicareAdvantage payment area, separate monthly payments with respect to—

''(i) benefits under the original medicare fee-for-service program under parts A and B in accordance with subsection (d); and

''(ii) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

''(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a MedicareAdvantage organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a MedicareAdvantage plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the MedicareAdvantage payment area (or such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease.

''(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

''(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

''(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a MedicareAdvantage organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

''(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

''(C) EQUALIZATION OF FEDERAL CONTRIBUTION.—In applying subparagraph (A), the Secretary shall ensure that the payment to the MedicareAdvantage organization for each individual enrolled with the organization shall equal the MedicareAdvantage benchmark amount for the payment area in which that individual resides (as determined under paragraph (4)), as adjusted—

''(i) by multiplying the benchmark amount for that payment area by the ratio of—

''(I) the payment amount determined under subsection (d)(4); to

''(II) the weighted service area benchmark amount determined under subsection (d)(2); and

''(ii) using such risk adjustment factor as specified by the Secretary under subsection (b)(1)(B).

''(3) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—

''(A) APPLICATION OF METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in subparagraph (B) to 100 percent of the amount of payments to plans under subsection (d)(4)(B).

''(B) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY DESCRIBED.—The comprehensive risk adjustment methodology described in this subparagraph is the risk adjustment methodology that would apply with respect to MedicareAdvantage plans offered by MedicareAdvantage organizations in 2005, except that if such methodology does not apply to groups of beneficiaries who are aged or disabled and groups of beneficiaries who have end-stage renal disease, the Secretary shall revise such methodology to apply to such groups.

''(C) UNIFORM APPLICATION TO ALL TYPES OF PLANS.—Subject to section 1859(e)(4), the comprehensive risk adjustment methodology established under this paragraph shall be applied uniformly without regard to the type of plan.

''(D) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require MedicareAdvantage organizations to submit such data and other information as the Secretary deems necessary.

''(E) IMPROVEMENT OF PAYMENT ACCURACY.—Notwithstanding any other provision of this paragraph, the Secretary may revise the comprehensive risk adjustment methodology described in subparagraph (B) from time to time to improve payment accuracy.

''(4) ANNUAL CALCULATION OF BENCHMARK AMOUNTS.—For each year, the Secretary shall calculate a benchmark amount for each MedicareAdvantage payment area for each month for such year with respect to coverage of the benefits available under the original medicare fee-for-service program option equal to the greater of the following amounts (adjusted as appropriate for the application of the risk adjustment methodology under paragraph (3)):

''(A) MINIMUM AMOUNT.—1/12 of the annual Medicare+Choice capitation rate determined under subsection (c)(1)(B) for the payment area for the year.

''(B) LOCAL FEE-FOR-SERVICE RATE.—The local fee-for-service rate for such area for the year (as calculated under paragraph (5)).

''(5) ANNUAL CALCULATION OF LOCAL FEE-FOR-SERVICE RATES.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'local fee-for-service rate' means the amount of payment for a month in a MedicareAdvantage payment area for benefits under this title and associated claims processing costs for an individual who has elected to receive benefits under the original medicare fee-for-service program option and not enrolled in a MedicareAdvantage plan under this part. The Secretary shall annually calculate such amount in a manner similar to the manner in which the Secretary calculated the adjusted average per capita cost under section 1876.

''(B) REMOVAL OF MEDICAL EDUCATION COSTS FROM CALCULATION OF LOCAL FEE-FOR-SERVICE RATE.—

''(i) IN GENERAL.—In calculating the local fee-for-service rate under subparagraph (A) for a year, the amount of payment described in such subparagraph shall be adjusted to exclude from such payment the payment adjustments described in clause (ii).

''(ii) PAYMENT ADJUSTMENTS DESCRIBED.—

''(I) IN GENERAL.—Subject to subclause (II), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates are payable during the year—

''(aa) for the indirect costs of medical education under section 1886(d)(5)(B); and

''(bb) for direct graduate medical education costs under section 1886(h).

''(II) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that the amount of the local fee-for-service rates reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

''(b) ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.—

''(1) ANNUAL ANNOUNCEMENT.—Beginning in 2005, at the same time as the Secretary publishes the risk adjusters under section 1860D–11, the Secretary shall annually announce (in a manner intended to provide notice to interested parties) the following payment factors:

''(A) The benchmark amount for each MedicareAdvantage payment area (as calculated under subsection (a)(4)) for the year.

''(B) The factors to be used for adjusting payments under the comprehensive risk adjustment methodology described in subsection (a)(3)(B) with respect to each MedicareAdvantage payment area for the year.

''(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall—

''(A) provide for notice to MedicareAdvantage organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement; and

''(B) provide such organizations with an opportunity to comment on such proposed changes.

''(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in

methodology used in the announcement in sufficient detail so that MedicareAdvantage organizations can compute each payment factor described in paragraph (1).

''(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

''(1) IN GENERAL.—For purposes of making payments under this part for years before 2006 and for purposes of calculating the annual Medicare+Choice capitation rates under paragraph (7) beginning with such year, subject to paragraph (6)(C), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area before 2006 or a MedicareAdvantage payment area beginning with such year for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), or (C):

''(A) BLENDED CAPITATION RATE.—The sum of—

''(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare+Choice capitation rate for the MedicareAdvantage payment area, as determined under paragraph (3) for the year; and

''(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year,

multiplied by the budget neutrality adjustment factor determined under paragraph (5).

''(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

''(i) For 1998, $367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

''(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

''(iii)(I) Subject to subclause (II), for 2001, for any area in a Metropolitan Statistical Area with a population of more than 250,000, $525, and for any other area $475.

''(II) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not exceed 120 percent of the amount determined under clause (ii) for such area for 2000.

''(iv) For 2002 through 2013, the minimum amount specified in this clause (or clause (iii)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

''(v) For 2014 and each succeeding year, the minimum amount specified in this clause (or clause (iv)) for the preceding year increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

''(C) MINIMUM PERCENTAGE INCREASE.—

''(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the Medicare+Choice payment area.

''(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

''(iv) For 2002 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

''(A) for 1998, the 'area-specific percentage' is 90 percent and the 'national percentage' is 10 percent;

''(B) for 1999, the 'area-specific percentage' is 82 percent and the 'national percentage' is 18 percent;

''(C) for 2000, the 'area-specific percentage' is 74 percent and the 'national percentage' is 26 percent;

''(D) for 2001, the 'area-specific percentage' is 66 percent and the 'national percentage' is 34 percent;

''(E) for 2002, the 'area-specific percentage' is 58 percent and the 'national percentage' is 42 percent; and

''(F) for a year after 2002, the 'area-specific percentage' is 50 percent and the 'national percentage' is 50 percent.

''(3) ANNUAL AREA-SPECIFIC MEDICARE+CHOICE CAPITATION RATE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraph (B), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

''(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

''(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

''(B) REMOVAL OF MEDICAL EDUCATION FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

''(i) IN GENERAL.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

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

''(I) 1998 is 20 percent;

''(II) 1999 is 40 percent;

''(III) 2000 is 60 percent;

''(IV) 2001 is 80 percent; and

''(V) a succeeding year is 100 percent.

''(C) PAYMENT ADJUSTMENT.—

''(i) IN GENERAL.—Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

''(I) for the indirect costs of medical education under section 1886(d)(5)(B); and

''(II) for direct graduate medical education costs under section 1886(h).

''(ii) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

''(D) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for 1997 a rate that is more representative of the costs of the enrollees in the area.

''(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICARE+CHOICE CAPITATION RATE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A), the input-price-adjusted annual national Medicare+Choice capitation rate for a Medicare+Choice payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

''(i) the national standardized annual Medicare+Choice capitation rate (determined under subparagraph (B)) for the year;

''(ii) the proportion of such rate for the year which is attributable to such type of services; and

''(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary may, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

''(B) NATIONAL STANDARDIZED ANNUAL MEDICARE+CHOICE CAPITATION RATE.—In subparagraph (A)(i), the 'national standardized annual Medicare+Choice capitation rate' for a year is equal to—

''(i) the sum (for all Medicare+Choice payment areas) of the product of—

''(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3); and

''(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

''(ii) the sum of the products described in clause (i)(II) for all areas for that year.

''(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (1)(A), for each year, the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iii) and (i)) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

''(6) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE DEFINED.—

''(A) IN GENERAL.—In this part, the 'national per capita Medicare+Choice growth percentage' for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to (or enrolled for) benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

''(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

''(i) for 1998, 0.8 percentage points;

''(ii) for 1999, 0.5 percentage points;

''(iii) for 2000, 0.5 percentage points;

''(iv) for 2001, 0.5 percentage points;

''(v) for 2002, 0.3 percentage points; and

''(vi) for a year after 2002, 0 percentage points.

''(C) ADJUSTMENT FOR OVER OR UNDER PROJECTION OF NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—Beginning with rates calculated for 1999, before

computing rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years.

''(7) TRANSITION TO MEDICAREADVANTAGE COMPETITION.—

''(A) IN GENERAL.—For each year (beginning with 2006) payments to MedicareAdvantage plans shall not be computed under this subsection, but instead shall be based on the payment amount determined under subsection (d).

''(B) CONTINUED CALCULATION OF CAPITATION RATES.—For each year (beginning with 2006) the Secretary shall calculate and publish the annual Medicare+Choice capitation rates under this subsection and shall use the annual Medicare+Choice capitation rate determined under subsection (c)(1) for purposes of determining the benchmark amount under subsection (a)(4).

''(d) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT.—

''(1) REVIEW OF PLAN BIDS.—The Secretary shall review each plan bid submitted under section 1854(a) for the coverage of benefits under the original medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part an are based on the assumptions described in section 1854(a)(2)(A)(iii).

''(2) DETERMINATION OF WEIGHTED SERVICE AREA BENCHMARK AMOUNTS.—The Secretary shall calculate a weighted service area benchmark amount for the benefits under the original medicare fee-for-service program option for each plan equal to the weighted average of the benchmark amounts for benefits under such original medicare fee-for-service program option for the payment areas included in the service area of the plan using the assumptions described in section 1854(a)(2)(A)(iii).

''(3) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under paragraph (1)) and the weighted service area benchmark amount (as determined under paragraph (2)) for purposes of determining—

''(A) the payment amount under paragraph (4); and

''(B) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

''(4) DETERMINATION OF PAYMENT AMOUNT FOR ORIGINAL MEDICARE FEE-FOR-SERVICE BENEFITS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall determine the payment amount for MedicareAdvantage plans for the benefits under the original medicare fee-for-service program option as follows:

''(i) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the weighted service area benchmark amount, the amount of each monthly payment to a MedicareAdvantage organization with respect to each individual enrolled in a plan shall be the weighted service area benchmark amount.

''(ii) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the weighted service area benchmark amount, the amount of each monthly payment to a MedicareAdvantage organization with respect to each individual enrolled in a plan shall be the weighted service area benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

''(B) APPLICATION OF COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall adjust the amounts determined under subparagraph (A) using the comprehensive risk adjustment methodology applicable under subsection (a)(3).

''(6) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to MedicareAdvantage organizations of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall appropriately adjust the benchmark amounts or payment amounts (as determined by the Secretary). Such projection and adjustment shall be based on an analysis by the Secretary of the actuarial costs associated with the new benefits.

''(7) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION DEFINED.—For purposes of this part, the term 'benefits under the original medicare fee-for-service program option' means those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to, or enrolled for, benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or an actuarially equivalent level of cost-sharing as determined in this part.

''(e) MEDICAREADVANTAGE PAYMENT AREA DEFINED.—

''(1) IN GENERAL.—In this part, except as provided in paragraph (3), the term 'MedicareAdvantage payment area' means a county, or equivalent area specified by the Secretary.

''(2) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the MedicareAdvantage payment area shall be a State or such other payment area as the Secretary specifies.

''(3) GEOGRAPHIC ADJUSTMENT.—

''(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 2005) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a MedicareAdvantage payment area in the State otherwise determined under paragraph (1)—

''(i) to a single statewide MedicareAdvantage payment area;

''(ii) to the metropolitan based system described in subparagraph (C); or

''(iii) to consolidating into a single MedicareAdvantage payment area noncontiguous counties (or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

''(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for MedicareAdvantage 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 MedicareAdvantage payment areas in the State in the absence of the adjustment under this paragraph.

''(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

''(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area, all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single MedicareAdvantage payment area; and

''(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single MedicareAdvantage payment area.

''(D) AREAS.—In subparagraph (C), the terms 'metropolitan statistical area', 'consolidated metropolitan statistical area', and 'primary metropolitan statistical area' mean any area designated as such by the Secretary of Commerce.

''(f) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

''(1) IN GENERAL.—If the amount of the MedicareAdvantage monthly MSA premium (as defined in section 1854(b)(2)(D)) for an MSA plan for a year is less than 1/12 of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a MedicareAdvantage MSA established (and, if applicable, designated) by the individual under paragraph (2).

''(2) ESTABLISHMENT AND DESIGNATION OF MEDICAREADVANTAGE MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

''(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a MedicareAdvantage MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986); and

''(B) if the individual has established more than 1 such MedicareAdvantage MSA, has designated 1 of such accounts as the individual's MedicareAdvantage MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

''(3) LUMP-SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the MedicareAdvantage MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

''(g) PAYMENTS FROM TRUST FUNDS.—Except as provided in section 1858A(c) (relating to payments for qualified prescription drug coverage), the payment to a MedicareAdvantage organization under this section for individuals enrolled under this part with the organization and payments to a MedicareAdvantage MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October

2006 shall be paid on the first business day of October 2006.

''(h) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

''(1) election under this part of a MedicareAdvantage plan offered by a MedicareAdvantage organization—

''(A) payment for such services until the date of the individual's discharge shall be made under this title through the MedicareAdvantage plan or the original medicare fee-for-service program option (as the case may be) elected before the election with such organization,

''(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge; and

''(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

''(2) termination of election with respect to a MedicareAdvantage organization under this part—

''(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge;

''(B) payment for such services during the stay shall not be made under section 1886(d) or by any succeeding MedicareAdvantage organization; and

''(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

''(i) SPECIAL RULE FOR HOSPICE CARE.—

''(1) INFORMATION.—A contract under this part shall require the MedicareAdvantage organization to inform each individual enrolled under this part with a MedicareAdvantage plan offered by the organization about the availability of hospice care if—

''(A) a hospice program participating under this title is located within the organization's service area; or

''(B) it is common practice to refer patients to hospice programs outside such service area.

''(2) PAYMENT.—If an individual who is enrolled with a MedicareAdvantage organization under this part makes an election under section 1812(d)(1) to receive hospice care from a particular hospice program—

''(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

''(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1812(d)(1), including services not related to the individual's terminal illness, shall be made by the Secretary to the MedicareAdvantage organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

''(C) the Secretary shall continue to make monthly payments to the MedicareAdvantage organization in an amount equal to the value of the additional benefits required under section 1854(f)(1)(A).''.

SEC. 204. SUBMISSION OF BIDS; PREMIUMS.

Section 1854 (42 U.S.C. 1395w–24) is amended to read as follows:

''SUBMISSION OF BIDS; PREMIUMS

''SEC. 1854. (a) SUBMISSION OF BIDS BY MEDICAREADVANTAGE ORGANIZATIONS.—

''(1) IN GENERAL.—Not later than the second Monday in September and except as provided in paragraph (3), each MedicareAdvantage organization shall submit to the Secretary, in such form and manner as the Secretary may specify, for each MedicareAdvantage plan that the organization intends to offer in a service area in the following year—

''(A) notice of such intent and information on the service area of the plan;

''(B) the plan type for each plan;

''(C) if the MedicareAdvantage plan is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in paragraph (2) with respect to each payment area;

''(D) the enrollment capacity (if any) in relation to the plan and each payment area;

''(E) the expected mix, by health status, of enrolled individuals; and

''(F) such other information as the Secretary may specify.

''(2) INFORMATION REQUIRED FOR COORDINATED CARE PLANS AND PRIVATE FEE-FOR-SERVICE PLANS.—For a MedicareAdvantage plan that is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in this paragraph is as follows:

''(A) INFORMATION REQUIRED WITH RESPECT TO BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—Information relating to the coverage of benefits under the original medicare fee-for-service program option as follows:

''(i) The plan bid, which shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of the benefits under the original medicare fee-for-service program option to an individual enrolled in the plan that resides in the service area of the plan for a month.

''(ii) For the enhanced medical benefits package offered—

''(I) the adjusted community rate (as defined in subsection (g)(3)) of the package;

''(II) the portion of the actuarial value of such benefits package (if any) that will be applied toward satisfying the requirement for additional benefits under subsection (g);

''(III) the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (as defined in subsection (b)(2)(C));

''(IV) a description of any cost-sharing;

''(V) a description of whether the amount of the unified deductible has been lowered or the maximum limitations on out-of-pocket expenses have been decreased (relative to the levels used in calculating the plan bid);

''(VI) such other information as the Secretary considers necessary.

''(iii) The assumptions that the MedicareAdvantage organization used in preparing the plan bid with respect to numbers, in each payment area, of enrolled individuals and the mix, by health status, of such individuals.

''(B) INFORMATION REQUIRED WITH RESPECT TO PART D.—The information required to be submitted by an eligible entity under section 1860D–12, including the monthly premiums for standard coverage and any other qualified prescription drug coverage available to individuals enrolled under part D.

''(C) DETERMINING PLAN COSTS INCLUDED IN PLAN BID.—For purposes of submitting its plan bid under subparagraph (A)(i) a MedicareAdvantage plan offered by a MedicareAdvantage organization satisfies subparagraphs (A) and (C) of section 1852(a)(1) if the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled in such plan under this part with respect to benefits under the original medicare fee-for-service program option on which that bid is based (ignoring any reduction in cost-sharing offered by such plan as enhanced medical benefits under paragraph (2)(A)(ii) or required under clause (ii) or (iii) of subsection (g)(1)(C)) equals the amount specified in subsection (f)(1)(B).

''(3) REQUIREMENTS FOR MSA PLANS.—For an MSA plan described in section 1851(a)(2)(B), the information described in this paragraph is the information that such a plan would have been required to submit under this part if the Prescription Drug and Medicare Improvements Act of 2003 had not been enacted.

''(4) REVIEW.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this subsection and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the MedicareAdvantage organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

''(B) MSA EXCEPTION.—The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3).

''(C) CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—Under the authority under subparagraph (A), the Secretary may disapprove the bid if the Secretary determines that the deductibles, coinsurance, or copayments applicable under the plan discourage access to covered services or are likely to result in favorable selection of MedicareAdvantage eligible individuals.

''(5) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under paragraph (1) for a MedicareAdvantage plan must reasonably and equitably reflect the cost of benefits provided under that plan.

''(b) MONTHLY PREMIUMS CHARGED.—

''(1) IN GENERAL.—

''(A) COORDINATED CARE AND PRIVATE FEE-FOR-SERVICE PLANS.—The monthly amount of the premium charged to an individual enrolled in a MedicareAdvantage plan (other than an MSA plan) offered by a MedicareAdvantage organization shall be equal to the sum of the following:

''(i) The MedicareAdvantage monthly basic beneficiary premium (if any).

''(ii) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (if any).

''(iii) The MedicareAdvantage monthly obligation for qualified prescription drug coverage (if any).

''(B) MSA PLANS.—The rules under this section that would have applied with respect to an MSA plan if the Prescription Drug and Medicare Improvements Act of 2003 had not been enacted shall continue to apply to MSA plans after the date of enactment of such Act.

''(2) PREMIUM TERMINOLOGY.—For purposes of this part:

''(A) MEDICAREADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM.—The term 'MedicareAdvantage monthly basic beneficiary premium' means, with respect to a MedicareAdvantage plan, the amount required to be charged under subsection (d)(2) for the plan.

''(B) MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term

'MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage' means, with respect to a MedicareAdvantage plan, the amount determined under section 1858A(d).

''(C) MEDICAREADVANTAGE MONTHLY BENEFICIARY PREMIUM FOR ENHANCED MEDICAL BENEFITS.—The term 'MedicareAdvantage monthly beneficiary premium for enhanced medical benefits' means, with respect to a MedicareAdvantage plan, the amount required to be charged under subsection (f)(2) for the plan, or, in the case of an MSA plan, the amount filed under subsection (a)(3).

''(D) MEDICAREADVANTAGE MONTHLY MSA PREMIUM.—The term 'MedicareAdvantage monthly MSA premium' means, with respect to a MedicareAdvantage plan, the amount of such premium filed under subsection (a)(3) for the plan.

''(c) UNIFORM PREMIUM.—The MedicareAdvantage monthly basic beneficiary premium, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, and the MedicareAdvantage monthly MSA premium charged under subsection (b) of a MedicareAdvantage organization under this part may not vary among individuals enrolled in the plan.

''(d) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—

''(1) BIDS BELOW THE BENCHMARK.—If the Secretary determines under section 1853(d)(3) that the weighted service area benchmark amount exceeds the plan bid, the Secretary shall require the plan to provide additional benefits in accordance with subsection (g).

''(2) BIDS ABOVE THE BENCHMARK.—If the Secretary determines under section 1853(d)(3) that the plan bid exceeds the weighted service area benchmark amount (determined under section 1853(d)(2)), the amount of such excess shall be the MedicareAdvantage monthly basic beneficiary premium (as defined in section 1854(b)(2)(A)).

''(e) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each MedicareAdvantage organization shall permit the payment of any MedicareAdvantage monthly basic premium, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits on a monthly basis, may terminate election of individuals for a MedicareAdvantage plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i), and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise (other than as an additional benefit described in subsection (g)(1)(C)(i)).

''(f) LIMITATION ON ENROLLEE LIABILITY.—

''(1) FOR BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—The sum of—

''(A) the MedicareAdvantage monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments (determined on the same basis as used in determining the plan's bid under paragraph (2)(C)) applicable on average to individuals enrolled under this part with a MedicareAdvantage plan described in subparagraph (A) or (C) of section 1851(a)(2) of an organization with respect to required benefits described in section 1852(a)(1)(A); must equal

''(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals who have elected to receive benefits under the original medicare fee-for-service program option if such individuals were not members of a MedicareAdvantage organization for the year (adjusted as determined appropriate by the Secretary to account for geographic differences and for plan cost and utilization differences).

''(2) FOR ENHANCED MEDICAL BENEFITS.—If the MedicareAdvantage organization provides to its members enrolled under this part in a MedicareAdvantage plan described in subparagraph (A) or (C) of section 1851(a)(2) with respect to enhanced medical benefits relating to benefits under the original medicare fee-for-service program option, the sum of the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits for a year must equal the adjusted community rate (as defined in subsection (g)(3)) for such benefits for the year minus the actuarial value of any additional benefits pursuant to clause (ii), (iii), or (iv) of subsection (g)(2)(C) that the plan specified under subsection (a)(2)(i)(II).

''(3) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in the same geographic area, the State, or in the United States, eligible to enroll in the MedicareAdvantage plan involved under this part or on the basis of other appropriate data.

''(4) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE PLANS.—With respect to a MedicareAdvantage private fee-for-service plan (other than a plan that is an MSA plan), in no event may—

''(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to required benefits described in subparagraphs (A), (C), and (D) of section 1852(a)(1); exceed

''(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to (or enrolled for) benefits under part A and enrolled under part B if they were not members of a MedicareAdvantage organization for the year.

''(g) REQUIREMENT FOR ADDITIONAL BENEFITS.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—Each MedicareAdvantage organization (in relation to a MedicareAdvantage plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits described in subparagraph (C) as the organization may specify in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (D)).

''(B) EXCESS AMOUNT.—For purposes of this paragraph, the term 'excess amount' means, for an organization for a plan, is 100 percent of the amount (if any) by which the weighted service area benchmark amount (determined under section 1853(d)(2)) exceeds the plan bid (as adjusted under section 1853(d)(1)).

''(C) ADDITIONAL BENEFITS DESCRIBED.—The additional benefits described in this subparagraph are as follows:

''(i) Subject to subparagraph (F), a monthly part B premium reduction for individuals enrolled in the plan.

''(ii) Lowering the amount of the unified deductible and decreasing the maximum limitations on out-of-pocket expenses for individuals enrolled in the plan.

''(iii) A reduction in the actuarial value of plan cost-sharing for plan enrollees.

''(iv) Subject to subparagraph (E), such additional benefits as the organization may specify.

''(v) Contributing to the stabilization fund under paragraph (2).

''(vi) Any combination of the reductions and benefits described in clauses (i) through (v).

''(D) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the term 'adjusted excess amount' means, for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

''(E) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—An organization may not specify any additional benefit that provides for the coverage of any prescription drug (other than that relating to prescription drugs covered under the original medicare fee-for-service program option).

''(F) PREMIUM REDUCTIONS.—

''(i) IN GENERAL.—Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a MedicareAdvantage organization may elect a reduction in its payments under section 1853(a)(1)(A)(i) with respect to a MedicareAdvantage plan and the Secretary shall apply such reduction to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).

''(ii) AMOUNT OF REDUCTION.—The amount of the reduction under clause (i) with respect to any enrollee in a MedicareAdvantage plan—

''(I) may not exceed 125 percent of the premium described under section 1839(a)(3); and

''(II) shall apply uniformly to each enrollee of the MedicareAdvantage plan to which such reduction applies.

''(G) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan.

''(H) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a MedicareAdvantage organization from providing enhanced medical benefits (described in section 1852(a)(3)) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such enhanced medical benefits.

''(2) STABILIZATION FUND.—A MedicareAdvantage organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the MedicareAdvantage plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such Trust Funds.

''(3) ADJUSTED COMMUNITY RATE.—For purposes of this subsection, subject to paragraph (4), the term 'adjusted community rate' for a service or services means, at the election of a MedicareAdvantage organization, either—

''(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicareAdvantage plan under this part if the rate of payment were determined under a 'community rating system' (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)); or

''(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other MedicareAdvantage coverage, or MedicareAdvantage eligible individuals in the area, in the State, or in the United States, eligible to elect MedicareAdvantage coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

''(4) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine the average amount of payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider-sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.

''(h) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to payments to MedicareAdvantage organizations under section 1853.

''(i) PERMITTING USE OF SEGMENTS OF SERVICE AREAS.—The Secretary shall permit a MedicareAdvantage organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of 1 or more MedicareAdvantage payment areas.''.

(b) STUDY AND REPORT ON CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—

(1) STUDY.—The Secretary, in consultation with beneficiaries, consumer groups, employers, and Medicare+Choice organizations, shall conduct a study to determine the extent to which the cost-sharing structures under Medicare+Choice plans under part C of title XVIII of the Social Security Act discourage access to covered services or discriminate based on the health status of Medicare+Choice eligible individuals (as defined in section 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w–21(a)(3))).

(2) REPORT.—Not later than December 31, 2004, the Secretary shall submit a report to Congress on the study conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

SEC. 205. SPECIAL RULES FOR PRESCRIPTION DRUG BENEFITS.

Part C of title XVIII (42 U.S.C. 1395w–21 et seq.) is amended by inserting after section 1857 the following new section:

''SPECIAL RULES FOR PRESCRIPTION DRUG BENEFITS

''SEC. 1858A. (a) AVAILABILITY.—

''(1) PLANS REQUIRED TO PROVIDE QUALIFIED PRESCRIPTION DRUG COVERAGE TO ENROLLEES.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), on and after January 1, 2006, a MedicareAdvantage organization offering a MedicareAdvantage plan (except for an MSA plan) shall make available qualified prescription drug coverage that meets the requirements for such coverage under this part and part D to each enrollee of the plan.

''(B) PRIVATE FEE-FOR-SERVICE PLANS MAY, BUT ARE NOT REQUIRED TO, PROVIDE QUALIFIED PRESCRIPTION DRUG COVERAGE.—Pursuant to section 1852(a)(2)(D), a private fee-for-service plan may elect not to provide qualified prescription drug coverage under part D to individuals residing in the area served by the plan.

''(2) REFERENCE TO PROVISION PERMITTING ADDITIONAL PRESCRIPTION DRUG COVERAGE.—For the provisions of part D, made applicable to this part pursuant to paragraph (1), that permit a plan to make available qualified prescription drug coverage that includes coverage of covered drugs that exceeds the coverage required under paragraph (1) of section 1860D–6 in an area, but only if the MedicareAdvantage organization offering the plan also offers a MedicareAdvantage plan in the area that only provides the coverage that is required under such paragraph (1), see paragraph (2) of such section.

''(3) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—Pursuant to sections 1854(g)(1)(F) and 1852(a)(3)(D), a MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage may not make available coverage of any prescription drugs (other than that relating to prescription drugs covered under the original medicare fee-for-service program option) to an enrollee as an additional benefit or as an enhanced medical benefit.

''(b) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a MedicareAdvantage organization under a MedicareAdvantage plan, the organization and plan shall meet the requirements of section 1860D–5, including requirements relating to information dissemination and grievance and appeals, and such other requirements under part D that the Secretary determines appropriate in the same manner as such requirements apply to an eligible entity and a Medicare Prescription Drug plan under part D. The Secretary shall waive such requirements to the extent the Secretary determines that such requirements duplicate requirements otherwise applicable to the organization or the plan under this part.

''(c) PAYMENTS FOR PRESCRIPTION DRUGS.—

''(1) PAYMENT OF FULL AMOUNT OF PREMIUM TO ORGANIZATIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—For each year (beginning with 2006), the Secretary shall pay to each MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage, an amount equal to the full amount of the monthly premium submitted under section 1854(a)(2)(B) for the year, as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

''(B) APPLICATION OF PART D RISK CORRIDOR, STABILIZATION RESERVE FUND, AND ADMINISTRATIVE EXPENSES PROVISIONS.—The provisions of subsections (b), (c), and (d) of section 1860D–16 shall apply to a MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage and payments made to such organization under subparagraph (A) in the same manner as such provisions apply to an eligible entity offering a Medicare Prescription Drug plan and payments made to such entity under subsection (a) of section 1860D–16.

''(2) PAYMENT FROM PRESCRIPTION DRUG ACCOUNT.—Payment made to MedicareAdvantage organizations under this subsection shall be made from the Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(d) COMPUTATION OF MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—In the case of a MedicareAdvantage eligible individual receiving qualified prescription drug coverage under a MedicareAdvantage plan during a year after 2005, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage of such individual in the year shall be determined in the same manner as the monthly beneficiary obligation is determined under section 1860D–17 for eligible beneficiaries enrolled in a Medicare Prescription Drug plan, except that, for purposes of this subparagraph, any reference to the monthly plan premium approved by the Secretary under section 1860D–13 shall be treated as a reference to the monthly premium for qualified prescription drug coverage submitted by the MedicareAdvantage organization offering the plan under section 1854(a)(2)(A) and approved by the Secretary.

''(e) COLLECTION OF MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The provisions of section 1860D–18, including subsection (b) of such section, shall apply to the amount of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage (as determined under subsection (d)) required to be paid by a MedicareAdvantage eligible individual enrolled in a MedicareAdvantage plan in the same manner as such provisions apply to the amount of the monthly beneficiary obligation required to be paid by an eligible beneficiary enrolled in a Medicare Prescription Drug plan under part D.

''(f) AVAILABILITY OF PREMIUM SUBSIDY AND COST-SHARING REDUCTIONS FOR LOW-INCOME ENROLLEES AND REINSURANCE PAYMENTS.—For provisions—

''(1) providing premium subsidies and cost-sharing reductions for low-income individuals receiving qualified prescription drug coverage through a MedicareAdvantage plan, see section 1860D–19; and

''(2) providing a MedicareAdvantage organization with reinsurance payments for certain expenses incurred in providing qualified prescription drug coverage through a MedicareAdvantage plan, see section 1860D–20.''.

(b) TREATMENT OF REDUCTION FOR PURPOSES OF DETERMINING GOVERNMENT CONTRIBUTION UNDER PART B.—Section 1844(c) (42 U.S.C. 1395w) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(d)(1)(A)(i)''.

SEC. 206. FACILITATING EMPLOYER PARTICIPATION.

Section 1858(h) (as added by section 211) is amended by inserting ''(including subsection (i) of such section)'' after ''section 1857''.

SEC. 207. ADMINISTRATION BY THE CENTER FOR MEDICARE CHOICES.

On and after January 1, 2006, the MedicareAdvantage program under part C of title XVIII of the Social Security Act shall be administered by the Center for Medicare Choices established under section 1808 such title (as added by section 301), and each reference to the Secretary made in such part shall be deemed to be a reference to the Administrator of the Center for Medicare Choices.

SEC. 208. CONFORMING AMENDMENTS.

(a) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICAREADVANTAGE ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS.—Section 1855 (42 U.S.C. 1395w–25) is amended—

(1) in subsection (b), in the matter preceding paragraph (1), by inserting ''subparagraphs (A), (B), and (D) of'' before ''section 1852(A)(1)''; and

(2) by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

(b) ESTABLISHMENT OF PSO STANDARDS.—Section 1856 (42 U.S.C. 1395w–26) is amended by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

(c) CONTRACTS WITH MEDICAREADVANTAGE ORGANIZATIONS.—Section 1857 (42 U.S.C. 1395w–27) is amended—

(1) in subsection (g)(1)—

(A) in subparagraph (B), by striking ''amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums'' and inserting ''amounts of the MedicareAdvantage monthly basic premium and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits'';

(B) in subparagraph (F), by striking ''or'' after the semicolon at the end;

(C) in subparagraph (G), by adding ''or'' after the semicolon at the end; and

(D) by inserting after subparagraph (G) the following new subparagraph:

''(H)(i) charges any individual an amount in excess of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage under section 1858A(d);

''(ii) provides coverage for prescription drugs that is not qualified prescription drug coverage;

''(iii) offers prescription drug coverage, but does not make standard prescription drug coverage available; or

''(iv) provides coverage for prescription drugs (other than that relating to prescription drugs covered under the original medicare fee-for-service program option described in section 1851(a)(1)(A)(i)) as an enhanced medical benefit under section 1852(a)(3)(D) or as an additional benefit under section 1854(g)(1)(F),''; and

(2) by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

(d) DEFINITIONS; MISCELLANEOUS PROVISIONS.—Section 1859 (42 U.S.C. 1395w–28) is amended—

(1) by striking subsection (c) and inserting the following new subsection:

''(c) OTHER REFERENCES TO OTHER TERMS.—

''(1) ENHANCED MEDICAL BENEFITS.—The term 'enhanced medical benefits' is defined in section 1852(a)(3)(E).

''(2) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.—The term 'MedicareAdvantage eligible individual' is defined in section 1851(a)(3).

''(3) MEDICAREADVANTAGE PAYMENT AREA.—The term 'MedicareAdvantage payment area' is defined in section 1853(d).

''(4) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—The 'national per capita Medicare+Choice growth percentage' is defined in section 1853(c)(6).

''(5) MEDICAREADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM; MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE; MEDICAREADVANTAGE MONTHLY BENEFICIARY PREMIUM FOR ENHANCED MEDICAL BENEFITS.—The terms 'MedicareAdvantage monthly basic beneficiary premium', 'MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage', and 'MedicareAdvantage monthly beneficiary premium for enhanced medical benefits' are defined in section 1854(b)(2).

''(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' has the meaning given such term in section 1860D(9).

''(7) STANDARD PRESCRIPTION DRUG COVERAGE.—The term 'standard prescription drug coverage' has the meaning given such term in section 1860D(10).''; and

(2) by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

(e) CONFORMING AMENDMENTS EFFECTIVE BEFORE 2006.—

(1) EXTENSION OF MSAS.—Section 1851(b)(4) (42 U.S.C. 1395w–21(b)(4)) is amended by striking ''January 1, 2003'' and inserting ''January 1, 2004''.

(2) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005.—Section 1851(e) of the Social Security Act (42 U.S.C. 1395w–21(e)) is amended—

(A) in paragraph (2)(A), by striking ''THROUGH 2004'' and ''December 31,2004'' and inserting ''THROUGH 2005'' and ''December 31, 2005'', respectively;

(B) in the heading of paragraph (2)(B), by striking ''DURING 2005'' and inserting ''DURING 2006'';

(C) in paragraphs (2)(B)(i) and (2)(C)(i), by striking ''2005'' and inserting ''2006'' each place it appears;

(D) in paragraph (2)(D), by striking ''2004'' and inserting ''2005''; and

(E) in paragraph (4), by striking ''2005'' and inserting ''2006'' each place it appears.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of enactment of this Act.

(e) OTHER CONFORMING AMENDMENTS.—

(1) CONFORMING MEDICARE CROSS-REFERENCES.—

(A) Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(g)(1)(C)(i)''.

(B) Section 1840(i) (42 U.S.C. 1395s(i)) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(g)(1)(C)(i)''.

(C) Section 1844(c) (42 U.S.C. 1395w(c)) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(g)(1)(C)(i)''.

(D) Section 1876(k)(3)(A) (42 U.S.C. 1395mm(k)(3)(A)) is amended by inserting ''(as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003)'' after section 1853(a).

(F) Section 1876(k)(4) (42 U.S.C. 1395mm(k)(4)(A)) is amended—

(i) in subparagraph (A), by striking ''section 1853(a)(3)(B)'' and inserting ''section 1853(a)(3)(D)''; and

(ii) in subparagraph (B), by striking ''section 1854(g)'' and inserting ''section 1854(h)''.

(G) Section 1876(k)(4)(C) (42 U.S.C. 1395mm(k)(4)(C)) in amended by inserting ''(as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003)'' after ''section 1851(e)(6)''.

(H) Section 1894(d) (42 U.S.C. 1395eee(d)) is amended by adding at the end the following new paragraph:

''(3) APPLICATION OF PROVISIONS.—For purposes of paragraphs (1) and (2), the references to section 1853 and subsection (a)(2) of such section in such paragraphs shall be deemed to be references to those provisions as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003.''.

(2) CONFORMING MEDICARE TERMINOLOGY.—Title XVIII (42 U.S.C. 1395 et seq.), except for part C of such title (42 U.S.C. 1395w–21 et seq.), and title XIX (42 U.S.C. 1396 et seq.) are each amended by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

SEC. 209. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in section 208(d)(3) and subsection (b), the amendments made by this title shall apply with respect to plan years beginning on and after January 1, 2006.

(b) MEDICAREADVANTAGE MSA PLANS.—Notwithstanding any provision of this title, the Secretary shall apply the payment and other rules that apply with respect to an MSA plan described in section 1851(a)(2)(B) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)(B)) as if this title had not been enacted.

Subtitle B—Preferred Provider Organizations

SEC. 211. ESTABLISHMENT OF MEDICAREADVANTAGE PREFERRED PROVIDER PROGRAM OPTION.

(a) ESTABLISHMENT OF PREFERRED PROVIDER PROGRAM OPTION.—Section 1851(a)(2) is amended by adding at the end the following new subparagraph:

''(D) PREFERRED PROVIDER ORGANIZATION PLANS.—A MedicareAdvantage preferred provider organization plan under the program established under section 1858.''.

(b) PROGRAM SPECIFICATIONS.—Part C of title XVIII (42 U.S.C. 1395w–21 et seq.) is amended by inserting after section 1857 the following new section:

''PREFERRED PROVIDER ORGANIZATIONS

''SEC. 1858. (a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—Beginning on January 1, 2006, there is established a preferred provider program under which preferred provider organization plans offered by preferred provider organizations are offered to MedicareAdvantage eligible individuals in preferred provider regions.

''(2) DEFINITIONS.—

''(A) PREFERRED PROVIDER ORGANIZATION.—The term 'preferred provider organization' means an entity with a contract under section 1857 that meets the requirements of this section applicable with respect to preferred provider organizations.

''(B) PREFERRED PROVIDER ORGANIZATION PLAN.—The term 'preferred provider organization plan' means a MedicareAdvantage plan that—

''(i) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

''(ii) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

''(iii) is offered by a preferred provider organization.

''(C) PREFERRED PROVIDER REGION.—The term 'preferred provider region' means—

''(i) a region established under paragraph (3); and

''(ii) a region that consists of the entire United States.

''(3) PREFERRED PROVIDER REGIONS.—For purposes of this part the Secretary shall establish preferred provider regions as follows:

''(A) There shall be at least 10 regions.

''(B) Each region must include at least 1 State.

''(C) The Secretary may not divide States so that portions of the State are in different regions.

''(D) To the extent possible, the Secretary shall include multistate metropolitan statistical areas in a single region. The Secretary may divide metropolitan statistical areas where it is necessary to establish regions of such size and geography as to maximize the participation of preferred provider organization plans.

''(E) The Secretary may conform the preferred provider regions to the service areas established under section 1860D–10.

''(b) ELIGIBILITY, ELECTION, AND ENROLLMENT; BENEFITS AND BENEFICIARY PROTECTIONS.—

''(1) IN GENERAL.—Except as provided in the succeeding provisions of this subsection, the provisions of sections 1851 and 1852 that apply with respect to coordinated care plans shall apply to preferred provider organization plans offered by a preferred provider organization.

''(2) SERVICE AREA.—The service area of a preferred provider organization plan shall be a preferred provider region.

''(3) AVAILABILITY.—Each preferred provider organization plan must be offered to each MedicareAdvantage eligible individual who resides in the service area of the plan.

''(4) AUTHORITY TO PROHIBIT RISK SELECTION.—The provisions of section 1852(a)(6) shall apply to preferred provider organization plans.

''(5) ASSURING ACCESS TO SERVICES IN PREFERRED PROVIDER ORGANIZATION PLANS.—

''(A) IN GENERAL.—In addition to any other requirements under this section, in the case of a preferred provider organization plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan.

''(B) DETERMINATION OF SUFFICIENT ACCESS.—The Secretary shall find that an organization has met the requirement under subparagraph (A) with respect to any category of health care professional or provider if, with respect to that category of provider the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan.

''(C) CONSTRUCTION.—Subparagraph (B) shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.

''(c) PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS.—

''(1) PAYMENTS TO ORGANIZATIONS.—

''(A) MONTHLY PAYMENTS.—

''(i) IN GENERAL.—Under a contract under section 1857 and subject to paragraph (5), subsection (e), and section 1859(e)(4), the Secretary shall make, to each preferred provider organization, with respect to coverage of an individual for a month under this part in a preferred provider region, separate monthly payments with respect to—

''(I) benefits under the original medicare fee-for-service program under parts A and B in accordance with paragraph (4); and

''(II) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

''(ii) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment applicable with respect to classes of individuals determined to have end-stage renal disease and enrolled in a preferred provider organization plan under this clause that are similar to the separate rates of payment described in section 1853(a)(1)(B).

''(B) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—The Secretary may retroactively adjust the amount of payment under this paragraph in a manner that is similar to the manner in which payment amounts may be retroactively adjusted under section 1853(a)(2).

''(C) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in section 1853(a)(3)(B) to 100 percent of the amount of payments to plans under paragraph (4)(D)(ii).

''(D) ADJUSTMENT FOR SPENDING VARIATIONS WITHIN A REGION.—The Secretary shall establish a methodology for adjusting the amount of payments to plans under paragraph (4)(D)(ii) that achieves the same objective as the adjustment described in paragraph 1853(a)(2)(C).

''(2) ANNUAL CALCULATION OF BENCHMARK AMOUNTS FOR PREFERRED PROVIDER REGIONS.—For each year (beginning in 2006), the Secretary shall calculate a benchmark amount for each preferred provider region for each month for such year with respect to coverage of the benefits available under the original medicare fee-for-service program option equal to the average of each benchmark amount calculated under section 1853(a)(4) for each MedicareAdvantage payment area for the year within such region, weighted by the number of MedicareAdvantage eligible individuals residing in each such payment area for the year.

''(3) ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.—

''(A) ANNUAL ANNOUNCEMENT.—Beginning in 2005, at the same time as the Secretary publishes the risk adjusters under section 1860D–11, the Secretary shall annually announce (in a manner intended to provide notice to interested parties) the following payment factors:

''(i) The benchmark amount for each preferred provider region (as calculated under paragraph (2)(A)) for the year.

''(ii) The factors to be used for adjusting payments described under—

''(I) the comprehensive risk adjustment methodology described in paragraph (1)(C) with respect to each preferred provider region for the year; and

''(II) the methodology used for adjustment for geographic variations within such region established under paragraph (1)(D).

''(B) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under subparagraph (A) for a year, the Secretary shall—

''(i) provide for notice to preferred provider organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement; and

''(ii) provide such organizations with an opportunity to comment on such proposed changes.

''(C) EXPLANATION OF ASSUMPTIONS.—In each announcement made under subparagraph (A), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that preferred provider organizations can compute each payment factor described in such subparagraph.

''(4) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT FOR BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—The Secretary shall determine the payment amount for plans as follows:

''(A) REVIEW OF PLAN BIDS.—The Secretary shall review each plan bid submitted under subsection (d)(1) for the coverage of benefits under the original medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part and are based on the assumptions described in section 1854(a)(2)(A)(iii) that the plan used with respect to numbers of enrolled individuals.

''(B) DETERMINATION OF PREFERRED PROVIDER REGIONAL BENCHMARK AMOUNTS.—The Secretary shall calculate a preferred provider regional benchmark amount for that plan for the benefits under the original medicare fee-for-service program option for each plan equal to the regional benchmark adjusted by using the assumptions described in section 1854(a)(2)(A)(iii) that the plan used with respect to numbers of enrolled individuals.

''(C) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under subparagraph (A)) and the preferred provider regional benchmark amount (as determined under subparagraph (B)) for purposes of determining—

''(i) the payment amount under subparagraph (D); and

''(ii) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

''(D) DETERMINATION OF PAYMENT AMOUNT.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall determine the payment amount to a preferred provider organization for a preferred provider organization plan as follows:

''(I) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount.

''(II) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

''(ii) APPLICATION OF ADJUSTMENT METHODOLOGIES.—The Secretary shall adjust the amounts determined under subparagraph (A) using the factors described in paragraph (3)(A)(ii).

''(E) FACTORS USED IN ADJUSTING BIDS AND BENCHMARKS FOR PREFERRED PROVIDER ORGANIZATIONS AND IN DETERMINING ENROLLEE PREMIUMS.—Subject to subparagraph (F), in addition to the factors used to adjust payments to plans described in section 1853(d)(6), the Secretary shall use the adjustment for geographic variation within the region established under paragraph (1)(D).

''(F) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—The Secretary shall provide for adjustments for national coverage determinations and legislative changes in benefits applicable with respect to preferred provider organizations in the same manner as the Secretary provides for adjustments under section 1853(d)(7).

''(5) PAYMENTS FROM TRUST FUND.—The payment to a preferred provider organization under this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in a manner similar to the manner described in section 1853(g).

''(6) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—Rules similar to the rules applicable under section 1853(h) shall apply with respect preferred provider organizations.

''(7) SPECIAL RULE FOR HOSPICE CARE.—Rules similar to the rules applicable under section 1853(i) shall apply with respect to preferred provider organizations.

''(d) SUBMISSION OF BIDS BY PPOs; PREMIUMS.—

''(1) SUBMISSION OF BIDS BY PREFERRED PROVIDER ORGANIZATIONS.—

''(A) IN GENERAL.—For the requirements on submissions by MedicareAdvantage preferred provider organization plans, see section 1854(a)(1).

''(B) UNIFORM PREMIUMS.—Each bid amount submitted under subparagraph (A) for a preferred provider organization plan in a preferred provider region may not vary among MedicareAdvantage eligible individuals residing in such preferred provider region.

''(C) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under subparagraph (A) for a preferred provider organization plan must reasonably and equitably reflect the cost of benefits provided under that plan.

''(D) REVIEW.—The Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this paragraph and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the preferred provider organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

''(E) AUTHORITY TO LIMIT NUMBER OF PLANS IN A REGION.—If there are bids for more than 3 preferred provider organization plans in a preferred provider region, the Secretary shall accept only the 3 lowest-cost credible bids for that region that meet or exceed the quality and minimum standards applicable under this section.

''(2) MONTHLY PREMIUMS CHARGED.—The amount of the monthly premium charged to an individual enrolled in a preferred provider organization plan offered by a preferred provider organization shall be equal to the sum of the following:

''(A) The MedicareAdvantage monthly basic beneficiary premium, as defined in section 1854(b)(2)(A) (if any).

''(B) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, as defined in section 1854(b)(2)(C) (if any).

''(C) The MedicareAdvantage monthly obligation for qualified prescription drug coverage, as defined in section 1854(b)(2)(B) (if any).

''(3) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—The rules for determining premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums under section 1854(d) shall apply with respect to preferred provider organizations.

''(4) PROHIBITION OF SEGMENTING PREFERRED PROVIDER REGIONS.—The Secretary may not permit a preferred provider organization to elect to apply the provisions of this section uniformly to separate segments of a preferred provider region (rather than uniformly to an entire preferred provider region).

''(e) PORTION OF TOTAL PAYMENTS TO AN ORGANIZATION SUBJECT TO RISK FOR 2 YEARS.—

''(1) NOTIFICATION OF SPENDING UNDER THE PLAN.—

''(A) IN GENERAL.—For 2007 and 2008, the preferred provider organization offering a preferred provider organization plan shall notify the Secretary of the total amount of costs that the organization incurred in providing benefits covered under parts A and B of the original medicare fee-for-service program for all enrollees under the plan in the previous year.

''(B) CERTAIN EXPENSES NOT INCLUDED.—The total amount of costs specified in subparagraph (A) may not include—

''(i) subject to subparagraph (C), administrative expenses incurred in providing the benefits described in such subparagraph; or

''(ii) amounts expended on providing enhanced medical benefits under section 1852(a)(3)(D).

''(C) ESTABLISHMENT OF ALLOWABLE ADMINISTRATIVE EXPENSES.—For purposes of applying subparagraph (B)(i), the administrative expenses incurred in providing benefits described in subparagraph (A) under a preferred provider organization plan may not exceed an amount determined appropriate by the Administrator.

''(2) ADJUSTMENT OF PAYMENT.—

''(A) NO ADJUSTMENT IF COSTS WITHIN RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)) for the plan for the year, then no additional payments shall be made by the Secretary and no reduced payments shall be made to the preferred provider organization offering the plan.

''(B) INCREASE IN PAYMENT IF COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—

''(i) IN GENERAL.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Secretary shall increase the total of the monthly payments made to the preferred provider organization offering the plan for the year under subsection (c)(1)(A) by an amount equal to the sum of—

''(I) 50 percent of the amount of such total costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(iv)); and

''(II) 90 percent of the amount of such total costs which are more than such second threshold upper limit of the risk corridor.

''(C) REDUCTION IN PAYMENT IF COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the Secretary shall reduce the total of the monthly payments made to the preferred provider organization offering the plan for the year under subsection (c)(1)(A) by an amount (or otherwise recover from the plan an amount) equal to—

''(i) 50 percent of the amount of such total costs which are less than such first threshold lower limit of the risk corridor and not less than the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(ii)); and

''(ii) 90 percent of the amount of such total costs which are less than such second threshold lower limit of the risk corridor.

''(3) ESTABLISHMENT OF RISK CORRIDORS.—

''(A) IN GENERAL.—For 2006 and 2007, the Secretary shall establish a risk corridor for each preferred provider organization plan. The risk corridor for a plan for a year shall be equal to a range as follows:

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

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to 5 percent of such target amount.

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

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to 10 percent of such target amount.

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

''(I) such target amount; and

''(II) the amount described in clause (i)(II).

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

''(I) such target amount; and

''(II) the amount described in clause (ii)(II).

''(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a preferred provider organization plan offered by a preferred provider organization in a year, an amount equal to the sum of—

''(i) the total monthly payments made to the organization for enrollees in the plan for the year under subsection (c)(1)(A); and

''(ii) the total MedicareAdvantage basic beneficiary premiums collected for such enrollees for the year under subsection (d)(2)(A).

''(4) PLANS AT RISK FOR ENTIRE AMOUNT OF ENHANCED MEDICAL BENEFITS.—A preferred provider organization that offers a preferred provider organization plan that provides enhanced medial benefits under section 1852(a)(3)(D) shall be at full financial risk for the provision of such benefits.

''(5) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the amount of the MedicareAdvantage basic beneficiary premium that a beneficiary is otherwise required to pay under the plan for the year under subsection (d)(2)(A).

''(6) DISCLOSURE OF INFORMATION.—The provisions of section 1860D–16(b)(7), including subparagraph (B) of such section, shall apply to a preferred provider organization and a preferred provider organization plan in the same manner as such provisions apply to an eligible entity and a Medicare Prescription Drug plan under part D.

''(f) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR PREFERRED PROVIDER ORGANIZATIONS.—A preferred provider organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State within the preferred provider region in which it offers a preferred provider organization plan.

''(g) INAPPLICABILITY OF PROVIDER-SPONSORED ORGANIZATION SOLVENCY STANDARDS.—The requirements of section 1856 shall not apply with respect to preferred provider organizations.

''(h) CONTRACTS WITH PREFERRED PROVIDER ORGANIZATIONS.—The provisions of section 1857 shall apply to a preferred provider organization plan offered by a preferred provider organization under this section.''.

(c) PREFERRED PROVIDER TERMINOLOGY DEFINED.—Section 1859(a) is amended by adding at the end the following new paragraph:

''(3) PREFERRED PROVIDER ORGANIZATION; PREFERRED PROVIDER ORGANIZATION PLAN; PREFERRED PROVIDER REGION.—The terms 'preferred provider organization', 'preferred provider organization plan', and 'preferred provider region' have the meaning given such terms in section 1858(a)(2).''.

Subtitle C—Other Managed Care Reforms

SEC. 221. EXTENSION OF REASONABLE COST CONTRACTS.

(a) FIVE-YEAR EXTENSION.—Section 1876(h)(5)(C) (42 U.S.C. 1395mm(h)(5)(C)) is amended by striking ''2004'' and inserting ''2009''.

(b) APPLICATION OF CERTAIN MEDICARE+CHOICE REQUIREMENTS TO COST CONTRACTS EXTENDED OR RENEWED AFTER 2003.—Section 1876(h) (42 U.S.C. 1395mm(h)(5)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

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

''(5) Any reasonable cost reimbursement contract with an eligible organization under this subsection that is extended or renewed on or after the date of enactment of the Prescription Drug and Medicare Improvements Act of 2003 for plan years beginning on or after January 1, 2004, shall provide that the following provisions of the Medicare+Choice program under part C (and, on and after January 1, 2006, the provisions of the MedicareAdvantage program under such part) shall apply to such organization and such contract in a substantially similar manner as such provisions apply to Medicare+Choice organizations and Medicare+Choice plans (or, on and after January 1, 2006, MedicareAdvantage organizations and MedicareAdvantage plans, respectively) under such part:

''(A) Paragraph (1) of section 1852(e) (relating to the requirement of having an ongoing quality assurance program) and paragraph (2)(B) of such section (relating to the required elements for such a program).

''(B) Section 1852(j)(4) (relating to limitations on physician incentive plans).

''(C) Section 1854(c) (relating to the requirement of uniform premiums among individuals enrolled in the plan).

''(D) Section 1854(g), or, on and after January 1, 2006, section 1854(h) (relating to restrictions on imposition of premium taxes with respect to payments to organizations).

''(E) Section 1856(b) (regarding compliance with the standards established by regulation pursuant to such section, including the provisions of paragraph (3) of such section relating to relation to State laws).

''(F) Section 1852(a)(3)(A) (regarding the authority of organizations to include supplemental health care benefits and, on and after January 1, 2006, enhanced medical benefits under the plan subject to the approval of the Secretary).

''(G) The provisions of part C relating to timelines for benefit filings, contract renewal, and beneficiary notification.

''(H) Section 1854(e), or, on and after January 1, 2006, section 1854(f) (relating to proposed cost-sharing under the contract being subject to review by the Secretary).''.

(c) PERMITTING DEDICATED GROUP PRACTICE HEALTH MAINTENANCE ORGANIZATIONS TO PARTICIPATE IN THE MEDICARE COST CONTRACT PROGRAM.—Section 1876(h)(6) of the Social Security Act (42 U.S.C. 1395mm(h)(6)), as redesignated and amended by subsections (a) and (b), is amended—

(1) in subparagraph (A), by striking ''After the date of the enactment'' and inserting ''Except as provided in subparagraph (C), after the date of the enactment'';

(2) in subparagraph (B), by striking ''subparagraph (C)'' and inserting ''subparagraph (D)'';

(3) by redesignating subparagraph (C) as subparagraph (D); and

(4) by inserting after subparagraph (B), the following new subparagraph:

''(C) Subject to paragraph (5) and subparagraph (D), the Secretary shall approve an application to enter into a reasonable cost contract under this section if—

''(i) the application is submitted to the Secretary by a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act) that, as of January 1, 2004, and except as provided in section 1301(b)(3)(B) of such Act, provides at least 85 percent of the services of a physician which are provided as basic health services through a medical group (or groups), as defined in section 1302(4) of such Act; and

''(ii) the Secretary determines that the organization meets the requirements applicable to such organizations and contracts under this section.''.

SEC. 222. 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–28(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–28) 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, 2008, the plan may restrict the enrollment of individuals under the plan to individuals who are within 1 or more classes of special needs beneficiaries.''.

(d) REPORT TO CONGRESS.—Not later than December 31, 2006, the Secretary shall submit to Congress a report that assesses the impact of specialized Medicare+Choice plans for special needs beneficiaries on the cost and quality of services provided to enrollees. 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 on the date of enactment of this Act.

(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.—No later than 1 year after the date of enactment of this Act, the Secretary 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. 223. PAYMENT BY PACE PROVIDERS FOR MEDICARE AND MEDICAID SERVICES FURNISHED BY NONCONTRACT PROVIDERS.

(a) MEDICARE SERVICES.—

(1) MEDICARE SERVICES FURNISHED BY PROVIDERS OF SERVICES.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(A) by striking ''part C or'' and inserting ''part C, with a PACE provider under section 1894 or 1934, or'';

(B) by striking ''(i)'';

(C) by striking ''and (ii)''; and

(D) by striking ''members of the organization'' and inserting ''members of the organization or PACE program eligible individuals enrolled with the PACE provider,''.

(2) MEDICARE SERVICES FURNISHED BY PHYSICIANS AND OTHER ENTITIES.—Section 1894(b) (42 U.S.C. 1395eee(b)) is amended by adding at the end the following new paragraphs:

''(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

''(A) APPLICATION OF MEDICARE+CHOICE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against Medicare+Choice organizations for noncontract physicians and other entities with respect to services covered under this title) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract establishing payment amounts for services furnished to such an individual in the same manner as such section applies to Medicare+Choice organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

''(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under this title furnished by noncontract providers of services, see section 1866(a)(1)(O).

''(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER TITLE XIX BUT NOT UNDER THIS TITLE.—For provisions relating to limitations on payments to providers participating under the State plan under title XIX that do not have a contract with a PACE provider establishing payment amounts for services covered under such plan (but not under this title) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).''.

(b) MEDICAID SERVICES.—

(1) REQUIREMENT UNDER STATE PLAN.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (64), by striking ''and'' at the end;

(B) in paragraph (65), by striking the period at the end and inserting ''; and''; and

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

''(66) provide, with respect to services covered under the State plan (but not under title XVIII) that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract with the PACE provider that establishes payment amounts for such services, that such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan for the State where the PACE provider is located (in accordance with regulations issued by the Secretary).''.

(2) REFERENCE IN MEDICAID STATUTE.—Section 1934(b) (42 U.S.C. 1396u–4(b)) is amended by adding at the end the following new paragraphs:

''(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

''(A) APPLICATION OF MEDICARE+CHOICE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against Medicare+Choice organizations for

noncontract physicians and other entities with respect to services covered under title XVIII) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract establishing payment amounts for services furnished to such an individual in the same manner as such section applies to Medicare+Choice organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

''(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under title XVIII furnished by noncontract providers of services, see section 1866(a)(1)(O).

''(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER THIS TITLE BUT NOT UNDER TITLE XVIII.—For provisions relating to limitations on payments to providers participating under the State plan under this title that do not have a contract with a PACE provider establishing payment amounts for services covered under such plan (but not under title XVIII) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004.

SEC. 224. INSTITUTE OF MEDICINE EVALUATION AND REPORT ON HEALTH CARE PERFORMANCE MEASURES.

(a) EVALUATION.—

(1) IN GENERAL.—Not later than the date that is 2 months after the date of enactment of this Act, the Secretary of Health and Human Services shall enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences (in this section referred to as the ''Institute'') shall conduct an evaluation of leading health care performance measures and options to implement policies that align performance with payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) SPECIFIC MATTERS EVALUATED.—In conducting the evaluation under paragraph (1), the Institute shall—

(A) catalogue, review, and evaluate the validity of leading health care performance measures;

(B) catalogue and evaluate the success and utility of alternative performance incentive programs in public or private sector settings; and

(C) identify and prioritize options to implement policies that align performance with payment under the medicare program that indicate—

(i) the performance measurement set to be used and how that measurement set will be updated;

(ii) the payment policy that will reward performance; and

(iii) the key implementation issues (such as data and information technology requirements) that must be addressed.

(3) SCOPE OF HEALTH CARE PERFORMANCE MEASURES.—The health care performance measures described in paragraph (2)(A) shall encompass a variety of perspectives, including physicians, hospitals, health plans, purchasers, and consumers.

(4) CONSULTATION WITH MEDPAC.—In evaluating the matters described in paragraph (2)(C), the Institute shall consult with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

(b) REPORT.—Not later than the date that is 18 months after the date of enactment of this Act, the Institute shall submit to the Secretary of Health and Human Services, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report on the evaluation conducted under subsection (a)(1) describing the findings of such evaluation and recommendations for an overall strategy and approach for aligning payment with performance in the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, the Medicare+Choice program under part C of such title, and any other programs under such title XVIII.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,000,000 for purposes of conducting the evaluation and preparing the report required by this section.

SEC. 225. EXPANDING THE WORK OF MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS TO INCLUDE PARTS C AND D.

(a) APPLICATION TO MEDICARE MANAGED CARE AND PRESCRIPTION DRUG COVERAGE.—Section 1154(a)(1) (42 U.S.C. 1320c–3(a)(1)) is amended by inserting '', Medicare+Choice organizations and MedicareAdvantage organizations under part C, and prescription drug card sponsors and eligible entities under part D'' after ''under section 1876''.

(b) PRESCRIPTION DRUG THERAPY QUALITY IMPROVEMENT.—Section 1154(a) (42 U.S.C. 1320c–3(a)) is amended by adding at the end the following new paragraph:

''(17) The organization shall execute its responsibilities under subparagraphs (A) and (B) of paragraph (1) by offering to providers, practitioners, prescription drug card sponsors and eligible entities under part D, and Medicare+Choice and MedicareAdvantage plans under part C quality improvement assistance pertaining to prescription drug therapy. For purposes of this part and title XVIII, the functions described in this paragraph shall be treated as a review function.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply on and after January 1, 2004.

TITLE III—CENTER FOR MEDICARE CHOICES

SEC. 301. ESTABLISHMENT OF THE CENTER FOR MEDICARE CHOICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 111, is amended by inserting after 1806 the following new section:

''ESTABLISHMENT OF THE CENTER FOR MEDICARE CHOICES

''SEC. 1808. (a) ESTABLISHMENT.—By not later than March 1, 2004, the Secretary shall establish within the Department of Health and Human Services the Center for Medicare Choices, which shall be separate from the Centers for Medicare & Medicaid Services.

''(b) ADMINISTRATOR AND DEPUTY ADMINISTRATOR.—

''(1) ADMINISTRATOR.—

''(A) IN GENERAL.—The Center for Medicare Choices shall be headed by an 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 report directly 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 Center for Medicare Choices, 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 Center for Medicare Choices. 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 Center for Medicare Choices as the Administrator considers necessary or appropriate, except that this subparagraph shall not apply with respect to any unit, component, or provision provided for by 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 Center for Medicare Choices 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 Center for Medicare Choices who shall be appointed by the Administrator.

''(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 the Acting Administrator of the Center for Medicare Choices 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) 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 MedicareAdvantage plans under part C, including the offering of qualified prescription drug coverage under such plans; and

''(ii) negotiating, entering into, and enforcing, contracts with eligible entities for the

offering of Medicare Prescription Drug plans under part D.

''(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or D, including duties relating to—

''(i) reasonable cost contracts with eligible organizations under section 1876(h); and

''(ii) demonstration projects carried out in part or in whole under such parts, including the demonstration project carried out through a MedicareAdvantage (formerly Medicare+Choice) project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of an interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

''(C) NONINTERFERENCE.—In order to promote competition under parts C and D, the Administrator, in carrying out the duties required under this section, may not, to the extent possible, interfere in any way with negotiations between eligible entities, MedicareAdvantage organizations, hospitals, physicians, other entities or individuals furnishing items and services under this title (including contractors for such items and services), and drug manufacturers, wholesalers, or other suppliers of covered drugs

''(D) ANNUAL REPORTS.—Not later than March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of the voluntary prescription drug delivery program under this part during the previous fiscal year.

''(2) MANAGEMENT STAFF.—

''(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, such management staff as determined appropriate. Any such manager shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in the following areas:

''(i) The review, negotiation, and administration of health care contracts.

''(ii) The design of health care benefit plans.

''(iii) Actuarial sciences.

''(iv) Compliance with health plan contracts.

''(v) Consumer education and decision making.

''(B) COMPENSATION.—

''(i) IN GENERAL.—Subject to clause (ii), the Administrator shall establish the rate of pay for an individual employed under subparagraph (A).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

''(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

''(A) IN GENERAL.—The Secretary, the Administrator of the Center for Medicare Choices, and the Administrator of the Centers for Medicare & Medicaid Services shall establish 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 of the Center for Medicare Choices as is appropriate to carry out the purposes of this section.

''(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator such information and data in the possession of the Administrator of the Centers for Medicare & Medicaid Services as the Administrator 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 Center for Medicare Choices an Office of Beneficiary Assistance to carry out functions relating to medicare beneficiaries under this title, including making determinations of eligibility of individuals for benefits under this title, providing for enrollment of medicare beneficiaries under this title, and the functions described in paragraph (2). The Office shall be a separate operating division within the Center for Medicare Choices.

''(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

''(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries, by mail, by posting on the Internet site of the Center for Medicare Choices, and through the toll-free telephone number provided for under section 1804(b), information with respect to the following:

''(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

''(ii) Benefits, and limitations on payment under parts A, and B, including information on medicare supplemental policies under section 1882.

''(iii) Other areas determined to be appropriate by the Administrator.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, and D, and medicare supplemental policies with benefits under MedicareAdvantage 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 MedicareAdvantage program under part C, and the voluntary prescription drug delivery program under part D.

''(3) MEDICARE OMBUDSMAN.—

''(A) IN GENERAL.—Within the Office of Beneficiary Assistance, there shall be a Medicare Ombudsman, appointed by the Secretary from among individuals with expertise and experience in the fields of health care and advocacy, to carry out the duties described in subparagraph (B).

''(B) DUTIES.—The Medicare Ombudsman shall—

''(i) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

''(ii) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

''(I) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, MedicareAdvantage organization, an eligible entity under part D, or the Secretary; and

''(II) assistance to such beneficiaries with any problems arising from disenrollment from a MedicareAdvantage plan under part C or a prescription drug plan under part D; and

''(iii) submit annual reports to Congress, the Secretary, and the Medicare Competitive Policy Advisory Board describing the activities of the Office, and including such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

''(C) COORDINATION WITH STATE OMBUDSMAN PROGRAMS AND CONSUMER ORGANIZATIONS.—The Medicare Ombudsman shall, to the extent appropriate, coordinate with State medical Ombudsman programs, and with State- and community-based consumer organizations, to—

''(i) provide information about the medicare program; and

''(ii) conduct outreach to educate medicare beneficiaries with respect to manners in which problems under the medicare program may be resolved or avoided.

''(e) MEDICARE COMPETITIVE POLICY ADVISORY BOARD.—

''(1) ESTABLISHMENT.—There is established within the Center for Medicare Choices the Medicare Competitive Policy Advisory Board (in this section referred to as the 'Board'). The Board shall advise, consult with, and make recommendations to the Administrator 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 such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the stability and solvency of the programs under such parts and 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 of 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) QUALITY.—Recommendations on ways to improve the quality of benefits provided under plans under parts C and D.

''(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.—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 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 7 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 chairman and the ranking minority member 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 Committee on Finance of the Senate.

''(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

''(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

''(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 3 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 such additional personnel as the Director considers appropriate.

''(C) ASSISTANCE FROM THE ADMINISTRATOR.—The Administrator 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 Prescription Drug Account), such sums as are necessary to carry out this section.''.

(b) USE OF CENTRAL, TOLL-FREE NUMBER (1–800–MEDICARE).—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: ''By not later than 1 year after the date of the enactment of the Prescription Drug and Medicare Improvement Act of 2003, 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.''.

SEC. 302. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.

(a) ADMINISTRATOR AS MEMBER AND CO-SECRETARY OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—The fifth sentence of sections 1817(b) and 1841(b) (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking ''shall serve as the Secretary'' and inserting ''and the Administrator of the Center for Medicare Choices shall serve as the Co-Secretaries''.

(b) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—Section 5314 of title 5, United States Code, is amended by adding at the end the following:

''Administrator of the Centers for Medicare & Medicaid Services.''.

(2) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking ''Administrator of the Health Care Financing Administration.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on March 1, 2004.

TITLE IV—MEDICARE FEE-FOR-SERVICE IMPROVEMENTS

Subtitle A—Provisions Relating to Part A

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

(a) IN GENERAL.—Section 1886(d)(3)(A)(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 2004, the operating standardized amount for hospitals located other than in a large urban area shall be increased by ½ of the difference between the operating 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 2005, the Secretary shall compute an operating standardized amount for hospitals located in any area within the United States and within each region equal to the operating standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2006, applicable for all hospitals in the previous fiscal year) increased by the applicable percentage increase under subsection (b)(3)(B)(i) for the fiscal year involved.''.

(b) CONFORMING AMENDMENTS.—

(1) COMPUTING DRG-SPECIFIC RATES.—Section 1886(d)(3)(D) (42 U.S.C. 1395ww(d)(3)(D)) is amended—

(A) in the heading, by striking ''IN DIFFERENT AREAS'';

(B) in the matter preceding clause (i), by striking ''each of which is'';

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2005,'' before ''for hospitals''; and

(ii) in subclause (II), by striking ''and'' after the semicolon at the end;

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2005,'' before ''for hospitals''; and

(ii) in subclause (II), by striking the period at the end and inserting ''; and''; and

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

''(iii) for a fiscal year beginning after fiscal year 2004, for hospitals located in all areas, to the product of—

''(I) the applicable operating standardized amount (computed under subparagraph (A)), reduced under subparagraph (B), and adjusted or reduced under subparagraph (C) for the fiscal year; and

''(II) the weighting factor (determined under paragraph (4)(B)) for that diagnosis-related group.''.

(2) TECHNICAL CONFORMING SUNSET.—Section 1886(d)(3) (42 U.S.C. 1395ww(d)(3)) is amended—

(A) in the matter preceding subparagraph (A), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional adjusted DRG prospective payment rate''; and

(B) in subparagraph (D), in the matter preceding clause (i), by inserting '', for fiscal years before fiscal year 1997,'' before ''a regional DRG prospective payment rate for each region,''.

SEC. 402. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

(a) IN GENERAL.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

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

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

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

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

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

''(II) HOLD HARMLESS FOR CERTAIN HOSPITALS.—If the application of subclause (I) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this clause had not been enacted.''.

(b) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: ''The Secretary shall apply the previous sentence for any period as if the amendments made by section 402(a) of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.''.

SEC. 403. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

''(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

''(A) PAYMENT ADJUSTMENT.—

''(i) IN GENERAL.—Notwithstanding any other provision of this section, for each cost reporting period (beginning with the cost reporting period that begins in fiscal year 2004), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in clause (iii)) for discharges occurring during that cost reporting period which is equal to the applicable percentage increase (determined under clause (ii)) in the amount paid to such hospital under this section for such discharges.

''(ii) APPLICABLE PERCENTAGE INCREASE.—The Secretary shall determine a percentage increase applicable under this paragraph that ensures that—

''(I) no percentage increase in payments under this paragraph exceeds 25 percent of the amount of payment that would (but for this paragraph) otherwise be made to a low-volume hospital under this section for each discharge;

''(II) low-volume hospitals that have the lowest number of discharges during a cost reporting period receive the highest percentage increases in payments due to the application of this paragraph; and

''(III) the percentage increase in payments to any low-volume hospital due to the application of this paragraph is reduced as the number of discharges per cost reporting period increases.

''(iii) LOW-VOLUME HOSPITAL DEFINED.—For purposes of this paragraph, the term 'low-volume hospital' means, for a cost reporting period, a subsection (d) hospital (as defined in paragraph (1)(B)) other than a critical access hospital (as defined in section 1861(mm)(1)) that—

''(I) the Secretary determines had an average of less than 2,000 discharges (determined with respect to all patients and not just individuals receiving benefits under this title) during the 3 most recent cost reporting periods for which data are available that precede the cost reporting period to which this paragraph applies; and

''(II) is located at least 15 miles from a like hospital (or is deemed by the Secretary to be so located by reason of such factors as the Secretary determines appropriate, including the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (after taking into account the location of such alternative source of inpatient care and any weather or travel conditions that may affect such travel time).

''(B) PROHIBITING CERTAIN REDUCTIONS.—Notwithstanding subsection (e), the Secretary shall not reduce the payment amounts under this section to offset the increase in payments resulting from the application of subparagraph (A).''.

SEC. 404. FAIRNESS IN THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT FOR RURAL HOSPITALS.

(a) EQUALIZING DSH PAYMENT AMOUNTS.—

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

(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in clause (iv)—

(i) in subclause (II)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xiii)'';

(ii) in subclause (III)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xii)'';

(iii) in subclause (IV)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (x) or (xi)'';

(iv) in subclause (V)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xi)''; and

(v) in subclause (VI)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (x)'';

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

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking ''For purposes'' and inserting ''With respect to discharges occurring before October 1, 2004, for purposes''.

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

SEC. 405. CRITICAL ACCESS HOSPITAL (CAH) IMPROVEMENTS.

(a) PERMITTING CAHS TO ALLOCATE SWING BEDS AND ACUTE CARE INPATIENT BEDS SUBJECT TO A TOTAL LIMIT OF 25 BEDS.—

(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) (42 U.S.C. 1395i–4(c)(2)(B)(iii)) is amended to read as follows:

''(iii) provides not more than a total of 25 extended care service beds (pursuant to an agreement under subsection (f)) and acute care inpatient beds (meeting such standards as the Secretary may establish) for providing inpatient care for a period that does not exceed, as determined on an annual, average basis, 96 hours per patient;''.

(2) CONFORMING AMENDMENT.—Section 1820(f) (42 U.S.C. 1395i–4(f)) is amended by striking ''and the number of beds used at any time for acute care inpatient services does not exceed 15 beds''.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall with respect to designations made on or after October 1, 2003.

(b) ELIMINATION OF THE ISOLATION TEST FOR COST-BASED CAH AMBULANCE SERVICES.—

(1) ELIMINATION.—

(A) IN GENERAL.—Section 1834(l)(8) (42 U.S.C. 1395m(l)(8)), as added by section 205(a) of BIPA (114 Stat. 2763A–482), is amended by striking the comma at the end of subparagraph (B) and all that follows and inserting a period.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to services furnished on or after January 1, 2004.

(2) TECHNICAL CORRECTION.—Section 1834(l) (42 U.S.C. 1395m(l)) is amended by redesignating paragraph (8), as added by section 221(a) of BIPA (114 Stat. 2763A–486), as paragraph (9).

(c) COVERAGE OF COSTS FOR CERTAIN EMERGENCY ROOM ON-CALL PROVIDERS.—

(1) IN GENERAL.—Section 1834(g)(5) (42 U.S.C. 1395m(g)(5)) is amended—

(A) in the heading—

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

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

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

(C) by striking ''physicians' services'' and inserting ''services covered under this title''.

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

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

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

(A) in subparagraph (C), by striking ''and'' after the semicolon at the end;

(B) in subparagraph (D), by adding ''and'' after the semicolon at the end; and

(C) by inserting after subparagraph (D) the following new subparagraph:

''(E) inpatient critical access hospital services;''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to payments for inpatient critical access facility services furnished on or after January 1, 2004.

(e) EXCLUSION OF NEW CAHS FROM PPS HOSPITAL WAGE INDEX CALCULATION.—Section 1886(d)(3)(E)(i) (42 U.S.C. 1395ww(d)(3)(E)(i)), as amended by section 402, is amended by inserting after the first sentence the following new sentence: ''In calculating the hospital wage levels under the preceding sentence applicable with respect to cost reporting periods beginning on or after January 1, 2003, the Secretary shall exclude the wage levels of any facility that became a critical access hospital prior to the cost reporting period for which such hospital wage levels are calculated.''.

(f) PROVISIONS RELATED TO CERTAIN RURAL GRANTS.—

(1) SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM.—Section 1820(g) (42 U.S.C. 1395i–4(g)) is amended—

(A) by redesignating paragraph (3)(F) as paragraph (5) and redesignating and indenting appropriately; and

(B) by inserting after paragraph (3) the following new paragraph:

''(4) SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM.—

''(A) GRANTS TO HOSPITALS.—The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (B) to assist eligible small rural hospitals (as defined in paragraph (3)(B)) in meeting the costs of reducing medical errors, increasing patient safety, protecting patient privacy, and improving hospital quality and performance.

''(B) APPLICATION.—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

''(C) AMOUNT OF GRANT.—A grant to a hospital under this paragraph may not exceed $50,000.

''(D) USE OF FUNDS.—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff, and obtaining technical assistance.''.

(2) AUTHORIZATION FOR APPROPRIATIONS.—Section 1820(j) (42 U.S.C. 1395i–4(j)) is amended to read as follows:

''(j) AUTHORIZATION OF APPROPRIATIONS.—

''(1) HI TRUST FUND.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under—

''(A) subsection (g), $25,000,000 in each of the fiscal years 1998 through 2002; and

''(B) paragraphs (1) and (2) of subsection (g), $40,000,000 in each of the fiscal years 2004 through 2008.

''(2) GENERAL REVENUES.—There are authorized to be appropriated from amounts in the Treasury not otherwise appropriated for making grants to all States under subsection (g)(4), $25,000,000 in each of the fiscal years 2004 through 2008.''.

(3) REQUIREMENT THAT STATES AWARDED GRANTS CONSULT WITH THE STATE HOSPITAL ASSOCIATION AND RURAL HOSPITALS ON THE MOST APPROPRIATE WAYS TO USE SUCH GRANTS.—

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

''(6) REQUIRED CONSULTATION FOR STATES AWARDED GRANTS.—A State awarded a grant under paragraph (1) or (2) shall consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds under such grant.''.

(B) EFFECTIVE DATE AND APPLICATION.—The amendment made by subparagraph (A) shall take effect on the date of enactment of this Act and shall apply to grants awarded on or after such date and to grants awarded prior to such date to the extent that funds under such grants have not been obligated as of such date.

SEC. 406. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

''(D) 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.

''(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.''.

(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 October 1, 2003.

SEC. 407. SERVICES PROVIDED TO HOSPICE PATIENTS BY NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, AND PHYSICIAN ASSISTANTS.

(a) IN GENERAL.—Section 1812(d)(2)(A) (42 U.S.C. 1395d(d)(2)(A) in the matter following clause (i)(II), is amended—

(1) by inserting ''or services described in section 1861(s)(2)(K)'' after ''except that clause (i) shall not apply to physicians' services''; and

(2) by inserting '', or by a physician assistant, nurse practitioner, or clinical nurse specialist whom is not an employee of the hospice program, and who the individual identifies as the health care provider having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care,'' after the ''(if not an employee of the hospice program)''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to hospice care furnished on or after October 1, 2003.

SEC. 408. AUTHORITY TO INCLUDE COSTS OF TRAINING OF PSYCHOLOGISTS IN PAYMENTS TO HOSPITALS UNDER MEDICARE.

Effective for cost reporting periods beginning on or after October 1, 2004, for purposes of payments to hospitals under the medicare program under title XVIII of the Social Security Act for costs of approved educational activities (as defined in section 413.85 of title 42 of the Code of Federal Regulations), such approved educational activities shall include professional educational training programs, recognized by the Secretary, for psychologists.

SEC. 409. REVISION 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, 2004, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

''(iii) on or after October 1, 2004, and before October 1, 2009, the applicable Puerto Rico percentage is 0 percent and the applicable Federal percentage is 100 percent; and

''(iv) on or after October 1, 2009, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent.''.

SEC. 410. AUTHORITY REGARDING GERIATRIC FELLOWSHIPS.

The Secretary shall have the authority to clarify that geriatric training programs are eligible for 2 years of fellowship support for purposes of making payments for direct graduate medical education under subsection (h) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) and indirect medical education under subsection (d)(5)(B) of such section on or after October 1, 2003.

SEC. 411. CLARIFICATION OF CONGRESSIONAL INTENT REGARDING THE COUNTING OF RESIDENTS IN A NONPROVIDER SETTING AND A TECHNICAL AMENDMENT REGARDING THE 3-YEAR ROLLING AVERAGE AND THE IME RATIO.

(a) CLARIFICATION OF REQUIREMENTS FOR COUNTING RESIDENTS TRAINING IN NONPROVIDER SETTING.—

(1) D-GME.—Section 1886(h)(4)(E) (42 U.S.C. 1395ww(h)(4)(E)) is amended by adding at the end the following new sentence: For purposes of the preceding sentence time shall only be counted from the effective date of a written agreement between the hospital and the entity owning or operating a nonprovider setting. The effective date of such written agreement shall be determined in accordance with generally accepted accounting principles. All, or substantially all, of the costs for the training program in that setting shall be defined as the residents' stipends and benefits and other costs, if any, as determined by the parties.''.

(2) IME.—Section 1886(d)(5)(B)(iv) (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended by adding at the end the following new sentence: For purposes of the preceding sentence time shall only be counted from the effective date of a written agreement between the hospital and the entity owning or operating a nonprovider setting. The effective date of such written agreement shall be determined in accordance with generally accepted accounting principles. All, or substantially all, of the costs for the training program in that setting shall be defined as the residents' stipends and benefits and other costs, if any, as determined by the parties.''.

(b) LIMITING ONE-YEAR LAG IN THE INDIRECT MEDICAL EDUCATION (IME) RATIO AND THREE-YEAR ROLLING AVERAGE IN RESIDENT COUNT FOR IME AND FOR DIRECT GRADUATE MEDICAL EDUCATION (D-GME) TO MEDICAL RESIDENCY PROGRAMS.—

(1) IME RATIO AND IME ROLLING AVERAGE.—Section 1886(d)(5)(B)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(vi)) is amended by adding at the end the following new sentence: ''For cost reporting periods beginning during fiscal years beginning on or after October 1, 2003, subclauses (I) and (II) shall be applied only with respect to a hospital's approved medical residency training programs in the fields of allopathic and osteopathic medicine.''.

(2) D-GME ROLLING AVERAGE.—Section 1886(h)(4)(G) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(G)) is amended by adding at the end the following new clause:

''(iv) APPLICATION FOR FISCAL YEAR 2004 AND SUBSEQUENT YEARS.—For cost reporting periods beginning during fiscal years beginning on or after October 1, 2003, clauses (i) through (iii) shall be applied only with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine.''.

SEC. 412. LIMITATION ON CHARGES FOR INPATIENT HOSPITAL CONTRACT HEALTH SERVICES PROVIDED TO INDIANS BY MEDICARE PARTICIPATING HOSPITALS.

(a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by striking ''and'' at the end;

(2) in subparagraph (S), by striking the period and inserting '', and''; and

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

''(T) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care—

''(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service,

an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

''(ii) under a program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 6 months after the date of enactment of this Act) to medicare participation agreements in effect (or entered into) on or after such date.

SEC. 413. GAO STUDY AND REPORT ON APPROPRIATENESS OF PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES.

(a) STUDY.—The Comptroller General of the United States, using the most current data available, shall conduct a study to determine—

(1) the appropriate level and distribution of payments in relation to costs under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for inpatient hospital services furnished by subsection (d) hospitals (as defined in subsection (d)(1)(B) of such section); and

(2) whether there is a need to adjust such payments under such system to reflect legitimate differences in costs across different geographic areas, kinds of hospitals, and types of cases.

(b) REPORT.—Not later than 24 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.

Subtitle B—Provisions Relating to Part B

SEC. 421. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC ADJUSTMENTS OF PAYMENTS FOR PHYSICIANS' SERVICES.

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

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

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

''(E) FLOOR FOR WORK GEOGRAPHIC INDICES.—

''(i) IN GENERAL.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2008, after calculating the work geographic indices in subparagraph (A)(iii), the Secretary shall increase the work geographic index to the work floor index for any locality for which such geographic index is less than the work floor index.

''(ii) WORK FLOOR INDEX.—For purposes of clause (i), the term 'applicable floor index' means—

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

''(II) 1.000 for services furnished during 2005, 2006, and 2007.

''(F) FLOOR FOR PRACTICE EXPENSE AND MALPRACTICE GEOGRAPHIC INDICES.—For purposes of payment for services furnished on or after January 1, 2005, and before January 1, 2008, after calculating the practice expense and malpractice indices in clauses (i) and (ii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.

SEC. 422. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS.

(a) PROCEDURES FOR SECRETARY, AND NOT PHYSICIANS, TO DETERMINE WHEN BONUS PAYMENTS UNDER MEDICARE INCENTIVE PAYMENT PROGRAM SHOULD BE MADE.—Section 1833(m) (42 U.S.C. 1395*l*(m)) is amended—

(1) by inserting ''(1)'' after ''(m)''; and

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

''(2) The Secretary shall establish procedures under which the Secretary, and not the physician furnishing the service, is responsible for determining when a payment is required to be made under paragraph (1).''.

(b) EDUCATIONAL PROGRAM REGARDING THE MEDICARE INCENTIVE PAYMENT PROGRAM.—The Secretary shall establish and implement an ongoing educational program to provide education to physicians under the medicare program on the medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395*l*(m)).

(c) ONGOING GAO STUDY AND ANNUAL REPORT ON THE MEDICARE INCENTIVE PAYMENT PROGRAM.—

(1) ONGOING STUDY.—The Comptroller General of the United States shall conduct an ongoing study on the medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395*l*(m)). Such study shall focus on whether such program increases the access of medicare beneficiaries who reside in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A))) as a health professional shortage area to physicians' services under the medicare program.

(2) ANNUAL REPORTS.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations as the Comptroller General considers appropriate.

SEC. 423. INCREASE IN RENAL DIALYSIS COMPOSITE RATE.

Notwithstanding any other provision of law, with respect to payment under part B of title XVIII of the Social Security Act for renal dialysis services furnished in 2005 and 2006, the composite rate for such services shall be increased by 1.6 percent under section 1881(b)(12) of such Act (42 U.S.C. 1395rr(b)(7)), as added by section 433(b)(5).

SEC. 424. EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND TREATMENT OF CERTAIN SOLE COMMUNITY HOSPITALS TO LIMIT DECLINE IN PAYMENT UNDER THE OPD PPS.

(a) SMALL RURAL HOSPITALS.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended by striking ''2004'' and inserting ''2006''.

(b) SOLE COMMUNITY HOSPITALS.—Section 1833(t)(7)(D) (42 U.S.C. 1395l(t)(7)(D)) is amended by adding at the end the following:

''(iii) TEMPORARY TREATMENT FOR SOLE COMMUNITY HOSPITALS .—In the case of a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area, for covered OPD services furnished in 2004, 2005, or 2006, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.''.

SEC. 425. INCREASE IN PAYMENTS FOR CERTAIN SERVICES FURNISHED BY SMALL RURAL AND SOLE COMMUNITY HOSPITALS UNDER MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) INCREASE.—

(1) IN GENERAL.—In the case of an applicable covered OPD service (as defined in paragraph (2)) that is furnished by a hospital described in clause (i) or (iii) of paragraph (7)(D) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t)), as amended by section 424, on or after January 1, 2004, and before January 1, 2008, the Secretary shall increase the medicare OPD fee schedule amount (as determined under paragraph (4)(A) of such section) that is applicable for such service in that year (determined without regard to any increase under this section in a previous year) by 5 percent.

(2) APPLICABLE COVERED OPD SERVICES DEFINED.—For purposes of this section, the term ''applicable covered OPD service'' means a covered clinic or emergency room visit that is classified within the groups of covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t))) established under paragraph (2)(B) of such section.

(b) NO EFFECT ON COPAYMENT AMOUNT.—The Secretary shall compute the copayment amount for applicable covered OPD services under section 1833(t)(8)(A) of the Social Security Act (42 U.S.C. 1395*l*(t)(8)(A)) as if this section had not been enacted.

(c) NO EFFECT ON INCREASE UNDER HOLD HARMLESS OR OUTLIER PROVISIONS.—The Secretary shall apply the temporary hold harmless provision under clause (i) and (iii) of paragraph (7)(D) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t)) and the outlier provision under paragraph (5) of such section as if this section had not been enacted.

(d) WAIVING BUDGET NEUTRALITY AND NO REVISION OR ADJUSTMENTS.—The Secretary shall not make any revision or adjustment under subparagraph (A), (B), or (C) of section 1833(t)(9) of the Social Security Act (42 U.S.C. 1395*l*(t)(9)) because of the application of subsection (a)(1).

(e) NO EFFECT ON PAYMENTS AFTER INCREASE PERIOD ENDS.—The Secretary shall not take into account any payment increase provided under subsection (a)(1) in determining payments for covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t))) under such section that are furnished after January 1, 2008.

(f) TECHNICAL AMENDMENT.—Section 1833(t)(2)(B) (42 U.S.C. 1395*l*(t)(2)(B)) is amended by inserting ''(and periodically revise such groups pursuant to paragraph (9)(A))'' after ''establish groups''.

SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES FURNISHED IN A RURAL AREA.

Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraph:

''(10) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES FURNISHED IN A RURAL AREA.—

''(A) IN GENERAL.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2008, for which the transportation originates in a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that

such rates otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent.

''(B) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.''.

SEC. 427. ENSURING APPROPRIATE COVERAGE OF AIR AMBULANCE SERVICES UNDER AMBULANCE FEE SCHEDULE.

(a) COVERAGE.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 426, is amended by adding at the end the following new paragraph:

''(11) ENSURING APPROPRIATE COVERAGE OF AIR AMBULANCE SERVICES.—

''(A) IN GENERAL.—The regulations described in section 1861(s)(7) shall ensure that air ambulance services (as defined in subparagraph (C)) are reimbursed under this subsection at the air ambulance rate if the air ambulance service—

''(i) is medically necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and

''(ii) complies with equipment and crew requirements established by the Secretary.

''(B) MEDICALLY NECESSARY.—An air ambulance service shall be considered to be medically necessary for purposes of subparagraph (A)(i) if such service is requested—

''(i) by a physician or a hospital in accordance with the physician's or hospital's responsibilities under section 1867 (commonly known as the Emergency Medical Treatment and Active Labor Act);

''(ii) as a result of a protocol established by a State or regional emergency medical service (EMS) agency;

''(iii) by a physician, nurse practitioner, physician assistant, registered nurse, or emergency medical responder who reasonably determines or certifies that the patient's condition is such that the time needed to transport the individual by land or the lack of an appropriate ground ambulance, significantly increases the medical risks for the individual; or

''(iv) by a Federal or State agency to relocate patients following a natural disaster, an act of war, or a terrorist attack.

''(C) AIR AMBULANCE SERVICES DEFINED.—For purposes of this paragraph, the term 'air ambulance service' means fixed wing and rotary wing air ambulance services.''.

(b) CONFORMING AMENDMENT.—Section 1861(s)(7) (42 U.S.C. 1395x(s)(7)) is amended by inserting '', subject to section 1834(l)(11),'' after ''but''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004.

SEC. 428. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A SOLE COMMUNITY HOSPITAL.

Notwithstanding subsections (a), (b), and (h) of section 1833 of the Social Security Act (42 U.S.C. 1395*l*) and section 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act that is furnished in 2004 or 2005 by a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))) as part of services furnished to patients of the hospital, the following rules shall apply:

(1) PAYMENT BASED ON REASONABLE COSTS.—The amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

(2) NO BENEFICIARY COST-SHARING.—Notwithstanding section 432, no coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under such part B shall apply with respect to such test.

SEC. 429. IMPROVEMENT IN RURAL HEALTH CLINIC REIMBURSEMENT.

Section 1833(f) (42 U.S.C. 1395*l*(f)) is amended—

(1) in paragraph (1), by striking '', and'' at the end and inserting a semicolon;

(2) in paragraph (2)—

(A) by striking ''in a subsequent year'' and inserting ''in 1989 through 2003''; and

(B) by striking the period at the end and inserting a semicolon; and

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

''(3) in 2004, at $80 per visit; and

''(4) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as so defined) applicable to primary care services (as so defined) furnished as of the first day of that year.''.

SEC. 430. ELIMINATION OF CONSOLIDATED BILLING FOR CERTAIN SERVICES UNDER THE MEDICARE PPS FOR SKILLED NURSING FACILITY SERVICES.

(a) CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Section 1888(e) (42 U.S.C. 1395yy(e)) is amended—

(1) in paragraph (2)(A)(i)(II), by striking ''clauses (ii) and (iii)'' and inserting ''clauses (ii), (iii), and (iv)''; and

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

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

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

''(II) Federally qualified health center services (as defined in paragraph (3) of such section);

that would be described in clause (ii) if such services were furnished by a physician or practitioner not affiliated with a rural health clinic or a Federally qualified health center.''.

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

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

(d) EFFECTIVE DATE.—The amendments made by this section and the provision of subsection (b) shall apply to services furnished on or after January 1, 2004.

SEC. 431. FREEZE IN PAYMENTS FOR CERTAIN ITEMS OF DURABLE MEDICAL EQUIPMENT AND CERTAIN ORTHOTICS; ESTABLISHMENT OF QUALITY STANDARDS AND ACCREDITATION REQUIREMENTS FOR DME PROVIDERS.

(a) FREEZE FOR DME.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (E), by striking ''and'' at the end;

(2) in subparagraph (F)—

(A) by striking ''a subsequent year'' and inserting ''2003''; and

(B) by striking ''the previous year.'' and inserting ''2002;''; and

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

''(G) for each of the years 2004 through 2010—

''(i) in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage increase described in subparagraph (B) for the year involved; and

''(ii) in the case of covered items not described in clause (i), 0 percentage points; and

''(H) for a subsequent year, the percentage increase described in subparagraph (B) for the year involved.''.

(b) FREEZE FOR OFF-THE-SHELF ORTHOTICS.—Section 1834(h)(4)(A) of the Social Security Act (42 U.S.C. 1395m(h)(4)(A)) is amended—

(1) in clause (vii), by striking ''and'' at the end;

(2) in clause (viii), by striking ''a subsequent year'' and inserting ''2003''; and

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

''(ix) for each of the years 2004 through 2010—

''(I) in the case of orthotics that have not been custom-fabricated, 0 percent; and

''(II) in the case of prosthetics, prosthetic devices, and custom-fabricated orthotics, the percentage increase described in clause (viii) for the year involved; and

''(x) for 2011 and each subsequent year, the percentage increase described in clause (viii) for the year involved;''.

(c) ESTABLISHMENT OF QUALITY STANDARDS AND ACCREDITATION REQUIREMENTS FOR DURABLE MEDICAL EQUIPMENT PROVIDERS.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended—

(1) by redesignating paragraph (17), as added by section 4551(c)(1) of the Balanced Budget Act of 1997 (111 Stat. 458), as paragraph (19); and

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

''(20) IDENTIFICATION OF QUALITY STANDARDS.—

''(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish and implement quality standards for providers of durable medical equipment throughout the United States that are developed by recognized independent accreditation organizations (as designated under subparagraph (B)(i)) and with which such providers shall be required to comply in order to—

''(i) participate in the program under this title;

''(ii) furnish any item or service described in subparagraph (D) for which payment is made under this part; and

''(iii) receive or retain a provider or supplier number used to submit claims for reimbursement for any item or service described in subparagraph (D) for which payment may be made under this title.

''(B) DESIGNATION OF INDEPENDENT ACCREDITATION ORGANIZATIONS.—

''(i) IN GENERAL.—Not later that the date that is 6 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall designate independent accreditation organizations for purposes of subparagraph (A).

''(ii) CONSULTATION.—In determining which independent accreditation organizations to designate under clause (i), the Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of physicians, practitioners, suppliers, and manufacturers to review (and advise the Secretary concerning) selection of accrediting organizations and the quality standards of such organizations.

''(C) QUALITY STANDARDS.—The quality standards described in subparagraph (A) may not be less stringent than the quality standards that would otherwise apply if this paragraph did not apply and shall include consumer services standards.

''(D) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are covered items (as defined in paragraph (13)) for which payment may otherwise be made under this subsection, other than items used in infusion, and inhalation drugs used in conjunction with durable medical equipment.

''(E) PHASED-IN IMPLEMENTATION.—The application of the quality standards described in subparagraph (A) shall be phased-in over a period that does not exceed 3 years.''.

SEC. 432. APPLICATION OF COINSURANCE AND DEDUCTIBLE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) COINSURANCE.—

(1) IN GENERAL.—Section 1833(a) (42 U.S.C. 1395*l*(a)) is amended—

(A) in paragraph (1)(D)(i), by striking ''(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis)''; and

(B) in paragraph (2)(D)(i), by striking ''(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866)''.

(2) CONFORMING AMENDMENT.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A) is amended by striking ''and with respect to clinical diagnostic laboratory tests for which payment is made under part B''.

(b) DEDUCTIBLE.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395*l*(b)) is amended—

(1) by striking paragraph (3); and

(2) by redesignating paragraphs (4), (5), and (6) as paragraphs (3), (4), and (5), respectively.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2004.

SEC. 433. BASING MEDICARE PAYMENTS FOR COVERED OUTPATIENT DRUGS ON MARKET PRICES.

(a) MEDICARE MARKET BASED PAYMENT AMOUNT.—Section 1842(o) (42 U.S.C. 1395u(o)) is amended—

(1) in paragraph (1), by striking ''equal to 95 percent of the average wholesale price.'' and inserting ''equal to—

''(A) in the case of a drug or biological furnished prior to January 1, 2004, 95 percent of the average wholesale price; and

''(B) in the case of a drug or biological furnished on or after January 1, 2004, the payment amount specified in—

''(i) in the case of such a drug or biological that is first available for payment under this part on or before April 1, 2003, paragraph (4); and

''(ii) in the case of such a drug or biological that is first available for payment under this part after such date, paragraph (5).''; and

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

''(4)(A) Subject to subparagraph (C), the payment amount specified in this paragraph for a year for a drug or biological is an amount equal to the lesser of—

''(i) the average wholesale price for the drug or biological; or

''(ii) the amount determined under subparagraph (B)

''(B)(i) Subject to clause (ii), the amount determined under this subparagraph is an amount equal to—

''(I) in the case of a drug or biological furnished in 2004, 85 percent of the average wholesale price for the drug or biological (determined as of April 1, 2003); and

''(II) in the case of a drug or biological furnished in 2005 or a subsequent year, the amount determined under this subparagraph for the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

''(ii) In the case of a vaccine described in subparagraph (A) or (B) of section 1861(s)(10), the amount determined under this subparagraph is an amount equal to the average wholesale price for the drug or biological.

''(C)(i) The Secretary shall establish a process under which the Secretary determines, for such drugs or biologicals as the Secretary determines appropriate, whether the widely available market price to physicians or suppliers for the drug or biological furnished in a year is different from the payment amount established under subparagraph (B) for the year. Such determination shall be based on the information described in clause (ii) as the Secretary determines appropriate.

''(ii) The information described in this clause is the following information:

''(I) Any report on drug or biological market prices by the Inspector General of the Department of Health and Human Services or the Comptroller General of the United States that is made available after December 31, 1999.

''(II) A review of drug or biological market prices by the Secretary, which may include information on such market prices from insurers, private health plans, manufacturers, wholesalers, distributors, physician supply houses, specialty pharmacies, group purchasing arrangements, physicians, suppliers, or any other source the Secretary determines appropriate.

''(III) Data and information submitted by the manufacturer of the drug or biological or by another entity.

''(IV) Other data and information as determined appropriate by the Secretary.

''(iii) If the Secretary makes a determination under clause (i) with respect to the widely available market price for a drug or biological for a year, the following provisions shall apply:

''(I) Subject to clause (iv), the amount determined under this subparagraph shall be substituted for the amount determined under subparagraph (B) for purposes of applying subparagraph (A)(ii)(I) for the year and all subsequent years.

''(II) The Secretary may make subsequent determinations under clause (i) with respect to the widely available market price for the drug or biological.

''(III) If the Secretary does not make a subsequent determination under clause (i) with respect to the widely available market price for the drug or biological for a year, the amount determined under this subparagraph shall be an amount equal to the amount determined under this subparagraph for the previous year increased by the percentage increase described in subparagraph (B)(i)(II) for the year involved.

''(iv) If the first determination made under clause (i) with respect to the widely available market price for a drug or biological would result in a payment amount in a year that is more than 15 percent less than the amount determined under subparagraph (B) for the drug or biological for the previous year (or, for 2004, the payment amount determined under paragraph (1)(A), determined as of April 1, 2003), the Secretary shall provide for a transition to the amount determined under clause (i) so that the payment amount is reduced in annual increments equal to 15 percent of the payment amount in such previous year until the payment amount is equal to the amount determined under clause (i), as increased each year by the percentage increase described in subparagraph (B)(i)(II) for the year. The preceding sentence shall not apply to a drug or biological where a generic version of the drug or biological first enters the market on or after January 1, 2004 (even if the generic version of the drug or biological is not marketed under the chemical name of such drug or biological).

''(5) In the case of a drug or biological that is first available for payment under this part after April 1, 2003, the following rules shall apply:

''(A) As a condition of obtaining a code to report such new drug or biological and to receive payment under this part, a manufacturer shall provide the Secretary (in a time, manner, and form approved by the Secretary) with data and information on prices at which the manufacturer estimates physicians and suppliers will be able to routinely obtain the drug or biological in the market during the first year that the drug or biological is available for payment under this part and such additional information that the manufacturer determines appropriate.

''(B) During the year that the drug or biological is first available for payment under this part, the manufacturer of the drug or biological shall provide the Secretary (in a time, manner, and form approved by the Secretary) with updated information on the actual market prices paid by such physicians or suppliers for the drug or biological in the year.

''(C) The amount specified in this paragraph for a drug or biological for the year described in subparagraph (B) is equal to an amount determined by the Secretary based on the information provided under subparagraph (A) and other information that the Secretary determines appropriate.

''(D) The amount specified in this paragraph for a drug or biological for the year after the year described in subparagraph (B) is equal to an amount determined by the Secretary based on the information provided under subparagraph (B) and other information that the Secretary determines appropriate.

''(E) The amount specified in this paragraph for a drug or biological for the year beginning after the year described in subparagraph (D) and each subsequent year is equal to the lesser of—

''(i) the average wholesale price for the drug or biological; or

''(ii) the amount determined—

''(I) by the Secretary under paragraph (4)(C)(i) with respect to the widely available market price for the drug or biological for the year, if such paragraph was applied by substituting 'the payment determined under paragraph (5)(E)(ii)(II) for the year' for 'established under subparagraph (B) for the year'; and

''(II) if no determination described in subclause (I) is made for the drug or biological for the year, under this subparagraph with respect to the drug or biological for the previous year increased by the percentage increase described in paragraph (4)(B)(i)(II) for the year involved.''.

(b) ADJUSTMENTS TO PAYMENT AMOUNTS FOR ADMINISTRATION OF DRUGS AND BIOLOGICALS.—

(1) ADJUSTMENT IN PHYSICIAN PRACTICE EXPENSE RELATIVE VALUE UNITS.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)) is amended—

(A) in subparagraph (B)—

(i) in clause (ii)(II), by striking ''The adjustments'' and inserting ''Subject to clause (iv), the adjustments''; and

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

''(iv) EXEMPTION FROM BUDGET NEUTRALITY IN 2004.—Any additional expenditures under this part that are attributable to subparagraph (H) shall not be taken into account in applying clause (ii)(II) for 2004.''; and

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

''(H) ADJUSTMENTS IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR DRUG ADMINISTRATION SERVICES FOR 2004.—In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished in 2004, the Secretary shall, in determining practice expense relative value units under this subsection, utilize a survey submitted to the Secretary as of January 1, 2003, by a physician specialty organization pursuant to section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 if the survey—

''(i) covers practice expenses for oncology administration services; and

''(ii) meets criteria established by the Secretary for acceptance of such surveys.''.

(2) PAYMENT FOR MULTIPLE CHEMOTHERAPY AGENTS FURNISHED ON A SINGLE DAY THROUGH THE PUSH TECHNIQUE.—

(A) REVIEW OF POLICY.—The Secretary shall review the policy, as in effect on the date of enactment of this Act, with respect to payment under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for the administration of more than 1 anticancer chemotherapeutic agent to an individual on a single day through the push technique.

(B) MODIFICATION OF POLICY.—After conducting the review under subparagraph (A), the Secretary shall modify such payment policy if the Secretary determines such modification to be appropriate.

(C) EXEMPTION FROM BUDGET NEUTRALITY UNDER PHYSICIAN FEE SCHEDULE.—If the Secretary modifies such payment policy pursuant to subparagraph (B), any increased expenditures under title XVIII of the Social Security Act resulting from such modification shall be treated as additional expenditures attributable to subparagraph (H) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as added by paragraph (1)(B), for purposes of applying the exemption to budget neutrality under subparagraph (B)(iv) of such section, as added by paragraph (1)(A).

(3) TREATMENT OF OTHER SERVICES CURRENTLY IN THE NONPHYSICIAN WORK POOL.—The Secretary shall make adjustments to the nonphysician work pool methodology (as such term is used in the final rule promulgated by the Secretary in the Federal Register on December 31, 2002 (67 Fed. Reg. 251)), for the determination of practice expense relative value units under the physician fee schedule under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)), so that the practice expense relative value units for services determined under such methodology are not disproportionately reduced relative to the practice expense relative value units of services not determined under such methodology, as a result of the amendments to such Act made by paragraph (1).

(4) ADMINISTRATION OF BLOOD CLOTTING FACTORS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2), is amended by adding at the end the following new paragraph:

''(6)(A) Subject to subparagraph (B), in the case of clotting factors furnished on or after January 1, 2004, the Secretary shall, after reviewing the January 2003 report to Congress by the Comptroller General of the United States entitled 'Payment for Blood Clotting Factor Exceeds Providers Acquisition Cost' (GAO–03–184), provide for a separate payment for the administration of such blood clotting factors in an amount that the Secretary determines to be appropriate.

''(B) In determining the separate payment amount under subparagraph (A) for blood clotting factors furnished in 2004, the Secretary shall ensure that the total amount of payments under this part (as estimated by the Secretary) for such factors under paragraphs (4) and (5) and such separate payments for such factors does not exceed the total amount of payments that would have been made for such factors under this part (as estimated by the Secretary) if the amendments made by section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

''(C) The separate payment amount under this subparagraph for blood clotting factors furnished in 2005 or a subsequent year shall be equal to the separate payment amount determined under this paragraph for the previous year increased by the percentage increase described in paragraph (4)(B)(i)(II) for the year involved.''.

(5) INCREASE IN COMPOSITE RATE FOR END STAGE RENAL DISEASE FACILITIES.—Section 1881(b) (42 U.S.C. 1395rr(b) is amended—

(A) in paragraph (7), by adding at the end the following new sentence: ''In the case of dialysis services furnished in 2004 or a subsequent year, the composite rate for such services shall be determined under paragraph (12).''; and

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

''(12)(A) In the case of dialysis services furnished during 2004, the composite rate for such services shall be the composite rate that would otherwise apply under paragraph (7) for the year increased by an amount to ensure (as estimated by the Secretary) that—

''(i) the sum of the total amount of—

''(I) the composite rate payments for such services for the year, as increased under this paragraph; and

''(II) the payments for drugs and biologicals (other than erythropoetin) furnished in connection with the furnishing of renal dialysis services and separately billed by renal dialysis facilities under paragraphs (4) and (5) of section 1842(o) for the year; is equal to

''(ii) the sum of the total amount of the composite rate payments under paragraph (7) for the year and the payments for the separately billed drugs and biologicals described in clause (i)(II) that would have been made if the amendments made by section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

''(B) Subject to subparagraph (E), in the case of dialysis services furnished in 2005, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (A), increased by 0.05 percent and further increased pursuant to section 423 of the Prescription Drug and Medicare Improvement Act of 2003.

''(C) Subject to subparagraph (E), in the case of dialysis services furnished in 2006, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (B), increased by 0.05 percent.

''(D) Subject to subparagraph (E), in the case of dialysis services furnished in 2007 or a subsequent year, the composite rate for such services shall be an amount equal to the composite rate established under this paragraph for the previous year (determined as if such section 423 had not been enacted), increased by 0.05 percent.

''(E) If the Secretary implements a reduction in the payment amount under paragraph (4)(C) or (5) for a drug or biological described in subparagraph (A)(i)(II) for a year after 2004, the Secretary shall, as estimated by the Secretary—

''(i) increase the composite rate for dialysis services furnished in such year in the same manner that the composite rate for such services for 2004 was increased under subparagraph (A); and

''(ii) increase the percentage increase under subparagraph (C) or (D) (as applicable) for years after the year described in clause (i) to ensure that such increased percentage would result in expenditures equal to the sum of the total composite rate payments for such services for such years and the total payments for drugs and biologicals described in subparagraph (A)(i)(II) is equal to the sum of the total amount of the composite rate payments under this paragraph for such years and the payments for the drugs and biologicals described in subparagraph (A)(i)(II) that would have been made if the reduction in payment amount described in subparagraph had not been made.

''(F) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under this paragraph.''.

(6) HOME INFUSION DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraph (4), is amended by adding at the end the following new paragraph:

''(7)(A) Subject to subparagraph (B), in the case of infusion drugs and biologicals furnished through an item of durable medical equipment covered under section 1861(n) on or after January 1, 2004, the Secretary may make separate payments for furnishing such drugs and biologicals in an amount determined by the Secretary if the Secretary determines such separate payment to be appropriate.

''(B) In determining the amount of any separate payment under subparagraph (A) for a year, the Secretary shall ensure that the total amount of payments under this part for such infusion drugs and biologicals for the year and such separate payments for the year does not exceed the total amount of payments that would have been made under this part for the year for such infusion drugs and biologicals if section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.''.

(7) INHALATION DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4) and (6), is amended by adding at the end the following new paragraph:

''(8)(A) Subject to subparagraph (B), in the case of inhalation drugs and biologicals furnished through durable medical equipment covered under section 1861(n) on or after January 1, 2004, the Secretary may increase payments for such equipment under section 1834(a) and may make separate payments for furnishing such drugs and biologicals if the Secretary determines such increased or separate payments are necessary to appropriately furnish such equipment and drugs and biologicals to beneficiaries.

''(B) The total amount of any increased payments and separate payments under subparagraph (A) for a year may not exceed an amount equal to 10 percent of the amount (as estimated by the Secretary) by which—

''(i) the total amount of payments that would have been made for such drugs and biologicals for the year if section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted; exceeds

''(ii) the total amount of payments for such drugs and biologicals under paragraphs (4) and (5).''.

(8) PHARMACY DISPENSING FEE FOR CERTAIN DRUGS AND BIOLOGICALS.—Section 1842(o)(2) (42 U.S.C. 1395u(o)(2)) is amended to read as follows:

''(2) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary—

''(A) in the case of an immunosuppressive drug described in subparagraph (J) of section 1861(s)(2) and an oral drug described in subparagraph (Q) or (T) of such section, shall

pay a dispensing fee determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts) to the pharmacy; and

''(B) in the case of a drug or biological not described in subparagraph (A), may pay a dispensing fee determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts) to the pharmacy.''.

(9) PAYMENT FOR CHEMOTHERAPY DRUGS PURCHASED BUT NOT ADMINISTERED BY PHYSICIANS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6) and (7), is amended by adding at the end the following new paragraph:

''(9)(A) Subject to subparagraph (B), the Secretary may increase (in an amount determined appropriate) the amount of payments to physicians for anticancer chemotherapeutic drugs or biologicals that would otherwise be made under this part in order to compensate such physicians for anticancer chemotherapeutic drugs or biologicals that are purchased by physicians with a reasonable intent to administer to an individual enrolled under this part but which cannot be administered to such individual despite the reasonable efforts of the physician.

''(B) The total amount of increased payments made under subparagraph (A) in a year (as estimated by the Secretary) may not exceed an amount equal to 1 percent of the total amount of payments made under paragraphs (4) and (5) for such anticancer chemotherapeutic drugs or biologicals furnished by physicians in such year (as estimated by the Secretary).''.

(c) LINKAGE OF REVISED DRUG PAYMENTS AND INCREASES FOR DRUG ADMINISTRATION.—The Secretary shall not implement the revisions in payment amounts for a category of drug or biological as a result of the amendments made by subsection (a) unless the Secretary concurrently implements the adjustments to payment amounts for administration of such category of drug or biological for which the Secretary is required to make an adjustment, as specified in the amendments made by, and provisions of, subsection (b).

(d) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL REVIEW.—

(1) DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6), (7), and (9) of subsection (b), is amended by adding at the end the following new paragraph:

''(10) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraph (2) or paragraphs (4) through (9).''.

(2) PHYSICIAN FEE SCHEDULE.—Section 1848(i)(1) (42 U.S.C. 1395w–4(i)(1)) is amended—

(A) in subparagraph (D), by striking ''and'' at the end;

(B) in subparagraph (E), by striking the period at the end and inserting '', and''; and

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

''(F) adjustments in practice expense relative value units under subsection (c)(2)(H).''.

(3) MULTIPLE CHEMOTHERAPY AGENTS AND OTHER SERVICES CURRENTLY ON THE NON-PHYSICIAN WORK POOL.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (2) and (3) of subsection (b).

(e) STUDIES AND REPORTS.—

(1) GAO STUDY AND REPORT ON BENEFICIARY ACCESS TO DRUGS AND BIOLOGICALS.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study that examines the impact the provisions of, and the amendments made by, this section have on access by medicare beneficiaries to drugs and biologicals covered under the medicare program.

(B) REPORT.—Not later than January 1, 2006, the Comptroller General shall submit a report to Congress on the study conducted under subparagraph (A) together with such recommendations as the Comptroller General determines to be appropriate.

(2) STUDY AND REPORT BY THE HHS INSPECTOR GENERAL ON MARKET PRICES OF DRUGS AND BIOLOGICALS.—

(A) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct 1 or more studies that—

(i) examine the market prices that drugs and biologicals covered under the medicare program are widely available to physicians and suppliers; and

(ii) compare such widely available market prices to the payment amount for such drugs and biologicals under section 1842(o) of the Social Security Act (42 U.S.C. 1395u(o).

(B) REQUIREMENT.—In conducting the study under subparagraph (A), the Inspector General shall focus on those drugs and biologicals that represent the largest portions of expenditures under the medicare program for drugs and biologicals.

(C) REPORT.—The Inspector General shall prepare a report on any study conducted under subparagraph (A).

SEC. 434. INDEXING PART B DEDUCTIBLE TO INFLATION.

The first sentence of section 1833(b) (42 U.S.C. 1395*l*(b)) is amended by striking ''and $100 for 1991 and subsequent years'' and inserting the following: '', $100 for 1991 through 2005, $125 for 2006, and for 2007 and thereafter, the amount in effect for the previous year, increase by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year, rounded to the nearest dollar''.

SEC. 435. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) IN GENERAL.—Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended to read as follows: ''(ii) where the service was provided under a contractual arrangement between such physician or other person and an entity (as defined by the Secretary), to the entity if under such arrangement such entity submits the bill for such service and such arrangement meets such program integrity and other safeguards as the Secretary may determine to be appropriate,''.

(b) CONFORMING AMENDMENT.—The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking ''except to an employer or facility as described in clause (A)'' and inserting ''except to an employer or entity as described in subparagraph (A)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made on or after the date of enactment of this Act.

SEC. 436. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of BIPA (114 Stat. 2763A–551) is amended by inserting '', and for services furnished during 2004 or 2005'' before the period at the end.

SEC. 437. ADEQUATE REIMBURSEMENT FOR OUTPATIENT PHARMACY THERAPY UNDER THE HOSPITAL OUTPATIENT PPS.

(a) SPECIAL RULES FOR DRUGS AND BIOLOGICALS.—Section 1833(t) (42 U.S.C. 1395(t)) is amended—

(1) by redesignating paragraph (13) as paragraph (14); and

(2) by inserting after paragraph (12) the following new paragraph:

''(13) SPECIAL RULES FOR CERTAIN DRUGS AND BIOLOGICALS.—

''(A) BEFORE 2007.—

''(i) IN GENERAL.—Notwithstanding paragraph (6), but subject to clause (ii), with respect to a separately payable drug or biological described in subparagraph (D) furnished on or after January 1, 2005, and before January 1, 2007, hospitals shall be reimbursed as follows:

''(I) DRUGS AND BIOLOGICALS FURNISHED AS PART OF A CURRENT OPD SERVICE.—The amount of payment for a drug or biological described in subparagraph (D) provided as a part of a service that was a covered OPD service on May 1, 2003, shall be the applicable percentage (as defined in subparagraph (C)) of the average wholesale price for the drug or biological that would have been determined under section 1842(o) on such date.

''(II) DRUGS AND BIOLOGICALS FURNISHED AS PART OF OTHER OPD SERVICES.—The amount of payment for a drug or biological described in subparagraph (D) provided as part of any other covered OPD service shall be the applicable percentage (as defined in subparagraph (C)) of the average wholesale price that would have been determined under section 1842(o) on May 1, 2003, if payment for such a drug or biological could have been made under this part on that date.

''(ii) UPDATE FOR 2006.—For 2006, the amounts determined under clauses (i) and (ii) shall be the amount established for 2005 increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

''(B) AFTER 2007.—

''(i) ONGOING STUDY AND REPORTS ON ADEQUATE REIMBURSEMENTS.—

''(I) STUDY.—The Secretary shall contract with an eligible organization (as defined in subclause (IV)) to conduct a study to determine the hospital acquisition and handling costs for each individual drug or biological described in subparagraph (D).

''(II) STUDY REQUIREMENTS.—The study conducted under subclause (I) shall—

''(aa) be accurate to within 3 percent of true mean hospital acquisition and handling costs for each drug and biological at the 95 percent confidence level;

''(bb) begin not later than January 1, 2005; and

''(cc) be updated annually for changes in hospital costs and the addition of newly marketed products.

''(III) REPORTS.—Not later than January 1 of each year (beginning with 2006), the Secretary shall submit to Congress a report on the study conducted under clause (i) together with recommendations for such legislative or administrative action as the Secretary determines to be appropriate.

''(IV) ELIGIBLE ORGANIZATION DEFINED.—In this clause, the term 'eligible organization' means a private, nonprofit organization within the meaning of section 501(c) of the Internal Revenue Code.

''(ii) ESTABLISHMENT OF PAYMENT METHODOLOGY.—Notwithstanding paragraph (6), the Secretary, in establishing a payment methodology on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, shall take into consideration the findings of the study conducted under clause (i)(I) in determining payment amounts for each drug and biological provided as part of a covered OPD service furnished on or after January 1, 2007.

''(C) APPLICABLE PERCENTAGE DEFINED.—In this paragraph, the term 'applicable percentage' means—

''(i) with respect to a biological product (approved under a biologics license application under section 351 of the Public Health Service Act), a single source drug (as defined in section 1927(k)(7)(A)(iv)), or an orphan product designated under section 526 of the Food, Drug, and Cosmetic Act to which the prospective payment system established under this subsection did not apply under the final rule for 2003 payments under such system, 94 percent;

''(ii) with respect to an innovator multiple source drug (as defined in section 1927(k)(7)(A)(ii)), 91 percent; and

''(iii) with respect to a noninnovator multiple source drug (as defined in as defined in section 1927(k)(7)(A)(iii)), 71 percent.

''(D) DRUGS AND BIOLOGICALS DESCRIBED.—A drug or biological described in this paragraph is any drug or biological—

''(i) for which the amount of payment was determined under paragraph (6) prior to January 1, 2005;

''(ii) which is assigned to a drug specific ambulatory payment classification on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003; and

''(iii) that would have been reimbursed under paragraph (6) but for the application of this paragraph.''.

(b) EXCEPTIONS TO BUDGET NEUTRALITY REQUIREMENT.—Section 1833(t)(9)(B) (42 U.S.C. 1395l(t)(9)(B)) is amended by adding at the end the following: ''In determining the budget neutrality adjustment required by the preceding sentence for fiscal years 2005 and 2006, the Secretary shall not take into account any expenditures that would not have been made but for the application of paragraph (13).''.

SEC. 438. LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.

Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—

''(i) IN GENERAL.—The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

''(ii) APPLICATION.—Paragraph (1) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003 unless—

''(I) such application was being made to such drug or biological prior to such date of enactment; and

''(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this title.

''(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed to effect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequvalent, as determined by the Commissioner of Food and Drugs.

SEC. 439. MEDICARE COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS.

(a) IN GENERAL.—With respect to the coverage of routine costs of care for beneficiaries participating in a qualifying clinical trial, as set forth on the date of the enactment of this Act in National Coverage Determination 30-1 of the Medicare Coverage Issues Manual, the Secretary shall deem clinical trials conducted in accordance with an investigational device exemption approved under section 520(g) of the Federal Food, Drug, and Cosmetic Act (42 U.S.C. 360j(g)) to be automatically qualified for such coverage.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as authorizing or requiring the Secretary to modify the regulations set forth on the date of the enactment of this Act at subpart B of part 405 of title 42, Code of Federal Regulations, or subpart A of part 411 of such title, relating to coverage of, and payment for, a medical device that is the subject of an investigational device exemption by the Food and Drug Administration (except as may be necessary to implement subsection (a)).

(c) EFFECTIVE DATE.—This section shall apply to clinical trials begun on or after January 1, 2005.

SEC. 440. 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 2002, 2003, 2004, or 2005 and who demonstrates to the Secretary before December 31, 2005, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary 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 2005. The Secretary shall establish a method for providing rebates of premium penalties paid for months on or after January 2005 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 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 shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin 1 year after the date of the enactment of this Act and shall end on December 31, 2005.

(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. 441. DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.

(a) DEFINITIONS.—In this section:

(1) CHIROPRACTIC SERVICES.—The term ''chiropractic services'' has the meaning given that term by the Secretary for purposes of the demonstration projects, but shall include, at a minimum—

(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and

(B) diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

(2) DEMONSTRATION PROJECT.—The term ''demonstration project'' means a demonstration project established by the Secretary under subsection (b)(1).

(3) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means an individual who is enrolled under part B of the medicare program.

(4) MEDICARE PROGRAM.—The term ''medicare program'' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.—

(1) ESTABLISHMENT.—The Secretary shall establish demonstration projects in accordance with the provisions of this section for the purpose of evaluating the feasibility and advisability of covering chiropractic services under the medicare program (in addition to the coverage provided for services consisting of treatment by means of manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))).

(2) NO PHYSICIAN APPROVAL REQUIRED.—In establishing the demonstration projects, the Secretary shall ensure that an eligible beneficiary who participates in a demonstration project, including an eligible beneficiary who is enrolled for coverage under a Medicare+Choice plan (or, on and after January 1, 2006, under a MedicareAdvantage plan), is not required to receive approval from a physician or other health care provider in order to receive a chiropractic service under a demonstration project.

(3) CONSULTATION.—In establishing the demonstration projects, the Secretary shall consult with chiropractors, organizations representing chiropractors, eligible beneficiaries, and organizations representing eligible beneficiaries.

(4) PARTICIPATION.—Any eligible beneficiary may participate in the demonstration projects on a voluntary basis.

(c) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) DEMONSTRATION SITES.—

(A) SELECTION OF DEMONSTRATION SITES.—The Secretary shall conduct demonstration projects at 6 demonstration sites.

(B) GEOGRAPHIC DIVERSITY.—Of the sites described in subparagraph (A)—

(i) 3 shall be in rural areas; and

(ii) 3 shall be in urban areas.

(C) SITES LOCATED IN HPSAS.—At least 1 site described in clause (i) of subparagraph (B) and at least 1 site described in clause (ii) of such subparagraph shall be located in an area that is designated under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area.

(2) IMPLEMENTATION; DURATION.—

(A) IMPLEMENTATION.—The Secretary shall not implement the demonstration projects before October 1, 2004.

(B) DURATION.—The Secretary shall complete the demonstration projects by the date that is 3 years after the date on which the first demonstration project is implemented.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration projects—

(A) to determine whether eligible beneficiaries who use chiropractic services use a lesser overall amount of items and services for which payment is made under the medicare program than eligible beneficiaries who do not use such services;

(B) to determine the cost of providing payment for chiropractic services under the medicare program;

(C) to determine the satisfaction of eligible beneficiaries participating in the demonstration projects and the quality of care received by such beneficiaries; and

(D) to evaluate such other matters as the Secretary determines is appropriate.

(2) REPORT.—Not later than the date that is 1 year after the date on which the demonstration projects conclude, the Secretary

shall submit to Congress a report on the evaluation conducted under paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines is appropriate.

(e) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program to the extent and for the period the Secretary finds necessary to conduct the demonstration projects.

(f) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(B) LIMITATION.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (d).

SEC. 442. MEDICARE HEALTH CARE QUALITY DEMONSTRATION PROGRAMS.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866B the following new section:

''HEALTH CARE QUALITY DEMONSTRATION PROGRAM

''SEC. 1866C. (a) DEFINITIONS.—In this section:

''(1) BENEFICIARY.—The term 'beneficiary' means a beneficiary who is enrolled in the original medicare fee-for-service program under parts A and B or a beneficiary in a staff model or dedicated group model health maintenance organization under the Medicare+Choice program (or, on and after January 1, 2006, under the MedicareAdvantage program) under part C.

''(2) HEALTH CARE GROUP.—

''(A) IN GENERAL.—The term 'health care group' means—

''(i) a group of physicians that is organized at least in part for the purpose of providing physician's services under this title;

''(ii) an integrated health care delivery system that delivers care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent, or contracted physicians; or

''(iii) an organization representing regional coalitions of groups or systems described in clause (i) or (ii).

''(B) INCLUSION.—As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such hospital, individual, or entity participates in a demonstration project under this section.

''(3) PHYSICIAN.—Except as otherwise provided for by the Secretary, the term 'physician' means any individual who furnishes services that may be paid for as physicians' services under this title.

''(b) DEMONSTRATION PROJECTS.—The Secretary shall establish a 5-year demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

''(1) the provision of incentives to improve the safety of care provided to beneficiaries;

''(2) the appropriate use of best practice guidelines by providers and services by beneficiaries;

''(3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;

''(4) encourage shared decision making between providers and patients;

''(5) the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;

''(6) the appropriate use of culturally and ethnically sensitive health care delivery; and

''(7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

''(c) ADMINISTRATION BY CONTRACT.—

''(1) IN GENERAL.—Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program established under section 1866A is administered in accordance with section 1866B.

''(2) ALTERNATIVE PAYMENT SYSTEMS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

''(A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b); and

''(B) streamline documentation and reporting requirements otherwise required under this title.

''(3) BENEFITS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the traditional fee-for-service program under parts A and B or the package of benefits available through a staff model or a dedicated group model health maintenance organization under part C. The criteria employed under the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient's surrogate) on the basis of the patient's age or expected length of life or of the patient's present or predicted disability, degree of medical dependency, or quality of life.

''(d) ELIGIBILITY CRITERIA.—To be eligible to receive assistance under this section, an entity shall—

''(1) be a health care group;

''(2) meet quality standards established by the Secretary, including—

''(A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;

''(B) the implementation of activities to increase the delivery of effective care to beneficiaries;

''(C) encouraging patient participation in preference-based decisions;

''(D) the implementation of activities to encourage the coordination and integration of medical service delivery; and

''(E) the implementation of activities to measure and document the financial impact on the health care marketplace of altering the incentives of health care delivery and changing the allocation of resources; and

''(3) meet such other requirements as the Secretary may establish.

''(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII as may be necessary to carry out the purposes of the demonstration program established under this section.

''(f) BUDGET NEUTRALITY.—With respect to the 5-year period of the demonstration program under subsection (b), the aggregate expenditures under this title for such period shall not exceed the aggregate expenditures that would have been expended under this title if the program established under this section had not been implemented.

''(g) NOTICE REQUIREMENTS.—In the case of an individual that receives health care items or services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules that are applicable to such individual under this title as a result of the participation of the individual in such program.

''(h) PARTICIPATION AND SUPPORT BY FEDERAL AGENCIES.—In carrying out the demonstration program under this section, the Secretary may direct—

''(1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical technologies and improve the foundation for evidence-based practice;

''(2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and

''(3) the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.

''(i) IMPLEMENTATION.—The Secretary shall not implement the demonstration program before October 1, 2004.''.

SEC. 443. MEDICARE COMPLEX CLINICAL CARE MANAGEMENT PAYMENT DEMONSTRATION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to make the medicare program more responsive to needs of eligible beneficiaries by promoting continuity of care, helping stabilize medical conditions, preventing or minimizing acute exacerbations of chronic conditions, and reducing adverse health outcomes, such as adverse drug interactions related to polypharmacy.

(2) SITES.—The Secretary shall designate 6 sites at which to conduct the demonstration program under this section, of which at least 3 shall be in an urban area and at least 1 shall be in a rural area. One of the sites shall be located in the State of Arkansas.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

(4) IMPLEMENTATION.—The Secretary shall not implement the demonstration program before October 1, 2004.

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a principal care physician who agrees to manage the complex clinical care of the eligible beneficiary under the demonstration program.

(c) PRINCIPAL CARE PHYSICIAN RESPONSIBILITIES.—The Secretary shall enter into an agreement with each principal care physician who agrees to manage the complex clinical care of an eligible beneficiary under subsection (b) under which the principal care physician shall—

(1) serve as the primary contact of the eligible beneficiary in accessing items and services for which payment may be made under the medicare program;

(2) maintain medical information related to care provided by other health care providers who provide health care items and services to the eligible beneficiary, including clinical reports, medication and treatments prescribed by other physicians, hospital and hospital outpatient services, skilled nursing home care, home health care, and medical equipment services;

(3) monitor and advocate for the continuity of care of the eligible beneficiary and the use of evidence-based guidelines;

(4) promote self-care and family caregiver involvement where appropriate;

(5) have appropriate staffing arrangements to conduct patient self-management and other care coordination activities as specified by the Secretary;

(6) refer the eligible beneficiary to community services organizations and coordinate the services of such organizations with the care provided by health care providers; and

(7) meet such other complex care management requirements as the Secretary may specify.

(d) COMPLEX CLINICAL CARE MANAGEMENT FEE.—

(1) PAYMENT.—Under an agreement entered into under subsection (c), the Secretary shall pay to each principal care physician, on behalf of each eligible beneficiary under the care of that physician, the complex clinical care management fee developed by the Secretary under paragraph (2).

(2) DEVELOPMENT OF FEE.—The Secretary shall develop a complex care management fee under this paragraph that is paid on a monthly basis and which shall be payment in full for all the functions performed by the principal care physician under the demonstration program, including any functions performed by other qualified practitioners acting on behalf of the physician, appropriate staff under the supervision of the physician, and any other person under a contract with the physician, including any person who conducts patient self-management and caregiver education under subsection (c)(4).

(e) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(g) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) ACTIVITY OF DAILY LIVING.—The term ''activity of daily living'' means eating, toiling, transferring, bathing, dressing, and continence.

(2) CHRONIC CONDITION.—The term ''chronic condition'' means a biological, physical, or mental condition that is likely to last a year or more, for which there is no known cure, for which there is a need for ongoing medical care, and which may affect an individual's ability to carry out activities of daily living or instrumental activities of daily living, or both.

(3) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means any individual who—

(A) is enrolled for benefits under part B of the medicare program;

(B) has at least 4 complex medical conditions (one of which may be cognitive impairment); and

(C) has—

(i) an inability to self-manage their care; or

(ii) a functional limitation defined as an impairment in 1 or more activity of daily living or instrumental activity of daily living.

(4) INSTRUMENTAL ACTIVITY OF DAILY LIVING.—The term ''instrumental activity of daily living'' means meal preparation, shopping, housekeeping, laundry, money management, telephone use, and transportation use.

(5) MEDICARE PROGRAM.—The term ''medicare program'' means the health care program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(6) PRINCIPAL CARE PHYSICIAN.—The term ''principal care physician'' means the physician with primary responsibility for overall coordination of the care of an eligible beneficiary (as specified in a written plan of care) who may be a primary care physician or a specialist.

SEC. 444. MEDICARE FEE-FOR-SERVICE CARE COORDINATION DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to contract with qualified care management organizations to provide health risk assessment and care management services to eligible beneficiaries who receive care under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) SITES.—The Secretary shall designate 6 sites at which to conduct the demonstration program under this section. In selecting sites under this paragraph, the Secretary shall give preference to sites located in rural areas.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(4) IMPLEMENTATION.—The Secretary shall not implement the demonstration program before October 1, 2004.

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a care management organization who agrees to furnish care management services to the eligible beneficiary under the demonstration program.

(c) CONTRACTS WITH CMOS.—

(1) IN GENERAL.—The Secretary shall enter into a contract with care management organizations to provide care management services to eligible beneficiaries residing in the area served by the care management organization.

(2) CANCELLATION.—The Secretary may cancel a contract entered into under paragraph (1) if the care management organization does not meet negotiated savings or quality outcomes targets for the year.

(3) NUMBER OF CMOS.—The Secretary may contract with more than 1 care management organization in a geographic area.

(d) PAYMENT TO CMOS.—

(1) PAYMENT.—Under an contract entered into under subsection (c), the Secretary shall pay care management organizations a fee for which the care management organization is partially at risk based on bids submitted by care management organizations.

(2) PORTION OF PAYMENT AT RISK.—The Secretary shall establish a benchmark for quality and cost against which the results of the care management organization are to be measured. The Secretary may not pay a care management organization the portion of the fee described in paragraph (1) that is at risk unless the Secretary determines that the care management organization has met the agreed upon savings and outcomes targets for the year.

(e) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(f) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(2) WAIVER OF MEDIGAP PREEMPTIONS.—The Secretary shall waive any provision of section 1882 of the Social Security Act that would prevent an insurance carrier described in subsection (h)(3)(D) from participating in the demonstration program under this section.

(g) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) CARE MANAGEMENT SERVICES.—The term ''care management services'' means services that are furnished to an eligible beneficiary (as defined in paragraph (2)) by a care management organization (as defined in paragraph (3)) in accordance with guidelines established by the Secretary that are consistent with guidelines established by the American Geriatrics Society.

(2) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means an individual who is—

(A) entitled to (or enrolled for) benefits under part A and enrolled for benefits under part B of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.);

(B) not enrolled with a Medicare+Choice plan or a MedicareAdvantage plan under part C; and

(C) at high-risk (as defined by the Secretary, but including eligible beneficiaries with multiple sclerosis or another disabling chronic condition, eligible beneficiaries residing in a nursing home or at risk for nursing home placement, or eligible beneficiaries eligible for assistance under a State plan under title XIX).

(3) CARE MANAGEMENT ORGANIZATION.—The term ''care management organization'' means an organization that meets such qualifications as the Secretary may specify and includes any of the following:

(A) A physician group practice, hospital, home health agency, or hospice program.

(B) A disease management organization.

(C) A Medicare+Choice or MedicareAdvantage organization.

(D) Insurance carriers offering medicare supplemental policies under section 1882 of the Social Security Act (42 U.S.C. 1395ss).

(E) Such other entity as the Secretary determines to be appropriate.

SEC. 445. 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;

(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;

(4) an evaluation of whether there is a sound economic basis for the implementation of the adjustment under subparagraphs (E) and (F) of section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)), as added by section 421, in those areas in which the adjustment applies;

(5) an evaluation of the effect of such adjustment on physician location and retention in areas affected by such adjustment, taking into account—

(A) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

(B) the mobility of physicians, including specialists, over the last decade; and

(6) an evaluation of appropriateness of extending such adjustment or making such adjustment permanent.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a). 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).

Subtitle C—Provisions Relating to Parts A and B

SEC. 451. INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) on or after October 1, 2003, and before October 1, 2005, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

(c) NO EFFECT ON SUBSEQUENT PERIODS.—The payment increase provided under subsection (a) for a period under such subsection—

(1) shall not apply to episodes and visits ending after such period; and

(2) shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.

SEC. 452. LIMITATION ON REDUCTION IN AREA WAGE ADJUSTMENT FACTORS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.

Section 1895(b)(4)(C) (42 U.S.C. 1395fff(b)(4)(C)) is amended—

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

''(i) IN GENERAL.—Subject to clause (ii), the Secretary''; and

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

''(ii) LIMITATION ON REDUCTION IN FISCAL YEAR 2005 AND 2006.—For fiscal years 2004, 2005, and 2006, the area wage adjustment factor applicable to home health services furnished in an area in the fiscal year may not be more that 3 percent less than the area wage adjustment factor applicable to home health services for the area for the previous year.''.

SEC. 453. CLARIFICATIONS TO CERTAIN EXCEPTIONS TO MEDICARE LIMITS ON PHYSICIAN REFERRALS.

(a) LIMITS ON PHYSICIAN REFERRALS.—

(1) OWNERSHIP AND INVESTMENT INTERESTS IN WHOLE HOSPITALS.—

(A) IN GENERAL.—Section 1877(d)(3) (42 U.S.C. 1395nn(d)(3)) is amended—

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

(ii) by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A) the following:

''(B) the hospital is not a specialty hospital (as defined in subsection (h)(7)); and''.

(B) DEFINITION.—Section 1877(h) (42 U.S.C. 1395nn(h)) is amended by adding at the end the following:

''(7) SPECIALTY HOSPITAL.—

''(A) IN GENERAL.—For purposes of this section, except as provided in subparagraph (B), the term 'specialty hospital' means a hospital that is primarily or exclusively engaged in the care and treatment of one of the following:

''(i) patients with a cardiac condition;

''(ii) patients with an orthopedic condition;

''(iii) patients receiving a surgical procedure; or

''(iv) any other specialized category of patients or cases that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

''(B) EXCEPTION.—For purposes of this section, the term 'specialty hospital' does not include any hospital—

''(i) determined by the Secretary—

''(I) to be in operation before June 12, 2003; or

''(II) under development as of such date;

''(ii) for which the number of beds and the number of physician investors at any time on or after such date is no greater than the number of such beds or investors as of such date; and

''(iii) that meets such other requirements as the Secretary may specify.''.

(2) OWNERSHIP AND INVESTMENT INTERESTS IN A RURAL PROVIDER.—Section 1877(d)(2) (42 U.S.C. 1395nn(d)(2)) is amended to read as follows:

''(2) RURAL PROVIDERS.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if—

''(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area;

''(B) the entity is not a specialty hospital (as defined in subsection (h)(7)); and

''(C) the Secretary determines, with respect to such entity, that such services would not be available in such area but for the ownership or investment interest.''.

(b) EFFECTIVE DATE.—Subject to paragraph (2), the amendments made by this section shall apply to referrals made for designated health services on or after January 1, 2004.

(c) APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT.—For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act, as added by subsection (a)(1)(B), in determining whether a hospital is under development as of June 12, 2003, the Secretary shall consider—

(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

SEC. 454. DEMONSTRATION PROGRAM FOR SUBSTITUTE ADULT DAY SERVICES.

(a) ESTABLISHMENT.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which the Secretary provides eligible medicare beneficiaries with coverage under the medicare program of substitute adult day services furnished by an adult day services facility.

(b) PAYMENT RATE FOR SUBSTITUTE ADULT DAY SERVICES.—

(1) PAYMENT RATE.—For purposes of making payments to an adult day services facility for substitute adult day services under the demonstration program, the following rules shall apply:

(A) ESTIMATION OF PAYMENT AMOUNT.—The Secretary shall estimate the amount that would otherwise be payable to a home health agency under section 1895 of the Social Security Act (42 U.S.C. 1395fff) for all home health services described in subsection (i)(4)(B)(i) under the plan of care.

(B) AMOUNT OF PAYMENT.—Subject to paragraph (3)(B), the total amount payable for substitute adult day services under the plan of care is equal to 95 percent of the amount estimated to be payable under subparagraph (A).

(2) LIMITATION ON BALANCE BILLING.—Under the demonstration program, an adult day services facility shall accept as payment in full for substitute adult day services (including those services described in clauses (ii) through (iv) of subsection (i)(4)(B)) furnished

by the facility to an eligible medicare beneficiary the amount of payment provided under the demonstration program for home health services consisting of substitute adult services.

(3) ADJUSTMENT IN CASE OF OVERUTILIZATION OF SUBSTITUTE ADULT DAY SERVICES TO ENSURE BUDGET NEUTRALITY.—The Secretary shall monitor the expenditures under the demonstration program and under title XVIII of the Social Security Act for home health services. If the Secretary estimates that the total expenditures under the demonstration program and under such title XVIII for home health services for a period determined by the Secretary exceed expenditures that would have been made under such title XVIII for home health services for such period if the demonstration program had not been conducted, the Secretary shall adjust the rate of payment to adult day services facilities under paragraph (1)(B) in order to eliminate such excess.

(c) DEMONSTRATION PROGRAM SITES.—The demonstration program shall be conducted in not more than 3 sites selected by the Secretary.

(d) DURATION; IMPLEMENTATION.—

(1) DURATION.—The Secretary shall conduct the demonstration program for a period of 3 years.

(2) IMPLEMENTATION.—The Secretary may not implement the demonstration program before October 1, 2004.

(e) VOLUNTARY PARTICIPATION.—Participation of eligible medicare beneficiaries in the demonstration program shall be voluntary.

(f) WAIVER AUTHORITY.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purposes of carrying out the demonstration program.

(2) MAY NOT WAIVE ELIGIBILITY REQUIREMENTS FOR HOME HEALTH SERVICES.—The Secretary may not waive the beneficiary eligibility requirements for home health services under title XVIII of the Social Security Act.

(g) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the clinical and cost effectiveness of the demonstration program.

(2) REPORT.—Not later than 30 months after the commencement of the demonstration program, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) and shall include in the report the following:

(A) An analysis of the patient outcomes and costs of furnishing care to the eligible medicare beneficiaries participating in the demonstration program as compared to such outcomes and costs to such beneficiaries receiving only home health services under title XVIII of the Social Security Act for the same health conditions.

(B) Such recommendations regarding the extension, expansion, or termination of the program as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

(1) ADULT DAY SERVICES FACILITY.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the term ''adult day services facility'' means a public agency or private organization, or a subdivision of such an agency or organization, that—

(i) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(ii) provides the items and services described in paragraph (4)(B); and

(iii) meets the requirements of paragraphs (2) through (8) of subsection (o).

(B) INCLUSION.—Notwithstanding subparagraph (A), the term ''adult day services facility'' shall include a home health agency in which the items and services described in clauses (ii) through (iv) of paragraph (4)(B) are provided—

(i) by an adult day services program that is licensed or certified by a State, or accredited, to furnish such items and services in the State; and

(ii) under arrangements with that program made by such agency.

(C) WAIVER OF SURETY BOND.—The Secretary may waive the requirement of a surety bond under section 1861(o)(7) of the Social Security Act (42 U.S.C. 1395x(o)(7)) in the case of an agency or organization that provides a comparable surety bond under State law.

(2) ELIGIBLE MEDICARE BENEFICIARY.—The term ''eligible medicare beneficiary'' means an individual eligible for home health services under title XVIII of the Social Security Act.

(3) HOME HEALTH AGENCY.—The term ''home health agency'' has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(4) SUBSTITUTE ADULT DAY SERVICES.—

(A) IN GENERAL.—The term ''substitute adult day services'' means the items and services described in subparagraph (B) that are furnished to an individual by an adult day services facility as a part of a plan under section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)) that substitutes such services for some or all of the items and services described in subparagraph (B)(i) furnished by a home health agency under the plan, as determined by the physician establishing the plan.

(B) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are the following items and services:

(i) Items and services described in paragraphs (1) through (7) of such section 1861(m).

(ii) Meals.

(iii) A program of supervised activities designed to promote physical and mental health and furnished to the individual by the adult day services facility in a group setting for a period of not fewer than 4 and not greater than 12 hours per day.

(iv) A medication management program (as defined in subparagraph (C)).

(C) MEDICATION MANAGEMENT PROGRAM.—For purposes of subparagraph (B)(iv), the term ''medication management program'' means a program of services, including medicine screening and patient and health care provider education programs, that provides services to minimize—

(i) unnecessary or inappropriate use of prescription drugs; and

(ii) adverse events due to unintended prescription drug-to-drug interactions.

SEC. 455. MEDICARE SECONDARY PAYOR (MSP) PROVISIONS.

(a) TECHNICAL AMENDMENT CONCERNING SECRETARY'S AUTHORITY TO MAKE CONDITIONAL PAYMENT WHEN CERTAIN PRIMARY PLANS DO NOT PAY PROMPTLY.—

(1) IN GENERAL.—Section 1862(b)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking ''promptly (as determined in accordance with regulations)'';

(B) in subparagraph (B)—

(i) by redesignating clauses (i) through (iii) as clauses (ii) through (iv), respectively; and

(ii) by inserting before clause (ii), as so redesignated, the following new clause:

''(i) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment under this title with respect to an item or service if a primary plan described in subparagraph (A)(ii) has not made or cannot reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be conditioned on reimbursement to the appropriate Trust Fund in accordance with the succeeding provisions of this subsection.''.

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall be effective as if included in the enactment of title III of the Medicare and Medicaid Budget Reconciliation Amendments of 1984 (Public Law 98-369).

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

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

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

(A) by striking the first sentence and inserting the following: ''A primary plan, and an entity that receives payment from a primary plan, shall reimburse the appropriate Trust Fund for any payment made by the Secretary under this title with respect to an item or service if it is demonstrated that such primary plan has or had a responsibility to make payment with respect to such item or service. A primary plan's responsibility for such payment may be demonstrated by a judgment, a payment conditioned upon the recipient's compromise, waiver, or release (whether or not there is a determination or admission of liability) of payment for items or services included in a claim against the primary plan or the primary plan's insured, or by other means.''; and

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

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

(c) CLERICAL AMENDMENTS.—Section 1862(b) (42 U.S.C. 1395y(b)) is amended—

(1) in paragraph (1)(A), by moving the indentation of clauses (ii) through (v) 2 ems to the left; and

(2) in paragraph (3)(A), by striking ''such'' before ''paragraphs''.

TITLE V—MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS

Subtitle A—Regulatory Reform

SEC. 501. RULES FOR THE PUBLICATION OF A FINAL REGULATION BASED ON THE PREVIOUS PUBLICATION OF AN INTERIM FINAL REGULATION.

(a) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

''(3)(A) With respect to the publication of a final regulation based on the previous publication of an interim final regulation—

''(i) subject to subparagraph (B), the Secretary shall publish the final regulation within the 12-month period that begins on the date of publication of the interim final regulation;

''(ii) if a final regulation is not published by the deadline established under this paragraph, the interim final regulation shall not continue in effect unless the Secretary publishes a notice described in subparagraph (B) by such deadline; and

''(iii) the final regulation shall include responses to comments submitted in response to the interim final regulation.

''(B) If the Secretary determines before the deadline otherwise established in this paragraph that there is good cause, specified in a notice published before such deadline, for delaying the deadline otherwise applicable under this paragraph, the deadline otherwise established under this paragraph shall be extended for such period (not to exceed 12 months) as the Secretary specifies in such notice.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act and shall apply to interim final regulations published on or after such date.

(c) STATUS OF PENDING INTERIM FINAL REGULATIONS.—Not later than 6 months after the date of enactment of this Act, the Secretary shall publish a notice in the Federal Register that provides the status of each interim final regulation that was published on or before the date of enactment of this Act and for which no final regulation has been published. Such notice shall include the date by which the Secretary plans to publish the final regulation that is based on the interim final regulation.

SEC. 502. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

''(d)(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 enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(d)(1), as added by subsection (a), is amended by adding at the end the following:

''(B) A compliance action may be made against a provider of services, physician, practitioner, or other supplier with respect to noncompliance with such a substantive change only for items and services furnished on or after the effective date of the change.

''(C)(i) Except as provided in clause (ii), a substantive change may not take effect before the date that is the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

''(ii) The Secretary may provide for a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of enactment of this Act.

SEC. 503. REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.

Section 1871 (42 U.S.C. 1395hh), as amended by section 502(a)(1), is amended by adding at the end the following new subsection:

''(e)(1) Not later than 2 years after the date of enactment of this subsection, and every 3 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 beneficiaries, providers of services, physicians, practitioners, and other suppliers with respect to such areas of inconsistency and conflict; and

''(B) information from medicare contractors that tracks the nature of all communications and correspondence.

''(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—Appeals Process Reform

SEC. 511. SUBMISSION OF PLAN FOR TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) SUBMISSION OF TRANSITION PLAN.—

(1) IN GENERAL.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title 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) CONTENTS.—The plan shall include information on the following:

(A) WORKLOAD.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) COST PROJECTIONS AND FINANCING.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan and how such transfer should be financed.

(C) TRANSITION TIMETABLE.—A timetable for the transition.

(D) REGULATIONS.—The establishment of specific regulations to govern the appeals process.

(E) CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) FEASIBILITY OF PRECEDENTIAL AUTHORITY.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

(G) ACCESS TO ADMINISTRATIVE LAW JUDGES.—The feasibility of—

(i) filing appeals with administrative law judges electronically; and

(ii) conducting hearings using tele- or video-conference technologies.

(H) INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES.—The steps that should be taken to ensure the independence of administrative law judges, including ensuring that such judges are in an office that is functionally and operationally separate from the Centers for Medicare & Medicaid Services and the Center for Medicare Choices.

(I) GEOGRAPHIC DISTRIBUTION.—The steps that should be taken to provide for an appropriate geographic distribution of administrative law judges throughout the United States to ensure timely access to such judges.

(J) HIRING.—The steps that should be taken to hire administrative law judges (and support staff).

(K) PERFORMANCE STANDARDS.—The establishment of performance standards for administrative law judges with respect to timelines for decisions in cases under title XVIII of the Social Security Act.

(L) SHARED RESOURCES.—The feasibility of the Secretary entering into such arrangements with the Commissioner of Social Security as may be appropriate with respect to transferred functions under the plan to share office space, support staff, and other resources, with appropriate reimbursement.

(M) TRAINING.—The training that should be provided to administrative law judges with respect to laws and regulations under title XVIII of the Social Security Act.

(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (as amended by sections 521 and 522 of BIPA (114 Stat. 2763A–534) and this Act).

(b) GAO EVALUATION.—The Comptroller General of the United States shall—

(1) evaluate the plan submitted under subsection (a); and

(2) not later than 6 months after such submission, submit to Congress, the Commissioner of Social Security, and the Secretary a report on such evaluation.

(c) SUBMISSION OF GAO REPORT REQUIRED BEFORE PLAN IMPLEMENTATION.—The Commissioner of Social Security and the Secretary may not implement the plan developed under subsection (a) before the date that is 6 months after the date the report required under subsection (b)(2) is submitted to the Commissioner and the Secretary.

SEC. 512. EXPEDITED ACCESS TO JUDICIAL REVIEW.

(a) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)) is amended—

(1) in paragraph (1)(A), by inserting '', subject to paragraph (2),'' before ''to judicial review of the Secretary's final decision''; and

(2) 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 a beneficiary who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

''(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity 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 entity—

''(I) determines that there are no material issues of fact in dispute and that the only issues to be adjudicated are ones of law or regulation that the Departmental Appeals Board does not have 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 the date of the determination described in such clause; or

''(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

''(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than 1 applicant, the judicial district in which the greatest number of applicants are located) or in the District Court for the District of Columbia.

''(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the 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, physicians, practitioners, and other suppliers under this Act.

''(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, a 'review entity' is a panel of no more than 3 members from the Departmental Appeals Board, selected for the purpose 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 beneficiaries may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.''.

(c) GAO STUDY AND REPORT ON ACCESS TO JUDICIAL REVIEW.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the access of medicare beneficiaries and health care providers to judicial review of actions of the Secretary and the Department of Health and Human Services with respect to items and services under title XVIII of the Social Security Act subsequent to February 29, 2000, the date of the decision of Shalala, Secretary of Health and Human Services, et al. v. Illinois Council on Long Term Care, Inc. (529 U.S. 1 (2000)).

(2) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations as the Comptroller General determines to be appropriate.

(d) CONFORMING AMENDMENT.—Section 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is amended to read as follows:

''(ii) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For the provision relating to expedited access to judicial review, see paragraph (2).''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

SEC. 513. EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.

(a) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—

(1) IN GENERAL.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which—

(A) the remedy of termination of participation has been imposed;

(B) a sanction described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) has been imposed, but only if such sanction has been imposed on an immediate basis; or

(C) the Secretary has required a skilled nursing facility to suspend operations of a nurse aide training program.

(2) PRIORITY FOR CASES OF TERMINATION.—Under the process described in paragraph (1), priority shall be provided in cases of termination described in subparagraph (A) of such paragraph.

(b) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums for fiscal year 2004 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges (and their staffs) at the Departmental Appeals Board of the Department of Health and Human Services and to educate such judges and staff on long-term care issues.

SEC. 514. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) TIMEFRAMES FOR THE COMPLETION OF THE RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 512(a)(2), is amended by adding at the end the following new paragraph:

''(3) TIMELY COMPLETION OF THE RECORD.—

''(A) DEADLINE.—Subject to subparagraph (B), the deadline to complete the record in a hearing before an administrative law judge or a review by the Departmental Appeals Board is 90 days after the date the request for the review or hearing is filed.

''(B) EXTENSIONS FOR GOOD CAUSE.—The person filing a request under subparagraph (A) may request an extension of such deadline for good cause. The administrative law judge, in the case of a hearing, and the Departmental Appeals Board, in the case of a review, may extend such deadline based upon a finding of good cause to a date specified by the judge or Board, as the case may be.

''(C) DELAY IN DECISION DEADLINES UNTIL COMPLETION OF RECORD.—Notwithstanding any other provision of this section, the deadlines otherwise established under subsection (d) for the making of determinations in hearings or review under this section are 90 days after the date on which the record is complete.

''(D) COMPLETE RECORD DESCRIBED.—For purposes of this paragraph, a record is complete when the administrative law judge, in the case of a hearing, or the Departmental Appeals Board, in the case of a review, has received—

''(i) written or testimonial evidence, or both, submitted by the person filing the request,

''(ii) written or oral argument, or both,

''(iii) the decision of, and the record for, the prior level of appeal, and

''(iv) such other evidence as such judge or Board, as the case may be, determines is required to make a determination on the request.''.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) 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)) 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 be provided in printed form and written in a manner to be understood by the beneficiary and shall include—

''(A) the reasons for the determination, including, as appropriate—

''(i) upon request in the case of an initial determination, the provision of the policy, manual, or regulation that resulted in the denial; and

''(ii) in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination (as appropriate);

''(B) the procedures for obtaining additional information concerning the determination or redetermination; and

''(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.''.

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended to read as follows:

''(E) EXPLANATION OF DECISION.—Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing in a manner to be understood by the beneficiary and shall include—

''(i) to the extent appropriate, a detailed explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision;

''(ii) a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section; and

''(iii) in the case of a determination of whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)) an explanation of the medical or scientific rationale for the decision.''.

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)) is amended—

(A) in the heading, by inserting ''; NOTICE'' after ''SECRETARY''; and

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

''(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner to be understood by the beneficiary 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) PREPARATION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) is amended by striking ''such information as is required for an appeal'' and inserting ''the record for the appeal''.

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c) (42 U.S.C. 1395ff(c)) is amended—

(A) in paragraph (2)—

(i) by inserting ''(except in the case of a utilization and quality control peer review organization, as defined in section 1152)'' after ''means an entity or organization that''; and

(ii) by striking the period at the end and inserting the following: ''and meets the following requirements:

''(A) GENERAL REQUIREMENTS.—

''(i) The entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing to carry out duties of a qualified independent contractor under this section on a timely basis.

''(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

''(iii) The entity or organization meets such other requirements as the Secretary provides by regulation.

''(B) INDEPENDENCE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), an entity or organization meets the independence requirements of this subparagraph with respect to any case if the entity—

''(I) is not a related party (as defined in subsection (g)(5));

''(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

''(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

''(ii) EXCEPTION FOR COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section 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.''; and

(B) in paragraph (3)(A), by striking '', and shall have sufficient training and expertise in medical science and legal matters to make reconsiderations under this subsection''.

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

''(D) QUALIFICATIONS OF 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).

''(2) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

''(i) not be a related party (as defined in paragraph (5));

''(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

''(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of affiliation with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

''(I) a nonaffiliated individual is not reasonably available;

''(II) the affiliated individual is not involved in the provision of items or services in the case under review;

''(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized representative) and neither party objects; and

''(IV) the affiliated 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 such affiliation if the affiliation is disclosed to the Secretary and the beneficiary (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).

''(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 physician (allopathic or osteopathic) or health care professional who—

''(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

''(B) has medical expertise in the field of practice that is appropriate for the items or services at issue.

''(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving an individual beneficiary, any of the following:

''(A) The Secretary, the medicare 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) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking ''12'' and inserting ''4''.

(e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—

(1) DELAY IN CERTAIN BIPA REFORMS.—Section 521(d) of BIPA (114 Stat. 2763A–543) is amended to read as follows:

''(d) EFFECTIVE DATE.—

''(1) IN GENERAL.—Except as specified in paragraph (2), the amendments made by this section shall apply with respect to initial determinations made on or after December 1, 2004.

''(2) EXPEDITED PROCEEDINGS AND RECONSIDERATION REQUIREMENTS.—For the following provisions, the amendments made by subsection (a) shall apply with respect to initial determinations made on or after October 1, 2003:

''(A) Subsection (b)(1)(F)(i) of section 1869 of the Social Security Act.

''(B) Subsection (c)(3)(C)(iii) of such section.

''(C) Subsection (c)(3)(C)(iv) of such section to the extent that it applies to expedited reconsiderations under subsection (c)(3)(C)(iii) of such section.

''(3) TRANSITIONAL USE OF PEER REVIEW ORGANIZATIONS TO CONDUCT EXPEDITED RECONSIDERATIONS UNTIL QICS ARE OPERATIONAL.—Expedited reconsiderations of initial determinations under section 1869(c)(3)(C)(iii) of the Social Security Act shall be made by peer review organizations until qualified independent contractors are available for such expedited reconsiderations.''.

(2) CONFORMING AMENDMENTS.—Section 521(c) of BIPA (114 Stat. 2763A–543) and section 1869(c)(3)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1395ff(c)(3)(C)(iii)(III)), as added by section 521 of BIPA, are repealed.

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, 114 Stat. 2763A–534.

(g) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by subsection (d)(2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 515. HEARING RIGHTS RELATED TO DECISIONS BY THE SECRETARY TO DENY OR NOT RENEW A MEDICARE ENROLLMENT AGREEMENT; CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.

(a) HEARING RIGHTS.—

(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

''(j) HEARING RIGHTS IN CASES OF DENIAL OR NONRENEWAL.—The Secretary shall establish by regulation procedures under which—

''(1) there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment); and

''(2) providers of services, physicians, practitioners, and suppliers whose application to enroll (or, if applicable, to renew enrollment) are denied are provided a mechanism to appeal such denial and a deadline for consideration of such appeals.''.

(2) EFFECTIVE DATE.—The Secretary shall provide for the establishment of the procedures under the amendment made by paragraph (1) within 18 months after the date of enactment of this Act.

(b) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—Section 1871 (42 U.S.C. 1395hh), as amended by sections 502 and 503, is amended by adding at the end the following new subsection:

''(f) The Secretary shall consult with providers of services, physicians, practitioners, and suppliers before making changes in the provider enrollment forms required of such providers, physicians, practitioners, and suppliers to be eligible to submit claims for which payment may be made under this title.''.

SEC. 516. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

''(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services, physician, practitioner, or other supplier to appeal any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 517. PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.

(a) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—Section 1869(f)(5) (42 U.S.C. 1395ff(f)(5)) is amended to read as follows:

''(5) AGGRIEVED PARTY DEFINED.—In this section, the term 'aggrieved party' means—

''(A) with respect to a national coverage determination, an individual entitled to benefits under part A, or enrolled under part B, or both, who is in need of the items or services that are the subject of the coverage determination; and

''(B) with respect to a local coverage determination—

''(i) an individual who is entitled to benefits under part A, or enrolled under part B, or both, who is adversely affected by such a determination; or

''(ii) a provider of services, physician, practitioner, or supplier that is adversely affected by such a determination.''.

(b) CLARIFICATION OF LOCAL COVERAGE DETERMINATION DEFINITION.—Section 1869(f)(2)(B) (42 U.S.C. 1395ff(f)(2)(B)) is amended by inserting '', including, where appropriate, the specific requirements and clinical indications relating to the medical necessity of an item or service'' before the period at the end.

(c) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—Section 1869 (42 U.S.C. 1395ff), as amended by section 514(d)(2)(B), is amended by adding at the end the following new subsection:

''(h) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—

''(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a process under which a provider of services, physician, practitioner, or supplier who certifies that they meet the requirements established in paragraph (3) may request a local coverage determination in accordance with the succeeding provisions of this subsection.

''(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUEST DEFINED.—In this subsection, the term 'provider local coverage determination request' means a request, filed with the Secretary, at such time and in such form and manner as the Secretary may specify, that the Secretary, pursuant to paragraph (4)(A), require a fiscal intermediary, carrier, or program safeguard contractor to make or revise a local coverage determination under this section with respect to an item or service.

''(3) REQUEST REQUIREMENTS.—Under the process established under paragraph (1), by not later than 30 days after the date on which a provider local coverage determination request is filed under paragraph (1), the Secretary shall determine whether such request establishes that—

''(A) there have been at least 5 reversals of redeterminations made by a fiscal intermediary or carrier after a hearing before an administrative law judge on claims submitted by the provider in at least 2 different cases before an administrative law judge;

''(B) each reversal described in subparagraph (A) involves substantially similar material facts;

''(C) each reversal described in subparagraph (A) involves the same medical necessity issue; and

''(D) at least 50 percent of the total number of claims submitted by such provider within the past year involving the substantially similar material facts described in subparagraph (B) and the same medical necessity issue described in subparagraph (C) have been denied and have been reversed by an administrative law judge.

''(4) APPROVAL OR REJECTION OF REQUEST.—

''(A) APPROVAL OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have been satisfied, the Secretary shall require the fiscal intermediary, carrier, or program safeguard contractor identified in the provider local coverage determination request, to make or revise a local coverage determination with respect to the item or service that is the subject of the request not later than the date that is 210 days after the date on which the Secretary makes the determination. Such fiscal intermediary, carrier, or program safeguard contractor shall retain the discretion to determine whether or not, and/or the circumstances under which, to cover the item or service for which a local coverage determination is requested. Nothing in this subsection shall be construed to require a fiscal intermediary, carrier or program safeguard contractor to develop a local coverage determination that is inconsistent with any national coverage determination, or any coverage provision in this title or in regulation, manual, or interpretive guidance of the Secretary.

''(B) REJECTION OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have not been satisfied, the Secretary shall reject the provider local coverage determination request and shall notify the provider of services, physician, practitioner, or supplier that filed the request of the reason for such rejection and no further proceedings in relation to such request shall be conducted.''.

(d) STUDY AND REPORT ON THE USE OF CONTRACTORS TO MONITOR MEDICARE APPEALS.—

(1) STUDY.—The Secretary shall conduct a study on the feasibility and advisability of requiring fiscal intermediaries and carriers to monitor and track—

(A) the subject matter and status of claims denied by the fiscal intermediary or carrier (as applicable) that are appealed under section 1869 of the Social Security Act (42 U.S.C. 1395ff), as added by section 522 of BIPA (114 Stat. 2763A–543) and amended by this Act; and

(B) any final determination made with respect to such claims.

(2) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation and administrative action as the Commission determines appropriate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) EFFECTIVE DATES.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendments made by subsections (a) and (b) shall apply to—

(A) any review of any local coverage determination filed on or after October 1, 2003;

(B) any request to make such a determination made on or after such date; or

(C) any local coverage determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUESTS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests (as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c)) filed on or after the date of enactment of this Act.

Subtitle C—Contracting Reform

SEC. 521. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

''CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

''SEC. 1874A. (a) AUTHORITY.—

''(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a 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, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services, physician, practitioner, facility, or supplier or class of provider of services, physician, practitioner, facility, or supplier.

''(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions (including the function of developing local coverage determinations, as defined in section 1869(f)(2)(B)), provider services functions, and beneficiary services functions 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, physicians, practitioners, facilities, 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.—Serving as a center for, and communicating to individuals entitled to benefits under part A or enrolled under part B, or both, with respect to education and outreach for those individuals, and assistance with specific issues, concerns, or problems of those individuals.

''(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services, physicians, practitioners, facilities, or suppliers.

''(E) COMMUNICATION WITH PROVIDERS.—Serving as a center for, and communicating to providers of services, physicians, practitioners, facilities, and suppliers, any information or instructions furnished to the medicare administrative contractor by the Secretary, and serving as a channel of communication from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

''(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions described in subsections (e) and (f), relating to education, training, and technical assistance to providers of services, physicians, practitioners, facilities, and suppliers.

''(G) ADDITIONAL FUNCTIONS.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title.

''(5) RELATIONSHIP TO MIP CONTRACTS.—

''(A) NONDUPLICATION OF ACTIVITIES.—In entering into contracts under this section, the Secretary shall assure that activities of medicare administrative contractors do not duplicate activities carried out under contracts entered into under the Medicare Integrity Program under section 1893. The 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, the Federal Acquisition Regulation, or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section.

''(B) RENEWAL OF CONTRACTS.—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 6 years.

''(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors without regard to any provision of law requiring competition. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred and contact information for the contractors involved) to providers of services, physicians, practitioners, facilities, and suppliers affected by the transfer.

''(D) INCENTIVES FOR QUALITY.—The Secretary may 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, and other matters as the Secretary finds pertinent.

''(3) PERFORMANCE REQUIREMENTS.—

''(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements. The Secretary shall make such performance requirements and measurement standards available to the public.

''(B) CONSIDERATIONS.—The Secretary shall include, as 1 of the standards, provider and beneficiary satisfaction levels.

''(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 published 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.

''(6) RETAINING DIVERSITY OF LOCAL COVERAGE DETERMINATIONS.—A contract with a medicare administrative contractor under this section to perform the function of developing local coverage determinations (as defined in section 1869(f)(2)(B)) shall provide that the contractor shall—

''(A) designate at least 1 different individual to serve as medical director for each State for which such contract performs such function;

''(B) utilize such medical director in the performance of such function; and

''(C) appoint a contractor advisory committee with respect to each such State to provide a formal mechanism for physicians in the State to be informed of, and participate in, the development of a local coverage determination in an advisory capacity.

''(c) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—Subject to subsection (a)(6), 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 the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

''(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (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 a payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

''(4) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the ''False Claims Act'').

''(5) INDEMNIFICATION BY SECRETARY.—

''(A) IN GENERAL.—Notwithstanding any other provision of law and subject to the succeeding provisions of this paragraph, in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from, or relating directly to, the claims administration process under this title, the Secretary may, to the extent specified in the contract with the contractor, indemnify the contractor (and such persons).

''(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the Secretary to be criminal in nature, fraudulent, or grossly negligent.

''(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

''(D) WRITTEN APPROVAL FOR 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 a settlement. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement are conditioned upon the Secretary's prior written approval of the final settlement.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

''(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.''.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act (as added by paragraph (1)) the Secretary shall consider 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 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,'';

(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'';

(E) in paragraph (5), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier'' and ''carrier responses'' and inserting ''contract under section 1874A that provides for making payments under this part shall require the medicare administrative contractor'' and ''contractor responses'', respectively; and

(F) by striking paragraph (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking ''carrier or carriers'' and inserting ''medicare administrative contractor or contractors''.

(7) Subsection (h) is amended—

(A) in paragraph (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, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this title, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(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, 2011.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO NEW AGREEMENTS AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to the date specified in paragraph (1)(A), the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 during the time period without regard to any of the provider nomination provisions of such section.

(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP ACTIVITIES UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION 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 agreements and contracts entered into pursuant to paragraph (2)(A).

(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) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(g) REPORTS ON IMPLEMENTATION.—

(1) PROPOSAL FOR IMPLEMENTATION.—At least 1 year before the date specified in subsection (d)(1)(A), the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes a plan for an appropriate transition. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation 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, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among 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.

Subtitle D—Education and Outreach Improvements

SEC. 531. 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 (e), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services, physicians, practitioners, and suppliers.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

(3) REPORT.—Not later than October 1, 2004, 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 521(a)(1), is amended by adding at the end the following new subsection:

''(e) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—

''(1) METHODOLOGY TO MEASURE CONTRACTOR ERROR RATES.—In order to give medicare contractors (as defined in paragraph (3)) an incentive to implement effective education and outreach programs for providers of services, physicians, practitioners, and suppliers, the Secretary shall develop and implement by October 1, 2004, a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.

''(2) GAO REVIEW OF METHODOLOGY.—The Comptroller General of the United States shall review, and make recommendations to the Secretary, regarding the adequacy of such methodology.

''(3) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' includes a medicare administrative contractor, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.''.

(2) REPORT.—The Secretary shall submit to Congress a report that describes how the Secretary intends to use the methodology developed under section 1874A(e)(1) of the Social Security Act, as added by paragraph (1), in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses.

(c) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) INCREASED FUNDING FOR ENHANCED EDUCATION AND TRAINING THROUGH MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4) (42 U.S.C. 1395i(k)(4)) is amended—

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

(B) in subparagraph (B), by striking ''The amount appropriated'' and inserting ''Subject to subparagraph (C), the amount appropriated''; and

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

''(C) ENHANCED PROVIDER EDUCATION AND TRAINING.—

''(i) IN GENERAL.—In addition to the amount appropriated under subparagraph (B), the amount appropriated under subparagraph (A) for a fiscal year (beginning with fiscal year 2004) is increased by $35,000,000.

''(ii) USE.—The funds made available under this subparagraph shall be used only to increase the conduct by medicare contractors of education and training of providers of services, physicians, practitioners, and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses to written and phone inquiries from providers of services, physicians, practitioners, and suppliers.''.

(2) TAILORING EDUCATION AND TRAINING FOR SMALL PROVIDERS OR SUPPLIERS.—

(A) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsection:

''(b) 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 take into consideration the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

''(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

''(A) an institutional provider of services with fewer than 25 full-time-equivalent employees; or

''(B) a physician, practitioner, or supplier with fewer than 10 full-time-equivalent employees.''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2004.

(d) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (c)(2), is amended by adding at the end the following new subsections:

''(c) 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, physicians, practitioners, or suppliers for the purpose of conducting any type of audit or prepayment review.

''(d) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor—

''(1) of the screens used for identifying claims that will be subject to medical review; or

''(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

''(e) DEFINITIONS.—For purposes of this section and section 1817(k)(4)(C), the term 'medicare contractor' includes the following:

''(1) A medicare administrative contractor with a contract under section 1874A, a fiscal intermediary with a contract under section 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, physician, practitioner, or supplier an entity that has no authority under this title or title XI with respect to such activities and such provider of services, physician, practitioner, or supplier.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

SEC. 532. ACCESS TO AND PROMPT RESPONSES FROM MEDICARE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by section 531(b)(1), is amended by adding at the end the following new subsection:

''(f) COMMUNICATING WITH BENEFICIARIES AND PROVIDERS.—

''(1) COMMUNICATION PROCESS.—The Secretary shall develop a process for medicare contractors to communicate with beneficiaries and with providers of services, physicians, practitioners, and suppliers under this title.

''(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare contractor (as defined in paragraph (5)) shall provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries by beneficiaries, providers of services, physicians, practitioners, and suppliers concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

''(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that medicare contractors provide a toll-free telephone number at which beneficiaries, providers, physicians, practitioners, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

''(4) MONITORING OF CONTRACTOR RESPONSES.—

''(A) IN GENERAL.—Each medicare contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

''(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

''(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

''(B) DEVELOPMENT OF STANDARDS.—

''(i) IN GENERAL.—The Secretary shall establish (and publish in the Federal Register) standards regarding the accuracy, consistency, and timeliness of the information provided in response to inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

''(ii) EVALUATION.—In conducting evaluations of individual medicare contractors, the Secretary shall consider the results of the monitoring conducted under subparagraph (A) 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.

''(5) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in subsection (e)(3).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect October 1, 2004.

SEC. 533. RELIANCE ON GUIDANCE.

(a) IN GENERAL.—Section 1871(d), as added by section 502(a), is amended by adding at the end the following new paragraph:

''(2) If—

''(A) a provider of services, physician, practitioner, or other supplier follows written guidance provided—

''(i) by the Secretary; or

''(ii) by a medicare contractor (as defined in section 1889(e) and whether in the form of a written response to a written inquiry under section 1874A(f)(1) or otherwise) acting within the scope of the contractor's contract authority,

in response to a written inquiry with respect to the furnishing of items or services or the submission of a claim for benefits for such items or services;

''(B) the Secretary determines that—

''(i) the provider of services, physician, practitioner, or supplier has accurately presented the circumstances relating to such items, services, and claim to the Secretary or the contractor in the written guidance; and

''(ii) there is no indication of fraud or abuse committed by the provider of services, physician, practitioner, or supplier against the program under this title; and

''(C) the guidance was in error;

the provider of services, physician, practitioner, or supplier shall not be subject to any penalty or interest under this title (or the provisions of title XI insofar as they relate to this title) relating to the provision of such items or service or such claim if the provider of services, physician, practitioner, or supplier reasonably relied on such guidance. In applying this paragraph with respect to guidance in the form of general responses to frequently asked questions, the Secretary retains authority to determine the extent to which such general responses apply to the particular circumstances of individual claims.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to penalties imposed on or after the date of enactment of this Act.

SEC. 534. MEDICARE PROVIDER 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.—

''(1) IN GENERAL.—By not later than 1 year after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall appoint a Medicare Provider Ombudsman.

''(2) DUTIES.—The Medicare Provider Ombudsman shall—

''(A) provide assistance, on a confidential basis, to entities and individuals providing items and services, including covered drugs under part D, under this title 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

''(B) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

''(i) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

''(ii) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

''(3) STAFF.—The Secretary shall provide the Medicare Provider Ombudsman with appropriate staff.''.

(b) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account)) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (42 U.S.C. 1395ee) (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

SEC. 535. BENEFICIARY OUTREACH DEMONSTRATION PROGRAMS.

(a) DEMONSTRATION ON THE PROVISION OF ADVICE AND ASSISTANCE TO MEDICARE BENEFICIARIES AT LOCAL OFFICES OF THE SOCIAL SECURITY ADMINISTRATION.—

(1) ESTABLISHMENT.—The Secretary shall establish a demonstration program (in this subsection referred to as the ''demonstration program'') under which medicare specialists

employed by the Department of Health and Human Services provide advice and assistance to medicare beneficiaries at the location of existing local offices of the Social Security Administration.

(2) LOCATIONS.—

(A) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to subparagraph (B), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by medicare beneficiaries.

(B) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(3) DURATION.—The demonstration program shall be conducted over a 3-year period.

(4) EVALUATION AND REPORT.—

(A) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(i) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(ii) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local social security offices.

(B) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing Medicare specialists at local social security offices.

(b) DEMONSTRATION ON PROVIDING PRIOR DETERMINATIONS.—

(1) ESTABLISHMENT.—By not later than 1 year after the date of enactment of this Act, the Secretary shall establish a demonstration project to test the administrative feasibility of providing a process for medicare beneficiaries and entities and individuals furnishing such beneficiaries with items and services under title XVIII of the Social Security Act program to make a request for, and receive, a determination (after an advance beneficiary notice is issued with respect to the item or service involved but before such item or service is furnished to the beneficiary) as to whether the item or service is covered under such title consistent with the applicable requirements of section 1862(a)(1)(A) of such Act (42 U.S.C. 1395y(a)(1)(A)) (relating to medical necessity).

(2) EVALUATION AND REPORT.—

(A) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program conducted under paragraph (1).

(B) REPORT.—By not later than January 1, 2006, the Secretary shall submit to Congress a report on such evaluation together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

Subtitle E—Review, Recovery, and Enforcement Reform

SEC. 541. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1) and 532(a), is amended by adding at the end the following new subsection:

''(g) CONDUCT OF PREPAYMENT REVIEW.—

''(1) STANDARDIZATION OF RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor shall conduct random prepayment review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

''(2) LIMITATIONS ON INITIATION OF NONRANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate nonrandom prepayment review of a provider of services, physician, practitioner, or supplier based on the initial identification by that provider of services, physician, practitioner, or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

''(3) TERMINATION OF NONRANDOM PREPAYMENT REVIEW.—The Secretary shall establish protocols or standards relating to the termination, including termination dates, of nonrandom prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review. In the case of a provider of services, physician, practitioner, or supplier with respect to which amounts were previously overpaid, nothing in this subsection shall be construed as limiting the ability of a medicare administrative contractor to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

''(5) RANDOM PREPAYMENT REVIEW DEFINED.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(g) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(g)(1) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of enactment of this Act) as the Secretary shall specify. The Secretary shall develop and publish the standard protocol under such section by not later than 1 year after the date of enactment of this Act.

SEC. 542. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1), 532(a), and 541(a), is amended by adding at the end the following new subsection:

''(h) RECOVERY OF OVERPAYMENTS.—

''(1) USE OF REPAYMENT PLANS.—

''(A) IN GENERAL.—If the repayment, within the period otherwise permitted by a provider of services, physician, practitioner, or other supplier, of an overpayment under this title meets the standards developed under subparagraph (B), subject to subparagraph (C), and the provider, physician, practitioner, or supplier requests the Secretary to enter into a repayment plan with respect to such overpayment, the Secretary shall enter into a plan with the provider, physician, practitioner, or supplier for the offset or repayment (at the election of the provider, physician, practitioner, or supplier) of such overpayment over a period of at least 1 year, but not longer than 3 years. Interest shall accrue on the balance through the period of repayment. The repayment plan shall meet terms and conditions determined to be appropriate by the Secretary.

''(B) DEVELOPMENT OF STANDARDS.—The Secretary shall develop standards for the recovery of overpayments. Such standards shall—

''(i) include a requirement that the Secretary take into account (and weigh in favor of the use of a repayment plan) the reliance (as described in section 1871(d)(2)) by a provider of services, physician, practitioner, and supplier on guidance when determining whether a repayment plan should be offered; and

''(ii) provide for consideration of the financial hardship imposed on a provider of services, physician, practitioner, or supplier in considering such a repayment plan.

In developing standards with regard to financial hardship with respect to a provider of services, physician, practitioner, or supplier, the Secretary shall take into account the amount of the proposed recovery as a proportion of payments made to that provider, physician, practitioner, or supplier.

''(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

''(i) the Secretary has reason to suspect that the provider of services, physician, practitioner, 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, physician, practitioner, or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

''(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) NO RECOUPMENT UNTIL RECONSIDERATION EXERCISED.—In the case of a provider of services, physician, practitioner, or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration of such determination by a qualified independent contractor under section 1869(c), 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.

''(B) PAYMENT OF INTEREST.—

''(i) RETURN OF RECOUPED AMOUNT WITH INTEREST IN CASE OF REVERSAL.—Insofar as such determination on appeal against the provider of services, physician, practitioner, or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest for the period in which the amount was recouped.

''(ii) INTEREST IN CASE OF AFFIRMATION.—Insofar as the determination on such appeal is against the provider of services, physician, practitioner, or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment.

''(iii) RATE OF INTEREST.—The rate of interest under this subparagraph shall be the rate otherwise applicable under this title in the case of overpayments.

''(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(e).

''(3) 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, physician, practitioner, or supplier under this title, the contractor shall provide the provider of services, physician, practitioner, or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

''(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services, physician, practitioner, or supplier under this title, the contractor shall—

''(i) give the provider of services, physician, practitioner, or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appropriate corrective action plan;

''(ii) inform the provider of services, physician, practitioner, or supplier of the appeal rights under this title as well as consent settlement options (which are at the discretion of the Secretary); and

''(iii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

''(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

''(4) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services, physicians, practitioners, and suppliers, a process under which the Secretary provides for notice to classes of providers of services, physicians, practitioners, and suppliers served by a medicare contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services, physicians, practitioners, or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

''(5) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare administrative contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

''(6) 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, physician, practitioner, or supplier a consent settlement, the Secretary shall—

''(i) communicate to the provider of services, physician, practitioner, or supplier in a nonthreatening manner 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; and

''(ii) provide for a 45-day period during which the provider of services, physician, practitioner, 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, physician, practitioner, 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, physician, practitioner, 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, physician, practitioner, 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, physician, practitioner, or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services, physician, practitioner, or supplier agrees not to appeal the claims involved.''.

(b) EFFECTIVE DATES AND DEADLINES.—

(1) Not later than 1 year after the date of enactment of this Act, the Secretary shall first—

(A) develop standards for the recovery of overpayments under section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a);

(B) establish the process for notice of overutilization of billing codes under section 1874A(h)(4) of the Social Security Act, as added by subsection (a); and

(C) establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1874A(h)(5) of the Social Security Act, as added by subsection (a).

(2) Section 1874A(h)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date that is 1 year after the date of enactment of this Act.

(3) Section 1874A(h)(3) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of enactment of this Act.

(4) Section 1874A(h)(6) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of enactment of this Act.

SEC. 543. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

(a) IN GENERAL.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(e) of the Social Security Act, as added by section 531(d)(1)) and representatives of providers of services, physicians, practitioners, facilities, 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, physician, practitioner, facility, 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.

(b) DEADLINE.—Not later than 1 year after the date of enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 544. 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 5 years, except that, upon the request of an administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries of that program, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, 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.''.

TITLE VI—OTHER PROVISIONS

SEC. 601. INCREASE IN MEDICAID DSH ALLOTMENTS FOR FISCAL YEARS 2004 AND 2005.

(a) IN GENERAL.—Section 1923(f)(4) (42 U.S.C. 1396r–4(f)(4)) is amended—

(1) in the paragraph heading, by striking ''FISCAL YEARS 2001 AND 2002'' and inserting ''CERTAIN FISCAL YEARS'';

(2) in subparagraph (A)—

(A) in clause (i)—

(i) by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (3)''; and

(ii) by striking ''and'' at the end;

(B) in clause (ii), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(iii) for fiscal year 2004, shall be the DSH allotment determined under paragraph (3) for that fiscal year increased by the amount equal to the product of 0.50 and the difference between—

''(I) the amount that the DSH allotment would be if the DSH allotment for the State determined under clause (ii) were increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002 and 2003; and

''(II) the DSH allotment determined under paragraph (3) for the State for fiscal year 2004; and

''(iv) for fiscal year 2005, shall be the DSH allotment determined under paragraph (3) for that fiscal year increased by the amount equal to the product of 0.50 and the difference between—

''(I) the amount that the DSH allotment would be if the DSH allotment for the State determined under clause (ii) were increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002, 2003, and 2004; and

''(II) the DSH allotment determined under paragraph (3) for the State for fiscal year 2005.''; and

(3) in subparagraph (C)—

(A) in the subparagraph heading, by striking ''AFTER FISCAL YEAR 2002'' and inserting ''FOR OTHER FISCAL YEARS''; and

(B) by striking ''2003 or'' and inserting ''2003, fiscal year 2006, or''.

(b) DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—Section 1923(f)(4) (42 U.S.C. 1396r–4(f)(4)), as amended by paragraph (1), is amended—

(1) in subparagraph (A), by inserting ''and except as provided in subparagraph (C)'' after ''paragraph (2)'';

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following:

''(C) DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—

''(i) IN GENERAL.—Notwithstanding subparagraph (A), the DSH allotment for the District of Columbia for fiscal year 2004, shall be determined by substituting ''49'' for ''32'' in the item in the table contained in paragraph (2) with respect to the DSH allotment for FY 00 (fiscal year 2000) for the District of Columbia, and then increasing such

allotment, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2000, 2001, 2002, and 2003.

''(ii) NO APPLICATION TO ALLOTMENTS AFTER FISCAL YEAR 2004.—The DSH allotment for the District of Columbia for fiscal year 2003, fiscal year 2005, or any succeeding fiscal year shall be determined under paragraph (3) without regard to the DSH allotment determined under clause (i).''.

(c) CONFORMING AMENDMENT.—Section 1923(f)(3) of such Act (42 U.S.C. 1396r–4(f)(3)) is amended by inserting '', paragraph (4),'' after ''subparagraph (B)''.

SEC. 602. INCREASE IN FLOOR FOR TREATMENT AS AN EXTREMELY LOW DSH STATE UNDER THE MEDICAID PROGRAM FOR FISCAL YEARS 2004 AND 2005.

(a) IN GENERAL.—Section 1923(f)(5) (42 U.S.C. 1396r–4(f)(5)) is amended—

(1) by striking ''In the case of'' and inserting the following:

''(A) IN GENERAL.—In the case of''; and

(2) by adding at the end the following:

''(B) INCREASE IN FLOOR FOR FISCAL YEARS 2004 AND 2005.—

''(i) FISCAL YEAR 2004.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2004 shall be increased to 3 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year.

''(ii) FISCAL YEAR 2005.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2001, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2004, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2005 shall be the DSH allotment determined for the State for fiscal year 2004 (under clause (i) or paragraph (4) (as applicable)), increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2004.

''(iii) NO APPLICATION TO ALLOTMENTS AFTER FISCAL YEAR 2005.—The DSH allotment for any State for fiscal year 2006 or any succeeding fiscal year shall be determined under this subsection without regard to the DSH allotments determined under this subparagraph.''.

(b) ALLOTMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

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

''(6) ALLOTMENT ADJUSTMENT.—Only with respect to fiscal year 2004 or 2005, if a statewide waiver under section 1115 that was implemented on January 1, 1994, is revoked or terminated before the end of either such fiscal year, the Secretary shall—

''(A) permit the State whose waiver was revoked or terminated to submit an amendment to its State plan that would describe the methodology to be used by the State (after the effective date of such revocation or termination) to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities (other than State-owned institutions or facilities), on the basis of the proportion of patients served by such hospitals that are low-income patients with special needs; and

''(B) provide for purposes of this subsection for computation of an appropriate DSH allotment for the State for fiscal year 2004 or 2005 (or both) that provides for the maximum amount (permitted consistent with paragraph (3)(B)(ii)) that does not result in greater expenditures under this title than would have been made if such waiver had not been revoked or terminated.''.

(2) TREATMENT OF INSTITUTIONS FOR MENTAL DISEASES.—Section 1923(h)(1) of the Social Security Act (42 U.S.C. 1396r–4(h)(1)) is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''(subject to paragraph (3))'' after ''the lesser of the following''; and

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

''(3) SPECIAL RULE.—The limitation of paragraph (1) shall not apply in the case of a State to which subsection (f)(6) applies.''.

SEC. 603. INCREASED REPORTING REQUIREMENTS TO ENSURE THE APPROPRIATENESS OF PAYMENT ADJUSTMENTS TO DISPROPORTIONATE SHARE HOSPITALS UNDER THE MEDICAID PROGRAM.

Section 1923 (42 U.S.C. 1396r–4) is amended by adding at the end the following new subsection:

''(j) ANNUAL REPORTS REGARDING PAYMENT ADJUSTMENTS.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1903(a)(1) with respect to a payment adjustment made under this section, to submit an annual report that—

''(1) identifies each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year; and

''(2) includes such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.''.

SEC. 604. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following: ''(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)''.

(b) ANTI-DIVERSION PROTECTION.—Section 1927(c)(1)(C) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)) is amended by adding at the end the following:

''(iii) APPLICATION OF AUDITING AND RECORDKEEPING REQUIREMENTS.—With respect to a covered entity described in section 340B(a)(4)(L) of the Public Health Service Act, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in section 340B(a)(5)(C) of the Public Health Service Act.''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2003.

SEC. 605. ASSISTANCE WITH COVERAGE OF LEGAL IMMIGRANTS UNDER THE MEDICAID PROGRAM AND SCHIP.

(a) MEDICAID PROGRAM.—Section 1903(v) (42 U.S.C. 1396b(v)) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''; and

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

''(4)(A) With respect to any or all of fiscal years 2005 through 2007, a State may elect (in a plan amendment under this title) to provide medical assistance under this title (including under a waiver authorized by the Secretary) for aliens who are lawfully residing in the United States (including battered aliens described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

''(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

''(ii) CHILDREN.—Children (as defined under such plan), including optional targeted low-income children described in section 1905(u)(2)(B).

''(B)(i) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

''(ii) The provisions of sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 shall not apply to a State that makes an election under subparagraph (A).''.

(b) SCHIP.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by redesignating subparagraphs (C) and (D) as subparagraph (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

''(C) Section 1903(v)(4) (relating to optional coverage of categories of permanent resident alien children), but only if the State has elected to apply such section to the category of children under title XIX and only with respect to any or all of fiscal years 2005 through 2007.''.

SEC. 606. ESTABLISHMENT OF CONSUMER OMBUDSMAN ACCOUNT.

(a) IN GENERAL.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(i) CONSUMER OMBUDSMAN ACCOUNT.—

''(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the 'Consumer Ombudsman Account' (in this subsection referred to as the 'Account').

''(2) APPROPRIATED AMOUNTS TO ACCOUNT FOR HEALTH INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE GRANTS.—

''(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year beginning with fiscal year 2005, the amount described in subparagraph (B) for such fiscal year for the purpose of making grants under section 4360 of the Omnibus Budget Reconciliation Act of 1990.

''(B) AMOUNT DESCRIBED.—For purposes of subparagraph (A), the amount described in this subparagraph for a fiscal year is the amount equal to the product of—

''(i) $1; and

''(ii) the total number of individuals receiving benefits under this title for the calendar year ending on December 31 of the preceding fiscal year.''.

(b) CONFORMING AMENDMENT.—Section 4360(g) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b–4(g)) is amended to read as follows:

''(g) FUNDING.—The Secretary shall use amounts appropriated to the Consumer Ombudsman Account in accordance with section 1817(i) of the Social Security Act for a fiscal year for making grants under this section for that fiscal year.''.

SEC. 607. GAO STUDY REGARDING IMPACT OF ASSETS TEST FOR LOW-INCOME BENEFICIARIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to determine the extent to which drug utilization and access to covered drugs for an individual described in subsection (b) differs from the drug utilization and access to covered drugs of an individual who qualifies for the transitional assistance prescription drug card program under section 1807A of the Social Security Act (as added by section 111) or for the premiums and cost-sharing subsidies applicable to a qualified medicare beneficiary, a specified low-income medicare beneficiary, or a qualifying individual under section 1860D–19 of the Social Security Act (as added by section 101).

(b) INDIVIDUAL DESCRIBED.—An individual is described in this subsection if the individual does not qualify for the transitional assistance prescription drug card program under section 1807A of the Social Security Act or for the premiums and cost-sharing subsidies applicable to a qualified medicare beneficiary, a specified low-income medicare beneficiary, or a qualifying individual under section 1860D–19 of the Social Security Act solely as a result of the application of an assets test to the individual.

(c) REPORT.—Not later than September 30, 2007, the Comptroller General shall submit a report to Congress on the study conducted under subsection (a) that includes such recommendations for legislation as the Comptroller General determines are appropriate.

(d) DEFINITIONS.—In this section:

(1) COVERED DRUGS.—The term ''covered drugs'' has the meaning given that term in section 1860D(a)(D) of the Social Security Act.

(2) QUALIFIED MEDICARE BENEFICIARY; SPECIFIED LOW-INCOME MEDICARE BENEFICIARY; QUALIFYING INDIVIDUAL.—The terms ''qualified medicare beneficiary'', ''specified low-income medicare beneficiary'' and ''qualifying individual'' have the meaning given those terms under section 1860D–19 of the Social Security Act.

SEC. 608. HEALTH CARE INFRASTRUCTURE IMPROVEMENT.

At the end of the Social Security Act, add the following new title:

''TITLE XXII—HEALTH CARE INFRASTRUCTURE IMPROVEMENT

''SEC. 2201. DEFINITIONS.

''In this title, the following definitions apply:

''(1) ELIGIBLE PROJECT COSTS.—The term 'eligible project costs' means amounts substantially all of which are paid by, or for the account of, an obligor in connection with a project, including the cost of—

''(A) development phase activities, including planning, feasibility analysis, revenue forecasting, environmental study and review, permitting, architectural engineering and design work, and other preconstruction activities;

''(B) construction, reconstruction, rehabilitation, replacement, and acquisition of facilities and real property (including land related to the project and improvements to land), environmental mitigation, construction contingencies, and acquisition of equipment;

''(C) capitalized interest necessary to meet market requirements, reasonably required reserve funds, capital issuance expenses, and other carrying costs during construction;

''(D) major medical equipment determined to be appropriate by the Secretary; and

''(E) refinancing projects or activities that are otherwise eligible for financial assistance under subparagraphs (A) through (D).

''(2) FEDERAL CREDIT INSTRUMENT.—The term 'Federal credit instrument' means a secured loan, loan guarantee, or line of credit authorized to be made available under this title with respect to a project.

''(3) INVESTMENT-GRADE RATING.—The term 'investment-grade rating' means a rating category of BBB minus, Baa3, or higher assigned by a rating agency to project obligations offered into the capital markets.

''(4) LENDER.—The term 'lender' means any non-Federal qualified institutional buyer (as defined in section 230.144A(a) of title 17, Code of Federal Regulations (or any successor regulation), known as Rule 144A(a) of the Securities and Exchange Commission and issued under the Securities Act of 1933 (15 U.S.C. 77a et seq.)), including—

''(A) a qualified retirement plan (as defined in section 4974(c) of the Internal Revenue Code of 1986) that is a qualified institutional buyer; and

''(B) a governmental plan (as defined in section 414(d) of the Internal Revenue Code of 1986) that is a qualified institutional buyer.

''(5) LINE OF CREDIT.—The term 'line of credit' means an agreement entered into by the Secretary with an obligor under section 2204 to provide a direct loan at a future date upon the occurrence of certain events.

''(6) LOAN GUARANTEE.—The term 'loan guarantee' means any guarantee or other pledge by the Secretary to pay all or part of the principal of and interest on a loan or other debt obligation issued by an obligor and funded by a lender.

''(7) LOCAL SERVICER.—The term 'local servicer' means a State or local government or any agency of a State or local government that is responsible for servicing a Federal credit instrument on behalf of the Secretary.

''(8) OBLIGOR.—The term 'obligor' means a party primarily liable for payment of the principal of or interest on a Federal credit instrument, which party may be a corporation, partnership, joint venture, trust, or governmental entity, agency, or instrumentality.

''(9) PROJECT.—The term 'project' means any project that is designed to improve the health care infrastructure, including the construction, renovation, or other capital improvement of any hospital, medical research facility, or other medical facility or the purchase of any equipment to be used in a hospital, research facility, or other medical research facility.

''(10) PROJECT OBLIGATION.—The term 'project obligation' means any note, bond, debenture, lease, installment sale agreement, or other debt obligation issued or entered into by an obligor in connection with the financing of a project, other than a Federal credit instrument.

''(11) RATING AGENCY.—The term 'rating agency' means a bond rating agency identified by the Securities and Exchange Commission as a Nationally Recognized Statistical Rating Organization.

''(12) SECURED LOAN.—The term 'secured loan' means a direct loan or other debt obligation issued by an obligor and funded by the Secretary in connection with the financing of a project under section 2203.

''(13) STATE.—The term 'State' has the meaning given the term in section 101 of title 23, United States Code.

''(14) SUBSIDY AMOUNT.—The term 'subsidy amount' means the amount of budget authority sufficient to cover the estimated long-term cost to the Federal Government of a Federal credit instrument, calculated on a net present value basis, excluding administrative costs and any incidental effects on governmental receipts or outlays in accordance with the provisions of the Federal Credit Reform Act of 1990 (2 U.S.C. 661 et seq.).

''(15) SUBSTANTIAL COMPLETION.—The term 'substantial completion' means the opening of a project to patients or for research purposes.

''SEC. 2202. DETERMINATION OF ELIGIBILITY AND PROJECT SELECTION.

''(a) ELIGIBILITY.—To be eligible to receive financial assistance under this title, a project shall meet the following criteria:

''(1) APPLICATION.—A State, a local servicer identified under section 2205(a), or the entity undertaking a project shall submit a project application to the Secretary.

''(2) ELIGIBLE PROJECT COSTS.—To be eligible for assistance under this title, a project shall have total eligible project costs that are reasonably anticipated to equal or exceed $40,000,000.

''(3) SOURCES OF REPAYMENTS.—Project financing shall be repayable, in whole or in part, from reliable revenue sources as described in the application submitted under paragraph (1).

''(4) PUBLIC SPONSORSHIP OF PRIVATE ENTITIES.—In the case of a project that is undertaken by an entity that is not a State or local government or an agency or instrumentality of a State or local government, the project that the entity is undertaking shall be publicly sponsored or sponsored by an entity that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code.

''(b) SELECTION AMONG ELIGIBLE PROJECTS.—

''(1) ESTABLISHMENT.—The Secretary shall establish criteria for selecting among projects that meet the eligibility criteria specified in subsection (a).

''(2) SELECTION CRITERIA.—

''(A) IN GENERAL.—The selection criteria shall include the following:

''(i) The extent to which the project is nationally or regionally significant, in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

''(ii) The creditworthiness of the project, including a determination by the Secretary that any financing for the project has appropriate security features, such as a rate covenant, credit enhancement requirements, or debt services coverages, to ensure repayment.

''(iii) The extent to which assistance under this title would foster innovative public-private partnerships and attract private debt or equity investment.

''(iv) The likelihood that assistance under this title would enable the project to proceed at an earlier date than the project would otherwise be able to proceed.

''(v) The extent to which the project uses or results in new technologies.

''(vi) The amount of budget authority required to fund the Federal credit instrument made available under this title.

''(vii) The extent to which the project helps maintain or protect the environment.

''(B) SPECIFIC REQUIREMENTS.—The selection criteria shall require that a project applicant—

''(i) be engaged in research in the causes, prevention, and treatment of cancer;

''(ii) be designated as a cancer center for the National Cancer Institute or be designated by the State as the official cancer institute of the State; and

''(iii) be located in a State that, on the date of enactment of this title, has a population of less than 3,000,000 individuals.

''(C) RATING LETTER.—For purposes of subparagraph (A)(ii), the Secretary shall require each project applicant to provide a rating letter from at least 1 rating agency indicating that the project's senior obligations have the potential to achieve an investment-grade rating with or without credit enhancement.

''SEC. 2203. SECURED LOANS.

''(a) IN GENERAL.—

''(1) AGREEMENTS.—Subject to paragraphs (2) through (4), the Secretary may enter into agreements with 1 or more obligors to make secured loans, the proceeds of which shall be used—

''(A) to finance eligible project costs;

''(B) to refinance interim construction financing of eligible project costs; or

''(C) to refinance existing debt or prior project obligations;

of any project selected under section 2202.

''(2) LIMITATION ON REFINANCING OF INTERIM CONSTRUCTION FINANCING.—A loan under paragraph (1) shall not refinance interim construction financing under paragraph (1)(B) later than 1 year after the date of substantial completion of the project.

''(3) RISK ASSESSMENT.—Before entering into an agreement for a secured loan under this subsection, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate capital reserve subsidy amount for each secured loan, taking into account such letter.

''(4) INVESTMENT-GRADE RATING REQUIREMENT.—The funding of a secured loan under this section shall be contingent on the project's senior obligations receiving an investment-grade rating, except that—

''(A) the Secretary may fund an amount of the secured loan not to exceed the capital reserve subsidy amount determined under paragraph (3) prior to the obligations receiving an investment-grade rating; and

''(B) the Secretary may fund the remaining portion of the secured loan only after the obligations have received an investment-grade rating by at least 1 rating agency.

''(b) TERMS AND LIMITATIONS.—

''(1) IN GENERAL.—A secured loan under this section with respect to a project shall be on such terms and conditions and contain such covenants, representations, warranties, and requirements (including requirements for audits) as the Secretary determines appropriate.

''(2) MAXIMUM AMOUNT.—The amount of the secured loan shall not exceed 100 percent of the reasonably anticipated eligible project costs.

''(3) PAYMENT.—The secured loan—

''(A) shall—

''(i) be payable, in whole or in part, from reliable revenue sources; and

''(ii) include a rate covenant, coverage requirement, or similar security feature supporting the project obligations; and

''(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

''(4) INTEREST RATE.—The interest rate on the secured loan shall be not less than the yield on marketable United States Treasury securities of a similar maturity to the maturity of the secured loan on the date of execution of the loan agreement.

''(5) MATURITY DATE.—The final maturity date of the secured loan shall be not later than 30 years after the date of substantial completion of the project.

''(6) NONSUBORDINATION.—The secured loan shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligor.

''(7) FEES.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of making a secured loan under this section.

''(c) REPAYMENT.—

''(1) SCHEDULE.—The Secretary shall establish a repayment schedule for each secured loan under this section based on the projected cash flow from project revenues and other repayment sources.

''(2) COMMENCEMENT.—Scheduled loan repayments of principal or interest on a secured loan under this section shall commence not later than 5 years after the date of substantial completion of the project.

''(3) SOURCES OF REPAYMENT FUNDS.—The sources of funds for scheduled loan repayments under this section shall include any revenue generated by the project.

''(4) DEFERRED PAYMENTS.—

''(A) AUTHORIZATION.—If, at any time during the 10 years after the date of substantial completion of the project, the project is unable to generate sufficient revenues to pay the scheduled loan repayments of principal and interest on the secured loan, the Secretary may, subject to subparagraph (C), allow the obligor to add unpaid principal and interest to the outstanding balance of the secured loan.

''(B) INTEREST.—Any payment deferred under subparagraph (A) shall—

''(i) continue to accrue interest in accordance with subsection (b)(4) until fully repaid; and

''(ii) be scheduled to be amortized over the remaining term of the loan beginning not later than 10 years after the date of substantial completion of the project in accordance with paragraph (1).

''(C) CRITERIA.—

''(i) IN GENERAL.—Any payment deferral under subparagraph (A) shall be contingent on the project meeting criteria established by the Secretary.

''(ii) REPAYMENT STANDARDS.—The criteria established under clause (i) shall include standards for reasonable assurance of repayment.

''(5) PREPAYMENT.—

''(A) USE OF EXCESS REVENUES.—Any excess revenues that remain after satisfying scheduled debt service requirements on the project obligations and secured loan and all deposit requirements under the terms of any trust agreement, bond resolution, reimbursement agreement, credit agreement, loan agreement, or similar agreement securing project obligations may be applied annually to prepay the secured loan without penalty.

''(B) USE OF PROCEEDS OF REFINANCING.—The secured loan may be prepaid at any time without penalty, regardless of whether such repayment is from the proceeds of refinancing from non-Federal funding sources.

''(6) FORGIVENESS OF INDEBTEDNESS.—The Secretary may forgive a loan secured under this title under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a et seq.), except that the Secretary shall condition such forgiveness on the establishment by the project of—

''(A) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

''(B) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and

''(C)(i) unique research resources (such as population databases); or

''(ii) an affiliation with an entity that has unique research resources.

''(d) SALE OF SECURED LOANS.—

''(1) IN GENERAL.—Subject to paragraph (2), as soon as practicable after substantial completion of a project and after notifying the obligor, the Secretary may sell to another entity or reoffer into the capital markets a secured loan for the project if the Secretary determines that the sale or reoffering can be made on favorable terms.

''(2) CONSENT OF OBLIGOR.—In making a sale or reoffering under paragraph (1), the Secretary may not change the original terms and conditions of the secured loan without the written consent of the obligor.

''(e) LOAN GUARANTEES.—

''(1) IN GENERAL.—The Secretary may provide a loan guarantee to a lender in lieu of making a secured loan if the Secretary determines that the budgetary cost of the loan guarantee is substantially the same as that of a secured loan.

''(2) TERMS.—The terms of a guaranteed loan shall be consistent with the terms set forth in this section for a secured loan, except that the rate on the guaranteed loan and any prepayment features shall be negotiated between the obligor and the lender, with the consent of the Secretary.

''SEC. 2204. LINES OF CREDIT.

''(a) IN GENERAL.—

''(1) AGREEMENTS.—Subject to paragraphs (2) through (4), the Secretary may enter into agreements to make available lines of credit to 1 or more obligors in the form of direct loans to be made by the Secretary at future dates on the occurrence of certain events for any project selected under section 2202.

''(2) USE OF PROCEEDS.—The proceeds of a line of credit made available under this section shall be available to pay debt service on project obligations issued to finance eligible project costs, extraordinary repair and replacement costs, operation and maintenance expenses, and costs associated with unexpected Federal or State environmental restrictions.

''(3) RISK ASSESSMENT.—Before entering into an agreement for a secured loan under this subsection, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate subsidy amount for each secured loan, taking into account such letter.

''(4) INVESTMENT-GRADE RATING REQUIREMENT.—The funding of a line of credit under this section shall be contingent on the project's senior obligations receiving an investment-grade rating from at least 1 rating agency.

''(b) TERMS AND LIMITATIONS.—

''(1) IN GENERAL.—A line of credit under this section with respect to a project shall be on such terms and conditions and contain such covenants, representations, warranties, and requirements (including requirements for audits) as the Secretary determines appropriate.

''(2) MAXIMUM AMOUNTS.—

''(A) TOTAL AMOUNT.—The total amount of the line of credit shall not exceed 33 percent of the reasonably anticipated eligible project costs.

''(B) 1-YEAR DRAWS.—The amount drawn in any 1 year shall not exceed 20 percent of the total amount of the line of credit.

''(3) DRAWS.—Any draw on the line of credit shall represent a direct loan and shall be made only if net revenues from the project (including capitalized interest, any debt service reserve fund, and any other available reserve) are insufficient to pay the costs specified in subsection (a)(2).

''(4) INTEREST RATE.—The interest rate on a direct loan resulting from a draw on the line of credit shall be not less than the yield on 30-year marketable United States Treasury securities as of the date on which the line of credit is obligated.

''(5) SECURITY.—The line of credit—

''(A) shall—

''(i) be payable, in whole or in part, from reliable revenue sources; and

''(ii) include a rate covenant, coverage requirement, or similar security feature supporting the project obligations; and

''(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

''(6) PERIOD OF AVAILABILITY.—The line of credit shall be available during the period beginning on the date of substantial completion of the project and ending not later than 10 years after that date.

''(7) RIGHTS OF THIRD-PARTY CREDITORS.—

''(A) AGAINST FEDERAL GOVERNMENT.—A third-party creditor of the obligor shall not have any right against the Federal Government with respect to any draw on the line of credit.

''(B) ASSIGNMENT.—An obligor may assign the line of credit to 1 or more lenders or to a trustee on the lenders' behalf.

''(8) NONSUBORDINATION.—A direct loan under this section shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligor.

''(9) FEES.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of providing a line of credit under this section.

''(10) RELATIONSHIP TO OTHER CREDIT INSTRUMENTS.—A project that receives a line of credit under this section also shall not receive a secured loan or loan guarantee under section 2203 of an amount that, combined with the amount of the line of credit, exceeds 100 percent of eligible project costs.

''(c) REPAYMENT.—

''(1) TERMS AND CONDITIONS.—The Secretary shall establish repayment terms and conditions for each direct loan under this section based on the projected cash flow from project revenues and other repayment sources.

''(2) TIMING.—All scheduled repayments of principal or interest on a direct loan under this section shall commence not later than 5 years after the end of the period of availability specified in subsection (b)(6) and be fully repaid, with interest, by the date that is 25 years after the end of the period of availability specified in subsection (b)(6).

''(3) SOURCES OF REPAYMENT FUNDS.—The sources of funds for scheduled loan repayments under this section shall include reliable revenue sources.

''SEC. 2205. PROJECT SERVICING.

''(a) REQUIREMENT.—The State in which a project that receives financial assistance under this title is located may identify a local servicer to assist the Secretary in servicing the Federal credit instrument made available under this title.

''(b) AGENCY; FEES.—If a State identifies a local servicer under subsection (a), the local servicer—

''(1) shall act as the agent for the Secretary; and

''(2) may receive a servicing fee, subject to approval by the Secretary.

''(c) LIABILITY.—A local servicer identified under subsection (a) shall not be liable for the obligations of the obligor to the Secretary or any lender.

''(d) ASSISTANCE FROM EXPERT FIRMS.—The Secretary may retain the services of expert firms in the field of project finance to assist in the underwriting and servicing of Federal credit instruments.

''SEC. 2206. STATE AND LOCAL PERMITS.

''The provision of financial assistance under this title with respect to a project shall not—

''(1) relieve any recipient of the assistance of any obligation to obtain any required State or local permit or approval with respect to the project;

''(2) limit the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or

''(3) otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

''SEC. 2207. REGULATIONS.

''The Secretary may issue such regulations as the Secretary determines appropriate to carry out this title.

''SEC. 2208. FUNDING.

''(a) FUNDING.—

''(1) IN GENERAL.—There are authorized to be appropriated to carry out this title, $49,000,000 to remain available during the period beginning on July 1, 2004 and ending on September 30, 2008.

''(2) ADMINISTRATIVE COSTS.—From funds made available under paragraph (1), the Secretary may use, for the administration of this title, not more than $2,000,000 for each of fiscal years 2004 through 2008.

''(b) CONTRACT AUTHORITY.—Notwithstanding any other provision of law, approval by the Secretary of a Federal credit instrument that uses funds made available under this title shall be deemed to be acceptance by the United States of a contractual obligation to fund the Federal credit instrument.

''(c) AVAILABILITY.—Amounts appropriated under this section shall be available for obligation on July 1, 2004.

''SEC. 2209. REPORT TO CONGRESS.

''Not later than 4 years after the date of enactment of this title, the Secretary shall submit to Congress a report summarizing the financial performance of the projects that are receiving, or have received, assistance under this title, including a recommendation as to whether the objectives of this title are best served—

''(1) by continuing the program under the authority of the Secretary;

''(2) by establishing a Government corporation or Government-sponsored enterprise to administer the program; or

''(3) by phasing out the program and relying on the capital markets to fund the types of infrastructure investments assisted by this title without Federal participation.''.

SEC. 609. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM.

(a) IN GENERAL.—Part A of title XVI of the Public Health Service Act (42 U.S.C. 300q et seq.) is amended by adding at the end the following new section:

''CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM

''SEC. 1603. (a) AUTHORITY TO MAKE AND GUARANTEE LOANS.—

''(1) AUTHORITY TO MAKE LOANS.—The Secretary may make loans from the fund established under section 1602(d) to any rural entity for projects for capital improvements, including—

''(A) the acquisition of land necessary for the capital improvements;

''(B) the renovation or modernization of any building;

''(C) the acquisition or repair of fixed or major movable equipment; and

''(D) such other project expenses as the Secretary determines appropriate.

''(2) AUTHORITY TO GUARANTEE LOANS.—

''(A) IN GENERAL.—The Secretary may guarantee the payment of principal and interest for loans made to rural entities for projects for any capital improvement described in paragraph (1) to any non-Federal lender.

''(B) INTEREST SUBSIDIES.—In the case of a guarantee of any loan made to a rural entity under subparagraph (A), the Secretary may pay to the holder of such loan, for and on behalf of the project for which the loan was made, amounts sufficient to reduce (by not more than 3 percent) the net effective interest rate otherwise payable on such loan.

''(b) AMOUNT OF LOAN.—The principal amount of a loan directly made or guaranteed under subsection (a) for a project for capital improvement may not exceed $5,000,000.

''(c) FUNDING LIMITATIONS.—

''(1) GOVERNMENT CREDIT SUBSIDY EXPOSURE.—The total of the Government credit subsidy exposure under the Credit Reform Act of 1990 scoring protocol with respect to the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, under subsection (a) may not exceed $50,000,000 per year.

''(2) TOTAL AMOUNTS.—Subject to paragraph (1), the total of the principal amount of all loans directly made or guaranteed under subsection (a) may not exceed $250,000,000 per year.

''(d) CAPITAL ASSESSMENT AND PLANNING GRANTS.—

''(1) NONREPAYABLE GRANTS.—Subject to paragraph (2), the Secretary may make a grant to a rural entity, in an amount not to exceed $50,000, for purposes of capital assessment and business planning.

''(2) LIMITATION.—The cumulative total of grants awarded under this subsection may not exceed $2,500,000 per year.

''(e) TERMINATION OF AUTHORITY.—The Secretary may not directly make or guarantee any loan under subsection (a) or make a grant under subsection (d) after September 30, 2008.''.

(b) RURAL ENTITY DEFINED.—Section 1624 of the Public Health Service Act (42 U.S.C. 300s–3) is amended by adding at the end the following new paragraph:

''(14)(A) The term 'rural entity' includes—

''(i) a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act;

''(ii) any medical facility with at least 1 bed, but with less than 50 beds, that is located in—

''(I) a county that is not part of a metropolitan statistical area; or

''(II) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725));

''(iii) a hospital that is classified as a rural, regional, or national referral center under section 1886(d)(5)(C) of the Social Security Act; and

''(iv) a hospital that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of the Social Security Act).

''(B) For purposes of subparagraph (A), the fact that a clinic, facility, or hospital has been geographically reclassified under the medicare program under title XVIII of the Social Security Act shall not preclude a hospital from being considered a rural entity under clause (i) or (ii) of subparagraph (A).''.

(c) CONFORMING AMENDMENTS.—Section 1602 of the Public Health Service Act (42 U.S.C. 300q–2) is amended—

(1) in subsection (b)(2)(D), by inserting ''or 1603(a)(2)(B)'' after ''1601(a)(2)(B)''; and

(2) in subsection (d)—

(A) in paragraph (1)(C), by striking ''section 1601(a)(2)(B)'' and inserting ''sections 1601(a)(2)(B) and 1603(a)(2)(B)''; and

(B) in paragraph (2)(A), by inserting ''or 1603(a)(2)(B)'' after ''1601(a)(2)(B)''.

SEC. 610. FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, $250,000,000 for each of fiscal years 2005 through 2008, for the purpose of making allotments under this section to States described in paragraph (1) or (2) of subsection (b). Funds appropriated under the preceding sentence shall remain available until expended.

(b) STATE ALLOTMENTS.—

(1) BASED ON PERCENTAGE OF UNDOCUMENTED ALIENS.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $167,000,000 of such amount to make allotments for such fiscal year in accordance with subparagraph (B).

(B) FORMULA.—The amount of the allotment for each State for a fiscal year shall be equal to the product of—

(i) the total amount available for allotments under this paragraph for the fiscal year; and

(ii) the percentage of undocumented aliens residing in the State with respect to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSION STATES.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $83,000,000 of such amount to make allotments for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

(B) DETERMINATION OF ALLOTMENTS.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall bear the same ratio to the total amount available for allotments under this paragraph for the fiscal year as the ratio of the number of undocumented alien apprehensions in the State in that fiscal year bears to the total of such numbers for all such States for such fiscal year.

(C) DATA.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the 4 most recent quarterly apprehension rates for undocumented aliens in such States, as reported by the Immigration and Naturalization Service.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a State that is described in both of paragraphs (1) and (2) from receiving an allotment under both paragraphs for a fiscal year.

(c) USE OF FUNDS.—

(1) AUTHORITY TO MAKE PAYMENTS.—From the allotments made for a State under subsection (b) for a fiscal year, the Secretary shall pay directly to local governments, hospitals, or other providers located in the State (including providers of services received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization) that provide uncompensated emergency health services furnished to undocumented aliens during that fiscal year, and to the State, such amounts (subject to the total amount available from such allotments) as the local governments, hospitals, providers, or State demonstrate were incurred for the provision of such services during that fiscal year.

(2) LIMITATION ON STATE USE OF FUNDS.—Funds paid to a State from allotments made under subsection (b) for a fiscal year may only be used for making payments to local governments, hospitals, or other providers for costs incurred in providing emergency health services to undocumented aliens or for State costs incurred with respect to the provision of emergency health services to such aliens.

(3) INCLUSION OF COSTS INCURRED WITH RESPECT TO CERTAIN ALIENS.—Uncompensated emergency health services furnished to aliens who have been allowed to enter the United States for the sole purpose of receiving emergency health services may be included in the determination of costs incurred by a State, local government, hospital, or other provider with respect to the provision of such services.

(d) APPLICATIONS; ADVANCE PAYMENTS.—

(1) DEADLINE FOR ESTABLISHMENT OF APPLICATION PROCESS.—

(A) IN GENERAL.—Not later than September 1, 2004, the Secretary shall establish a process under which States, local governments, hospitals, or other providers located in the State may apply for payments from allotments made under subsection (b) for a fiscal year for uncompensated emergency health services furnished to undocumented aliens during that fiscal year.

(B) INCLUSION OF MEASURES TO COMBAT FRAUD.—The Secretary shall include in the process established under subparagraph (A) measures to ensure that fraudulent payments are not made from the allotments determined under subsection (b).

(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The process established under paragraph (1) shall allow for making payments under this section for each quarter of a fiscal year on the basis of advance estimates of expenditures submitted by applicants for such payments and such other investigation as the Secretary may find necessary, and for making reductions or increases in the payments as necessary to adjust for any overpayment or underpayment for prior quarters of such fiscal year.

(e) DEFINITIONS.—In this section:

(1) HOSPITAL.—The term ''hospital'' has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)).

(2) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms ''Indian tribe'' and ''tribal organization'' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(3) PROVIDER.—The term ''provider'' includes a physician, any other health care professional licensed under State law, and any other entity that furnishes emergency health services, including ambulance services.

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

(5) STATE.—The term ''State'' means the 50 States and the District of Columbia.

SEC. 611. INCREASE IN APPROPRIATION TO THE HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.

Section 1817(k)(3)(A) (42 U.S.C. 1395i(k)(3)(A)) is amended—

(1) in clause (i)—

(A) in subclause (II), by striking ''and'' at the end; and

(B) by striking subclause (III), and inserting the following new subclauses:

''(III) for fiscal year 2004, the limit for fiscal year 2003 increased by $10,000,000;

''(IV) for fiscal year 2005, the limit for fiscal year 2003 increased by $15,000,000;

''(V) for fiscal year 2006, the limit for fiscal year 2003 increased by $25,000,000; and

''(VI) for each fiscal year after fiscal year 2006, the limit for fiscal year 2003.''; and

(2) in clause (ii)—

(A) in subclause (VI), by striking ''and'' at the end;

(B) in subclause (VII)—

(i) by striking ''each fiscal year after fiscal year 2002'' and inserting ''fiscal year 2003''; and

(ii) by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

''(VIII) for fiscal year 2004, $170,000,000;

''(IX) for fiscal year 2005, $175,000,000;

''(X) for fiscal year 2006, $185,000,000; and

''(XI) for each fiscal year after fiscal year 2006, not less than $150,000,000 and not more than $160,000,000.''.

SEC. 612. INCREASE IN CIVIL PENALTIES UNDER THE FALSE CLAIMS ACT.

(a) IN GENERAL.—Section 3729(a) of title 31, United States Code, is amended—

(1) by striking ''$5,000'' and inserting ''$7,500''; and

(2) by striking ''$10,000'' and inserting ''$15,000''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations occurring on or after January 1, 2004.

SEC. 613. INCREASE IN CIVIL MONETARY PENALTIES UNDER THE SOCIAL SECURITY ACT.

(a) IN GENERAL.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), in the matter following paragraph (7), is amended—

(1) by striking ''$10,000'' each place it appears and inserting ''$12,500'';

(2) by striking ''$15,000'' and inserting ''$18,750''; and

(3) striking ''$50,000'' and inserting ''$62,500''.

(b) EFFECTIVE DATE.—The amendments made by subsection (a) shall apply to violations occurring on or after January 1, 2004.

TITLE VII—ACCESS TO AFFORDABLE PHARMACEUTICALS

SEC. 701. SHORT TITLE.

This title may be cited as the ''Greater Access to Affordable Pharmaceuticals Act''.

SEC. 702. 30-MONTH STAY-OF-EFFECTIVENESS PERIOD.

(a) ABBREVIATED NEW DRUG APPLICATIONS.—Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended—

(1) in paragraph (2), by striking subparagraph (B) and inserting the following:

''(B) NOTICE OF OPINION THAT PATENT IS NOT VALID OR WILL NOT BE INFRINGED.—

''(i) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall include in the application a statement that the applicant will give notice as required by this subparagraph.

''(ii) TIMING OF NOTICE.—An applicant that makes a certification described in subparagraph (A)(vii)(IV) shall give notice as required under this subparagraph—

''(I) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

''(II) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

''(iii) RECIPIENTS OF NOTICE.—An applicant required under this subparagraph to give notice shall give notice to—

''(I) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

''(II) the holder of the approved application under subsection (b) for the drug that is

claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

''(iv) CONTENTS OF NOTICE.—A notice required under this subparagraph shall—

''(I) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

''(II) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is not valid or will not be infringed.''; and

(2) in paragraph (5)—

(A) in subparagraph (B)—

(i) by striking ''under the following'' and inserting ''by applying the following to each certification made under paragraph (2)(A)(vii)''; and

(ii) in clause (iii)—

(I) in the first sentence, by striking ''unless'' and all that follows and inserting ''unless, before the expiration of 45 days after the date on which the notice described in paragraph (2)(B) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under subsection (b)(1) or (c)(2) before the date on which the application (excluding an amendment or supplement to the application), which the Secretary later determines is substantially complete, was submitted.''; and

(II) in the second sentence—

(aa) by striking subclause (I) and inserting the following:

''(I) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

''(aa) the date on which the court enters judgment reflecting the decision; or

''(bb) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;'';

(bb) by striking subclause (II) and inserting the following:

''(II) if before the expiration of such period the district court decides that the patent has been infringed—

''(aa) if the judgment of the district court is appealed, the approval shall be made effective on—

''(AA) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

''(BB) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

''(bb) if the judgment of the district court is not appealed or is affirmed, the approval shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;'';

(cc) in subclause (III), by striking ''on the date of such court decision.'' and inserting ''as provided in subclause (I); or''; and

(dd) by inserting after subclause (III) the following:

''(IV) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in subclause (II).'';

(B) by redesignating subparagraphs (C) and (D) as subparagraphs (E) and (F), respectively; and

(C) by inserting after subparagraph (B) the following:

''(C) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

''(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent does not bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice given under paragraph (2)(B) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval.

''(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—

''(I) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or (c) on the ground that the patent does not claim either—

''(aa) the drug for which the application was approved; or

''(bb) an approved method of using the drug.

''(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

''(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under subparagraph (i) or a counterclaim under subparagraph (ii).''.

(b) APPLICATIONS GENERALLY.—Section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) is amended—

(1) in subsection (b), by striking paragraph (3) and inserting the following:

''(3) NOTICE OF OPINION THAT PATENT IS NOT VALID OR WILL NOT BE INFRINGED.—

''(A) AGREEMENT TO GIVE NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall include in the application a statement that the applicant will give notice as required by this paragraph.

''(B) TIMING OF NOTICE.—An applicant that makes a certification described in paragraph (2)(A)(iv) shall give notice as required under this paragraph—

''(i) if the certification is in the application, not later than 20 days after the date of the postmark on the notice with which the Secretary informs the applicant that the application has been filed; or

''(ii) if the certification is in an amendment or supplement to the application, at the time at which the applicant submits the amendment or supplement, regardless of whether the applicant has already given notice with respect to another such certification contained in the application or in an amendment or supplement to the application.

''(C) RECIPIENTS OF NOTICE.—An applicant required under this paragraph to give notice shall give notice to—

''(i) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

''(ii) the holder of the approved application under this subsection for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

''(D) CONTENTS OF NOTICE.—A notice required under this paragraph shall—

''(i) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

''(ii) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is not valid or will not be infringed.''; and

(2) in subsection (c)(3)—

(A) in the first sentence, by striking ''under the following'' and inserting ''by applying the following to each certification made under subsection (b)(2)(A)(iv)'';

(B) in subparagraph (C)—

(i) in the first sentence, by striking ''unless'' and all that follows and inserting ''unless, before the expiration of 45 days after the date on which the notice described in subsection (b)(3) is received, an action is brought for infringement of the patent that is the subject of the certification and for which information was submitted to the Secretary under paragraph (2) or subsection (b)(1) before the date on which the application (excluding an amendment or supplement to the application) was submitted.'';

(ii) in the second sentence—

(I) by striking ''paragraph (3)(B)'' and inserting ''subsection (b)(3)'';

(II) by striking clause (i) and inserting the following:

''(i) if before the expiration of such period the district court decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity), the approval shall be made effective on—

''(I) the date on which the court enters judgment reflecting the decision; or

''(II) the date of a settlement order or consent decree signed and entered by the court stating that the patent that is the subject of the certification is invalid or not infringed;'';

(III) by striking clause (ii) and inserting the following:

''(ii) if before the expiration of such period the district court decides that the patent has been infringed—

''(I) if the judgment of the district court is appealed, the approval shall be made effective on—

''(aa) the date on which the court of appeals decides that the patent is invalid or not infringed (including any substantive determination that there is no cause of action for patent infringement or invalidity); or

''(bb) the date of a settlement order or consent decree signed and entered by the court of appeals stating that the patent that is the subject of the certification is invalid or not infringed; or

''(II) if the judgment of the district court is not appealed or is affirmed, the approval

shall be made effective on the date specified by the district court in a court order under section 271(e)(4)(A) of title 35, United States Code;'';

(IV) in clause (iii), by striking ''on the date of such court decision.'' and inserting ''as provided in clause (i); or''; and

(V) by inserting after clause (iii), the following:

''(iv) if before the expiration of such period the court grants a preliminary injunction prohibiting the applicant from engaging in the commercial manufacture or sale of the drug until the court decides the issues of patent validity and infringement and if the court decides that such patent has been infringed, the approval shall be made effective as provided in clause (ii).''; and

(iii) in the third sentence, by striking ''paragraph (3)(B)'' and inserting ''subsection (b)(3)'';

(C) by redesignating subparagraph (D) as subparagraph (E); and

(D) by inserting after subparagraph (C) the following:

''(D) CIVIL ACTION TO OBTAIN PATENT CERTAINTY.—

''(i) DECLARATORY JUDGMENT ABSENT INFRINGEMENT ACTION.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent does not bring a civil action against the applicant for infringement of the patent on or before the date that is 45 days after the date on which the notice given under subsection (b)(3) was received, the applicant may bring a civil action against the owner or holder (but not against any owner or holder that has brought such a civil action against that applicant, unless that civil action was dismissed without prejudice) for a declaratory judgment under section 2201 of title 28, United States Code, that the patent is invalid or will not be infringed by the drug for which the applicant seeks approval.

''(ii) COUNTERCLAIM TO INFRINGEMENT ACTION.—

''(I) IN GENERAL.—If an owner of the patent or the holder of the approved application under subsection (b) for the drug that is claimed by the patent or a use of which is claimed by the patent brings a patent infringement action against the applicant, the applicant may assert a counterclaim seeking an order requiring the holder to correct or delete the patent information submitted by the holder under subsection (b) or this subsection on the ground that the patent does not claim either—

''(aa) the drug for which the application was approved; or

''(bb) an approved method of using the drug.

''(II) NO INDEPENDENT CAUSE OF ACTION.—Subclause (I) does not authorize the assertion of a claim described in subclause (I) in any civil action or proceeding other than a counterclaim described in subclause (I).

''(iii) NO DAMAGES.—An applicant shall not be entitled to damages in a civil action under clause (i) or a counterclaim under clause (ii).''.

(c) INFRINGEMENT ACTIONS.—Section 271(e) of title 35, United States Code, is amended by adding at the end the following:

''(5) The filing of an application described in paragraph (2) that includes a certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355), and the failure of the owner of the patent to bring an action for infringement of a patent that is the subject of the certification before the expiration of 45 days after the date on which the notice given under subsection (b)(3) or (j)(2)(B) of that section is received, shall establish an actual controversy between the applicant and the patent owner sufficient to confer subject matter jurisdiction in the courts of the United States in any action brought by the applicant under section 2201 of title 28 for a declaratory judgment that any patent that is the subject of the certification is invalid or not infringed.''.

(d) APPLICABILITY.—

(1) IN GENERAL.—Except as provided in paragraphs (2) and (3), the amendments made by subsections (a), (b), and (c) apply to any proceeding under section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) that is pending on or after the date of enactment of this Act regardless of the date on which the proceeding was commenced or is commenced.

(2) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—The amendments made by subsections (a)(1) and (b)(1) apply with respect to any certification under subsection (b)(2)(A)(iv) or (j)(2)(A)(vii)(IV) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) after the date of enactment of this Act in an application filed under subsection (b)(2) or (j) of that section or in an amendment or supplement to an application filed under subsection (b)(2) or (j) of that section.

(3) EFFECTIVE DATE OF APPROVAL.—The amendments made by subsections (a)(2)(A)(ii)(I) and (b)(2)(B)(i) apply with respect to any patent information submitted under subsection (b)(1) or (c)(2) of section 505 of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355) made after the date of enactment of this Act.

SEC. 703. FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.

(a) IN GENERAL.—Section 505(j)(5) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)) (as amended by section ____02) is amended—

(1) in subparagraph (B), by striking clause (iv) and inserting the following:

''(iv) 180-DAY EXCLUSIVITY PERIOD.—

''(I) DEFINITIONS.—In this paragraph:

''(aa) 180-DAY EXCLUSIVITY PERIOD.—The term '180-day exclusivity period' means the 180-day period ending on the day before the date on which an application submitted by an applicant other than a first applicant could become effective under this clause.

''(bb) FIRST APPLICANT.—The term 'first applicant' means an applicant that, on the first day on which a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) is submitted for approval of a drug, submits a substantially complete application containing a certification described in paragraph (2)(A)(vii)(IV) for the drug.

''(cc) SUBSTANTIALLY COMPLETE APPLICATION.—The term 'substantially complete application' means an application under this subsection that on its face is sufficiently complete to permit a substantive review and contains all the information required by paragraph (2)(A).

''(dd) TENTATIVE APPROVAL.—

''(AA) IN GENERAL.—The term 'tentative approval' means notification to an applicant by the Secretary that an application under this subsection meets the requirements of paragraph (2)(A), but cannot receive effective approval because the application does not meet the requirements of this subparagraph, there is a period of exclusivity for the listed drug under subparagraph (E) or section 505A, or there is a 7-year period of exclusivity for the listed drug under section 527.

''(BB) LIMITATION.—A drug that is granted tentative approval by the Secretary is not an approved drug and shall not have an effective approval until the Secretary issues an approval after any necessary additional review of the application.

''(II) EFFECTIVENESS OF APPLICATION.—Subject to subparagraph (D), if the application contains a certification described in paragraph (2)(A)(vii)(IV) and is for a drug for which a first applicant has submitted an application containing such a certification, the application shall be made effective on the date that is 180 days after the date of the first commercial marketing of the drug (including the commercial marketing of the listed drug) by any first applicant.''; and

(2) by inserting after subparagraph (C) the following:

''(D) FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.—

''(i) DEFINITION OF FORFEITURE EVENT.—In this subparagraph, the term 'forfeiture event', with respect to an application under this subsection, means the occurrence of any of the following:

''(I) FAILURE TO MARKET.—The first applicant fails to market the drug by the later of—

''(aa) the earlier of the date that is—

''(AA) 75 days after the date on which the approval of the application of the first applicant is made effective under subparagraph (B)(iii); or

''(BB) 30 months after the date of submission of the application of the first applicant; or

''(bb) with respect to the first applicant or any other applicant (which other applicant has received tentative approval), the date that is 75 days after the date as of which, as to each of the patents with respect to which the first applicant submitted a certification qualifying the first applicant for the 180-day exclusivity period under subparagraph (B)(iv), at least 1 of the following has occurred:

''(AA) In an infringement action brought against that applicant with respect to the patent or in a declaratory judgment action brought by that applicant with respect to the patent, a court enters a final decision from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the patent is invalid or not infringed.

''(BB) In an infringement action or a declaratory judgment action described in subitem (AA), a court signs a settlement order or consent decree that enters a final judgment that includes a finding that the patent is invalid or not infringed.

''(CC) The patent expires.

''(DD) The patent is withdrawn by the holder of the application approved under subsection (b).

''(II) WITHDRAWAL OF APPLICATION.—The first applicant withdraws the application or the Secretary considers the application to have been withdrawn as a result of a determination by the Secretary that the application does not meet the requirements for approval under paragraph (4).

''(III) AMENDMENT OF CERTIFICATION.—The first applicant amends or withdraws the certification for all of the patents with respect to which that applicant submitted a certification qualifying the applicant for the 180-day exclusivity period.

''(IV) FAILURE TO OBTAIN TENTATIVE APPROVAL.—The first applicant fails to obtain tentative approval of the application within 30 months after the date on which the application is filed, unless the failure is caused by a change in or a review of the requirements for approval of the application imposed after the date on which the application is filed.

''(V) AGREEMENT WITH ANOTHER APPLICANT, THE LISTED DRUG APPLICATION HOLDER, OR A PATENT OWNER.—The first applicant enters into an agreement with another applicant under this subsection for the drug, the holder of the application for the listed drug, or

an owner of the patent that is the subject of the certification under paragraph (2)(A)(vii)(IV), the Federal Trade Commission or the Attorney General files a complaint, and there is a final decision of the Federal Trade Commission or the court with regard to the complaint from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the agreement has violated the antitrust laws (as defined in section 1 of the Clayton Act (15 U.S.C. 12), except that the term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that that section applies to unfair methods of competition).

''(VI) EXPIRATION OF ALL PATENTS.—All of the patents as to which the applicant submitted a certification qualifying it for the 180-day exclusivity period have expired.

''(ii) FORFEITURE.—The 180-day exclusivity period described in subparagraph (B)(iv) shall be forfeited by a first applicant if a forfeiture event occurs with respect to that first applicant.

''(iii) SUBSEQUENT APPLICANT.—If all first applicants forfeit the 180-day exclusivity period under clause (ii)—

''(I) approval of any application containing a certification described in paragraph (2)(A)(vii)(IV) shall be made effective in accordance with subparagraph (B)(iii); and

''(II) no applicant shall be eligible for a 180-day exclusivity period.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in paragraph (2), the amendment made by subsection (a) shall be effective only with respect to an application filed under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) after the date of enactment of this Act for a listed drug for which no certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act.

(2) COLLUSIVE AGREEMENTS.—If a forfeiture event described in section 505(j)(5)(D)(i)(V) of that Act occurs in the case of an applicant, the applicant shall forfeit the 180-day period under section 505(j)(5)(B)(iv) of that Act without regard to when the first certification under section 505(j)(2)(A)(vii)(IV) of that Act for the listed drug was made.

(3) DECISION OF A COURT WHEN THE 180-DAY EXCLUSIVITY PERIOD HAS NOT BEEN TRIGGERED.—With respect to an application filed before, on, or after the date of enactment of this Act for a listed drug for which a certification under section 505(j)(2)(A)(vii)(IV) of that Act was made before the date of enactment of this Act and for which neither of the events described in subclause (I) or (II) of section 505(j)(5)(B)(iv) of that Act (as in effect on the day before the date of enactment of this Act) has occurred on or before the date of enactment of this Act, the term ''decision of a court'' as used in clause (iv) of section 505(j)(5)(B) of that Act means a final decision of a court from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken.

SEC. 704. BIOAVAILABILITY AND BIOEQUIVALENCE.

(a) IN GENERAL.—Section 505(j)(8) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(8)) is amended—

(1) by striking subparagraph (A) and inserting the following:

''(A)(i) The term 'bioavailability' means the rate and extent to which the active ingredient or therapeutic ingredient is absorbed from a drug and becomes available at the site of drug action.

''(ii) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may assess bioavailability by scientifically valid measurements intended to reflect the rate and extent to which the active ingredient or therapeutic ingredient becomes available at the site of drug action.''; and

(2) by adding at the end the following:

''(C) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may establish alternative, scientifically valid methods to show bioequivalence if the alternative methods are expected to detect a significant difference between the drug and the listed drug in safety and therapeutic effect.''.

(b) EFFECT OF AMENDMENT.—The amendment made by subsection (a) does not alter the standards for approval of drugs under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

SEC. 705. REMEDIES FOR INFRINGEMENT.

Section 287 of title 35, United States Code, is amended by adding at the end the following:

''(d) CONSIDERATION.—In making a determination with respect to remedy brought for infringement of a patent that claims a drug or a method or using a drug, the court shall consider whether information on the patent was filed as required under 21 U.S.C. 355 (b) or (c), and, if such information was required to be filed but was not, the court may refuse to award treble damages under section 284.''.

SEC. 706. CONFORMING AMENDMENTS.

Section 505A of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355a) is amended—

(1) in subsections (b)(1)(A)(i) and (c)(1)(A)(i), by striking ''(j)(5)(D)(ii)'' each place it appears and inserting ''(j)(5)(F)(ii)'';

(2) in subsections (b)(1)(A)(ii) and (c)(1)(A)(ii), by striking ''(j)(5)(D)'' each place it appears and inserting ''(j)(5)(F)''; and

(3) in subsections (e) and (l), by striking ''505(j)(5)(D)'' each place it appears and inserting ''505(j)(5)(F)''.

TITLE VIII—IMPORTATION OF PRESCRIPTION DRUGS

SEC. 801. IMPORTATION OF PRESCRIPTION DRUGS.

(A) IN GENERAL.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 804 and inserting the following:

''SEC. 804. IMPORTATION OF PRESCRIPTION DRUGS.

''(a) DEFINITIONS.—In this section:

''(1) IMPORTER.—The term 'importer' means a pharmacist or wholesaler.

''(2) PHARMACIST.—The term 'pharmacist' means a person licensed by a State to practice pharmacy, including the dispensing and selling of prescription drugs.

''(3) PRESCRIPTION DRUG.—The term 'prescription drug' means a drug subject to section 503(b), other than—

''(A) a controlled substance (as defined in section 102 of the Controlled Substances Act (21 U.S.C. 802));

''(B) a biological product (as defined in section 351 of the Public Health Service Act (42 U.S.C. 262));

''(C) an infused drug (including a peritoneal dialysis solution);

''(D) an intravenously injected drug; or

''(E) a drug that is inhaled during surgery.

''(4) QUALIFYING LABORATORY.—The term 'qualifying laboratory' means a laboratory in the United States that has been approved by the Secretary for the purposes of this section.

''(5) WHOLESALER.—

''(A) IN GENERAL.—The term 'wholesaler' means a person licensed as a wholesaler or distributor of prescription drugs in the United States under section 503(e)(2)(A).

''(B) EXCLUSION.—The term 'wholesaler' does not include a person authorized to import drugs under section 801(d)(1).

''(b) REGULATIONS.—The Secretary, after consultation with the United States Trade Representative and the Commissioner of Customs, shall promulgate regulations permitting pharmacists and wholesalers to import prescription drugs from Canada into the United States.

''(c) LIMITATION.—The regulations under subsection (b) shall—

''(1) require that safeguards be in place to ensure that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug), with sections 501 and 502, and with other applicable requirements of this Act;

''(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e); and

''(3) contain any additional provisions determined by the Secretary to be appropriate as a safeguard to protect the public health or as a means to facilitate the importation of prescription drugs.

''(d) INFORMATION AND RECORDS.—

''(1) IN GENERAL.—The regulations under subsection (b) shall require an importer of a prescription drug under subsection (b) to submit to the Secretary the following information and documentation:

''(A) The name and quantity of the active ingredient of the prescription drug.

''(B) A description of the dosage form of the prescription drug.

''(C) The date on which the prescription drug is shipped.

''(D) The quantity of the prescription drug that is shipped

''(E) The point of origin and destination of the prescription drug.

''(F) The price paid by the importer for the prescription drug.

''(G) Documentation from the foreign seller specifying—

''(i) the original source of the prescription drug; and

''(ii) the quantity of each lot of the prescription drug originally received by the seller from that source.

''(H) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

''(I) The name, address, telephone number, and professional license number (if any) of the importer.

''(J)(i) In the case of a prescription drug that is shipped directly from the first foreign recipient of the prescription drug from the manufacturer:

''(I) Documentation demonstrating that the prescription drug was received by the recipient from the manufacturer and subsequently shipped by the first foreign recipient to the importer.

''(II) Documentation of the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity being imported into the United States is not more than the quantity that was received by the first foreign recipient.

''(III)(aa) In the case of an initial imported shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested for authenticity and degradation.

''(bb) In the case of any subsequent shipment, documentation demonstrating that a statistically valid sample of the shipment was tested for authenticity and degradation.

''(ii) In the case of a prescription drug that is not shipped directly from the first foreign recipient of the prescription drug from the manufacturer, documentation demonstrating that each batch in each shipment offered for importation into the United States was statistically sampled and tested for authenticity and degradation.

''(K) Certification from the importer or manufacturer of the prescription drug that the prescription drug—

''(i) is approved for marketing in the United States; and

''(ii) meets all labeling requirements under this Act.

''(L) Laboratory records, including complete data derived from all tests necessary to ensure that the prescription drug is in compliance with established specifications and standards.

''(M) Documentation demonstrating that the testing required by subparagraphs (J) and (L) was conducted at a qualifying laboratory.

''(N) Any other information that the Secretary determines is necessary to ensure the protection of the public health.

''(2) MAINTENANCE BY THE SECRETARY.—The Secretary shall maintain information and documentation submitted under paragraph (1) for such period of time as the Secretary determines to be necessary.

''(e) TESTING.—The regulations under subsection (b) shall require—

''(1) that testing described in subparagraphs (J) and (L) of subsection (d)(1) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory;

''(2) if the tests are conducted by the importer—

''(A) that information needed to—

''(i) authenticate the prescription drug being tested; and

''(ii) confirm that the labeling of the prescription drug complies with labeling requirements under this Act;

be supplied by the manufacturer of the prescription drug to the pharmacist or wholesaler; and

''(B) that the information supplied under subparagraph (A) be kept in strict confidence and used only for purposes of testing or otherwise complying with this Act; and

''(3) may include such additional provisions as the Secretary determines to be appropriate to provide for the protection of trade secrets and commercial or financial information that is privileged or confidential.

''(f) REGISTRATION OF FOREIGN SELLERS.—Any establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment.

''(g) SUSPENSION OF IMPORTATION.—The Secretary shall require that importations of a specific prescription drug or importations by a specific importer under subsection (b) be immediately suspended on discovery of a pattern of importation of that specific prescription drug or by that specific importer of drugs that are counterfeit or in violation of any requirement under this section, until an investigation is completed and the Secretary determines that the public is adequately protected from counterfeit and violative prescription drugs being imported under subsection (b).

''(h) APPROVED LABELING.—The manufacturer of a prescription drug shall provide an importer written authorization for the importer to use, at no cost, the approved labeling for the prescription drug.

''(i) PROHIBITION OF DISCRIMINATION.—

''(1) IN GENERAL.—It shall be unlawful for a manufacturer of a prescription drug to discriminate against, or cause any other person to discriminate against, a pharmacist or wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the drug manufacturer.

''(2) DISCRIMINATION.—For the purposes of paragraph (1), a manufacturer of a prescription drug shall be considered to discriminate against a pharmacist or wholesaler if the manufacturer enters into a contract for sale of a prescription drug, places a limit on supply, or employs any other measure, that has the effect of—

''(A) providing pharmacists or wholesalers access to prescription drugs on terms or conditions that are less favorable than the terms or conditions provided to a foreign purchaser (other than a charitable or humanitarian organization) of the prescription drug; or

''(B) restricting the access of pharmacists or wholesalers to a prescription drug that is permitted to be imported into the United States under this section.

''(j) CHARITABLE CONTRIBUTIONS.—Notwithstanding any other provision of this section, section 801(d)(1) continues to apply to a prescription drug that is donated or otherwise supplied at no charge by the manufacturer of the drug to a charitable or humanitarian organization (including the United Nations and affiliates) or to a government of a foreign country.

''(k) WAIVER AUTHORITY FOR IMPORTATION BY INDIVIDUALS.—

''(1) DECLARATIONS.—Congress declares that in the enforcement against individuals of the prohibition of importation of prescription drugs and devices, the Secretary should—

''(A) focus enforcement on cases in which the importation by an individual poses a significant threat to public health; and

''(B) exercise discretion to permit individuals to make such importations in circumstances in which—

''(i) the importation is clearly for personal use; and

''(ii) the prescription drug or device imported does not appear to present an unreasonable risk to the individual.

''(2) WAIVER AUTHORITY.—

''(A) IN GENERAL.—The Secretary may grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition of importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate.

''(B) GUIDANCE ON CASE-BY-CASE WAIVERS.—The Secretary shall publish, and update as necessary, guidance that accurately describes circumstances in which the Secretary will consistently grant waivers on a case-by-case basis under subparagraph (A), so that individuals may know with the greatest practicable degree of certainty whether a particular importation for personal use will be permitted.

''(3) DRUGS IMPORTED FROM CANADA.—In particular, the Secretary shall by regulation grant individuals a waiver to permit individuals to import into the United States a prescription drug that—

''(A) is imported from a licensed pharmacy for personal use by an individual, not for resale, in quantities that do not exceed a 90-day supply;

''(B) is accompanied by a copy of a valid prescription;

''(C) is imported from Canada, from a seller registered with the Secretary;

''(D) is a prescription drug approved by the Secretary under chapter V;

''(E) is in the form of a final finished dosage that was manufactured in an establishment registered under section 510; and

''(F) is imported under such other conditions as the Secretary determines to be necessary to ensure public safety.

''(l) STUDIES; REPORTS.—

''(1) BY THE INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES.—

''(A) STUDY.—

''(i) IN GENERAL.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct a study of—

''(I) importations of prescription drugs made under the regulations under subsection (b); and

''(II) information and documentation submitted under subsection (d).

''(ii) REQUIREMENTS.—In conducting the study, the Institute of Medicine shall—

''(I) evaluate the compliance of importers with the regulations under subsection (b);

''(II) compare the number of shipments under the regulations under subsection (b) during the study period that are determined to be counterfeit, misbranded, or adulterated, and compare that number with the number of shipments made during the study period within the United States that are determined to be counterfeit, misbranded, or adulterated; and

''(III) consult with the Secretary, the United States Trade Representative, and the Commissioner of Patents and Trademarks to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under Federal law.

''(B) REPORT.—Not later than 2 years after the effective date of the regulations under subsection (b), the Institute of Medicine shall submit to Congress a report describing the findings of the study under subparagraph (A).

''(2) BY THE COMPTROLLER GENERAL.—

''(A) STUDY..—he Comptroller General of the United States shall conduct a study to determine the effect of this section on the price of prescription drugs sold to consumers at retail.

''(B) REPORT.—Not later than 18 months after the effective date of the regulations under subsection (b), the Comptroller General of the United States shall submit to Congress a report describing the findings of the study under subparagraph (A).

''(m) CONSTRUCTION.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

''(n) EFFECTIVENESS OF SECTION.—

''(1) IN GENERAL.—If, after the date that is 1 year after the effective date of the regulations under subsection (b) and before the date that is 18 months after the effective date, the Secretary submits to Congress a certification that, in the opinion of the Secretary, based on substantial evidence obtained after the effective date, the benefits of implementation of this section do not outweigh any detriment of implementation of this section, this section shall cease to be effective as of the date that is 30 days after the date on which the Secretary submits the certification.

''(2) PROCEDURE.—The Secretary shall not submit a certification under paragraph (1) unless, after a hearing on the record under sections 556 and 557 of title 5, United States Code, the Secretary—

''(A)(i) determines that it is more likely than not that implementation of this section would result in an increase in the risk to the public health and safety;

''(ii) identifies specifically, in qualitative and quantitative terms, the nature of the increased risk;

''(iii) identifies specifically the causes of the increased risk; and

''(iv)(I) considers whether any measures can be taken to avoid, reduce, or mitigate the increased risk; and

''(II) if the Secretary determines that any measures described in subclause (I) would require additional statutory authority, submits to Congress a report describing the legislation that would be required;

''(B) identifies specifically, in qualitative and quantitative terms, the benefits that would result from implementation of this section (including the benefit of reductions in the cost of covered products to consumers in the United States, allowing consumers to procure needed medication that consumers might not otherwise be able to procure without foregoing other necessities of life); and

''(C)(i) compares in specific terms the detriment identified under subparagraph (A) with the benefits identified under subparagraph (B); and

''(ii) determines that the benefits do not outweigh the detriment.

''(o) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.''.

(b) CONFORMING AMENDMENTS.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301(aa) (21 U.S.C. 331(aa)), by striking ''covered product in violation of section 804'' and inserting ''prescription drug in violation of section 804''; and

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6), by striking ''covered product pursuant to section 804(a)'' and inserting ''prescription drug under section 804(b)''.

TITLE IX—OFFSET

SEC. 901. INCREASE IN MEDICAID BEST PRICE REBATE PERCENTAGE.

Section 1927(c)(1)(B)(i) (42 U.S.C. 1396r–8(c)(1)(B)(i)) is amended—

(1) in subclause (IV), by striking ''and'' at the end;

(2) in subclause (V)—

(A) by inserting ''and before January 1, 2004,'' after ''December 31, 1995,''; and

(B) by striking the period at the end and inserting ''; and''; and

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

''(V) after December 31, 2003, is 20 percent.''.

Make such changes in subsidy payments to employers under 1860D–21, as added by section 101, to ensure that the total cost of this Act does not exceed $393,000,000,000 during the 10-fiscal-year period that begins on October 1, 2003.

Mr. THOMPSON of California (during the reading). Mr. Speaker, I ask unanimous consent that the motion to recommit be considered as read and printed in the RECORD.

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

There was no objection.

The SPEAKER pro tempore. The gentleman from California (Mr. THOMPSON) is recognized for 5 minutes on his motion to recommit.

Mr. THOMPSON of California. Mr. Speaker, I yield myself 1 minute.

Mr. Speaker, during tonight's debate we have heard a number of times the Democrats do not have a feasible Medicare prescription drug proposal. This is just not true. The Blue Dogs have a motion to recommit that offers a real and an affordable prescription drug alternative, and it does so without calling for an end of Medicare. And we have included strong safeguard language that specifically instructs the Secretary to keep the costs of this measure within the $400 billion budget window. The Blue Dog motion to recommit provides Medicare fallback, unlike the Republican bill, protects traditional fee for service Medicare, unlike the Republican bill, and provides billions of dollars of relief for rural providers.

Unfortunately, for America's seniors, our proposal will only get 5 minutes of discussion tonight, 5 minutes to protect Medicare from privatization, 5 minutes to ensure rural seniors have a benefit if the PPOs do not come to their areas. And for all of the Members tonight who have said they are supporting the Republican bill in order to move the debate, the best way to do that is to support this recommit so we can promptly get a measure back here in the morning to vote on.

□ 0115

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to the gentleman from Texas (Mr. STENHOLM).

Mr. STENHOLM. Mr. Speaker, I rise in humble appreciation for the 45 seconds being allowed to me tonight to speak for what I am for in Medicare and to express my extreme disappointment in the leadership of this House for bringing to the floor a bill based on an ideological agenda that will undermine the traditional Medicare program and fail to offer reliable prescription drug coverage for seniors in rural areas, or seriously address the issue of prescription drug costs.

The motion to recommit promptly reported back to the floor will have a guaranteed fallback within Medicare for rural areas if private plans are not available, stronger provisions for rural providers, stays within the $400 billion allocation which safeguards to make sure that that happens, and it is based on the compromise in the other body that will give strong bipartisan support and become law.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to the gentleman from Tennessee (Mr. TANNER).

Mr. TANNER. Mr. Speaker, I did not vote for the Democratic substitute because I thought it was too light on reform. The Republican bill is too light on substance.

Mr. Speaker, we have a middle ground here, if we were only allowed to offer it; and it is what the gentleman from Texas (Mr. STENHOLM) said. Basically, any meaningful reform in the Medicare or health care area, the crux of that matter is, one, a Federal backstop for rural America, which is not in the bill we are considering; and, two, some measure of cost containment. That is how we save the program. Neither one of these essential elements in my judgment is in the bill. If we could get this motion to recommit, we could fix it and we could come back here with strong bipartisan support.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to our colleague, the gentleman from Georgia (Mr. SCOTT).

Mr. SCOTT of Georgia. Mr. Speaker, I say to my colleagues, I plead with my colleagues to let us have this opportunity to recommit. We have had so much debate where we have talked about the cost of these plans, and I thought it was an unfair dig at my good friends, the gentleman from New York (Mr. RANGEL) and the gentleman from Michigan (Mr. DINGELL), and their bill being $1 trillion. That was not true, because there was no effort to put the cost containment in.

But we and the Blue Dogs have put together a budget; we put together a plan at $400 billion that falls right within the issue.

This is an important issue to all the people of this Nation. And here we are at 1:30 in the morning on my birthday. But I will tell my colleagues this: I could not find a better thing to do on my birthday than to be down here fighting for these seniors, that the Democratic Party has been fighting for ever since we have had a Democratic Party. I would hope that we would get this opportunity to recommit.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to our colleague, the gentleman from Vermont (Mr. SANDERS).

Mr. SANDERS. Mr. Speaker, I am not really a Blue Dog.

Mr. Speaker, the Republican proposal ignores the most important prescription drug issue facing our country: cost containment and the need to end the national disgrace by which our citizens are forced to pay, by far, the highest prices in the world for prescription drugs. If we do not pass this motion to recommit, the pharmaceutical industry will have succeeded in keeping prices high and their profits high.

This motion to recommit removes the poison pill in H.R. 1, the so-called Cochran amendment, and establishes a real prescription drug reimportation program with Canada. This provision alone, without costing the taxpayers one penny, will do more to help seniors and all Americans get affordable drugs than the $400 billion being spent by the Republicans.

Mr. THOMPSON of California. Mr. Speaker, I yield 45 seconds to our colleague, the gentleman from Illinois (Mr. EMANUEL), who is not a Blue Dog, but knows a good deal when he sees one.

Mr. EMANUEL. Mr. Speaker, the speaker earlier talked about using competition and market forces. This bill allows competition between generics versus name brand, so we get the best price. It allows us to have competition whether we want to buy here in the United States, England, France, or Germany, and allows competition between those prices. It would save money. It uses market forces to reduce prices.

Third, it allows the Secretary of HHS to get the best available price, just like all of the Sam's Clubs all over America. It does that here. It allows competition and market forces to reduce prices.

These provisions have, in the past, received bipartisan support. They should receive bipartisan support today because they represent our common

principles of reducing prices and making medications affordable to all Americans.

Mr. THOMPSON of California. Mr. Speaker, I urge this body to vote to send this motion back to committee and promptly report back a solid Medicare prescription drug benefit that we can pass tomorrow.

Mr. THOMAS. Mr. Speaker, I rise in opposition to the motion to recommit.

I do want to announce that today is the gentleman from Iowa's (Mr. NUSSLE) birthday as well.

As my colleagues know, I have a reputation for reading legislation. I apologize. As I began reading the motion to recommit, as I got to page 3, the comment of the gentleman from Vermont ringing in my ears, about how they are really concerned about cost containment.

It turns out subtitle D has been scratched from the bill, my colleagues might like to know. It contains section 131, additional requirements for annual financial report and oversight on the Medicare program. Section 132, trustee report on Medicare's unfunded obligations. That has been scratched from the bill.

And I continued to try to go through; but, actually, you only need the front page. My colleagues heard them say over and over again: ''promptly.'' We know by now: ''forthwith,'' ''it works.'' ''It comes back, we can vote on it.''

I say: promptly, it does not mean a thing.

Vote ''no'' on the motion to recommit.

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

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Without objection, the previous question is ordered on the motion to recommit.

There was no objection.

The SPEAKER pro tempore. The question is on the motion to recommit.

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

RECORDED VOTE

Mr. THOMPSON of California. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 208, noes 223, not voting 4, as follows:

[Roll No. 331]

AYES—208

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

NOES—223

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

NOT VOTING—4

LaTourette
McInnis
Smith (WA)
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

□ 0138

So the motion to recommit was rejected.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. 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. LEVIN. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, this 15-minute vote will be followed by a 5-minute vote on H.R. 2417.

The vote was taken by electronic device, and there were—ayes 216, noes 215, answered ''present'' 1, not voting 3, as follows:

[Roll No. 332]

AYES—216

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

Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Hall
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Houghton
Hulshof
Hunter
Hyde
Isakson
Israel
Issa
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
Matheson
McCotter
McCrery
McHugh
McKeon
Mica
Miller (MI)
Miller, Gary
Murphy
Myrick
Nethercutt
Neugebauer
Ney
Northup
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Pearce
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Saxton
Schrock
Sessions
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)

NOES—215

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

ANSWERED ''PRESENT''—1

Istook

NOT VOTING—3

McInnis
Smith (WA)
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

□ 0233

Live pair:

On this vote:

Mr. ISTOOK with Mr. YOUNG of Florida:

Mr. ISTOOK. Mr. Speaker, on my vote just recorded I voted ''no.'' I have a pair with the gentleman from Florida, Mr. YOUNG, who is at a funeral, and desire to change my vote and be recorded as ''present.''

''Mr. OTTER and Mrs. EMERSON changed their vote from ''no'' to ''aye.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore. Pursuant to section 3 of House Resolution 299, the text of H.R. 2596 will be appended to the engrossment of H.R. 1; and H.R. 2596 shall be laid on the table.

INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The pending business is the question of the passage of the bill, H.R. 2417, on which further proceedings were postponed earlier today.

The Clerk read the title of the bill.

The SPEAKER pro tempore. The question is on the passage of the bill on which the yeas and nays are ordered.

This will be a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 410, nays 9, not voting 15, as follows:

[Roll No. 333]

YEAS—410

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Allen
Andrews
Baca
Bachus
Baird
Baldwin
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bell
Bereuter
Berkley
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (OH)
Brown (SC)
Brown, Corrine
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Cubin
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeGette
Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Dunn
Edwards
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Gephardt
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Gonzalez
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinchey
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jefferson
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Lee
Levin
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McDermott
McGovern
McHugh
McIntyre
McKeon
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Miller, George
Mollohan
Moore
Moran (KS)
Moran (VA)
Murphy
Murtha
Nadler
Napolitano
Neal (MA)
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Oberstar
Obey
Olver
Ortiz
Osborne
Ose
Otter
Oxley
Pallone
Pascrell
Pastor
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Rahall
Ramstad
Regula

Rehberg	Shadegg	Tiahrt
Renzi	Shaw	Tiberi
Reyes	Shays	Tierney
Reynolds	Sherman	Toomey
Rodriguez	Sherwood	Towns
Rogers (AL)	Shimkus	Turner (OH)
Rogers (KY)	Shuster	Turner (TX)
Rogers (MI)	Simmons	Udall (CO)
Rohrabacher	Simpson	Udall (NM)
Ros-Lehtinen	Skelton	Upton
Ross	Slaughter	Van Hollen
Rothman	Smith (MI)	Velazquez
Roybal-Allard	Smith (NJ)	Visclosky
Royce	Smith (TX)	Vitter
Ruppersberger	Snyder	Walden (OR)
Rush	Solis	Walsh
Ryan (OH)	Souder	Wamp
Ryan (WI)	Spratt	Watson
Ryun (KS)	Stearns	Watt
Sabo	Stenholm	Waxman
Sanchez, Linda T.	Strickland	Weiner
	Stupak	Weldon (FL)
Sanchez, Loretta	Sullivan	Weldon (PA)
Sanders	Sweeney	Weller
Sandlin	Tanner	Wexler
Saxton	Tauscher	Whitfield
Schakowsky	Tauzin	Wicker
Schiff	Taylor (MS)	Wilson (NM)
Schrock	Taylor (NC)	Wilson (SC)
Scott (GA)	Terry	Wolf
Scott (VA)	Thomas	Woolsey
Sensenbrenner	Thompson (CA)	Wu
Serrano	Thompson (MS)	Wynn
Sessions	Thornberry	Young (AK)

NAYS—9

Capuano	Filner	Owens
Duncan	Kucinich	Paul
Fattah	Lewis (GA)	Waters

NOT VOTING—15

Baker	Manzullo	Rangel
DeFazio	McInnis	Smith (WA)
Dicks	Musgrave	Stark
Garrett (NJ)	Myrick	Tancredo
Jones (NC)	Radanovich	Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. OSE) (during the vote). The Chair announces that one panel on the board is not operational and Members may confirm their votes at the voting stations.

□ 0242

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

PROVIDING FOR AN ADJOURNMENT OR RECESS OF THE TWO HOUSES

Mr. DELAY. Mr. Speaker, pursuant to section 5 of House Resolution 299, I send to the desk a concurrent resolution (H. Con. Res. 231) and ask for its immediate consideration.

The Clerk read the concurrent resolution, as follows:

H. CON. RES. 231

Resolved by the House of Representatives (the Senate concurring), That when the House adjourns on the legislative day of Thursday, June 26, 2003, Friday, June 27, 2003, or Saturday, June 28, 2003, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand adjourned until 2 p.m. on Monday, July 7, 2003, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first; and that when the Senate recesses or adjourns on Thursday, June 26, 2003, Friday, June 27, 2003, or Saturday, June 28, 2003, on a motion offered pursuant to this concurrent resolution by its Majority Leader or his designee, it stand recessed or adjourned until noon on Monday, July 7, 2003, or at such other time on that day as may be specified by its Majority Leader or his designee in the motion to recess or adjourn, or until the time of any reassembly pursuant to section 2 of this concurrent resolution, whichever occurs first.

SEC. 2. The Speaker of the House and the Majority Leader of the Senate, or their respective designees, acting jointly after consultation with the Minority Leader of the House and the Minority Leader of the Senate, shall notify the Members of the House and the Senate, respectively, to reassemble at such place and time as they may designate whenever, in their opinion, the public interest shall warrant it.

The concurrent resolution was agreed to.

A motion to reconsider was laid on the table.

CONDITIONAL ADJOURNMENT OF THE HOUSE TO TUESDAY, JULY 1, 2003

Mr. DELAY. Mr. Speaker, I ask unanimous consent that when the House adjourns today, it adjourn to meet at 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its concurrence in House Concurrent Resolution 231, in which case the House shall stand adjourned pursuant to that concurrent resolution.

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

There was no objection.

DISPENSING WITH CALENDAR WEDNESDAY BUSINESS ON WEDNESDAY, JULY 9, 2003

Mr. DELAY. Mr. Speaker, I ask unanimous consent that the business in order under the Calendar Wednesday rule be dispensed with on Wednesday, July 9, 2003.

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

There was no objection.

□ 0245

APPOINTMENT OF HON. TOM DAVIS OF VIRGINIA TO ACT AS SPEAKER PRO TEMPORE TO SIGN ENROLLED BILLS AND JOINT RESOLUTIONS THROUGH JULY 7, 2003

The SPEAKER pro tempore laid before the House the following Communication from the Speaker:

WASHINGTON, DC,
June 26, 2003.

I hereby appoint the Honorable TOM DAVIS to act as Speaker pro tempore to sign enrolled bills and joint resolutions through July 7, 2003.

J. DENNIS HASTERT,
Speaker of the House of Representatives.

The SPEAKER pro tempore (Mr. OSE). Without objection, the appointment is approved.

There was no objection.

REMOVAL OF NAME OF MEMBER AS COSPONSOR OF H.R. 3364

Mr. MICHAUD. Mr. Speaker, I ask unanimous consent that my name be removed as cosponsor of H.R. 2407.

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

There was no objection.

HONORING THE NORTHWESTERN BAND OF THE SHOSHONE NATION

(Mr. BISHOP of Utah asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. BISHOP of Utah. Mr. Speaker, I rise today to honor the Northwestern Band of the Shoshone Nation, headquartered in my hometown of Brigham City, Utah, and located throughout northern Utah and southern Idaho, and specifically to pay tribute to this tribe as it enters a new chapter in its history.

For more than 1,500 years, the Northwestern Band of the Shoshone Nation has cared for much of the land that consumes my district as well as the districts of my colleagues in Idaho and Nevada. Last month, the Shoshones took ownership of a portion of the land along the Bear River in Idaho where as many as 380 of their ancestors were killed by the U.S. Cavalry on January 29, 1863. The Bear River Massacre, as it is called, was the worst slaughter of Native Americans west of the Mississippi, with an estimate of double the number of deaths of those at Wounded Knee. Now, for the first time in its history, 26 acres where so many Shoshones perished will be treated as the sacred burial ground that it is. In a solemn and very moving ceremony, the Northwestern Band of the Shoshone Nation was able to perform burial rites for the men, women and children who died on that site 140 years ago. Mr. Speaker, today I wish to honor those members of this tribe who gave their lives on that day in 1863.

I also want to commend the efforts of the tribe, the American West Heritage Center, and the Trust for Public Lands for working together to bring closure to this issue.

Mr. Speaker, I rise today to honor the Northwestern Band of the Shoshone Nation, headquartered in my hometown of Brigham City, Utah, and located throughout Northern Utah and Southern Idaho, and to pay tribute to this tribe as it celebrates a new chapter in its history.

For more than 1,500 years, the Northwestern Band of the Shoshone Nation has cared for much of the land that makes up my district—and the districts of my colleagues from Idaho and Nevada. Last month, the Northwestern Shoshones took ownership of a portion of the land along the Bear River in Idaho where as many as 380 of their ancestors were killed by the U.S. Cavalry on January 29, 1863. The Bear River Massacre, as it

is called, was the worst slaughter west of the Mississippi of Native Americans, with estimates of the dead nearly double those of Wounded Knee, South Dakota. Now, for the first time in its history, 26 acres where so many Shoshones perished will be treated as the sacred burial ground that it is. In a solemn and moving ceremony, the Northwestern Band of the Shoshone Nation was able to perform burial rites for the men, women, and children who died on that site over 140 years ago. Mr. Speaker, today I wish to honor those members of the tribe who gave their lives on that day in 1863.

I want to commend the efforts of the tribe, the American West Heritage Center, and the Trust for Public Lands for working together to bring closure to this episode in our nation's history. Their goal is to obtain a total of 150 acres so that the Bear River Massacre site can be turned into a memorial. This story, along with the tribe's history and culture, will be preserved and shared with the public at the nearby American West Heritage Center in Wellsville, Utah, which is also located in my district.

Mr. Speaker, for the benefit of our colleagues, I am also submitting an article for the RECORD from a Salt Lake newspaper, which details the history of this site. I commend the past and current Shoshone leadership for their vision and efforts.

[From the Salt Lake Tribune, Feb. 4, 2003]

THIS HALLOWED GROUND

It never made any sense to call what happened at Idaho's Bear River 140 years ago a ''battle.'' When soldiers based in Salt Lake City went on a mad rampage and killed at least 250 men, women and children of the Northwestern Shoshone tribe on Jan. 29, 1863, it was a massacre.

And it still makes no sense that the site of that blot on our shared history is not officially designated as a national historic site.

Descendants of the Northwestern Shoshone see the historic significance of the place, and so does the National Park Service. But, while the site near Preston in southeastern Idaho drew a small crowd of devoted friends to mark Wednesday's anniversary of the horrible event, what happened there remains something that has been largely air-brushed, Stalin-like, from our official memory.

The stumbling block, apparently, is that Idaho Sen. Larry Craig has for eight years been bottling up a resolution to create a $14 million Bear River National Historic Site and Visitors Center. Craig says the park service has more immediate needs and, given the constant scuffle within all federal agencies for adequate funding, it is true that not every idea for a new national historic site can be fulfilled.

But the Bear River massacre is important enough that it needs to be burned into our collective memory. It was one of the earliest and one of the bloodiest encounters between Native Americans and European settlers in the Far West. Its memory has been kept alive by the tireless efforts of a few Shoshone, most notably Utah's Mae Timbimboo Parry, efforts that themselves deserve to be chronicled at an official historic site.

As the United States gears up to mark the 200th anniversary of Lewis and Clark's Corps of Discovery, with proper notice given to their Shoshone guide Sacagawea, now would be the proper time to note this terribly sad bit of fallout from that courageous expedition. The extra amount of attention that will be focused on Lewis and Clark should be used to earn support from historians, Congress, foundations and the general public to properly mark the site of the Bear River Massacre and formally mourn those who died there.

The place of the Bear River Massacre is a national historic site, whether we say so or not.

We should say so.

THE CRISIS IN LIBERIA

The SPEAKER pro tempore. Under a previous order of the House, the gentlewoman from Texas (Ms. JACKSON-LEE) is recognized for 5 minutes.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise today in response to the troubling situation of unrest in our ally nation of Liberia. Because of the rich history of its birth in 1820 with the valiant acts of freed American slaves in founding the capital of Christopolis, now Monrovia, we certainly have a stake in the need for restoring peace.

Since the end of the seven-year civil war that claimed the lives of over 250,000 people, more than 1.3 million residents have had to flee the country for refuge in neighboring countries, many of which have already reached the end of their meager resources. The series of events in Liberia presents a harsh irony in light of yesterday's events: we celebrated a Constitutional victory in the Grutter v. Bollinger decision that came out of the highest court in the nation. Similarly ironic, on that same day, we saluted the Honorable Mayor Maynard Jackson, Jr., one of the most charismatic civic leaders of all time in his departure at age 65. This ironic juxtaposition of emotions reminds us that no matter how far we think we've gotten, there is always distance to be traveled in the work of making peace in the world.

The U.N. High Court indictment of Liberian President Charles Taylor on charges of crimes against humanity, largely stemming from his participaion in the civil war in Sierra Leone, has created a panic in Monrovia. A Liberian woman stated that ''We are all tired of Charles Taylor, but we are afraid that his arrest in Ghana will create chaos.'' We in the United States now know the feeling of panic as we check the terror threat on a daily basis—today's threat level being Yellow, or ''heightened.'' People shouldn't have to live in fear.

The economic effect of the renewed arms embargo, ban on dealing in rough diamonds, and airline restrictions on Liberia will be substantial for the citizens and business community. However, the human rights abuses such as summary executions, recruitment of child soldiers. sexual violence, looting of civilian property, and forced labor must end now. The mass evacuation aboard the French vessel *Orage* of the hundreds of foreigners, including Americans, holding dual U.S. and Liberian citizenship, Europeans, Lebanese, Ivorian and Indian nationals, Egyptians, and some Africans represents a departure from our goal of uniting our international community in peace. It is a moral imperative that we end the chaos caused by anarchy and criminal behavior. The Ceasefire Agreement between the Republic of Liberia, the Liberians United for Reconciliation and Democracy (LUR) groups, and the Movement for Democracy in Liberia (MODEL) is a start, but our help is imperative. We must make our voices heard and incite action from our colleagues in order to restore peace.

LEAVE OF ABSENCE

By unanimous consent, leave of absence was granted to:

Mr. WYNN (at the request of Ms. PELOSI) for today until 11:00 a.m. on account of personal business.

Mr. YOUNG of Florida (at the request of Mr. DELAY) for today from 6:00 p.m. and the balance of the week on account of attending a funeral.

SPECIAL ORDERS GRANTED

By unanimous consent, permission to address the House, following the legislative program and any special orders heretofore entered, was granted to:

(The following Member (at the request of Ms. JACKSON-LEE of Texas) to revise and extend their remarks and include extraneous material:)

Ms. JACKSON-LEE of Texas, for 5 minutes, today.

SENATE BILLS REFERRED

Bills of the Senate of the following titles were taken from the Speaker's table and, under the rule, referred as follows:

S. 163. An act to reauthorize the United States Institute for Environmental Conflict Resolution, and for other purposes; to the Committee on Education and the Work Force and the Committee on Resources.

S. 498. An act to authorize the President to posthumously award a gold medal on behalf of Congress to Joseph A. De Laine, in recognition of his contributions to the Nation; to the Committee on Financial Services.

S. 867. An act to designate the facility of the United States Postal Service located at 710 Wicks Lane in Billings, Montana, as the ''Ronald Reagan Post Office Building''; to the Committee on Government Reform.

ENROLLED BILLS SIGNED

Mr. Trandahl, Clerk of the House, reported and found truly enrolled bills of the House of the following titles, which were thereupon signed by the Speaker:

H.R. 825. An act to redesignate the facility of the United States Postal Service located at 7401 West 100th Place in Bridgeview, Illinois, as the ''Michael J. Healy Post Office Building''.

H.R. 917. An act to designate the facility of the United States Postal Service located at 1830 South Lake Drive in Lexington, South Carolina, as the ''Floyd Spence Post Office Building''.

H.R. 925. An act to redesignate the facility of the United States Postal Service located at 1859 South Ashland Avenue in Chicago, Illinois, as the ''Cesar Chavez Post Office''.

H.R. 981. An act to designate the facility of the United States Postal Service located at

141 Erie Street in Linesville, Pennsylvania, as the ''James R. Merry Post Office''.

H.R. 985. An act to designate the facility of the United States Postal Service located at 111 West Washington Street in Bowling Green, Ohio, as the ''Delbert L. Latta Post Office Building''.

H.R. 1055. An act to designate the facility of the United States Postal Service located at 1901 West Evans Street in Florence, South Carolina, as the ''Dr. Roswell N. Beck Post Office Building''.

H.R. 1368. An act to designate the facility of the United States Postal Service located at 7554 Pacific Avenue in Stockton, California, as the ''Norman D. Shumway Post Office Building''.

H.R. 1465. An act to designate the facility of the United States Postal Service located at 4832 East Highway 27 in Iron Station, North Carolina, as the ''General Charles Gabriel Post Office''.

H.R. 1596. An act to designate the facility of the United States Postal Service located at 2318 Woodson Road in St. Louis, Missouri, as the ''Timothy Michael Gaffney Post Office Building''.

H.R. 1609. An act to designate the facility of the United States Postal Service located at 201 West Boston Street in Brookfield, Missouri, as the ''Admiral Donald Davis Post Office Building''.

H.R. 1740. An act to designate the facility of the United States Postal Service located at 1502 East Kiest Boulevard in Dallas, Texas, as the ''Dr. Caesar A.W. Clark, Sr. Post Office Building''.

H.R. 2030 An act to designate the facility of the United States Postal Service located at 120 Baldwin Avenue in Paia, Maui, Hawaii, as the ''Patsy Takemoto Mink Post Office Building''.

SENATE ENROLLED BILL SIGNED

The Speaker announced his signature on an enrolled bill of the Senate of the following title:

S. 858. A act to extend the Abraham Lincoln Bicentennial Commission and for other purposes.

ADJOURNMENT

Mr. DELAY. Mr. Speaker, pursuant to House Concurrent Resolution 231, I move that the House do now adjourn.

The motion was agreed to.

The SPEAKER pro tempore. Pursuant to the previous order of the House of today, the House stands adjourned until 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its adoption of House Concurrent Resolution 231, in which case the House shall stand adjourned pursuant to that concurrent resolution.

Thereupon (at 2 o'clock and 47 minutes a.m. Friday, June 27, 2003, legislative day of June 26, 2003), pursuant to the previous order of the House of today, the House adjourned until 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its adoption of House Concurrent Resolution 231.

EXECUTIVE COMMUNICATIONS, ETC.

Under clause 8 of rule XII, executive communications were taken from the Speaker's table and referred as follows:

2886. A letter from the Deputy Secretary, Department of Defense, transmitting notification of munitions disposal, pursuant to 50 U.S.C. 1512(4); to the Committee on Armed Services.

2887. A letter from the Acting Under Secretary, Department of Defense, transmitting a report on the results of an evaluation of the programmatic impact of combining funding and administration for the Historically Black Colleges and Universities and Minority Institutions program, the Hispanic-Serving Institutions program, and the American Indian Tribal Colleges program; to the Committee on Armed Services.

2888. A letter from the Secretary, Department of Transportation, transmitting The Department's annual report as required by the Superfund Amendments and Reauthorization Act (SARA) of 1986, as amended, pursuant to 42 U.S.C. 9620; to the Committee on Energy and Commerce.

2889. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Natural Emission Standards for Hazardous Air Pollutants for Source Categories: General Provisions; and Requirements for Control Technology Determinations for Major Sources in Accordance with Clean Air Act Sections, Sections 112(g) and 112(j) [FRL-7498-8] (RIN: 2060-AK52) received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2890. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Approval and Promulgation of State Air Quality Plans for Designated Facilities and Pollutants; State of West Virginia; Control of Emissions from Existing Small Municipal Waste Combustion Units [WV06-6027a; FRL-7503-2] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2891. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Approval and Promulgation of State Plans For Designated Facilities and Pollutants: Vermont; Negative Declaration [VT-1226a; FRL-7502-1] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2892. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Approval of the Clean Air Act, Section 112(I), Authority for Hazardous Air Pollutants: Management and Control of Asbestos Disposal Sites Not Operated After July 9, 1981: State of New Hampshire Department of Environmental Services [FRL-7490-6] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2893. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Revisions to Regional Haze Rule to Incorporate Sulfur Dioxide Milestones and Backstop Emissions Trading Program for Nine Western States and Eligible Indian Tribes Within that Geographic Area [FRL-7504-4] received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2894. A letter from the Acting Prinicpal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — Standards of Performance for Stationary Gas Turbines [OAR-2002-0053, FRL-7502-4] (RIN: 2060-AK35) received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2895. A letter from the Acting Principal Deputy Associate Administrator, Environmental Protection Agency, transmitting the Agency's final rule — National Emission Standards for Hazardous Air Pollutants for Chemical Recovery Combustion Sources at Kraft, Soda, Sulfite, and Stand-Alone Semichemical Pulp Mills [OAR-2002-0045, FRL-7502-7] (RIN: 2060-AK53) received May 22, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Energy and Commerce.

2896. A letter from the Director, Defense Security Cooperation Agency, transmitting the Department of Defense's proposed lease of defense articles to the Government of the Hashemite Kingdom of Jordan (Transmittal No. 02-03), pursuant to 22 U.S.C. 2796a(a); to the Committee on International Relations.

2897. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting notification that effective May 18, 2003 a 25% danger pay allowance has been designated for Saudi Arabia, pursuant to 5 U.S.C. 5928; to the Committee on International Relations.

2898. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting the FY 2002 Annual Report on U.S. Government Assistance to and Cooperative Activities with Eurasia; to the Committee on International Relations.

2899. A letter from the Assistant Attorney General, Department of Justice, transmitting the Department's proposed legislation relating to sexual abuse and contraband offenses relating to Federal prisoners; to the Committee on the Judiciary.

2900. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Airbus Model A319-131, -132, and -133; A320-232 and -233; and A321-231 Series Airplanes; Equipped with International Aero Engines (IAE) V25()()-A5 Engines [Docket No. 2003-NM-124-AD; Amendment 39-13159; AD 2003-10-14] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2901. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Dassault Model Mystere-Falcon 50 Series Airplanes [Docket No. 2003-NM-118-AD; Amendment 39-13149; AD 2003-10-04] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2902. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Raytheon Aircraft Company Model 390 Airplanes [Docket No. 2003-CE-17-AD; Amendment 39-13150; AD 2003-10-05] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2903. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; CFM International (CFMI) CFM56-5C Series Turbofan Engines [Docket No. 95-ANE-64-AD; Amendment 39-13094; AD 97-09-02R2] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2904. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Dornier-Werke G.m.b.H. Model Do 27 Q-6 Airplanes [Docket No. 2002-CE-55-AD; Amendment 39-13096; AD 2003-06-08] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2905. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; SOCATA — Groupe AEROPATIALE Models MS 892A-150, MS 892E-150, MS 893A, MS 893E, MS 894E, Rallye 150T, and Rallye 150ST Airplanes [Docket No. 2002-CE-49-AD; Amendment 39-13095; AD 2003-06-07] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2906. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-2B19 (Regional Jet Series 440) Series Airplanes [Docket No. 2002-NM-100-AD; Amendment 39-13070; AD 2003-04-21] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2907. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Dornier Model 328-100 and -300 Series Airplanes [Docket No. 2002-NM-218-AD; Amendment 39-13084; AD 2003-05-08] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2908. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Hartzell Propeller Inc. Model HC-C2Y(K,R)-1BF/F8477- Propellers [Docket No. 2001-NE-47-AD; Amendment 39-13089; AD 2003-06-02] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2909. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Fokker Model F.28 Mark 0070 and 0100 Series Airplanes [Docket No. 2001-NM-289-AD; Amendment 39-13068; AD 2003-04-19] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2910. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model MD-90-30 Airplanes [Docket No. 2001-NM-212-AD; Amendment 39-13067; AD 2003-04-18] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2911. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Dowty Aerospace Propellers, Models R354, R375, R389, and R390 Propellers [Docket No. 2000-NE-18-AD; Amendment 39-13074; AD 2003-04-25] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2912. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Hartzell Propeller Inc. Model HC-B3TN-5() Propellers [Docket No. 2001-NE-44-AD; Amendment 39-13072; AD 2003-04-23] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2913. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Hartzell Propeller Inc. Model HD-E6C-3B/E13890K [Docket No. 2000-NE-60-AD; Amendment 39-13071; AD 2003-04-22] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2914. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-2C10 Series Airplanes [Docket No. 2002-NM-93-AD; Amendment 39-13076; AD 2003-04-27] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2915. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Raytheon Aircraft Company Model 1900D Airplanes [Docket No. 2002-CE-32-AD; Amendment 39-13075; AD 2003-04-26] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2916. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bell Helicopter Textron Canada (Bell) Model 427 Helicopters [Docket No. 2002-SW-19-AD; Amendment 39-13063; AD 2003-04-14] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2917. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Fokker Model F.28 Mark 1000, 2000, 3000, and 4000 Series Airplanes [Docket No. 2001-NM-334-AD; Amendment 39-13057; AD 2003-04-09] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2918. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Eurocopter France Model SA341G and SA342J Helicopters [Docket No. 2002-SW-47-AD; Amendment 39-13062; AD 2003-04-13] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2919. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bell Helicopter Textron Canada Limited Model 427 Helicopters [Docket No. 2001-SW-43-AD; Amendment 39-13061; AD 2003-04-12] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2920. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Agusta S.p.A. Model A109E Helicopters [Docket No. 2002-SW-55-AD; Amendment 39-13060; AD 2002-25-51] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2921. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Sikorsky Aircraft Corporation Model S-76A, B, and C Helicopters [Docket No. 2003-SW-06-AD; Amendment 39-13064; AD 2003-04-15] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2922. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model MD-90-30 Airplanes [Docket No. 2001-NM-389-AD; Amendment 39-13058; AD 2003-04-10] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2923. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Bombardier Model CL-600-2B19 (Regional Jet Series 100 & 440) Airplanes [Docket No. 2002-NM-100-AD; Amendment 39-13070; AD 2003-04-21 R1] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2924. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model 717-200 Airplanes [Docket No. 2002-NM-353-AD; Amendment 39-13073; AD 2003-04-24] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2925. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Schweizer Aircraft Corporation Model 269D Helicopters [Docket No. 2002-SW-57-AD; Amendment 39-13134; AD 2003-09-05] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2926. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; McDonnell Douglas Model DC-9-10, -20, -30, -40, and -50 Series Airplanes; and DC-9-81 (MD-81), DC-9-82 (MD-82), DC-9-83 (MD-83), DC-9-87 (MD-87), and MD-88 Airplanes [Docket No. 2001-NM-170-AD; Amendment 39-13136; AD 2003-09-07] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2927. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Cessna Aircraft Company Models 441 and F406 Airplanes [Docket No. 2002-CE-18-AD; Amendment 39-13138; AD 2003-09-09] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2928. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce Deutschland Ltd & Co KG Models BR700-710A1-10 and BR700-710A2-20 Turbofan Engines; Correction [Docket No. 2000-NE-48-AD; Amendment 39-13107; AD 2003-07-11] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2929. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce Deutschland Ltd & Co KG Models BR700-710A1-10 and BR700-710A2-20 Turbofan Engines [Docket No. 2000-NE-48-AD; Amendment 39-13107; AD 2003-07-11] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2930. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Rolls-Royce Corporation (Formerly Allison Engine Company) 501-D Series Turboprop Engines [Docket No. 2001-NE-01-AD; Amendment 39-13098; AD 2003-07-02] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2931. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Boeing Model 747-200B and -200F Series Airplanes Powered by Pratt & Whitney JT9D-70 Series Engines [Docket No. 2002-NM-23-AD; Amendment 39-13059; AD 2003-04-11] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2932. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Raytheon Model DH.125, HS.125, and BH.125 Series Airplanes; Model BAe.125 Series 800A, 800A (C-29A), 800A (U-125), 800B, 1000A, and 1000B Airplanes; and Model Hawker 800, 800 (including variant U-125A), 1000, and 800XP Airplanes [Docket No. 2002-NM-15-AD; Amendment 39-13069; AD 2003-04-20] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2933. A letter from the Program Analyst, FAA, Department of Transportation, transmitting the Department's final rule — Airworthiness Directives; Raytheon Aircraft Company Beech Models 1900, 1900C, and 1900D Airplanes [Docket No. 2003-CE-07-AD; Amendment 39-13043; AD 2003-03-18] (RIN: 2120-AA64) received June 19, 2003, pursuant to 5 U.S.C. 801(a)(1)(A); to the Committee on Transportation and Infrastructure.

2934. A letter from the Assistant Secretary for Legislative Affairs, Department of State, transmitting a report entitled, ''Suspension of Limitations Under the Jerusalem Embassy Act'' (Presidential Determination No. 2003-26), pursuant to Public Law 104—45, section 6 (109 Stat. 400); jointly to the Committees on International Relations and Appropriations.

2935. A letter from the Associate Administrator, Office of Veterans Business Development, Small Business Administration, transmitting a letter regarding a report describing the activities of the Committee and any recommendations developed by the Committee for the promotion of small business concerns owned and controlled by veterans; jointly to the Committees on Small Business and Veterans' Affairs.

2936. A letter from the Railroad Retirement Board, transmitting a copy of the 22nd Actuarial Valuation of the Assets and Liabilities Under the Railroad Retirement Acts, pursuant to 45 U.S.C. 231f—1; jointly to the Committees on Ways and Means and Transportation and Infrastructure.

REPORTS OF COMMITTEE ON PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XIII, reports of committees were delivered to the Clerk for printing and reference to the proper calendar, as follows:

Mr. BOEHNER: Committee on Education and the Workforce. H.R. 438. A bill to increase the a mount of student loans that may be forgiven for teachers in mathematics, science, and special education; with an amendment (Rept. 108–182). Referred to the Committee of the Whole House on the State of the Union.

Mr. BOEHNER: Committee on Education and the Workforce. H.R. 2211. A bill to reauthorize title II of the Higher Education Act of 1965; with an amendment (Rept. 108–183). Referred to the Committee of the Whole House on the State of the Union.

Mr. BOEHNER: Committee on Education and the Workforce. H.R. 2210. A bill to reauthorize the Head Start Act to improve school readiness of disadvantaged children, and for other purposes; with an amendment (Rept. 108–184). Referred to the Committee of the Whole House on the State of the Union.

Mr. POMBO: Committee on Resources. H.R. 74. A bill to direct the Secretary of agriculture to convey certain land in the lake Tahoe Basin Management Unit, Nevada, to the Secretary of the Interior, in trust for the Washoe Indian Tribe of Nevada and California (Rept. 108–185). Referred to the Committee of the Whole House and the State of the Union.

PUBLIC BILLS AND RESOLUTIONS

Under clause 2 of rule XII, public bills and resolutions were introduced and severally referred, as follows:

By Mr. CASE (for himself, Mr. SANDERS, Ms. BORDALLO, and Mr. FROST):

H.R. 2607. A bill to modify the contract consolidation requirements in the Small Business Act, and for other purposes; to the Committee on Small Business.

By Mr. SMITH of Michigan (for himself and Mr. BAIRD):

H.R. 2608. A bill to reauthorize the National Earthquake Hazards Reduction Program, and for other purposes; to the Committee on Science, and in addition to the Committee on Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. CONYERS:

H.R. 2609. A bill to amend title 11, United States Code, to provide for the avoidance of certain transfers, and the alternate prosecution of certain actions, relating to certain retirement benefits; to the Committee on the Judiciary.

By Mr. PETERSON of Minnesota (for himself, Mr. LATHAM, Mr. CRAMER, Mr. BOEHNER, Mr. HALL, Mr. SIMPSON, Mr. DOOLEY of California, Mr. GUTKNECHT, Mr. BOSWELL, Mr. JANKLOW, Mr. LUCAS of Kentucky, and Ms. HARRIS):

H.R. 2610. A bill to amend the Internal Revenue Code of 1986 to restore the estate tax and repeal the carryover basis rule, to increase the estate and gift tax unified credit to an exclusion equivalent of $5,000,000, and to reduce the rate of the estate and gifts taxes to the generally applicable capital gains income tax rate; to the Committee on Ways and Means.

By Mr. MICHAUD (for himself, Mr. BROWN of South Carolina, Mr. EVANS, Mr. FILNER, Mr. GUTIERREZ, Ms. CORRINE BROWN of Florida, Mr. RODRIGUEZ, Mr. RYAN of Ohio, and Mr. FROST):

H.R. 2611. A bill to amend title II of the Social Security Act to exempt from the windfall elimination provision of such title individuals who are entitled to retired pay based on at least 20 years of service as a member of a uniformed service; to the Committee on Ways and Means.

By Mr. MICHAUD (for himself and Mr. EVANS):

H.R. 2612. A bill to amend title 38, United States Code, to authorize the Secretary of Veterans Affairs to provide specially adapted housing assistance to veterans with permanent and total service-connected disabilities due to the loss, or loss of use of both upper extremities such as to preclude use of the arms at and below the elbows; to the Committee on Veterans' Affairs.

By Mr. SABO (for himself, Ms. KAPTUR, and Mr. FROST):

H.R. 2613. A bill to amend title 17, United States Code, to exclude from copyright protection works resulting from scientific research substantially funded by the Federal Government; to the Committee on the Judiciary.

By Mr. MCGOVERN (for himself, Mr. SHAYS, and Mr. FERGUSON):

H.R. 2614. A bill to amend the Internal Revenue Code of 1986 to equalize the exclusion from gross income of parking and transportation fringe benefits and to provide for a common cost-of-living adjustment; to the Committee on Ways and Means.

By Mr. COSTELLO (for himself, Mr. DAVIS of Tennessee, Mr. OBERSTAR, Mr. RAHALL, Mr. FILNER, Mr. MENENDEZ, Mr. CUMMINGS, Mr. LIPINSKI, Mrs. TAUSCHER, Mr. BISHOP of New York, Mr. BLUMENAUER, Mr. EMANUEL, Mr. NADLER, Mr. CLAY, Mr. HOLDEN, Ms. NORTON, Mr. HONDA, Mr. CAPUANO, Mr. BAIRD, Ms. EDDIE BERNICE JOHNSON of Texas, Mr. MICHAUD, Mr. LARSEN of Washington, Mr. WEINER, Mr. DEFAZIO, Ms. MILLENDER-MCDONALD, Ms. BERKLEY, Mr. PASCRELL, Mr. BOSWELL, Ms. CORRINE BROWN of Florida, Ms. CARSON of Indiana, Mr. THOMPSON of California, Mr. HOEFFEL, Mr. LAMPSON, Mr. MATHESON, and Mr. CARSON of Oklahoma):

H.R. 2615. A bill to provide funding for infrastructure investment to restore the United States economy and to enhance the security of transportation and environmental facilities throughout the United States; to the Committee on Transportation and Infrastructure, and in addition to the Committees on Ways and Means, Energy and Commerce, Financial Services, and Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. FARR (for himself, Mr. WOLF, Mr. HOEFFEL, Mr. LEACH, and Mr. WEXLER):

H.R. 2616. A bill to increase the capabilities of the United States to provide reconstruction assistance to countries or regions impacted by armed conflict, and for other purposes; to the Committee on International Relations.

By Mr. SHADEGG:

H.R. 2617. A bill to protect American consumers from identity theft and other forms of fraud; to the Committee on Financial Services, and in addition to the Committees on Ways and Means, and Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. OBEY:

H.R. 2618. A bill making appropriations for the Departments of Labor, Health and Human Services, and Education, and related agencies for the fiscal year ending September 30, 2004, and for other purposes; to the Committee on Appropriations.

By Mr. CASE:

H.R. 2619. A bill to provide for the expansion of Kilauea Point National Wildlife Refuge; to the Committee on Resources.

By Mr. SMITH of New Jersey (for himself, Mr. LANTOS, Mr. PITTS, Ms. SLAUGHTER, and Ms. ESHOO):

H.R. 2620. A bill to authorize appropriations for fiscal years 2004 and 2005 for the Trafficking Victims Protection Act of 2000, and for other purposes; to the Committee on International Relations, and in addition to the Committee on the Judiciary, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. ALLEN (for himself, Mr. SIMMONS, Mr. DELAHUNT, Mrs. CAPPS, Mr. CAPUANO, Mr. FARR, Mr. MARKEY, Mr. GEORGE MILLER of California, and Ms. WOOLSEY):

H.R. 2621. A bill to amend the Magnuson-Stevens Fishery Conservation and Management Act to establish requirements for fishing quota systems; to the Committee on Resources.

By Mr. BACHUS (for himself, Ms. HOOLEY of Oregon, Mrs. BIGGERT, Mr. MOORE, Mr. LATOURETTE, Mr. KANJORSKI, Mr. CASTLE, Mrs. MALONEY, Mr. SHADEGG, Mr. FORD, Mr. TIBERI, Mr. HINOJOSA, Mr. HENSARLING, Mr. CROWLEY, Mr. SESSIONS, Mr. ROSS, Mr. MATHESON, Mr. DAVIS of Alabama, Mr. BAKER, Mr. KING of New York, Mr. LUCAS of Oklahoma, Mr. LUCAS of Kentucky, Mr. NEY, Mrs. KELLY, Mr. JONES of North Carolina, Mr. ISRAEL, Ms. HART, Mr. MILLER of North Carolina, Mrs. CAPITO, Mrs. MCCARTHY of New York, Mr. BARRETT of South Carolina, Mr. FEENEY, and Ms. HARRIS):

H.R. 2622. A bill to amend the Fair Credit Reporting Act, to prevent identity theft, improve resolution of consumer disputes, improve the accuracy of consumer records, make improvements in the use of, and consumer access to, credit information, and for other purposes; to the Committee on Financial Services.

By Mr. BACHUS:

H.R. 2623. A bill to provide for the expansion of the Cahaba River National Wildlife Refuge in Bibb County, Alabama; to the Committee on Resources.

By Mr. BOSWELL:

H.R. 2624. A bill to amend title XVIII of the Social Security Act to improve the provision of items and services provided to Medicare beneficiaries residing in rural areas; to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. WAXMAN (for himself, Mr. FROST, Mr. KIND, Mr. ACKERMAN, Ms. BERKLEY, Mr. CARSON of Oklahoma, Mr. DAVIS of Florida, Mr. DOOLEY of California, Mr. ENGEL, Mr. ETHERIDGE, Mr. FORD, Mr. HILL, Mr. ISRAEL, Mr. LYNCH, Mrs. MALONEY, Mr. MARKEY, Mr. MEEHAN, Mr. PASCRELL, Ms. SCHAKOWSKY, Mr. SCHIFF, Mr. SHERMAN, Mrs. TAUSCHER, Mr. WEINER, and Mr. WEXLER):

H.R. 2625. A bill to establish the Independent Commission on Intelligence about Iraq; to the Committee on Intelligence (Permanent Select).

By Mr. UPTON (for himself and Mr. KIND):

H.R. 2626. A bill to amend the Richard B. Russell National School Lunch Act and the Child Nutrition Act of 1966 to improve certain child nutrition programs, and for other purposes; to the Committee on Education and the Workforce.

By Mr. BURTON of Indiana (for himself, Mr. PALLONE, and Mr. PAUL):

H.R. 2627. A bill to amend the Internal Revenue Code of 1986 to provide that amounts paid for foods for special dietary use, dietary supplements, or medical foods shall be treated as medical expenses; to the Committee on Ways and Means.

By Mr. CAPUANO (for himself, Mr. QUINN, Mr. ABERCROMBIE, Mr. REYES, Ms. LEE, Mr. GRIJALVA, Mr. LEWIS of Kentucky, Ms. SCHAKOWSKY, Mr. RANGEL, Mr. HINCHEY, Ms. MILLENDER-MCDONALD, Mr. OWENS, and Mr. LANTOS):

H.R. 2628. A bill to provide affordable housing opportunities for families that are headed by grandparents and other relatives of children; to the Committee on Financial Services.

By Mr. CROWLEY (for himself, Mr. SANDERS, Mr. CASE, Mr. HINCHEY, and Mrs. MALONEY):

H.R. 2629. A bill to provide for the importation of drugs into the United States from Canada and Mexico, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. JACKSON-LEE of Texas (for herself, Mr. CONYERS, Mr. GUTIERREZ, Mr. REYES, Mr. RODRIGUEZ, Mr. GREEN of Texas, Mr. GONZALEZ, Mr. LAMPSON, Mr. FROST, Mr. GRIJALVA, Ms. SOLIS, Mr. SANDLIN, Mr. BECERRA, Ms. WATSON, Mr. MEEK of Florida, Ms. EDDIE BERNICE JOHNSON of Texas, Ms. LEE, Mr. HINCHEY, Mr. MEEKS of New York, Mr. MENENDEZ, Mr. BACA, Mr. ORTIZ, Ms. VELAZQUEZ, Mrs. NAPOLITANO, Mr. HONDA, Mr. SERRANO, Mr. HINOJOSA, Mr. FARR, Mr. BERMAN, Ms. LORETTA SANCHEZ of California, Ms. LINDA T. SANCHEZ of California, Mr. LEWIS of Georgia, Ms. MILLENDER-MCDONALD, Mr. MEEHAN, and Ms. LOFGREN):

H.R. 2630. A bill to prevent commercial alien smuggling, and for other purposes; to the Committee on the Judiciary.

By Mr. TOM DAVIS of Virginia (for himself, Mr. WOLF, Mrs. JO ANN DAVIS of Virginia, and Mr. MORAN of Virginia):

H.R. 2631. A bill to provide that the actuarial value of the prescription drug benefits offered to Medicare eligible enrollees by a plan under the Federal employees health benefits program shall be at least equal to the actuarial value of the prescription drug benefits offered by such plan to its enrollees generally; to the Committee on Government Reform.

By Mr. DUNCAN:

H.R. 2632. A bill to direct the Secretary of Transportation to issue a regulation requiring the installation of 2 combination cockpit voice recorder and digital flight data recorder systems in each commercial passenger aircraft, currently required to carry each of those recorders, and for other purposes; to the Committee on Transportation and Infrastructure.

By Mr. EMANUEL (for himself, Mr. OSE, Mr. FROST, Mr. SANDERS, Ms. HOOLEY of Oregon, Mr. OBERSTAR, Ms. DELAURO, Mr. BOUCHER, Mr. DAVIS of Alabama, Ms. CARSON of Indiana, Mr. DAVIS of Illinois, Mr. LANTOS, Mr. CARDOZA, Mr. TIERNEY, Mr. CASE, Mr. GRIJALVA, Mrs. MCCARTHY of New York, Ms. LINDA T. SANCHEZ of California, and Mr. SERRANO):

H.R. 2633. A bill to establish methods for preventing identity theft and to amend the Fair Credit Reporting Act to protect consumers' sensitive, private health-related information, and for other purposes; to the Committee on Ways and Means, and in addition to the Committees on Energy and Commerce, the Judiciary, and Financial Services, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. ENGLISH (for himself and Mr. HAYWORTH):

H.R. 2634. A bill to suspend temporarily the duty on certain steam generators and certain reactor vessel heads for use in nuclear reactors; to the Committee on Ways and Means.

By Mr. ENGLISH:

H.R. 2635. A bill to make permanent the reduction in capital gains rates for individuals made by the Jobs and Growth Tax Relief Reconciliation Act of 2003; to the Committee on Ways and Means.

By Mr. GREEN of Wisconsin (for himself, Mr. MCINNIS, and Mr. RYAN of Wisconsin):

H.R. 2636. A bill to authorize the Secretary of the Interior to make grants to State and tribal governments to assist State and tribal efforts to manage and control the spread of chronic wasting disease in deer and elk herds, and for other purposes; to the Committee on Resources, and in addition to the Committee on Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. GUTIERREZ (for himself, Ms. DELAURO, Mr. ENGEL, Mr. FROST, Mr. KUCINICH, Ms. BORDALLO, Mr. GRIJALVA, Mr. MCDERMOTT, Ms. ESHOO, Ms. LEE, Mr. OWENS, Mr. LANTOS, Mr. SERRANO, and Mr. EMANUEL):

H.R. 2637. A bill to amend the Electronic Fund Transfer Act to require additional disclosures relating to exchange rates in transfers involving international transactions; to the Committee on Financial Services.

By Mr. HERGER:

H.R. 2638. A bill to amend the Internal Revenue Code of 1986 to make permanent the increase in expensing of certain depreciable business assets enacted by the Jobs and Growth Tax Relief Reconciliation Act 2003; to the Committee on Ways and Means.

By Ms. HOOLEY of Oregon:

H.R. 2639. A bill to expedite procedures for hazardous fuels reduction activities and restoration in wildland fire prone National Forests, and for other purposes; to the Committee on Agriculture, and in addition to the Committee on Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. KENNEDY of Rhode Island (for himself, Mr. FROST, and Ms. NORTON):

H.R. 2640. A bill to provide greater access to affordable pharmaceuticals, and for other purposes; to the Committee on Energy and Commerce, and in addition to the Committee on Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. GEORGE MILLER of California (for himself and Mrs. TAUSCHER):

H.R. 2641. A bill to authorize the Secretary of the Interior to implement the Calfed Bay-Delta Program; to the Committee on Resources, and in addition to the Committee on Transportation and Infrastructure, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mrs. MYRICK:

H.R. 2642. A bill to suspend temporarily the duty on Procion Yellow H-EXL; to the Committee on Ways and Means.

By Mrs. MYRICK:

H.R. 2643. A bill to suspend temporarily the duty on Procion Crimson H-EXL; to the Committee on Ways and Means.

By Mrs. MYRICK:

H.R. 2644. A bill to suspend temporarily the duty on Procion Navy H-EXL; to the Committee on Ways and Means.

By Mrs. MYRICK:

H.R. 2645. A bill to suspend temporarily the duty on Dianix Black XF; to the Committee on Ways and Means.

By Mrs. MYRICK:

H.R. 2646. A bill to suspend temporarily the duty on Dianix Crimson SF; to the Committee on Ways and Means.

By Ms. NORTON:

H.R. 2647. A bill to provide for nuclear disarmament and economic conversion in accordance with District of Columbia Initiative Measure Number 37 of 1992; to the Committee on Armed Services, and in addition to the Committee on International Relations, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. POMBO:

H.R. 2648. A bill to amend the Internal Revenue Code of 1986 to permit the use of proceeds of tax exempt private activity bonds for community and water facility loans guaranteed under the Consolidated Farm and Rural Development Act; to the Committee on Ways and Means.

By Mr. PORTER (for himself, Mr. CARTER, and Mr. COLE):

H.R. 2649. A bill to prohibit the Secretary of Education from making any funds available to a State under any program administered by the Department of Education unless the Secretary determines that the State has in place a criminal information sharing system; to the Committee on Education and the Workforce.

By Mr. RAHALL (for himself, Ms. PELOSI, Mr. UDALL of New Mexico, Mr. RODRIGUEZ, and Mr. HOYER):

H.R. 2650. A bill to prohibit the study or implementation of any plan to privatize, divest, or transfer any part of the mission, function, or responsibility of the National Park Service; to the Committee on Resources.

By Ms. LINDA T. SANCHEZ of California (for herself, Mr. GEORGE MILLER of California, Mr. TOWNS, Mr. RUSH, Ms. MILLENDER-MCDONALD, Mr. FROST, Mr. GRIJALVA, Mr. PASTOR, Mr. ORTIZ, Mr. REYES, Mr. HINOJOSA, Mr. BACA, Ms. JACKSON-LEE of Texas, Mr. MCGOVERN, Mr. SERRANO, Mr. ETHERIDGE, Mr. ENGEL, Mr. MCDERMOTT, Mr. NADLER, Mrs. DAVIS of California, and Ms. DELAURO):

H.R. 2651. A bill to direct the Secretary of Education to make grants to States to establish antibullying programs; to the Committee on Education and the Workforce.

By Mr. STUPAK:

H.R. 2652. A bill to amend the Federal Food, Drug, and Cosmetic Act with respect to the sale of prescription drugs through the Internet; to the Committee on Energy and Commerce.

By Mr. UDALL of Colorado:

H.R. 2653. A bill to facilitate acquisition by the Secretary of the Interior of certain mineral rights, and for other purposes; to the Committee on Resources.

By Mr. VITTER:

H.R. 2654. A bill to amend the Outer Continental Shelf Lands Act to direct the Secretary of the Interior to issue regulations under which the Secretary may authorize use of a decommissioned offshore oil and gas platform for culture of marine organisms, an artificial reef, or scientific research, and for other purposes; to the Committee on Ways and Means, and in addition to the Committee on Resources, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. WALSH (for himself, Mr. KING of New York, Mr. NEAL of Massachusetts, Mr. CROWLEY, Mr. SWEENEY, Mr. MCDERMOTT, Mrs. MCCARTHY of New York, Mr. DOYLE, Mr. QUINN, Mr. MOLLOHAN, Mr. HOLDEN, Mr. SMITH of New Jersey, Mr. ACKERMAN, Mr. MCNULTY, Mr. ENGEL, Mr. PAYNE, Mr. FROST, and Mr. DUNCAN):

H.R. 2655. A bill to amend and extend the Irish Peace Process Cultural and Training Program Act of 1998; to the Committee on the Judiciary, and in addition to the Committee on International Relations, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Ms. WOOLSEY (for herself and Mr. THOMPSON of California):

H.R. 2656. A bill to amend the Graton Rancheria Restoration Act to give the Secretary of the Interior discretion regarding taking land into trust; to the Committee on Resources.

By Mr. KING of New York (for himself, Mr. WALSH, Mr. NEAL of Massachusetts, Mr. CROWLEY, Mr. SWEENEY, Mr. SMITH of New Jersey, Mr. DELAHUNT, Mr. QUINN, Mr. CAPUANO, Mr. ACKERMAN, Mr. ENGEL, Mr. EVANS, Mr. FOSSELLA, Mr. HOLDEN, Mrs. MALONEY, Mr. MCNULTY, Mr. OWENS, Mr. SOUDER, and Mr. WEINER):

H.J. Res. 62. A joint resolution recognizing Commodore John Barry as the first flag officer of the United States Navy; to the Committee on Armed Services.

By Mr. DELAY:

H. Con. Res. 231. Concurrent resolution providing for a conditional adjournment of the House of Representatives and a conditional recess or adjournment of the Senate; considered and agreed to.

By Mr. ANDREWS (for himself, Mr. SESSIONS, Mr. HEFLEY, Mr. SOUDER, Mr. PENCE, Mr. BURTON of Indiana, and Mr. WU):

H. Con. Res. 232. Concurrent resolution expressing the sense of Congress regarding security for Taiwan; to the Committee on International Relations.

By Mr. FOSSELLA (for himself and Mr. TOWNS):

H. Con. Res. 233. Concurrent resolution expressing the sense of Congress regarding the dire humanitarian situation in Liberia and efforts to introduce peace and justice to that country; to the Committee on International Relations.

By Ms. KILPATRICK (for herself, Mrs. CHRISTENSEN, Mr. SERRANO, Mr. STARK, Mr. OWENS, Mr. HOEFFEL, Mr. DAVIS of Illinois, Ms. CARSON of Indiana, Mr. WAXMAN, Ms. LEE, Mrs. JONES of Ohio, Ms. NORTON, and Mr. KILDEE):

H. Con. Res. 234. Concurrent resolution recognizing the importance of preserving the survival of essential urban hospitals; to the Committee on Ways and Means, and in addition to the Committee on Energy and Commerce, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. PASCRELL (for himself, Mr. OXLEY, Mr. BROWN of Ohio, Mr. CLAY, Mr. ETHERIDGE, Mr. FERGUSON, Mr. FORD, Mr. FROST, Mr. HOLT, Mr. JEFFERSON, Mr. KUCINICH, Mr. PAYNE, Mr. TOWNS, Mr. GRIJALVA, Mr. MCDERMOTT, Mrs. CHRISTENSEN, Mr. PALLONE, Mr. SABO, Mr. KING of New York, Mr. FRANK of Massachusetts, Ms. KAPTUR, Mr. ACEVEDO-VILA, Mr. NEAL of Massachusetts, Mr. DOYLE, Mr. CAPUANO, and Mr. BRADY of Pennsylvania):

H. Con. Res. 235. Concurrent resolution celebrating the life and achievements of Lawrence Eugene ''Larry'' Doby; to the Committee on Government Reform.

By Mr. POMEROY:

H. Con. Res. 236. Concurrent resolution permitting the use of the rotunda of the Capitol for a ceremony to commemorate the unveiling of the statue of Sakakawea provided by the State of North Dakota for display in Statuary Hall; to the Committee on House Administration.

By Mr. RENZI (for himself, Mr. FRANKS of Arizona, and Mr. GRIJALVA):

H. Con. Res. 237. Concurrent resolution honoring the late Rick Lupe, lead forestry technician for the Bureau of Indian Affairs Fort Apache Agency, for his dedication and service to the United States and for his essential service in fighting wildfires and protecting the environment and communities of Arizona; to the Committee on Resources.

By Mr. ROHRABACHER:

H. Con. Res. 238. Concurrent resolution supporting efforts to advance regional and community based water and sanitation needs of Israelis, Palestinians, and Jordanians as an effective bridge for peace building in the Middle East; to the Committee on International Relations.

By Ms. WATSON (for herself, Mr. LANTOS, and Mr. PAYNE):

H. Con. Res. 239. Concurrent resolution expressing the sense of the Congress that the global diamond industry, as represented by the World Diamond Council, should provide transition development assistance to communities in Sierra Leone, Angola, and the Democratic Republic of Congo, where the illicit trade in conflict diamonds for arms fueled civil war, and for other purposes; to the Committee on International Relations.

By Mr. HOEKSTRA:

H. Res. 300. A resolution recognizing the outstanding contributions of the faculty, staff, students, and alumni of Christian colleges and universities; to the Committee on Education and the Workforce.

By Mr. ABERCROMBIE:

H. Res. 301. A resolution expressing the sense of the House of Representatives that the Federal Government should actively pursue a unified approach to strengthen and promote the national policy on aquaculture; to the Committee on Resources, and in addition to the Committee on Agriculture, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned.

By Mr. FILNER (for himself, Mr. TOWNS, Mr. COOPER, Mrs. TAUSCHER, Mr. MCGOVERN, Mr. ABERCROMBIE, Mr. PALLONE, Mr. KIRK, and Mr. KUCINICH):

H. Res. 302. A resolution calling for the immediate and unconditional release from prison of certain Kurdish members of the Parliament of the Republic of Turkey; to the Committee on International Relations.

By Mr. LEWIS of Georgia (for himself, Mr. SCOTT of Georgia, Mr. MARSHALL, Mr. BISHOP of Georgia, Ms. MAJETTE, Mr. ISAKSON, Mr. LINDER, Mr. NORWOOD, Mr. KINGSTON, Mr. BURNS, Mr. GINGREY, Mr. COLLINS, Mr. DEAL of Georgia, Mr. FORD, Ms. LEE, Mr. DAVIS of Illinois, Mr. BALLANCE, Mrs. JONES of Ohio, Mr. WATT, Ms. CORRINE BROWN of Florida, Mr. RUSH, Mr. SCOTT of Virginia, Mr. OWENS, Mr. JEFFERSON, Mr. CLAY, Mr. RANGEL, Mr. MEEK of Florida, Mr. CUMMINGS, Ms. WATERS, Ms. JACKSON-LEE of Texas, Mrs. CHRISTENSEN, Mr. PAYNE, Ms. MILLENDER-MCDONALD, and Mr. THOMPSON of Mississippi):

H. Res. 303. A resolution honoring Maynard Holbrook Jackson, Jr., former Mayor of the City of Atlanta, and extending the condolences of the House of Representatives on his death; to the Committee on Government Reform.

By Mrs. NORTHUP:

H. Res. 304. A resolution expressing the sense of the House of Representatives regarding United States citizens adopting children from the People's Republic of China; to the Committee on the Judiciary.

By Mr. ROTHMAN (for himself, Mr. GARRETT of New Jersey, Mr. ANDREWS, Mr. LOBIONDO, Mr. PASCRELL, Mr. FERGUSON, Mr. PALLONE, Mr. SAXTON, Mr. PAYNE, Mr. FRELINGHUYSEN, Mr. HOLT, Mr. SMITH of New Jersey, and Mr. MENENDEZ):

H. Res. 305. A resolution congratulating the New Jersey Devils for winning the 2003 Stanley Cup championship; to the Committee on Government Reform.

By Mr. SERRANO (for himself and Mr. NEY):

H. Res. 306. A resolution congratulating the New York Yankees on the occasion of their 100th anniversary; to the Committee on Government Reform.

By Mrs. TAUSCHER (for herself, Mr. TAYLOR of Mississippi, Mr. WAXMAN, Mr. SPRATT, Mr. ALLEN, Mr. COOPER, Mr. SKELTON, Mr. FROST, Mr. SCHIFF, and Mr. DOOLEY of California):

H. Res. 307. A resolution creating a select committee to investigate the effectiveness of the United States' intelligence structure to meet global threats; to the Committee on Rules.

MEMORIALS

Under clause 3 of rule XII:

134. The SPEAKER presented a memorial of the Senate of the State of Hawaii, relative to Senate Resolution No. 36 memorializing the United States Congress to appropriate adequate financial impact assistance for health, education, and other social services for Hawaii's Freely Associated States citizens; jointly to the Committees on Agriculture, Financial Services, Ways and Means, and Energy and Commerce.

ADDITIONAL SPONSORS

Under clause 7 of rule XII, sponsors were added to public bills and resolutions as follows:

H.R. 22: Mr. WAMP.
H.R. 91: Mr. NEUGEBAUER.
H.R. 193: Mr. BOOZMAN.
H.R. 218: Mr. KILDEE and Mr. HOEKSTRA.
H.R. 236: Mr. ROSS, Mr. RUPPERSBERGER, and Mr. SCOTT of Georgia.
H.R. 276: Mr. HASTINGS of Washington.
H.R. 284: Mrs. MILLER of Michigan, Mr. YOUNG of Alaska, Mr. DICKS, Mr. BOOZMAN, and Mr. LEWIS of Georgia.
H.R. 290: Mr. WHITFIELD, Mr. WYNN, Mr. OWENS, and Mr. UPTON.
H.R. 339: Mr. ROGERS of Michigan.
H.R. 384: Mr. GOODE.
H.R. 401: Mr. MURPHY.
H.R. 438: Mr. BRADLEY of New Hampshire and Ms. EDDIE BERNICE JOHNSON of Texas.
H.R. 465: Mr. LEWIS of Kentucky and Mr. MANZULLO.
H.R. 466: Mr. JANKLOW.
H.R. 505: Mrs. WILSON of New Mexico.
H.R. 528: Mr. RAMSTAD and Mr. FERGUSON.
H.R. 577: Mr. DINGELL and Mr. BALLANCE.
H.R. 594: Mr. BISHOP of Utah, Mr. PETERSON of Minnesota, and Mr. MCDERMOTT.
H.R. 643: Mr. EVANS.
H.R. 648: Mr. BOOZMAN.
H.R. 668: Ms. WATSON.
H.R. 716: Mr. SADLIN.
H.R. 745: Mr. GEPHARDT.
H.R. 806: Mrs. NORTHUP, Mr. KINGSTON, Ms. LEE, Mr. RANGEL, Mr. UPTON, and Mr. OLVER.
H.R. 812: Mr. SESSIONS.
H.R. 817: Mr. NORWOOD.
H.R. 834: Ms. MCCARTHY of Missouri, Mr. ISTOOK, Ms. JACKSON-LEE of Texas, Mr. LUCAS of Oklahoma, and Mr. OWENS.
H.R. 839: Mr. GERLACH, Mr. RYAN of Ohio, Mr. TOWNS, Mr. LAMPSON, Mr. POMBO, Mr. PASCRELL, Mr. EMANUEL, Mrs. MALONEY, Mr. JEFFERSON, Mr. STUPAK, and Mr. KANJORSKI.
H.R. 876: Mr. KENNEDY of Minnesota.
H.R. 898: Ms. MILLENDER-MCDONALD, Mr. SERRANO, Mr. WAXMAN, Mr. OSBORNE, Mr. CONYERS, Mrs. KELLY, Mr. GARRETT of New Jersey, Mr. CLYBURN, and Mr. MARSHALL.
H.R. 918: Mr. OBERSTAR, Mr. LAHOOD, Mr. MEEHAN, Mr. ROGERS of Michigan, Mr. STUPAK, Mr. PASCRELL, Mr. HOLT, Ms. MCCOLLUM, Ms. BALDWIN, and Mr. PAYNE.
H.R. 919: Mr. SHAW.
H.R. 970: Mr. SPRATT, Mr. GREEN of Wisconsin, Ms. DELAURO, and Mr. ROGERS of Michigan.
H.R. 980: Mr. HINCHEY, Mr. FILNER, and Mr. TIERNEY.
H.R. 990: Mr. BISHOP of Utah, Mr. BURGESS, Mr. BARTLETT of Maryland, Mrs. CUBIN, Mr. COLLINS, Mr. DEMINT, Mr. SANDLIN, Mr. CARTER, Mr. ROGERS of Kentucky, Mr. KELLER, and Mr. FOLEY.
H.R. 996: Mr. PORTMAN and Mr. TIAHRT.
H.R. 997: Mr. MILLER of Florida.
H.R. 1006: Mr. KUCINICH and Ms. LINDA T. SANCHEZ of California.
H.R. 1008: Mr. LATHAM and Mr. BEAUPREZ.
H.R. 1046: Mr. MCDERMOTT.
H.R. 1049: Mr. FRANKS of Arizona.
H.R. 1059: Mr. MCGOVERN.
H.R. 1066: Mr. CANNON.
H.R. 1068: Mr. SMITH of New Jersey, Mr. UDALL of New Mexico, Mr. MURPHY, Mr. SCHROCK, Mr. ISRAEL, and Mr. TOOMEY.
H.R. 1088: Ms. ROS-LEHTINEN and Mr. OWENS.
H.R. 1097: Mr. LARSON of Connecticut and Mr. OWENS.
H.R. 1102: Mr. POMEROY.
H.R. 1117: Mr. BARTON of Texas.
H.R. 1157: Mr. OBERSTAR, Mr. CUMMINGS, and Mrs. DAVIS of California.
H.R. 1169: Mr. JANKLOW.
H.R. 1196: Mr. WU.
H.R. 1207: Mr. CLYBURN.
H.R. 1220: Mr. ISSA.
H.R. 1231: Mr. CLYBURN, Mr. SMITH of Texas, Mrs. MUSGRAVE, Mr. MEEK of Florida, Mr. LAMPSON, Mr. PETERSON of Minnesota, Mr. GOSS, and Mr. QUINN.
H.R. 1244: Ms. CORRINE BROWN of Florida, Mr. MCGOVERN, and Ms. BERKLEY.
H.R. 1260: Mr. THORNBERRY.
H.R. 1268: Mr. CLYBURN and Mr. DEUTSCH.
H.R. 1279: Mr. KILDEE.
H.R. 1288: Mrs. MUSGRAVE and Mr. EMANUEL.
H.R. 1301: Ms. LOFGREN, Mr. GERLACH, Mr. LYNCH, and Mr. GOODE.
H.R. 1310: Mr. SESSIONS.
H.R. 1347: Mr. MCGOVERN, Mr. OWENS, and Mr. FROST.
H.R. 1372: Mr. SAM JOHNSON of Texas, Mr. HENSARLING, Mr. BELL, Mr. ROHRABACHER, and Mr. MEEHAN.
H.R. 1385: Mr. OBERSTAR, Mr. MATHESON, Mr. ENGLISH, and Ms. VELAZQUEZ.
H.R. 1400: Mr. BLUMENAUER.
H.R. 1414: Mr. DEFAZIO.
H.R. 1429: Mr. EVANS.
H.R. 1461: Mr. ROTHMAN.
H.R. 1466: Mr. GORDON.
H.R. 1477: Mr. ANDREWS.
H.R. 1482: Mr. OWENS.
H.R. 1499: Mr. OWENS.
H.R. 1501: Mrs. NAPOLITANO.
H.R. 1532: Ms. SLAUGHTER, Ms. HARMAN, Mr. FILNER, Mr. ALLEN, and Mr. DICKS.
H.R. 1563: Mr. WEXLER.
H.R. 1582: Mr. JANKLOW, Mr. HENSARLING, Mr. WU, Mr. GONZALEZ, and Mr. KING of Iowa.
H.R. 1592: Mrs. DAVIS of California.
H.R. 1611: Ms. DELAURO.
H.R. 1622: Mr. DEMINT, Mr. BOOZMAN, and Mr. BONILLA.
H.R. 1639: Mr. MORAN of Virginia, Mr. WEXLER, and Mr. GREEN of Texas.
H.R. 1641: Mr. BLUMENAUER.
H.R. 1675: Mr. HASTINGS of Washington.
H.R. 1684: Mr. VAN HOLLEN, Ms. DEGETTE, Mr. MOORE, Mr. CROWLEY, Mr. FARR, Mr. MORAN of Virginia, Ms. CARSON of Indiana, Mr. ENGEL, Mr. TIERNEY, Mr. RANGEL, Mr. MEEKS of New York, Ms. ESHOO, Mr. SCHIFF, Mr. MCDERMOTT, Mr. BELL, Ms. NORTON, Mr. WEXLER, Mr. FILNER, Mr. HOLT, Mr. SERRANO, Mrs. NAPOLITANO, Mr. FRANK of Massachusetts, Mr. PRICE of North Carolina, and Mr. BLUMENAUER.
H.R. 1690: Mr. FILNER.
H.R. 1707: Mr. SOUDER, Mr. ADERHOLT, Mr. FORBES, Mrs. JO ANN DAVIS of Virginia, and Mr. CLYBURN.
H.R. 1749: Mr. PUTNAM, Mr. LEWIS of Kentucky, Mr. FROST, and Mrs. CHRISTENSEN.
H.R. 1767: Mr. HASTINGS of Washington, Mr. TOOMEY, Mr. BILIRAKIS, Mr. MORAN of Virginia, and Mr. NETHERCUTT.
H.R. 1769: Mr. THOMPSON of California and Ms. LINDA T. SANCHEZ of California.
H.R. 1771: Mr. CALVERT.
H.R. 1776: Mr. EMANUEL.
H.R. 1792: Mr. FROST, Mr. RODRIGUEZ, Ms. BORDALLO, Mr. SANDERS, Mr. WILSON of South Carolina, Mr. SOUDER, Mr. TOWNS, Mr. GRIJALVA, and Mr. OWENS.
H.R. 1819: Mr. LEACH and Mr. FLETCHER.
H.R. 1824: Mr. DICKS, Mr. ROTHMAN, Mr. BRADY of Pennsylvania, Mr. BAIRD, and Mr. PASCRELL.
H.R. 1828: Ms. NORTON, Mr. BECERRA, Mr. UDALL of New Mexico, Mr. COOPER, Mr. MENENDEZ, Mr. FRELINGHUYSEN, Mr. LOBIONDO, Mr. FLETCHER, Mrs. CAPITO, and Mr. CASTLE.
H.R. 1829: Mr. PLATTS and Mr. MEEHAN.
H.R. 1865: Mr. LEACH.
H.R. 1867: Mr. PAUL and Mr. DUNCAN.
H.R. 1874: Mr. ENGEL and Mr. KUCINICH.
H.R. 1886: Ms. VELAZQUEZ and Mr. DAVIS of Tennessee.
H.R. 1918: Mr. MURPHY.
H.R. 1919: Mr. MCGOVERN, Mr. GRIJALVA, and Ms. CARSON of Indiana.
H.R. 1920: Mr. MCGOVERN, Mr. OWENS, and Mrs. CHRISTENSEN.
H.R. 1921: Mr. MCGOVERN and Mr. OWENS.
H.R. 1924: Mr. MCGOVERN, Mr. OWENS, Mr. FROST, and Mr. MCINTYRE.
H.R. 1997: Mr. RAHALL and Mr. LUCAS of Oklahoma.
H.R. 2008: Mrs. CHRISTENSEN.
H.R. 2009: Mr. MCGOVERN and Mr. SIMMONS.
H.R. 2011: Mr. DEUTSCH, Ms. WATERS, Mr. HAYES, Mr. MCHUGH, Mr. PASTOR, and Ms. MCCOLLUM.
H.R. 2042: Ms. LEE, Mr. PAYNE, Ms. MCCARTHY of Missouri, Mr. INSLEE, Ms. BALDWIN, Mrs. NAPOLITANO, Ms. SLAUGHTER, Mr. CASE, Mrs. TAUSCHER, Ms. CARSON of Indiana, Mr. DELAHUNT, and Mr. ISRAEL.
H.R. 2047: Mr. POMEROY.
H.R. 2053: Mr. ABERCROMBIE and Mr. GRIJALVA.
H.R. 2075: Mr. GOSS, Mr. FOLEY, Ms. ROS-LEHTINEN, and Mr. CRENSHAW.
H.R. 2090: Mr. KUCINICH.
H.R. 2096: Mr. GREEN of Texas, Mr. FOLEY, Mr. COLLINS, Mr. SIMMONS, Mr. SKELTON, Ms. VELAZQUEZ, Mr. SMITH of New Jersey, and Mr. MORAN of Virginia.
H.R. 2125: Mr. STUPAK.
H.R. 2154: Mr. LIPINSKI.

H.R. 2172: Mr. GILLMOR, Mr. MCGOVERN, and Mr. CAMP.
H.R. 2178: Mr. RAMSTAD.
H.R. 2180: Mrs. BIGGERT.
H.R. 2193: Mr. ACKERMAN and Mrs. MCCARTHY of New York.
H.R. 2203: Mr. OWENS.
H.R. 2220: Mr. BRADY of Texas.
H.R. 2237: Mrs. JONES of Ohio and Mr. NEY.
H.R. 2249: Mr. OSBORNE.
H.R. 2309: Mr. MCKEON, Mr. DREIER, Mr. HERGER, Mr. OSE, Mr. DOOLITTLE, Mr. POMBO, Mr. RADANOVICH, Mr. NUNES, Mr. THOMAS, Mr. GALLEGLY, Mr. ROYCE, Mr. LEWIS of California, Mr. GARY G. MILLER of California, Mr. CALVERT, Mrs. BONO, Mr. ROHRABACHER, Mr. COX, Mr. ISSA, Mr. CUNNINGHAM, Mr. HUNTER, Mr. THOMPSON of California, and Ms. ROYBAL-ALLARD.
H.R. 2314: Mr. CASE, Mr. KENNEDY of Rhode Island, Mr. MCINTYRE, and Mr. BROWN of Ohio.
H.R. 2327: Mrs. CAPITO.
H.R. 2333: Mr. REHBERG.
H.R. 2340: Mr. BURR and Mr. KOLBE.
H.R. 2357: Mrs. JO ANN DAVIS of Virginia.
H.R. 2379: Mr. PAUL.
H.R. 2386: Mrs. CUBIN, Mr. REHBERG, Mr. BISHOP of Utah, and Mr. HAYWORTH.
H.R. 2393: Mr. OWENS.
H.R. 2419: Mr. BLUMENAUER.
H.R. 2433: Mr. GUTIERREZ, Mr. MICHAUD, and Mr. SNYDER.
H.R. 2435: Mr. NADLER, Mr. THOMPSON of California, and Mr. DAVIS of Florida.
H.R. 2441: Mrs. MCCARTHY of New York, Mrs. NAPOLITANO, Mr. SHIMKUS, Ms. MCCOLLUM, Mr. CALVERT, Mr. PLATTS, Mr. LARSON of Connecticut, and Mr. SCHIFF.
H.R. 2455: Mr. BERMAN.
H.R. 2462: Mr. CLAY and Mr. OBEY.
H.R. 2470: Mr. CROWLEY, Mr. PAYNE, Mr. MCNULTY, Mr. CONYERS, Mrs. CHRISTENSEN, and Mr. EVANS.
H.R. 2478: Mr. MCDERMOTT, Mr. LANTOS, and Mr. OWENS.
H.R. 2485: Mr. KUCINICH.
H.R. 2505: Mr. OWENS.
H.R. 2517: Mr. COBLE.
H.R. 2519: Mr. SABO, Mr. SIMMONS, Mr. KLECZKA, and Mr. GILCHREST.
H.R. 2524: Mr. WAXMAN and Mr. SANDERS.
H.R. 2533: Mr. LINDER, Mr. ISAKSON, and Mr. SCOTT of Georgia.
H.R. 2537: Mr. OWENS.
H.R. 2546: Ms. LEE.
H.R. 2553: Ms. LOFGREN, Mr. ABERCROMBIE, Mr. RANGEL, and Mr. ROSS.
H.R. 2556: Mr. COX, Mr. TERRY, and Mr. SOUDER.
H.R. 2564: Mr. MCGOVERN.
H.R. 2568: Mr. GORDON and Ms. DEGETTE.
H.R. 2570: Mr. WU and Mr. CLYBURN.
H.R. 2595: Mr. ABERCROMBIE, Mr. CASE, and Ms. BORDALLO.
H.J. Res. 9: Mr. BARRETT of South Carolina.
H.J. Res. 36: Mr. SPRATT.
H.J. Res. 59: Mr. LAHOOD.
H. Con. Res. 19: Mr. DINGELL and Mr. BALLANCE.
H. Con. Res. 60: Mr. BEAUPREZ, Mr. DEMINT, and Mr. ROHRABACHER.
H. Con. Res. 78: Ms. ESHOO.
H. Con. Res. 98: Ms. BORDALLO, Mr. SCOTT of Georgia, and Mr. AKIN.
H. Con. Res. 99: Ms. EDDIE BERNICE JOHNSON of Texas.
H. Con. Res. 111: Ms. EDDIE BERNICE JOHNSON of Texas and Mr. ISSA.
H. Con. Res. 119: Mr. SHIMKUS, Mrs. TAUSCHER, and Mr. BERMAN.
H. Res. 49: Mr. SCHIFF.
H. Res. 103: Mr. SANDERS.
H. Res. 142: Mr. NADLER and Mr. GUTIERREZ.
H. Res. 234: Mr. CARSON of Oklahoma and Mr. WATT.
H. Res. 237: Ms. MAJETTE.
H. Res. 259: Mr. MCGOVERN and Mr. ACKERMAN.
H. Res. 285: Mr. MCNULTY, Mr. WAXMAN, and Mr. BURR.
H. Res. 290: Ms. Slaughter.

DELETIONS OF SPONSORS FROM PUBLIC BILLS AND RESOLUTIONS

Under clause 7 of rule XII, sponsors were deleted from public bills and resolutions as follows:

H.R. 2407: Mr. MICHAUD.

DISCHARGE PETITIONS

Under clause of rule XV, the following discharge petition was filed:

Petition 3. June 25, 2003, by Mr. GENE TAYLOR on House Resolution 275, was signed by the following Members: Gene Taylor, Jane Harman, John S. Tanner, Charles W. Stenholm, Ed Case, and Leonard L. Boswell.

DISCHARGE PETITIONS—ADDITIONS OR DELETIONS

The following Members added their names to the following discharge petitions:

Petition 2 by Mr. JIM MARSHALL on House Resolution 251: Michael E. Capuano, Carolyn C. Kilpatrick, Luis V. Gutierrez, Norman D. Dicks, Martin Olav Sabo, William O. Lipinski, David R. Obey, Richard A. Gephardt, Richard E. Neal, and John M. Spratt, Jr.