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House of Representatives

The House met at 10 a.m.

Rabbi Milton Balkany, Dean, Bais Yaakov of Brooklyn, New York, offered the following prayer:

Our Father in Heaven, the majestic sequoias tower over the Alpine expanses, and yet they continue to stretch upward toward the Sun. The mighty Colorado River carved the awesome grandeur of the Grand Canyon eons ago, yet it continues to surge ever onward. The thrashing tide of the Atlantic has brought innumerable ships to port, and yet the waves ebb and flow without cease. I stand here today among the jewels of our Nation, among men and women who are precious, who radiate dedication, and they have been selected as the leaders of our land. And I pray to You, O Lord, that they too remain unsatisfied with yesterday. Let them grow with insight and turn the tide for our land, for we need them, their wisdom, devotion and energy, now more than ever. Amen.

THE JOURNAL

The SPEAKER. The Chair has examined the Journal of the last day's proceedings and announces to the House his approval thereof.

Pursuant to clause 1, rule I, the Journal stands approved.

Mr. MCNULTY. Mr. Speaker, pursuant to clause 1, rule I, I demand a vote on agreeing to the Speaker's approval of the Journal.

The SPEAKER. The question is on the Speaker's approval of the Journal.

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

Mr. MCNULTY. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER. Pursuant to clause 8, rule XX, further proceedings on this question are postponed until later today.

PLEDGE OF ALLEGIANCE

The SPEAKER. Will the gentleman from Tennessee (Mr. COOPER) come forward and lead the House in the Pledge of Allegiance.

Mr. COOPER led the Pledge of Allegiance as follows:

I pledge allegiance to the Flag of the United States of America, and to the Republic for which it stands, one nation under God, indivisible, with liberty and justice for all.

MESSAGE FROM THE SENATE

A message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate has passed without amendment bills of the House of the following titles:

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 redesignate 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''.

The message also announced that the Senate has passed bills of the following titles in which the concurrence of the House is requested:

S. 163. An act to reauthorize the United States Institute for Environmental Conflict Resolution, and for other purposes.

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.

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''.

S. 1207. An act to redesignate the facility of the United States Postal Service located at 120 East Ritchie Avenue in Marceline, Missouri, as the ''Walt Disney Post Office Building''.

ANNOUNCEMENT BY THE SPEAKER

The SPEAKER. The gentlewoman from New York (Mrs. KELLY) will be recognized for 1 minute, followed by 5 one-minutes on each side.

WELCOMING RABBI MILTON BALKANY

(Mrs. KELLY asked and was given permission to address the House for 1 minute.)

Printed on recycled paper.

Mrs. KELLY. Mr. Speaker, Rabbi Milton Balkany, Dean of Bais Yaakov in Brooklyn, New York, is an acquaintance of mine. He has been an active participant and leader in the Jewish community in New York City for many, many years. Rabbi Balkany has worked hard to bring the community together in order to continue traditional religious and cultural values. Not only does he help younger generations understand the intrinsic and extraordinary Jewish culture to which they belong, but he also welcomes others of all religions to engage in prayer, meditation and community.

I applaud you, Rabbi, on this special occasion and welcome you as the guest chaplain of the House of Representatives.

REGARDING AMENDMENT TO INTELLIGENCE BILL

(Mr. KUCINICH asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. KUCINICH. Madam Speaker, yesterday in debate over H.R. 2417, the intelligence bill, the chairman of the committee refused to commit to an Intelligence Committee audit of all telephone and electronic communications between the Central Intelligence Agency and the Vice President to determine whether or not the Vice President influenced intelligence produced by the CIA on Iraq's alleged weapons of mass destruction, the cause of war. First, the chairman said the material may be classified and, second, working documents of the executive are respected and privileged. Some Members want the Permanent Select Committee on Intelligence to have jurisdiction over the issue which top committee members clearly do not want to investigate. If an executive official pressured or manipulated CIA analysts to disseminate false, raw, unreliable information to justify a war, that matter should be neither classified nor shielded nor privileged. My amendment to the intelligence bill would direct the Inspector General of the CIA to audit all electronic communications between the Office of the Vice President and CIA to get to the bottom of numerous public reports which raise questions as to whether or not the Vice President played a role in making false information to become the public reason the President went to war in Iraq.

MEDICARE MODERNIZATION

(Mr. FORBES asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. FORBES. Madam Speaker, I rise today in support of a comprehensive prescription drug benefit for all seniors. The Prescription Drug and Medicare Modernization Act of 2003 will guarantee prescription drug coverage to all our seniors and future generations. I firmly belief that no senior should be forced to choose between putting food on the table or buying the medicines they need. The Prescription Drug and Medicare Modernization Act would build on the strengths and successes of the current Medicare system while guaranteeing that all seniors will have access to a prescription drug benefit.

Just the other day the Secretary of Health and Human Services released a study which says that seniors will get an up-front drug discount of 25 percent. That is a significant savings for many of the seniors in my district. The reforms in this legislation will put patients before paperwork and ensure that doctors will continue to serve seniors through Medicare. The House has acted in the past and will work with the Senate to provide affordable, voluntary coverage for every senior immediately. Let us pass this important legislation. Our seniors have waited too long for this much-needed relief.

MEDICARE MODERNIZATION

(Mr. DEFAZIO ASKED AND WAS GIVEN PERMISSION TO ADDRESS THE HOUSE FOR 1 MINUTE.)

Mr. DEFAZIO. Madam Speaker, the Republican Medicare prescription drug bill will provide unprecedented benefits and protection. Unfortunately, the benefits and protection under this perverse legislation will all flow to the pharmaceutical and insurance industries, not the seniors who need help paying their prescription drug bills. That is right. The biggest beneficiaries are the wildly profitable pharmaceutical industry and the anticompetitive insurance industry. You cannot provide a meaningful benefit unless you deal with the obscene price of prescription drugs. And this bill does nothing, not reasonable pricing, not reimportation, not negotiated lowering of prices, nothing, because that would hurt the profits of the pharmaceutical industry. The insurance industry, they will get a subsidy under this bill to offer some sort of benefit without any requirement what those benefits might be, without any limit on the premiums they might charge, without any requirement who they might provide coverage to or exclude, all beginning in 2006.

We just heard about the great affordable plan we are going to offer today. This begins in the year 2006 and seniors who pay $4,500 a year for drugs will get $3,500 out of their pocket and a thousand from this bill. This is the pharmaceutical industry and insurance industry protection legislation.

HONORING THE 40TH ANNIVERSARY OF THE NATIONAL DRAFT GOLDWATER RALLY

(Mr. WILSON of South Carolina asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WILSON of South Carolina. Madam Speaker, yesterday was the funeral for a great statesman from Arizona, former House Armed Services Chairman Bob Stump. I was reminded of another late Arizona statesman, Senator Barry Goldwater. In fact, next week marks the 40th anniversary of his significant step in the historic presidential campaign he waged in 1964. On July 4, 1963, the National Draft Goldwater Rally was held at the Washington National Guard Armory. I was honored as a young teenager to come on a bus from South Carolina with some of the founders of the modern Republican Party, Drake Edens, Floyd Spence and Rusty DePass. This failed presidential campaign actually was spectacularly successful in launching a political revolution for limited government and expanded freedom. Especially in the South, Republican conservatism has risen from virtual nonexistence to majority status on the local, State and Federal level.

I am grateful for the lasting influence of Barry Goldwater, who inspired victory over communism, achieved by Ronald Reagan, and an emphasis on expanding freedom by reducing taxation, promoted by George W. Bush.

In conclusion, God bless our troops.

MEDICARE PRESCRIPTION DRUG BENEFIT

(Mr. COOPER asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. COOPER. Madam Speaker, today is the day that our seniors have been waiting for for many, many years, the day that we will pass a Medicare prescription drug benefit. Unfortunately, the real debate took place last night upstairs in an attic room in this building in the dark of night, literally starting after midnight, from 1 to 4 a.m., burglar hours, not lawmaker hours. In that debate, they foreclosed real debate on this floor today. They allowed only two bills to be considered, the Republican plan which is deeply flawed, which will end Medicare as we know it, and another plan which is too large to fit within the budget window. I supported the Dooley alternative, a much more sensible piece of legislation. Our seniors deserve better, much better than will be done for them on this House floor today.

□ 1015

PRESCRIPTION DRUG LEGISLATION

(Mr. PENCE asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. PENCE. Madam Speaker, as Congress considers the prescription drug legislation today, I think it is important for the American people to remember a few simple facts. This would be the biggest new Federal entitlement since 1965 when Medicare was created.

Medicare currently costs seven and a half times what this Congress said it would cost when they invented it.

Seventy-six percent of seniors in America today already have prescription drug coverage and according to the CBO under some versions of this legislation more than a third of those Americans who enjoy coverage from a private employer from whom they have retired could lose that coverage.

If the foundations be destroyed, what can the righteous do? Let us not in this Congress today sow the seeds to destroy the foundation of a free market system by creating a universal drug benefit in Medicare. The answer is the reforms the President called for giving Americans the same choices that the Members of Congress have. It is not to create a massive new Federal entitlement.

REPUBLICAN MEDICARE BILL

(Ms. LORETTA SANCHEZ of California asked and was given permission to address the House for 1 minute.)

Ms. LORETTA SANCHEZ of California. Madam Speaker, I heard a strange rumor last night that the Republican Party was going to change its mascot from the elephant to the night owl. This would be fitting since most legislation these days is being discussed by Republicans in the dark of night behind closed doors without giving Democrats a fair chance to debate it here on the House floor.

Today we are going to vote on legislation that will provide the most significant reform in Medicare since its creation in 1965. This legislation will impact millions of seniors across the Nation, yet many of the Representatives in Congress will not have seen this legislation until today. Would someone sign their name on a long-term mortgage for their home if they had never stepped inside that house?

Moreover, many well thought out amendments today will not be debated. For example, my simple, cost effective proposal for a Medicare prescription drug benefit, they did not allow us to bring it to the floor to discuss it. The night owls have yet again ruined a perfect opportunity on what should really be bipartisan legislation. Ain't that a hoot.

HONORING SERGEANT JACOB BUTLER

(Mr. RYUN of Kansas asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. RYUN of Kansas. Mr. Speaker, I rise today on behalf of a true patriot. It will soon be July 4, a date etched in America's heart. A day that serves as a time of reflection and celebration in the memory of sacrifices made; sacrifices made throughout history that granted us the freedoms that we enjoy today.

As our Nation celebrates our independence, it seems appropriate to pay tribute to an Army sergeant that meant a great deal to Kansas and our country. Sergeant Jacob Butler, from Wellsville, Kansas, joined the Army as a private at the young age of 19. He later rose to the rank of sergeant and accepted the demanding task of a scout. Unfortunately, Jacob Butler was killed April 1 when a rocket propelled grenade hit his vehicle in Iraq. It was an honor to attend Jacob's memorial service and funeral with his parents, Jim and Cindy, his friends, his family, and his fellow soldiers. The ceremony reminded me once again that great sacrifices for the causes of freedom did not end on July 4, 1776. Sacrifices continue today.

Jacob is no longer only a blessing to his friends and family, he is now a blessing to an entire Nation. On behalf of the people of Kansas and this grateful Nation, I ask that we remember Sergeant Jacob Butler as a son, a friend, a soldier, and a patriot.

INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

The SPEAKER pro tempore (Mr. PENCE). Pursuant to House Resolution 295 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the further consideration of the bill, H.R. 2417.

□ 1020

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the further consideration of the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes, with Mrs. BIGGERT (Chairman pro tempore) in the chair.

The Clerk read the title of the bill.

The CHAIRMAN pro tempore. When the Committee of the Whole rose on Wednesday, June 25, 2003, a request for a recorded vote on amendment No. 6 printed in House report 108–176 by the gentlewoman from California (Ms. LEE) had been postponed.

SEQUENTIAL VOTES POSTPONED IN COMMITTEE OF THE WHOLE

The CHAIRMAN pro tempore. Pursuant to clause 6 of rule XVIII, proceedings will now resume on those amendments on which further proceedings were postponed in the following order:

Amendment No. 4 offered by the gentleman from Florida (Mr. HASTINGS); amendment No. 5 offered by the gentleman from Ohio (Mr. KUCINICH); amendment No. 6 by the gentlewoman from California (Ms. LEE).

The first electronic vote, if ordered, will be conducted as a 15-minute vote. Remaining electronic votes will be conducted as 5-minute votes.

AMENDMENT NO. 4 OFFERED BY HASTINGS OF FLORIDA

The CHAIRMAN pro tempore. The unfinished business is the demand for a recorded vote on the amendment offered by the gentleman from Florida (Mr. HASTINGS) on which further proceedings were postponed and on which the ayes prevailed by voice vote.

The Clerk will redesignate the amendment.

The text of the amendment is as follows:

Amendment No. 4 offered by Mr. HASTINGS of Florida:

At the end of subtitle D of title III, insert the following new section:

SEC. 337. IMPROVEMENT OF RECRUITMENT, HIRING AND RETENTION OF ETHNIC AND CULTURAL MINORITIES IN THE INTELLIGENCE COMMUNITY.

(a) PILOT PROJECT TO IMPROVE DIVERSITY THROUGHOUT THE INTELLIGENCE COMMUNITY USING INNOVATIVE METHODOLOGIES FOR THE RECRUITMENT, HIRING AND RETENTION OF ETHNIC AND CULTURAL MINORITIES AND WOMEN WITH THE DIVERSITY OF SKILLS, LANGUAGES AND EXPERTISE REFLECTIVE OF THE CURRENT MISSION.—The Director of Central Intelligence shall carry out a pilot project under this section to test and evaluate alternative, innovative methods to recruit and hire for the intelligence community women and minorities with diverse ethnic and cultural backgrounds, skills, language proficiency, and expertise.

(b) METHODS.—In carrying out the pilot project, the Director shall employ methods such as advertising in foreign language newspapers in the United States, site visits to institutions with a high percentage of students who study English as a second language, and other methods that are not used by the Director under the DCI Diversity Strategic Plan to increase diversity of officers and employees in the intelligence community.

(c) DURATION OF PROJECT.—The Director shall carry out the project under this section for a 3-year period.

(d) REPORT.—Not later than 2 years after the date the Director implements the pilot project under this section, the Director shall submit to Congress a report on the project. The report shall include—

(1) an assessment of the effectiveness of the project; and

(2) recommendations on the continuation of the project as well as for improving the effectiveness of the project in meeting the goals of increasing the recruiting and hiring of women and minorities within the intelligence community.

(e) DIVERSITY PLAN.—(1) Not later than February 15, 2004, the Director of Central Intelligence shall submit to Congress a report which describes the plan of the Director, entitled the ''DCI Diversity Strategic Plan'', and any subsequent revision to that plan, to increase diversity of officers and employees in the intelligence community, including the short- and long-term goals of the plan. The report shall also provide a detailed description of the progress that has been made by each element of the intelligence community in implementing the plan.

(2) In implementing the plan, the Director shall incorporate innovative methods for the recruitment and hiring of women and minorities that the Director has determined to be effective from the pilot project carried out under this section.

(f) DEFINITION.—In this section, the term ''intelligence community'' has the meaning given that term in section 3(4) of the National Security Act of 1947 (50 U.S.C. 401(4))).

RECORDED VOTE

The CHAIRMAN pro tempore. A recorded vote has been demanded.

A recorded vote was ordered.

The vote was taken by electronic device, and there were—ayes 418, noes 0, not voting 16, as follows:

[Roll No. 318]

AYES—418

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
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
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
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
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel
Emerson
English
Eshoo
Etheridge
Evans
Everett
Farr
Feeney
Ferguson
Filner
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Frank (MA)
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
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, E. B.
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
Kucinich
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
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
McInnis
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
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
Ramstad
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
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Slaughter
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stark
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)
Weller
Wexler
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Wu
Young (FL)

NOT VOTING—16

Brown-Waite, Ginny
Conyers
Cubin
Engel
Fattah
Gephardt
Hulshof
Jefferson
Kaptur
Kleczka
Rangel
Sessions
Smith (WA)
Weldon (PA)
Wynn
Young (AK)

ANNOUNCEMENT BY THE CHAIRMAN PRO TEMPORE

The CHAIRMAN pro tempore (Mrs. BIGGERT) (during the vote). Members are reminded there are 2 minutes remaining on this vote.

□ 1042

Messrs. TANCREDO, SIMPSON, CANTOR, GARY G. MILLER of California, and FLAKE changed their vote from ''no'' to ''aye.''

So the amendment was agreed to.

The result of the vote was announced as above recorded.

AMENDMENT NO. 5 OFFERED BY MR. KUCINICH

The CHAIRMAN pro tempore. The unfinished business is the demand for a recorded vote on Amendment No. 5 offered by the gentleman from Ohio (Mr. KUCINICH) on which further proceedings were postponed and on which the noes prevailed by voice vote.

The Clerk will redesignate the amendment.

The text of the amendment is as follows:

Amendment No. 5 offered by Mr. KUCINICH:

At the end of title III, add the following new section:

SEC. 345. REPORT ON COMMUNICATIONS BETWEEN THE CENTRAL INTELLIGENCE AGENCY AND THE OFFICE OF THE VICE PRESIDENT ON WEAPONS OF MASS DESTRUCTION IN IRAQ.

(a) AUDIT.—The Inspector General of the Central Intelligence Agency shall conduct an audit of all telephone and electronic communications between the Central Intelligence Agency and the Office of the Vice President that relate to weapons of mass destruction obtained or developed by Iraq preceding Operation Iraqi Freedom on or after September 11, 2001.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Inspector General shall submit to Congress a report on the audit conducted under sub-section (a). The report shall be submitted in unclassified form, but may contain a classified annex.

RECORDED VOTE

The CHAIRMAN pro tempore. A recorded vote has been demanded.

A recorded vote was ordered.

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

The vote was taken by electronic device, and there were—ayes 76, noes 347, not voting 11, as follows:

[Roll No. 319]

AYES—76

Allen
Baldwin
Becerra
Berkley
Blumenauer
Brown (OH)
Brown, Corrine
Capps
Capuano
Carson (IN)
Clay
Clyburn
Davis (IL)
DeFazio
Delahunt
Dingell
Doggett
Farr
Filner
Frank (MA)
Grijalva
Gutierrez
Hinchey
Honda
Inslee
Jackson (IL)
Jackson-Lee (TX)
Johnson, E. B.
Jones (OH)
Kleczka
Kucinich
Lee
Lewis (GA)
Lofgren
Maloney
Markey
McDermott
McGovern
Meehan
Meeks (NY)
Miller, George
Moran (VA)
Nadler
Napolitano
Neal (MA)
Oberstar
Olver
Owens
Pastor
Paul
Payne
Rahall
Rush
Ryan (OH)
Sanders
Schakowsky
Scott (VA)
Serrano
Slaughter
Solis
Stark
Strickland
Thompson (MS)
Tierney
Towns
Udall (CO)
Udall (NM)
Van Hollen
Velazquez
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey

NOES—347

Abercrombie
Ackerman
Aderholt
Akin
Alexander
Andrews
Baca
Bachus
Baird
Baker
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bell
Bereuter
Berman
Berry
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (PA)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Cardin
Cardoza
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Coble
Cole
Collins
Cooper
Costello
Cox
Cramer
Crane
Crenshaw
Crowley
Culberson
Cummings
Cunningham
Davis (AL)
Davis (CA)
Davis (FL)
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeGette
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Edwards
Ehlers
Emanuel

Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Fattah
Feeney
Ferguson
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
Gutknecht
Hall
Harman
Harris
Hart
Hastings (FL)
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hill
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Hooley (OR)
Hostettler
Houghton
Hoyer
Hulshof
Hunter
Hyde
Isakson
Israel
Issa
Istook
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Kanjorski
Keller
Kelly
Kennedy (MN)
Kennedy (RI)
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Latham
LaTourette
Leach
Levin
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Manzullo
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McHugh
McInnis
McIntyre
McKeon
McNulty
Meek (FL)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Mollohan
Moore
Moran (KS)
Murphy
Murtha
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Obey
Ortiz
Osborne
Ose
Otter
Oxley
Pallone
Pascrell
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reyes
Reynolds
Rodriguez
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Ross
Rothman
Roybal-Allard
Royce
Ruppersberger
Ryan (WI)
Ryun (KS)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sandlin
Saxton
Schiff
Schrock
Scott (GA)
Sensenbrenner
Shadegg
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Smith (MI)
Smith (NJ)
Smith (TX)
Snyder
Souder
Spratt
Stearns
Stenholm
Stupak
Sullivan
Sweeney
Tancredo
Tanner
Tauscher
Tauzin
Taylor (MS)
Taylor (NC)
Terry
Thomas
Thompson (CA)
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Turner (TX)
Upton
Visclosky
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Wu
Young (FL)

NOT VOTING—11

Brown-Waite, Ginny
Conyers
Cubin
Gephardt
Jefferson
Kaptur
Rangel
Sessions
Smith (WA)
Wynn
Young (AK)

ANNOUNCEMENT BY THE CHAIRMAN PRO TEMPORE

The CHAIRMAN pro tempore (Mrs. BIGGERT) (during the vote). Members are reminded that there are 2 minutes remaining in this vote.

□ 1051

Ms. DELAURO and Mr. REYNOLDS changed their vote from ''aye'' to ''no.''

So the amendment was rejected.

The result of the vote was announced as above recorded.

AMENDMENT NO. 6 OFFERED BY MS. LEE

The CHAIRMAN pro tempore. The unfinished business is the demand for a recorded vote on amendment No. 6 offered by the gentlewoman from California (Ms. LEE) on which further proceedings were postponed and on which the noes prevailed by voice vote.

The Clerk will redesignate the amendment.

The text of the amendment is as follows:

Amendment No. 6 offered by Ms. LEE:

At the end of title III, add the following new section:

SEC. 345. REPORT ON INTELLIGENCE SHARING WITH UNITED NATIONS WEAPONS INSPECTORS SEARCHING FOR WEAPONS OF MASS DESTRUCTION IN IRAQ.

(a) IN GENERAL.—The Comptroller General of the United States shall conduct a study to determine the extent to which intelligence developed by the Department of Defense and by the intelligence community with respect to weapons of mass destruction obtained or developed by Iraq preceding Operation Iraqi Freedom was made available to the United Nations weapons inspectors and the quantity and quality of the information that was provided (if any).

(b) SPECIFIC MATTER STUDIED.—The study shall provide for an analysis of the sufficiency of the intelligence provided by the Director of Central Intelligence to those weapons inspectors, and whether the information was provided in a timely manner and in a sufficient quantity and quality to enable the inspectors to locate, visit, and conduct investigations on all high and medium value suspected sites of weapons of mass destruction.

(c) ACCESS TO INFORMATION.—(1) Subject to paragraph (2), the Comptroller General may secure directly from any agency or department of the United States information necessary to carry out the study under subsection (a).

(2) The appropriate Federal agencies or departments shall cooperate with the Comptroller General in expeditiously providing appropriate security clearance to individuals carrying out the study to the extent possible pursuant to existing procedures and requirements, except that no person shall be provided with access to classified information under this section without the appropriate security clearances.

(d) REPORT.—Not later than 12 months 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 be submitted in unclassified form, but may contain a classified annex.

RECORDED VOTE

The CHAIRMAN pro tempore. A recorded vote has been demanded.

A recorded vote was ordered.

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

The vote was taken by electronic device, and there were—ayes 185, noes 239, not voting 10, as follows:

[Roll No. 320]

AYES—185

Abercrombie
Ackerman
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
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Costello
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Majette
Maloney
Markey
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Moore
Moran (VA)
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Paul
Payne
Pelosi
Pomeroy
Price (NC)
Rahall
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Rush
Ryan (OH)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velazquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu

NOES—239

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
Bradley (NH)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Cardoza
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cooper
Cox
Cramer
Crane
Crenshaw
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris

Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
Herger
Hobson
Hoekstra
Holden
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Istook
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Lantos
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
Marshall
McCotter
McCrery
McHugh
McInnis
McKeon
McNulty
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Mollohan
Moran (KS)
Murphy
Murtha
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
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
Ruppersberger
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (FL)

NOT VOTING—10

Brown-Waite, Ginny
Conyers
Cubin
Gephardt
Lynch
Rangel
Sessions
Smith (WA)
Wynn
Young (AK)

ANNOUNCEMENT BY THE CHAIRMAN PRO TEMPORE

The CHAIRMAN pro tempore (during the vote). Members are reminded that there are 2 minutes remaining in this vote.

□ 1059

So the amendment was rejected.

The result of the vote was announced as above recorded.

□ 1100

The CHAIRMAN pro tempore (Mrs. BIGGERT). The question is on the committee amendment in the nature of a substitute, as amended.

The committee amendment in the nature of a substitute, as amended, was agreed to.

The CHAIRMAN pro tempore. Under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore (Mr. SHIMKUS) having assumed the chair, Mrs. BIGGERT, Chairman pro tempore of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes, pursuant to House Resolution 295, she reported the bill back to the House with an amendment adopted by the Committee of the Whole.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

Is a separate vote demanded on any amendment to the committee amendment in the nature of a substitute adopted by the Committee of the Whole? If not, the question is on the amendment.

The amendment was agreed to.

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.

(By unanimous consent, Mrs. HARMAN was allowed to speak out of order.)

THANKING MEMBERS AND STAFF

Ms. HARMAN. Mr. Speaker, now that we have completed debate on our intelligence authorization bill for 2004, I just wanted to thank our chairman who is graceful, collaborative and bipartisan and the members and staff on the majority side and to thank the strong team we have on the Democratic side and especially our staff. By name: Christine Healey, John Keefe, Marcel Lettre, Wyndee Parker, Beth Larson, Kirk McConnell, Bob Emmett and Ilene Romack; and also David Flanders of my personal staff for all the effort they put into yesterday's very thorough and, I thought, outstanding debate.

(By unanimous consent, Mr. GOSS was allowed to speak out of order.)

THANKING MEMBERS AND STAFF

Mr. GOSS. Mr. Speaker, I too would like to congratulate my ranking member and the members of the staff on both sides of the aisle. Normally I would name all those staff. This year I am just going to point to one individual who really was the architect of the bill for the majority, put it together, did the hard work as he always does. He does the budget number and he understands the programs. His name is Mike Meermans. In addition to the spectacular work he did for us in a bipartisan and a thoroughly professional way, Mr. Meermans and his family had a sudden and significant illness in the family. We wish his family well and we wish his son Godspeed, full and complete recovery.

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.

Mr. GOSS. Mr. Speaker, on that I demand the yeas and nays.

The yeas and nays were ordered.

The SPEAKER pro tempore. Pursuant to clause 8 of rule XX, further proceedings on this question will be postponed.

GENERAL LEAVE

Mr. GOSS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous material on H.R. 2417.

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

There was no objection.

PROVIDING FOR CONSIDERATION OF MOTIONS TO SUSPEND THE RULES

Mr. LINDER. Madam Speaker, by direction of the Committee on Rules, I call up House Resolution 297 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 297

Resolved, That during the remainder of the One Hundred Eighth Congress, the Speaker may entertain motions that the House suspend the rules on Wednesdays as though under clause 1 of rule XV.

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

Mr. LINDER. Madam Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Massachusetts (Mr. MCGOVERN), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Madam Speaker, H. Res. 297 is a simple, straightforward measure that authorizes the Speaker to entertain motions to suspend the rules on Wednesdays for the remainder of the 108th Congress. I strongly supported this proposal and urge all of my colleagues in the House to join with me in approving this measure.

This past Monday, the Rules Subcommittee on Technology and the House, which I chair, held a hearing to consider this very proposal. The chairman of the Committee on Rules testified on this proposal, and the subcommittee gathered testimony from the minority whip, the gentleman from Maryland (Mr. HOYER), and the gentleman from Massachusetts (Mr. FRANK) as well.

During the debate on H. Res. 297, I urge my colleagues to keep their remarks to the underlying measure, rather than use this modest proposal as an excuse to debate other matters. Extending the Speaker's ability to entertain motions to suspend the rules on Wednesdays provides the House leadership with another tool that can be used to easily move noncontroversial legislation through the Chamber.

By way of background, when the House convened on January 7, 2003, we adopted H. Res. 5, the House rules for the 108th Congress. Specifically, clause 1 of rule XV provides that it is in order for the House to entertain a motion to suspend the rules on Mondays, Tuesdays, and in the last 6 days of session

of Congress. That very same day, the House also approved a standing order that authorized the Speaker to entertain motions to suspend the rules on Wednesdays, through the second Wednesday in April. On April 30, 2003, the House adopted a unanimous consent agreement that extended the authority of the Speaker to entertain motions to suspend the rules through yesterday, June 25. There have been a total of 16 Wednesdays this year on which the House could have considered legislation under suspension of the rules. Through yesterday, this authority was exercised 13 times.

Entertaining motions to suspend the rules on Wednesdays has been a valuable and helpful tool for the House leadership. In fact, just a few weeks ago, the minority showed how much clout they can have actually in defeating these suspensions when they opposed two Senate-passed public lands bills and both measures failed under suspension of the rules. Eventually, we brought both measures back to the floor where they were overwhelmingly approved. There is simply no evidence to support any claim that permitting the Speaker to entertain motions to suspend the rules on Wednesdays limits or infringes on the rights of the minority.

Madam Speaker, approving this resolution is the right thing to do.

Madam Speaker, I reserve the balance of my time.

Mr. MCGOVERN. Madam Speaker, I thank the gentleman from Georgia for yielding me this time, and I yield myself 5½ minutes.

This resolution is simple. It allows the Republican leadership to consider suspension bills on Wednesdays. Current rules allow this body to consider suspension bills on Mondays and Tuesdays. A special provision in the rules allows the majority to place items under the suspension of the rules on Wednesday as well. That special provision expires soon, and it is my understanding that the majority would like to extend it through the 108th Congress.

Madam Speaker, I am rising today to strongly oppose this resolution, and I urge my colleagues to vote ''no'' and defeat the resolution. I have serious concerns about not only the suspension process but about the way this House is being managed. Suspensions should be reserved for noncontroversial items that do not require lengthy debate by the full House. Controversial issues or substantive issues should not be brought to the House floor under the suspension process, a process that allows little debate and no amendments.

But, Madam Speaker, this House is becoming a place where trivial issues get debated passionately and important ones not at all. The majority of this House already allows far too little debate on critical issues facing the American people. Later today, we will debate the most sweeping changes to Medicare since the program was created 38 years ago. Two days ago, I asked the chairman of the Committee on Rules when as a Member of the House I could examine this hugely important bill, and I was told emphatically that it would be available online yesterday morning. So I got up early yesterday morning, and I logged on at home; but there was no bill. I checked again during the day, but again no bill. Finally at 11:50 p.m. last night, we were given a copy of the bill and told the Committee on Rules would hold an emergency meeting an hour later to consider this bill, and we reported the rule at 5 a.m. this morning.

Why the rush to do this bill in the middle of the night? Is this bill so important, so time sensitive that the Republicans need to force it through the Committee on Rules in the dead of night? When I asked the distinguished chairman of the Committee on Rules why it was considered an emergency hearing, all he could tell me was that he called the emergency hearing because it is his prerogative as chairman of the committee and he wanted to do it this way. We had only an hour to look at this final bill, a bill that is close to 700 pages long.

This process, Madam Speaker, is disgraceful. It demeans this body, and it insults the American people who rely on us to read, to debate, and to vote knowledgeably on legislation. It is clear that the Republican leadership wants to rush this bill through this body as quickly as possible. The other body has already spent 2 weeks debating this bill. They will consider over 70 amendments before they are done. Republicans and Democrats alike have been able to bring their amendments to the floor in the other body and to be heard and to debate these issues. Fifty-eight amendments on the Medicare bill were brought to the Committee on Rules this morning. Only one substitute was made in order. Everything else, including some very thoughtful amendments offered by Republicans, was denied. We will have a grand total of 4 hours to discuss a bill that will fundamentally change the way 40 million Americans pay for the medicines that they need.

This process is awful, Madam Speaker; and this resolution will make it worse. The question is quite simple. Rather than naming more post offices on Wednesdays, why do we not have more debate? What is wrong, for example, with this House spending a few days or even a week on the Medicare prescription drug bill? Why not let more Members, Democrats and Republicans alike, have an opportunity to be heard? We obviously have the time; otherwise you would not be here asking for more suspensions to be scheduled. I understand that the majority has a responsibility to run the House, to move legislation through this process. The Committee on Rules can be a tool in that effort; but under this Republican leadership, the Committee on Rules has become not a tool but a weapon, a weapon that stifles debate, that shuts Members and their constituents out of the legislative process, destroys the committee process and harms the public interest, all behind closed doors and often in the middle of the night.

As Members know, and the American people are noticing, the Committee on Rules is where the sausage gets made and it is not pretty.

□ 1115

The facts speak for themselves. Two thirds of the rules reported by this committee in the 106th Congress were closed or restricted. That increased almost three-fourths in the 107th Congress. In fact, less than 30 percent of the rules reported by this committee in the 107th Congress were open. And so far this year of the 52 rules reported by the Committee on Rules six have been open rules, six of 52.

All of this may sound like Inside Baseball to most Americans, but as we can see with the prescription drug bill this stuff matters. In the House of Representatives process determines a great deal, and lately, Madam Speaker, the process around here has been lousy.

When they were in the minority, Republicans consistently complained about their treatment by the then Democratic majority. So if this is payback for the way Democrats ran the House, then call it payback, but please do not claim that this is fair and balanced when it is clearly not. Americans are better served with an open democratic process. It is in the public interest to allow the full and free debate and to have many people and many different points of view heard and considered by Members of the people's House.

In 1994, while still in the minority, Chairman DREIER gave a speech about the undemocratic nature of the Committee on Rules. In that speech he said that ''the arrogance of power with which they prevent Members, rank-and-file Democrats and Republicans, from being able to offer amendments, that is what really creates the outrage here.'' The wisdom of his words still apply today. The arrogance of power is indeed a dangerous thing.

Madam Speaker, I reserve the balance of my time.

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

Mr. MCGOVERN. Madam Speaker, I yield 5 minutes to the distinguished gentleman from Texas (Mr. FROST), the ranking member on the House Committee on Rules.

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

Mr. FROST. Madam Speaker, I thank the gentleman for yielding me this time.

Let us be very clear about what is happening on the floor today. The United States Senate has a procedure called a filibuster where Members can get up and talk and fill time. Up until today the House does not have a filibuster. What we are doing is to pass a

bill, a change in our rules, that would create a filibuster on the floor of the House and prevent Members from having the opportunity to debate substantive matters.

Why do I say that? We are going to add an extra day of suspensions. Why do the Republicans want to add an extra day of suspensions? They want to use our valuable floor time for minor noncontroversial matters. Why do they want to use our valuable floor time for minor noncontroversial matters? Because they do not want to provide full debate on matters like changing Medicare and the new prescription drug plan. Why do they not want to provide full debate on Medicare and prescription drugs? They do not have enough time. There is not enough time for us to do this. Why do not we have enough time? Because they are bringing more noncontroversial bills to the floor.

It is very interesting. This is of course the oft remarked case of the young person who killed his parents and throws himself on the mercy of the court because he is an orphan.

Let us be very clear what the Republicans are doing. They do not want to debate the key substantive issues that face this country. What did they do in the rule last night, this morning? We were here until 5:15 a.m. this morning. Why were we here until 5:15 a.m. this morning in the Committee on Rules? Because our meeting did not start until 12:50 a.m. this morning. Why did it not start until 12:50 this morning? Because the Republicans did not want a meeting that would be widely covered by the press and it would be easily accessible to our Members to come and testify. A lot of very good Members, a lot of conscientious Members on both sides of the aisle stayed up. They were there at 12:50 a.m. and they testified until 5 a.m. this morning, and what did the Republicans on the Committee on Rules do? They told them thanks for coming but no thanks, they are not going to give them any time on the floor, they will not give them an amendment. They did this to some of their own Members as well as to Democrats. Why are they doing that? Because they do not want their own Members to have to vote on things that might be embarrassing for them when they go back to the next election.

So that brings us to where we are today. We are going to create a filibuster rule in the House. We are going to permit the Republican leadership to filibuster, to use our time, our valuable floor time, by bringing noncontroversial bills commending people for things they have done, naming facilities, all kinds of things. We used to just do those in a day or two. Now we are going to have 3 days of those bills and now, ''Oh, by the way, we will not have any time for you to offer your amendment on Medicare, we will not have any time for you to offer your amendment on prescription drugs. We have used up all our time. We have created another suspension day.''

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

Mr. MCGOVERN. Madam Speaker, I yield 3½ minutes to the distinguished gentleman from Florida (Mr. HASTINGS), another member of the Committee on Rules.

Mr. HASTINGS of Florida. Madam Speaker, I thank the gentleman from Massachusetts (Mr. MCGOVERN) for yielding me this time. And the gentleman from Texas (Mr. FROST), the ranking member who is a most distinguished member of the Committee on Rules, is very generous to my colleagues on other side when he says they will bring up nonsubstantive matters on the suspension calendar under the rule that is proposed now, to add a day where suspension matters of the rules can be brought to our attention.

I am not that generous because among the things that I believe that are likely to happen is that we are going to see substantive legislation here on the floor of the House under the suspension calendar. And when that happens that means it did not come to the Committee on Rules. Members did not have an opportunity to amend it. When it is here on the House floor they each have 20 minutes per side and one can bring the most major matter; for example, we were up last night, as has been pointed out, from 12:50 until 5:15 this morning in the Committee on Rules. That is all right, but would the Members believe that under this particular rule that is coming in the middle of a session that what we could also do is bring this same Medicare measure up if we wanted to under the majority provision?

I cannot say it too well, but I said to the chairman of the committee, why are we doing this in the middle of the night? It would seem to me that what we can do is work 9 to 5 Monday through Friday rather than having to have this lack of time. The American people send us up here to work. They do not send us up here to avoid time.

Mr. DREIER. Madam Speaker, will the gentleman yield?

Mr. HASTINGS of Florida. I yield to the gentleman from California.

Mr. DREIER. Madam Speaker, I thank my friend for yielding. And let me begin by expressing my appreciation to him for the hard work that he put into the Committee on Rules meeting last night.

My friend just mentioned the fact that measures that are considered under suspension of the rules are nonsubstantive and his concern is the fact that we may bring up substantive measures under suspension of the rules. The fact of the matter is major substantive pieces of legislation should come up under suspension of the rules. They can only pass if there is a two-thirds vote. The only requirement is that in fact 61 Democrats joined with every Republican to pass the measure.

I thank my friend for yielding. I just wanted to make that clear.

Mr. HASTINGS of Florida. Madam Speaker, reclaiming my time, the gentleman from Massachusetts (Mr. FRANK) will speak to that a little later and tell us how tricky that is when they put matters on and Members cannot, for example, make a distinction between whether they want to vote yes or no and when many times they will want to vote no and find themselves in a box. I believe the gentleman from Massachusetts (Mr. FRANK) will be able to explain it better than I.

The gentleman's chairman and mine, the gentleman's good friend and mine, Gerald Solomon, said the following: Every time we deny an open amendment process on an important piece of legislation, we are disenfranchising the people and their representatives from the legislative process. The people and their representatives are not being even treated as second class citizens. And what I said to the chairman is that roughly 48.9 percent of the people in this country are represented by Democrats.

Let me end by saying what Gerald Solomon said: The people are sick and tired of this political gamesmanship. They want back into their House, and they do want it open and democratic, not closed and dictatorial.

Anybody that believes that this measure is going to help this House of Representatives is participating in what Gerald Solomon described as a closed and dictatorial body, and time will tell.

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

Mr. MCGOVERN. Madam Speaker, I yield 2 minutes to the gentlewoman from Ohio (Ms. KAPTUR).

Ms. KAPTUR. Madam Speaker, I thank the gentleman for yielding me this time and rise in strong opposition to this rule today. Imagine, a bill that will affect over 40 million people. But not until 2006 they tell us, which is very interesting, and we do not even get a chance to read the bill before we vote on it. Last night, I was one of those people that managed to stay in the Committee on Rules until 5 a.m. this morning trying to amend this bill. I thought: ''What a punitive process.'' Yet this is how they are treating the American people, too. It will be harder on them than it was obviously on us staying up all night on this measure that is so vastly important to grandmothers, grandfathers, to older citizens across this country.

They want to privatize Medicare. They want to take this prescription drug benefit and put our seniors into Medicare HMOs. Try to find one that still exists in your area. And they denied me the opportunity to offer my amendment to permit the Secretary of Health and Human Services to have negotiated prices for prescription drugs. Everybody knows bulk buying gets one a better price. They denied me that ability, and not only that but in the base bill in section 8–1800 they forbid the Secretary of Health and Human Services to have negotiated prices to get people the best price for prescription drugs, moreover, in their bill, if a

person's drugs cost over $2,000 a year, well, it's just too bad. Seniors will have to pay between $2,000 and $4,000 for what they cannot afford. How many seniors earning $8,000 a year on Social Security can afford that?

What is the matter with you people? What is the matter with you?

And then they try to limit the amount of time for debate on the floor here. Let's look at negotiated prices on this accompanying chart, which I am trying to get in this bill, take this medicine for high blood pressure, for example, in Canada that costs about $152. In our country it costs about $182 if one goes to the regular drugstore. And if one has a negotiated price like the Department of Veterans Affairs has, you can get it for $102. The consumer saves all that money.

All my amendment tries to do is to use what the Department of Veterans Affairs does to have bulk buying, to have negotiated prices, and apply it to this program so we use the power of the people, the consumer power of the people, to get them the best price for prescription drugs. They will not allow my amendment on this floor today.

I should at least have the right to offer my amendment. You can vote no on it, but you have no right to do this to the senior citizens of our country. I urge my colleagues to vote no on this rule.

Mr. LINDER. Madam Speaker, on my time, I would like to ask the Clerk to reread the rule.

The SPEAKER pro tempore (Mrs. BIGGERT). Without objection, the Clerk will reread the resolution.

There was no objection.

The Clerk reread the resolution.

Mr. LINDER. Madam Speaker, I thought I was correct. This is a rule on suspensions, not on Medicare.

Madam Speaker, I continue to reserve the balance of my time.

Mr. MCGOVERN. Madam Speaker, I yield 2½ minutes to the gentleman from Illinois (Mr. EMANUEL).

Mr. EMANUEL. Madam Speaker, I thank the gentleman from Massachusetts (Mr. MCGOVERN) for yielding me this time.

What are the consequences of what we are talking about? I will give an example. When we were debating the tax bill a couple weeks ago, we found out after the fact because we only had an hour to debate this major tax bill that 12 million children of working parents, 6½ million families, were left on the editing room floor not getting a tax cut that they were promised, a $1,000 tax cut. It costs us $3.5 billion to make those children whole while millionaires were getting their tax cut.

General Musharraf of Pakistan came to the White House the other day, walked out in 24 hours with a $3.5 billion check, equal to the amount it would be to keep the children, 12 million children, 6½ million families, the same amount of money to give them a full $1,000 child tax credit.

They do not have time to debate these things. They learn the consequences later that 12 million children, American children, have been left on the editing room floor because they did not have a lobbyist in the conference room. And we did not know this fact because we had to debate this bill and move it immediately within 1 hour. Six and one half million working families who make $12,000 a year, equal to what a Member of Congress earns in 1 month, yet General Musharraf of Pakistan walked out in 24 hours with that check, equal amount.

That is a consequence. It is a real consequence about whether we have time on the floor to debate these issues, give voice to our values and principles. Whether they are Democrats or Republicans, there are common values, common principles we can find.

□ 1130

Now, if we want to have noncontroversial time on the floor, that is fine. But find in your heart, in your mind, that same sense of justice for controversial issues to debate. Respect the public that we are here to give voice to their values, that we should debate those issues. That is just one consequence.

I had a bipartisan amendment on the prescription drug bill that would allow generics to come to market to compete with name brands to reduce prices. It would also allow us to import drugs from American-made drugs that are sold in Canada, Germany, and England at cheaper prices, that would bring market forces to bear, bring real competition, make drugs affordable, would save close to a half of $1 trillion. There was no room for this debate on prescription drugs for that amendment.

So whether we want noncontroversial, it is not controversial to me, but whether we have real issues debated here on this floor, so people can vote and be held accountable, that, to me, is significant. Let us have time to bring our common values and common principles, to debate them, and stand up in front of our public to let them know where we stand.

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

Mr. MCGOVERN. Madam Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GREEN).

Mr. GREEN of Texas. Madam Speaker, I thank my colleague from Massachusetts for allowing me to talk on this rule, but mainly talk about a rule that will come up in a few minutes.

Madam Speaker, a critical part of the legislative process is to be able to amend legislation so that we can improve it. The rule on Medicare prescription drugs does not allow us to do that. The continued efforts by the leadership of the House to stifle debate on this issue can no longer be tolerated.

Although the rule does allow a substitute, which is better than last year, which I appreciate, there are so many other important amendments that should be debated on the floor on this, one of the most important issues this Congress will consider this year, this prescription drug package for our senior citizens.

The Committee on Energy and Commerce marked up this legislation for 3 days last week, the Democratic side offered dozens of amendments that would significantly improve the legislation. Several of these amendments were very close or tie votes, including one amendment that I offered to close that gap in coverage that is part of the so-called prescription drug benefit plan. That would close that doughnut hole that our seniors are going to fall into under the majority Republican plan. But the Committee on Rules would not let us offer these same amendments, amendments which should have been offered and may have passed on this floor.

One amendment was discussed by my colleague, the gentlewoman from Ohio, regarding a provision in this bill that prohibits the Health and Human Services Secretary from negotiating for cheaper prices for our seniors. That is just wrong. We do not prohibit the VA from doing it. We do not prohibit our States from doing it. In fact, the Committee on Energy and Commerce bill that passed allowed States to do that; yet we are saying that the Federal Government cannot get cheaper prices for our seniors. That amendment should be on this floor.

Madam Speaker, it is far too important for us to rush a debate on a prescription drug benefit for seniors and only have 1 day. The Senate has been debating this bill for the past 2 weeks, but in the House we are going to do this and rush it through in one afternoon. That is not the way our forefathers designed this House to legislate.

I urge my colleagues to oppose the rule when it comes up and obviously to oppose the underlying bill.

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

Mr. MCGOVERN. Madam Speaker, I yield 5½ minutes to the gentleman from Massachusetts (Mr. FRANK).

Mr. FRANK of Massachusetts. Madam Speaker, the disrespect that the majority has for the democratic process is evident today.

The majority brings this to the floor, does not deign to discuss it. Perhaps they are going to wait until they have the very last word, which they are entitled to under the rule; but I do not understand why they should think it is not worth their time and energy to discuss the issues we are trying to solve.

Mr. LINDER. Madam Speaker, will the gentleman yield?

Mr. FRANK of Massachusetts. I will yield to the gentleman from Georgia on his time.

Mr. LINDER. Madam Speaker, I am happy to give the gentleman 2 minutes.

Mr. FRANK of Massachusetts. Madam Speaker, I am happy to yield.

Mr. LINDER. Madam Speaker, I have explained this rule, and the Clerk has

read it twice. I do not know what the gentleman does not understand about it or what needs to be discussed about it. This was a rule that was passed in April under unanimous consent. If the gentleman wants to discuss the rule, I will be delighted to engage him. But if the gentleman wants to discuss something else, he is all on his own.

Mr. FRANK of Massachusetts. Madam Speaker, reclaiming my time, I thank the gentleman for confirming my point. He said the Clerk has read it twice. Okay, America. You have heard specifically the language read twice. You should be grateful for that.

There are philosophical implications here. We have been meeting only on an average of 2½ days a week. You are now going to make 3 out of 2½ days eligible for suspensions.

The chairman of the Committee on Rules said previously, 25 years ago the Democrats went from 1 day to 2. That was 2 days out of 4 days. You have shrunk the time we are in session and increased the amount for suspensions.

The refusal to discuss this announcement, arrogantly, Hey, I read the rule, what more do you want, is what we are getting at.

What we have here is what political philosophers have called authoritarian democracy. It is a view that as long as ultimately a majority ratifies a result, that is all that counts. Well, that is a very unfortunate view of democracy. It is not the view of democracy of the U.S. Constitution, of the Rules of the House of Representatives, or any self-respecting parliamentary democracy.

What we want to have is debate. What we want to have is to air for the public. We are here as the representative body for a great democracy. What is important is not simply the result, not simply your ability, which I envy, to get your Members to vote in a majority for things that they do not like. You are going to produce a majority today for a prescription drug bill for which most of your Members are going to go home and take a prescription drug to cure the headache and the stomach ache and the backache and the twisted arms that they are going to get either from voting for it or after voting for it. But you can get them to do it.

Well, here is what happens. In fact, the chairman of the Committee on Rules said as we debated this in the Committee on Rules, it is partly because there is such a narrow majority that you have to go to these tactics. That is backwards. The narrower the majority in the House, the more respect there ought to be for the procedural forums that allow things not to be forced.

Here is what we have: an ideologically driven majority on the Republican side, very much controlled on key issues by their most extreme ideological cohort, and they are determined to put legislation through that many of their Members do not like. And the key, by the way, is not yes or no on the final bill. This is where you go on suspension. It is a terrible abuse of the democratic process to take a complex issue like we had on Israel yesterday, and I voted for it, but I would have liked to have voted for some amendments. I would like to be able to affirm that Israel has a right of self-defense, but ought to consider as a matter of prudence and as a matter of their own self-interests whether or not they should use it as often as they are entitled to. But it comes up on suspension.

And the important questions are often not ''yes'' or ''no,'' but ''yes, but,'' and ''no, except.'' You do not allow that. You bring them up under suspension because this is your view, only the end result counts. If you can get a majority for the end result, the debate process gets collapsed; and whether or not there are amendments, whether or not there is any modification, that is not allowed.

Here is why: there are people on the Republican side who campaign in their own districts on one set of principles and then come here and enable exactly the opposite to become the law of the land. And here is how they do it. They say to people, oh, I would not vote on that. We are going to vote next week on whether or not, or 2 weeks, whether or not you should be allowed to receive Federal money for secular purposes, and then deny employment to people because you do not like their religion. That is what is going to be up. And we are not going to get to vote on this if past practice is any guide, because we have twice asked to vote on that specific issue; and the Republicans said, no, no, we do not want you to vote on that.

The reason is that if their Members had to vote individually on that, many of them would have to vote not to allow that discrimination because that is what they told people they stand for. So what the Republicans will do will be to bring forward what we call a rule. It is a procedure which will prevent people from voting on the very issue that they claim to support. And then having voted to prevent themselves from voting, they will go to their own constituents and say, you know, I agree; but I was not given a chance to vote. That is what we are dealing with.

That is what happens when you have more suspensions, and this is very relevant to this rule. You take things like the Israel resolution and resolutions on the war and on the troops and on genetically modified foods, all of those were resolutions which I supported, but with which I had some subordinate cause differences. I would have liked to have been able to participate in a democratic process to try to amend them, I think, to strengthen them.

You were afraid, you in the majority, Madam Speaker, to allow that to happen. You wanted to make some political points, so you bring these forward in an unamendable form and you say to people, you are going to have to vote for it. Even if you only agree with 90 percent, we are not going to let you try and change or modify the 10 percent, because then we will say, oh, you are not patriotic, you are not a supporter of the State of Israel, you are not a supporter of the American economy.

That is an abuse of the process, because democracy does not simply means the end result. It means an open process of debate. It means letting people try to change each other's minds. It means letting the American people through the media understand what is going on. What we have is a systemic process here not to allow that.

Madam Speaker, it is not a matter of time. We are told we do not have enough time.

By the way, when I came here and was told by the majority, well, that is the way it used to be. No, it was not. By the way, to the extent that there were abuses in the past, I objected. When I was in the majority, I helped lead a change in the rules because too often, both sides in a conference report took the same position. And I fought for the rights of minorities to take 20 minutes on the conference report.

Madam Speaker, when I came here, we had something called the 5-minute rule. We debated. We yielded to each other. We debated defense bills for 3, 4, and 5 days.

The majority, in the interests of making sure that it gets its Members to do whatever they are told to do without being embarrassed on subordinate issues, has beaten down democracy. They have collapsed democracy into meaning simply the end product. And debates on amendments and public discussion, as evidenced by this today, hey, I read the rule; what do you need? Well, democracy needs debate, discussion. It needs a joinder of the issues, and we do not get that. And we do not get it, as I said, primarily to protect; and we have Members who are not as conservative as the center of gravity on the Republican Party, and I apologize to some in the Republican Party for saying ''center of gravity,'' because I know to many of them ''center'' is a dirty word.

So there are moderate Republicans, so-called, who do not agree with their party's positions. What they are now doing is voting with their party on a series of procedures that disallow democracy, disallow debate, disallow amendments, and that allows them then to appear to be for certain positions when they have voted to collapse them. That is why this rule is a great disservice to democracy.

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

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

First of all, let me echo a point that was made by my colleague from Massachusetts about the importance of the amendment process and how it promotes congressional accountability. Let me read my colleagues a quote: ''What does the ability to offer an amendment have to do with accountability? If a Member has the power to

offer an amendment, he can no longer claim to support one thing, but then say that he was blocked in his effort to make a change in the law. In addition, with more floor votes and more clear issues, Members will be forced to take clear positions with their votes. That is exactly what the American people want: fewer excuses and more elected officials who actually stand for something.''

That quote, Madam Speaker, was made by the distinguished chairman of the Committee on Rules, the gentleman from California (Mr. DREIER). I agree with that quote.

The gentleman from Georgia (Mr. LINDER), my friend, seems confused as to why we are having this debate. He has asked for the amendment resolution to be read over and over, so let me try to clear something up. The reason why we are having this debate today is because we believe that this House is becoming a place where trivial issues get debated passionately, and important ones, not at all. The fact that what they are asking for is an additional day to debate essentially nonconsequential, trivial issues bothers us because we are constantly being told by the majority that we do not have enough time to make everybody's amendments in order. We do not have enough time to allow this House to deliberate. We do not have enough time to make sure that the democratic process works, and that all Members, Democrats and Republicans, have an opportunity to have their constituents' voices be heard on this House floor. So that is why we are having this debate.

We are having it in a particularly passionate way today because of what went on earlier this morning in the Committee on Rules. The prescription drug bill, perhaps one of the most important pieces of legislation that we will deal with, an issue that impacts 40 million of our senior citizens in this country, this bill was brought to the Committee on Rules in the middle of the night, and virtually every amendment and all of the substitutes except one were ruled out of order, were denied. So these people will not have an opportunity to be heard on the floor today.

□ 1145

I mean, we are stunned. We are shocked. We are appalled that on a bill this important that they are rushing it to the floor under an extremely restrictive process, limiting debate so that we are not going to have much of a debate here on this House floor.

In the other body they have been debating it for 2 weeks, over 70 amendments, and they are still debating it; but here in the people's House, we are supposed to represent the people. We are supposed to be the body of government closest to the people. We are being told that we have to do it in a matter of a few hours, let us do it quickly, no amendments and get out of here. That is not the way to do it.

This is too important; and for some of us who worry that they are trying to privatize and weaken Medicare, it is appalling that we do not have an opportunity to have amendments on this floor to protect Medicare, to make sure that it does not wither on the vine, to make sure that it is there for future generations.

That is what is at stake here. That is what we are talking about is so important.

I want to close by making an appeal to some of my Republican colleagues who routinely come before the Committee on Rules and, like many Democrats, get routinely shut out of the process. Many of them were there last night, early this morning, at 2:00, 3:00, 4:00 in the morning trying to get their amendments made in order, very thoughtful amendments. They were shut out of the process. I want to speak to them just for one second and urge them to join with us in voting against this resolution. Send a message to your leadership that everybody in this Congress deserves respect and everybody should be heard, that the constituents that I represent are as important as the constituents that you represent, are as important as the constituents that are represented by the Speaker of the House and the majority leader of this Chamber.

So this is an important vote, and the debate we are having today is very relevant and very relevant to the topic at hand. So I urge my colleagues on both sides of the aisle to vote ''no'' on this. We are spending too much time naming post offices and not enough time debating the issues that real people care about. So I urge a ''no'' vote.

Madam Speaker, I yield back the remainder of my time.

Mr. LINDER. Madam Speaker, I yield myself such time as I may consume.

I do not agree with my Massachusetts colleague who said it is dumbing down democracy to do suspensions and not have amendments. To get to a conclusion at many times is good for the process, good for the country.

Ms. JACKSON-LEE of Texas. Mr. Speaker, I rise in opposition to H. Res. 297 which provides for the Speaker the option to entertain motions to suspend the rules on Wednesdays during the remainder of the One Hundred Eighth Congress. Functionally, this proposal hinders the legislative business of the House. Furthermore, by implication, this bill appears to be nothing more than an another attempt by the Majority to diminish the opportunity of the Minority to debate more substantive issues on this floor.

The purpose for allocating time for these items is to expedite their adoption and entry into the records because they are not controversial. To slow down the legislative calender with three days, instead of two, of noncontroversial items is patently wasteful. Passing legislation to commemorate great citizens and to instill widely-held moral values is quite important but should yield to the simple principle of prioritization. An appropriations bill for projects queued by the Department of Homeland Security to protect our Nation's critical infrastructure and bioterrorism readiness clearly deserve's priority over non-substantive matters. We have a moral duty not to take lightly the lives of our children and grandchildren. Quite frankly, this bill appears to be somewhat of a mockery to our democratic process.

In the years leading up to the election of 1994, the Republican Party in the House of Representatives complained loudly and vociferously that the then-Democratic majority ruled the House with an autocratic iron fist. The Members of the Rules Committee heard this complaint on a daily basis. Democrats were accused of stifling debate and gagging the House.

After eight and a half years of a Republican-controlled House, the Democratic Members of the Rules Committee can report that the House of Representatives is less democratic and more autocratic than ever before. Instead of reforming the House, the Republican majority has taken filibuster and gagging the House to new heights. The Democratic Members of the Rules Committee, as do the other Members of the Democratic Caucus, believe that the Republican majority has, in the years since it took control of this institution, made a concerted effort to shut down debate and stifle the deserving advocates of this legislative institution. We believe this effort by the Republic leadership goes against the public interest and the pledges made by a host of Republican Members in the years leading up to the 1994 election. Furthermore, the ''substance'' of this bill, if you will, completely obliterates legitimate legislative order.

Mr. Speaker, I point that our children and grandchildren deserve better. The first responders on the front line awaiting the necessary funds to staff the ports and the posts against the threat of terrorist attack deserve better. Our brothers in Liberia who have been displaced because of civil and political strife deserve better. The seniors citizens whose ability to obtain prescription drugs in a reasonable fashion deserve better. We, as Member of the House of Representatives are charged to do better.

For the foregoing reasons, I oppose H. Res. 297.

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

The previous question was ordered.

The SPEAKER pro tempore (Mrs. BIGGERT). The question is on the resolution.

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

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

The SPEAKER pro tempore. Pursuant to clause 8, rule XX and the Chair's prior announcement, further proceedings on this motion will be postponed.

The point of no quorum is considered withdrawn.

RECESS

The SPEAKER pro tempore. Pursuant to clause 12(a) of rule I, the Chair

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

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

□ 1253

AFTER RECESS

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

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

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

The Clerk read the resolution, as follows:

H. RES. 299

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

SEC. 2. Upon the adoption of this resolution it shall be in order on the legislative day of June 26 or June 27, 2003, without intervention of any point of order to consider in the House the bill (H.R. 2596) to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes. The bill shall be considered as read for amendment. The previous question shall be considered as ordered on the bill to final passage without intervening motion except: (1) one hour of debate on the bill equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means; and (2) one motion to recommit.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

□ 1300

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

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

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

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

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

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

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

for one of our Nation's most trusted programs.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

□ 1315

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

It will not help our mothers, nor our grandmothers.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

□ 1330

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

These are wonderful steps forward for the cancer community.

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

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

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

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

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

□ 1345

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

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

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

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

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

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

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

□ 1400

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

private sector contributions which are already providing prescription drug benefits.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

There was no objection.

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

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

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

□ 1415

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

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

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

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

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

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

Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare Rx Now Act of 2003''.

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

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

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE RX NOW

Sec. 100. Purpose.

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

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

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

Subtitle B—Benefits for Low-income Beneficiaries

Sec. 111. Benefits for low-income beneficiaries.

Sec. 112. Improving enrollment process under medicaid.

TITLE II—RURAL HEALTH CARE IMPROVEMENTS

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

TITLE I—MEDICARE RX NOW

SEC. 100. PURPOSE.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''OUTPATIENT PRESCRIPTION DRUG COVERAGE

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

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

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

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

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

''(2) ANNUAL DEDUCTIBLE.—

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

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

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

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

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

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

''(3) COST-SHARING.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(A) A Medicare+Choice plan.

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

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

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

''(E) A medicare supplemental policy.

''(F) State pharmaceutical assistance program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(C) STANDARDS.—

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

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

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

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

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

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

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

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

''(iii) DEADLINES.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(D) inappropriate use of antibiotics;

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

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

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

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

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

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

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

''(e) PAYMENT OF PLANS.—

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

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

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

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

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

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

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

''(2) EXCLUSIONS.—

''(A) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3), as the Secretary may specify and does not include such other medicines, classes, and uses as the Secretary may specify consistent with the goals of providing quality care and containing costs under this section.

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

(b) NO EFFECT ON PART B PREMIUM.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Subtitle B—Benefits for Low-income Beneficiaries

SEC. 111. BENEFITS FOR LOW-INCOME BENEFICIARIES.

(a) IN GENERAL.—

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

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

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

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

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

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

''(2) DETERMINATION OF ELIGIBILITY.—

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

''(i) is enrolled under this part;

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

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

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

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

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

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

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

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

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

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

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

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

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

''(4) RELATION TO MEDICAID PROGRAM.—

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

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

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

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

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

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

(b) MEDICAID AMENDMENTS.—

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

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

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

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

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

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

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

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

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

''SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

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

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

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

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

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

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

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

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

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

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

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

''(I) 2007 is 20 percent; or

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(A) 2006 is 90 percent;

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

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

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

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

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

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

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

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

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

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

(d) TREATMENT OF TERRITORIES.—

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

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

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

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

''(f) TREATMENT OF TERRITORIES.—

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

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

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

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

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

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

''(3) INCREASED AMOUNT.—

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

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

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

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

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

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

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

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

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

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

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

SEC. 112. IMPROVING ENROLLMENT PROCESS UNDER MEDICAID.

(a) AUTOMATIC REENROLLMENT WITHOUT NEED TO REAPPLY.—

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

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

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

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

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

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

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

(c) ROLE OF SOCIAL SECURITY OFFICES.—

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

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

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

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

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

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

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

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

TITLE II—RURAL HEALTH CARE IMPROVEMENTS

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

(a) EQUALIZING DSH PAYMENT AMOUNTS.—

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

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

(A) in clause (iv)—

(i) in subclause (II)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xiii)'';

(ii) in subclause (III)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xii)'';

(iii) in subclause (IV)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with

the applicable formula described in clause (vii)'' after ''clause (x) or (xi)'';

(iv) in subclause (V)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (xi)''; and

(v) in subclause (VI)—

(I) by inserting ''and before October 1, 2003,'' after ''April 1, 2001,''; and

(II) by inserting ''or, for discharges occurring on or after October 1, 2003, is equal to the percent determined in accordance with the applicable formula described in clause (vii)'' after ''clause (x)'';

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

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

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

SEC. 202. IMMEDIATE ESTABLISHMENT OF UNIFORM STANDARDIZED AMOUNT IN RURAL AND SMALL URBAN AREAS.

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

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

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

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

(b) CONFORMING AMENDMENTS.—

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

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

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

(C) in clause (i)—

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

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

(D) in clause (ii)—

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

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

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

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

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

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

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

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

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

SEC. 203. ESTABLISHMENT OF ESSENTIAL RURAL HOSPITAL CLASSIFICATION.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 205. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) INCREASE IN PAYMENT AMOUNTS.—

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

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

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

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

(A) in the heading—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

''(4) FUNDING.—

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

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

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

SEC. 206. REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.

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

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

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

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

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

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

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

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

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

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

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

''(ii) REDISTRIBUTION.—

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

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

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

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

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

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

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

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

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

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

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

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

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

(a) HOLD HARMLESS PROVISIONS.—

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

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

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

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

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

(b) STUDY; ADJUSTMENT.—

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

SEC. 211. THREE-YEAR INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) during 2004, 2005, and 2006, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

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

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

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

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

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

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

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

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

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish, on an expedited basis, standards relating to the exception described in section 1128B(b)(3)(H) of the Social Security Act, as added by subsection (a), for health center entity arrangements to the antikickback penalties.

(B) FACTORS TO CONSIDER.—The Secretary shall consider the following factors, among others, in establishing standards relating to the exception for health center entity arrangements under subparagraph (A):

(i) Whether the arrangement between the health center entity and the other party results in savings of Federal grant funds or increased revenues to the health center entity.

(ii) Whether the arrangement between the health center entity and the other party restricts or limits a patient's freedom of choice.

(iii) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

(2) INTERIM FINAL EFFECT.—No later than 180 days after the date of enactment of this Act, the Secretary shall publish a rule in the Federal Register consistent with the factors under paragraph (1)(B). Such rule shall be effective and final immediately on an interim basis, subject to such change and revision, after public notice and opportunity (for a period of not more than 60 days) for public comment, as is consistent with this subsection.

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

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

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

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

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

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the

Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

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

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

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

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

SEC. 215. EXTENSION OF TELEMEDICINE DEMONSTRATION PROJECT.

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

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

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

SEC. 216. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

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

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

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

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

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

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

''(II) HOLD HARMLESS FOR CERTAIN HOSPITALS.—If the application of subclause (I) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this clause had not been enacted.''.

(b) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: ''The Secretary shall apply the previous sentence for any period as if the amendments made by section 202(a) of the Medicare Rx Now Act of 2003 had not been enacted.''.

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

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

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

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

''(E) FLOOR FOR WORK GEOGRAPHIC INDICES.—

''(i) IN GENERAL.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2008, after calculating the work geographic indices in subparagraph (A)(iii), the Secretary shall increase the work geographic index to the work floor index for any locality for which such geographic index is less than the work floor index.

''(ii) WORK FLOOR INDEX.—For purposes of clause (i), the term 'applicable floor index' means—

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

''(II) 1.000 for services furnished during 2005, 2006, and 2007.

''(F) FLOOR FOR PRACTICE EXPENSE AND MALPRACTICE GEOGRAPHIC INDICES.—For purposes of payment for services furnished on or after January 1, 2005, and before January 1, 2008, after calculating the practice expense and malpractice indices in clauses (i) and (ii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.''.

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

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

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

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

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

The Sergeant at Arms will notify absent Members.

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

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

[Roll No. 321]

YEAS—226

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

NAYS—203

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

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

NOT VOTING—6

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

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

□ 1436

Mr. SANDLIN and Mr. TURNER of Texas changed their vote from ''yea'' to ''nay.''

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore (Mr. LATOURETTE). The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Ms. SLAUGHTER. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote, followed by a second 5-minute vote on the question of adoption of House Resolution 297 debated earlier today.

The vote was taken by electronic device, and there were—ayes 221, noes 203, not voting 11, as follows:

[Roll No. 322]

AYES—221

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Hall
Harris
Hart
Hastert
Hastings (WA)
Hayes
Hayworth
Hensarling
Herger
Hobson
Hoekstra
Hostettler
Houghton
Hulshof
Hunter
Hyde
Isakson
Issa
Janklow
Jenkins
Johnson (CT)
Johnson (IL)
Johnson, Sam
Keller
Kelly
Kennedy (MN)
King (IA)
King (NY)
Kingston
Kirk
Kline
Knollenberg
Kolbe
LaHood
Latham
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Young (AK)
Young (FL)

NOES—203

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Bartlett (MD)
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Flake
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hefley
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
Jefferson
John
Johnson, E. B.
Jones (OH)
Kanjorski
Kaptur
Kennedy (RI)
Kildee
Kilpatrick
Kind
Kleczka
Kucinich
Lampson
Langevin
Lantos
Larsen (WA)
Larson (CT)
Lee
Levin
Lewis (GA)
Lipinski
Lofgren
Lowey
Lucas (KY)
Lynch
Majette
Maloney
Markey
Marshall
Matheson
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Ryan (OH)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (GA)
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Toomey
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velazquez
Visclosky
Waters
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—11

Carter
Gephardt
Gutknecht
Istook
Jones (NC)
Matsui
McInnis
Rush
Smith (WA)
Watson
Wolf

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised there are 2 minutes remaining in this vote.

□ 1444

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

The SPEAKER pro tempore. Pursuant to section 6 of House Resolution 299 and clause 1 of rule XXI, all points of order are reserved against provisions contained in the bill making appropriations for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes.

PROVIDING FOR CONSIDERATION OF MOTIONS TO SUSPEND THE RULES

The SPEAKER pro tempore. The pending business is the question of agreeing to the resolution, House Resolution 297.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the resolution.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

RECORDED VOTE

Mr. MCGOVERN. Mr. Speaker, I demand a recorded vote.

A recorded vote was ordered.

The SPEAKER pro tempore. This will be a 5-minute vote.

The vote was taken by electronic device, and there were—ayes 226, noes 203, not voting 5, as follows:

[Roll No. 323]

AYES—226

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Brown-Waite, Ginny
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Crane
Crenshaw
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest

Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Hall
Harris
Hart
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
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
LoBiondo
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Ros-Lehtinen
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Sensenbrenner
Sessions
Shadegg
Shaw
Shays
Sherwood
Shimkus
Shuster
Simmons
Simpson
Smith (MI)
Smith (NJ)
Smith (TX)
Souder
Stearns
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)
Young (FL)

NOES—203

Abercrombie
Ackerman
Alexander
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boswell
Boucher
Boyd
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Case
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cubin
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeFazio
DeGette
Delahunt
DeLauro
Deutsch
Dicks
Dingell
Doggett
Dooley (CA)
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
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
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velazquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—5

Cox
Gephardt
McInnis
Slaughter
Smith (WA)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LATOURETTE) (during the vote). Members are reminded there are 2 minutes remaining on this vote.

□ 1453

So the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

Stated against:

Mr. MATSUI. Mr. Speaker, on rollcall No. 322, had I been present, I would have voted "no."

PROVIDING FOR CONSIDERATION OF H.R. 2559, MILITARY CONSTRUCTION APPROPRIATIONS ACT, 2004

Mrs. MYRICK. Mr. Speaker, by direction of the Committee on Rules, I call up House Resolution 298 and ask for its immediate consideration.

The Clerk read the resolution, as follows:

H. RES. 298

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of the bill (H.R. 2559) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes. The first reading of the bills shall be dispensed with. General debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Appropriations. After general debate the bill shall be considered for amendment under the five-minute rule. Points of order against provisions in the bill for failure to comply with clause 2 of rule XXI are waived. During consideration of the bill for amendment, the Chairman of the Committee of the Whole may accord priority in recognition on the basis of whether the Member offering an amendment has caused it to be printed in the portion of the CONGRESSIONAL RECORD designated for that purpose in clause 8 of rule XVIII. Amendments so printed shall be considered as read. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto the final passage without intervening motion except one motion to recommit with or without instructions.

The SPEAKER pro tempore. The gentlewoman from North Carolina (Mrs. MYRICK) is recognized for 1 hour.

Mrs. MYRICK. Mr. Speaker, for the purpose of debate only, I yield the customary 30 minutes to the gentleman from Massachusetts (Mr. MCGOVERN), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

Last night, the Committee on Rules met and granted an open rule for H.R. 2559, the Fiscal Year 2004 Military Construction Appropriations Act.

The United States military is clearly the best in the world. The young men and women in our Army, Navy, Air Force, Marines, and Coast Guard are thoroughly dedicated and patriotic professionals, the best our Nation has to offer. We are asking a lot from our military today. Our personnel on active duty know that they may well be deployed overseas and, perhaps, on dangerous missions. So we want to provide them a quality of life for themselves and their families that will allow them to serve, knowing that their families will be taken care of with good housing and good health care.

Mr. Speaker, H.R. 2559 recognizes the dedication and commitment of our troops by providing for their most basic needs: improved military facilities, including the previously mentioned housing and medical facilities.

□ 1500

Mr. Speaker, we must honor the most basic commitments we have made to the men and women of our Armed Services. We must ensure a reasonable quality of life to recruit and retain the best and brightest for America's fighting forces. Most importantly, we must do it all, everything in our power to ensure a strong, able, dedicated American military so this Nation will be ever vigilant, ever prepared, so much more important now than it has been in the past.

This bill provides nearly $1.2 billion for barracks, and $176 million for hospitals and medical facilities for our troops and their families. It also provides $2.7 billion to operate and maintain existing housing units, and $1.2 billion for new housing units, much, much needed.

Military families also have a tremendous need for quality child care, especially single parents and families in which one or both parents may face lengthy deployment. To help meet this need, the bill provides $16 million for child development centers. H.R. 2559 is more than just a signal to our soldiers, sailors, airmen and Marines that this Nation recognizes their services and their sacrifice. It is a means by which we meet our commitment to providing

them a decent quality of life so as to sustain the commitment and professionalism of America's all voluntary armed services and the families that support them.

While our men and women in uniform have swiftly dispatched our enemies abroad, they face increasingly complex personal and professional challenges here at home. We must do more to take care of those who are putting their lives on the line to defend our freedoms, and for the families who support them in their efforts. And I am really glad we are getting this done before we head home for the July 4th work break.

Mr. Speaker, I urge my colleagues to support the rule and to support the conference report.

Mr. Speaker, I reserve the balance of my time.

Mr. MCGOVERN. Mr. Speaker, I yield myself 6½ minutes.

Mr. Speaker, I thank the gentlewoman from North Carolina (Mrs. MYRICK) for yielding me the customary 30 minutes.

Mr. Speaker, the rule under consideration for H.R. 2559, the Fiscal Year 2004 Military Construction Appropriations Act, is an open rule. It provides for one hour of general debate, waives all points of order against consideration of the bill, allows for germane amendments and provides for one motion to recommit with or without instructions.

Mr. Speaker, I would like to express my appreciation for the work of the gentleman from Michigan (Chairman KNOLLENBERG) and the ranking member, the gentleman from Texas (Mr. EDWARDS) of the Subcommittee on Military Construction along with the chairman of the Committee on Appropriations, the gentleman from Florida (Chairman YOUNG) and the ranking member, the gentleman from Wisconsin (Mr. OBEY) for continuing the tradition of bipartisan action on this bill and for doing the best with a terrible allocation.

Mr. Speaker, I have a terrible feeling of deja vu. Almost exactly 1 year ago, on June 27 of 2002, I stood on this House floor as the minority manager of the rule on the fiscal year 2003 military construction bill. Along with the then-chairman, the gentleman from Ohio (Mr. HOBSON) and the ranking member, the gentleman from Massachusetts (Mr. OLVER), we all bemoaned the inadequacy of that bill. We all pledged to do better next year and called upon President Bush to increase the budget for desperately needed military construction, housing, base realignment and base closure.

Well, 1 year later none of that has happened. In fact, this year is even worse. If last year's appropriations bill was inadequate, this one is woefully inadequate, to quote the gentleman from Michigan (Chairman KNOLLENBERG). In fact, the fiscal year 2004 bill is $1.5 billion less than last year's bill. Let me repeat that. This bill is $1.5 billion less than the fiscal year 2003 funding levels. It is even $41 million less than the chairman's request.

Mr. Speaker, I would ask my colleagues what in the world are we doing? How can we stand on this House floor day after day, week after week and declare how much we support our uniformed men and women when the funding provided for family housing in this bill is $270 million less than last year? How can we stand on the floor of this House day after day, week after week and say that we are engaged in a long-term struggle against a global enemy when funding for military construction in this bill is $1 billion less than last year?

Mr. Speaker, poor facility conditions are not only unsafe, they hamper readiness and decrease troop retention. According to the Pentagon, 180,000 of the 300,000 units of military housing are substandard. According to the Pentagon, 68 percent of the Department's facilities have deficiencies so serious that they might impede mission readiness or they are so deteriorated that they cannot support mission requirements. The current reductions in funding for construction in these facility categories means that the rate at which buildings are renovated or replaced has just increased from 83 years to 150 years.

This is a national scandal. And let us be clear, this bill is not only about new housing, it is about the operation and maintenance of existing family housing. One of the few increases in family housing in this bill is for the Army. It receives an $81 million increase. Unfortunately, funding for the operation and maintenance of existing Army family housing is cut by $63 million, allowing more and more current housing units to deteriorate and fall into substandard condition. Talk about robbing Peter to pay Paul.

Mr. Speaker, I keep hearing that since the events of September 11 we live in a changed world. I keep on hearing how much we appreciate our Armed Forces, how much we appreciate their sacrifice and service. Then why do we keep cutting and cutting and cutting the military construction appropriations bill? We obviously do not appreciate them enough to give them decent housing. We obviously do not admire them enough to give them quality facilities. Are we going to be on the floor of this House next year expressing our disappointment over how inadequate the military construction appropriations bill is again?

Now, I have been told that we should just wait until the 2005 round of base closings, then we will see some modest increases for housing at the bases that survive the next round of closures. That is as cynical a rationalization as I have ever heard. Do we honestly believe that inadequate housing and facilities exist only on bases likely to be closed down?

Mr. Speaker, this crisis in funding for family housing and military construction is nationwide. It exists at nearly every single base and installation across the land and overseas, and it affects every branch of our Armed Forces. And if base closure is somehow magically supposed to balance the ledgers, then why are we in such a housing and construction crisis right now?

It does not have to be this way, Mr. Speaker, and there is a remedy. The ranking member of the Committee on Appropriations, the gentleman from Wisconsin (Mr. OBEY), tried to provide an extra $958 million above the allocation level for military construction and housing. His solution is not hard to accept. This House would simply scale back 5 percent of the scheduled tax cut for people with adjusted gross incomes of over $1 million for 1 year. This would mean that the tax refund for these individuals would be reduced from about $88,000 to $83,000.

Now, Mr. Speaker, according to the most recent census, there are more than 280 million people in the United States. This modest change in the tax cut would affect about 200,000 individuals, or less than one-tenth of 1 percent of all taxpayers. Such a small adjustment, however, would provide nearly a billion dollars to help ensure that more than 1.4 million men and women who serve our country on active duty have decent housing and workplaces for themselves and their families. But the Republicans on the Committee on Appropriations rejected the gentleman from Wisconsin's (Mr. OBEY) proposal, and last night the Republicans on the Committee on Rules refused to allow the gentleman from Wisconsin's (Mr. OBEY) amendment to even be debated and voted on in this House.

So we are faced with the results of what happens when we rob our Nation of the most basic revenue needed to adequately fund our Nation's priorities. We rob our valiant military personnel of decent homes and facilities. We rob our veterans of their basic benefits. We cut back funding for schools and child care for military families. And we are faced with passing this woefully inadequate bill, a bill I believe that for all the hard work of the gentleman from Michigan (Chairman KNOLLENBERG) and the ranking member, the gentleman from Texas (Mr. EDWARDS), can only be viewed as a shameful scandal on the part of this House.

Mr. Speaker, I reserve the balance of my time.

Mrs. MYRICK. Mr. Speaker, I reserve the balance of my time.

Mr. MCGOVERN. Mr. Speaker, I yield 9 minutes to the distinguished gentleman from Wisconsin (Mr. OBEY), the ranking Democrat on the Committee on Appropriations.

(Mr. OBEY asked and was given permission to revise and extend his remarks, and include extraneous material.)

Mr. OBEY. Mr. Speaker, it would be so nice if the force of our rhetoric is matched by the force of our deeds. That certainly is not the case with this bill.

Just a few months ago this House passed this resolution and it said,

among other things, ''Resolved by the House of Representatives, the Senate concurring, that the Congress express the unequivocal support and appreciation of the Nation to the members of the United States Armed Forces serving in Operation Iraqi Freedom who are carrying out their missions with excellence, patriotism and bravery and also to their families.''

Well, the sad news, unfortunately, is that the check is not in the mail. We have given them a resolution but we are short-sheeting them in terms of things that military families need in order to make their life better. I do not understand why we are doing that. This bill shows the House's ''support and appreciation'' by providing $1.5 billion less than we appropriated last year to provide the military with decent housing and work places.

The bill also thanks the military supposedly by cutting the President's own request for the Pentagon by $180 million. This is for hangers, offices, fitness centers and teaching facilities that even OMB and the administration said the military needed. But this bill cuts them out.

Many Members of this House have seen the problems for themselves. The Pentagon itself rates the readiness of most military facilities as marginal or worse. Over 225,000 service members and their families cannot get decent barracks or decent housing. This bill is not up to the job and we all know why. It is not the fault of the subcommittee chairman. It is the fault of every single Member of this House who voted for the budget resolution which said that the only priorities for this year was going to be tax cuts. And as you know, the lion's share of the tax cuts went into the pockets of the most wealthy 1 percent of people in this country.

So as a result of that decision by the Republican leadership to put tax cuts as the primary goal of this Congress, the budget resolution, for instance, that was passed is on track to cut $28 billion from veterans benefits. There would be, under the White House budget, $200 million in cuts to impact aid to the school districts that educate the children of military families. As many as 230,000 military families have been cut out of the low income child tax provision.

We are taking millionaires off the tax roll, but we are not giving the people who need the help the most anything but table scraps on the tax side.

The defense bill, which was marked up this morning in full committee, will cut raises for the most junior enlisted and officer personnel from the 4.1 percent they have been expecting to just 2 percent. I want to see how many of you who have cried about the fact that you have Army personnel on food stamps, I want to see how many of you vote to cut that. I want to watch that.

A realistic budget resolution has been beyond the reach of the Congress, and this is the result as we are seeing today. Now, I want to be able to offer an amendment to correct the problem. My amendment would reinstate the $160 million in cuts from the President's budget. I would like to restore all of them. I think the White House is right. We need them. I would also add $480 million for family housing. That would help at least 2,500 military families. That would be a useful first step in replacing the 134,000 inadequate units that service members and their families are forced to live in today.

Finally, the amendment would provide $318 million for new barracks that would help 5,300 single service members into decent housing. The Pentagon says we need over 83,000 units, so even this amendment goes just an inch. My amendment is an opportunity to restore the projects the President said were needed, to help about 8,000 service members and their families, and it would help Congress to keep its promise to the troops.

Now, as the gentleman from Massachusetts has indicated, I would pay for it by changing the tax package that was just passed by this Congress. What I would say is that for persons with adjusted gross incomes of more than $1 million, instead of their getting the $88,000 tax cut they will get next year, we would cut that to $83,000. That is hardly starvation wages. Now, these are not just millionaires. These are people with adjusted gross incomes of more than $1 million each year, about 200,000 people in this society. And I bet if you asked them, they would say they would happily take that reduction in order to provide a real improvement in the quality of life for our troops.

□ 1515

We are saying let them keep 95 percent of their tax cut but use that $5,000 difference to give people who are putting their lives on the line for this country better living conditions.

I do not know if you saw the article in the ''Army Times'' June 30, 2003. Mr. Speaker, I will insert this article in the RECORD immediately after my remarks.

I would also like to read you two paragraphs from a news story today out of The New York Times. It reads as follows: ''The 400 wealthiest taxpayers who accounted for more than 1 percent of all income in the United States in the year 2000 more than doubled their share from 8 years earlier, but their tax burden plummeted over that same period of time.''

The article then goes on to say why, and then it says that ''had President Bush's latest tax cuts been in effect in 2000, the average tax bill for the top 400 earners in the country would have been about $30.4 million, a savings of $8.3 million, or more than a fifth.''

Now, when we are in tough times, we have to ask, in my judgment, who needs help the most. I think that decent military housing ought to come before $88,000 tax cuts for the most comfortable people in this society. We are not saying cut them out. We are simply saying shave them back by 5 percent.

Our problem is, we will not even be able to offer this amendment on the floor today because the Committee on Rules said, ''No way, baby.'' So that means that once again, the Republican majority is able to hide behind its budget resolution which did not specify where the cuts would come from in order to pay for the tax cuts.

We have a serious problem in this House. The budget process is supposed to force the Congress to make choices, to recognize trade-offs, and explicitly make those choices in full view of the country. Instead, the budget process is being used in conjunction with the rules out of the Committee on Rules to deny the public the understanding of what the costs are from those tax cuts. So they get to think that they are cost-free.

They do not know, for instance, that they will cost the public an extra $27 billion in interest payments next year. If we could take just $10 billion of that extra interest payment, we could take care of the shortcomings in education, in health care, in military housing, and every other appropriation bill that comes before us. That is what we would do if we had any sense of common sense. That is what we would do if we had any sense of justice.

I urge you to vote against the previous question on the rule so that we can offer the amendment that I have just described.

[From the Army Times, June 30, 2003]

NOTHING BUT LIP SERVICE

In recent months, President Bush and the Republican-controlled Congress have missed no opportunity to heap richly deserved praise on the military. But talk is cheap—and getting cheaper by the day, judging from the nickel-and-dime treatment the troops are getting lately.

For example, the White House griped that various pay-and-benefits incentives added to the 2004 defense budget by Congress are wasteful and unnecessary—including a modest proposal to double the $6,000 gratuity paid to families of troops who die on active duty. This comes at a time when Americans continue to die in Iraq at a rate of about one a day.

Similarly, the administration announced that on Oct. 1 it wants to roll back recent modest increases in monthly imminent-danger pay (from $225 to $150) and family-separation allowance (from $250 to $100) for troops getting shot at in combat zones.

Then there's military tax relief—or the lack thereof. As Bush and Republican leaders in Congress preach the mantra of tax cuts, they can't seem to find time to make progress on minor tax provisions that would be a boon to military homeowners, reservists who travel long distances for training and parents deployed to combat zones, among others.

Incredibly, one of those tax provisions—easing residency rules for service members to qualify for capital-gains exemptions when selling a home—has been a homeless orphan in the corridors of power for more than five years now.

The chintz even extends to basic pay. While Bush's proposed 2004 defense budget would continue higher targeted raises for some ranks, he also proposed capping raises

for E–1s, E–2s and O–1s at 2 percent, well below the average raise of 4.1 percent.

The Senate version of the defense bill rejects that idea, and would provide minimum 3.7 percent raises for all and higher targeted hikes for some. But the House version of the bill goes along with Bush, making this an issue still to be hashed out in upcoming negotiations.

All of which brings us to the latest indignity—Bush's $9.2 billion military construction request for 2004, which was set a full $1.5 billion below this year's budget on the expectation that Congress, as has become tradition in recent years, would add funding as it drafted the construction appropriations bill.

But Bush's tax cuts have left little elbow room in the 2004 federal budget that is taking shape, and the squeeze is on across the board.

The result: Not only has the House Appropriations military construction panel accepted Bush's proposed $1.5 billion cut, it voted to reduce construction spending by an additional $41 million next year.

Rep. David Obey, D-Wis., senior Democrat on the House Appropriations Committee, took a stab at restoring $1 billion of the $1.5 billion cut in Bush's construction budget. He proposed to cover that cost by trimming recent tax cuts for the roughly 200,000 Americans who earn more than $1 million a year. Instead of a tax break of $88,300, they would receive $83,500.

The Republican majority on the construction appropriations panel quickly shot Obey down. And so the outlook for making progress next year in tackling the huge backlog of work that needs to be done on crumbling military housing and other facilities is bleak at best.

Taken piecemeal, all these corner-cutting moves might be viewed as mere flesh wounds. But even flesh wounds are fatal if you suffer enough of them. It adds up to a troubling pattern that eventually will hurt morale—especially if the current breakneck operations tempo also rolls on unchecked and the tense situations in Iraq and Afghanistan do not ease.

Rep. Chet Edwards, D-Texas, who notes that the House passed a resolution in March pledging ''unequivocal support'' to service members and their families, puts it this way: ''American military men and women don't deserve to be saluted with our words and insulted by our actions.''

Translation: Money talks—and we all know what walks.

Mr. MCGOVERN. Mr. Speaker, I yield 6 minutes to the distinguished gentleman from Texas (Mr. EDWARDS), who has worked very hard on this bill.

Mr. EDWARDS. Mr. Speaker, several weeks ago, the gentleman from Texas (Mr. DELAY), the majority leader of this House, said that in time of war nothing is more important than tax cuts. Well, this bill proves it. Because of the tax cuts, including dividend tax cuts for the wealthiest Americans, because of the $88,000 tax cut that every American on average making over $1 million a year will receive, we now bring a bill to this House that should be an embarrassment to the Members of Congress who stood on this floor and said we should honor our servicemen and -women.

I noted the gentlewoman from North Carolina (Mrs. MYRICK) a few minutes ago said this bill is more than a signal to our servicemen and -women. Well, I agree. It is a flashing red light. It says that while we honor you with our words, we cut your quality of life programs with our deeds and with our votes. Yes, it is more than a signal. This bill is a slap in the face to every serviceman and -woman, every military child in America who this year and in years past has made tremendous sacrifices, including the sacrifice of life, to defend our country and our way of life.

The dollar figures in this bill are not the fault of the gentleman from Michigan (Mr. KNOLLENBERG), the great chairman of this subcommittee, of which I am the ranking member. He did the very best any human could do to fairly put together the highest list of priorities given the woefully inadequate funding in this bill; but let us tell the American people, Mr. Speaker, like it is. They deserve the truth and so do our servicemen and -women.

What this Republican leadership in Congress this year has said is that it is more important to give a person making more than $1 million dollar a year an $88,000 tax cut rather than an $83,000 tax cut. It is more important to do that than it is to provide adequate housing and day care and health clinics and training ranges for our brave servicemen and -women, many of whom are serving in Iraq today.

Let us be clear. What this House leadership is saying is that while we salute our troops as they get on the airplane to fly to Iraq or Afghanistan and risk their lives for us, we are handing them a slip saying the administration wants to cut their children's education funding and the IMPACT aid program; and on the very night of March 21 when we voted to salute our troops in Iraq, 8 minutes later the House Republican majority voted to cut those troops' future veterans benefits by $28 billion. There is a clear record here; and, yes, it is a clear signal to our servicemen and -women.

It is that we are going to cut your benefits, your housing, your children's education, your day care clinics, your health facilities in order to pay for the promise of the gentleman from Texas (Mr. DELAY), who said that in time of war, nothing is more important than tax cuts.

Unfortunately, the vast majority of the 44,000 Army soldiers that I have the privilege to represent at Fort Hood in Texas will not get anything or very little at all out of those tax cuts, while the millionaires will average, not the millionaires but the people making over $1 million a year will average more than $88,000 in tax cuts.

How serious is the housing problem for our servicemen and -women? Maybe they already have quality housing. Perhaps there is some Member of this House or some member of the public, Mr. Speaker, that has not visited our military installations recently. Maybe they think they live in the lap of luxury. Let me present the facts.

The fact is that there are 83,000 servicemen and -women living in inadequate barracks that do not even meet the lowest Department of Defense standards. The truth is that there are 128,860 military families, people that on this floor just a few minutes ago were called professional, the best, clearly dedicated, 128,000 of those families are now living in housing that does not meet very low DOD standards.

By the way, just for the record, let me point out what is defined as meeting the quality standard required by the Department of Defense. In the Navy that means that $15,000 could fix up your house where it could meet those lowest minimum DOD standards and you are living in adequate housing. Forget the fact that you may never get that $15,000 to fix your leaky roof or to fix the washer and dryer that are not working or to repair the damage to the structure of the house. If $15,000 would fix it, even if you never get that money to fix that house, you are living in adequate housing.

The truth is, as the gentlewoman from North Carolina said, we ask a lot from our servicemen and -women; and I stand in this House today to say that this bill, despite the tremendous, valiant efforts of the gentleman from Michigan (Mr. KNOLLENBERG) who did the best anybody could with the amount of money given to him, this bill is a slap in the face to our servicemen and -women; and just as the ''Army Times'' in its editorial recently said that our soldiers are in effect getting tired of lip service from Congress, this bill salutes them by insulting them.

It defines our rhetoric of appreciation with the reality of a $1.5 billion cut in important programs that would have meant a better quality of life, better training so that many of our troops might come home safely to the hugs of their families rather than in body bags.

What this House is saying, despite all the intentions that one might have, good or bad, what this House is saying with our votes is that we value more an $88,000 tax cut for millionaires, those making more than $1 million, more than them getting an $83,000 tax cut, we value that more than treating with respect our servicemen and -women.

We should oppose this rule, support the Obey amendment, and back up our rhetoric with our actions.

Mr. MCGOVERN. Mr. Speaker, I yield myself such time as I may consume, and I will close for our side.

Mr. Speaker, first I want to thank the gentleman from Texas (Mr. EDWARDS) and the gentleman from Wisconsin (Mr. OBEY) for their eloquent and powerful words and for reminding us all how we are not living up to our promise to our uniformed men and women, and it is something that every single Member in this House should listen to very carefully; and we now have an opportunity to be able to do something about that.

Mr. Speaker, I will ask for a recorded vote on the previous question, and I will urge Members to vote ''no'' on the

previous question. If the previous question is defeated, I will offer an amendment to the rule that will make in order the Obey amendment to restore funding for military construction programs. This amendment was submitted to the Committee on Rules and rejected by the Republican majority.

The bill provides $9.2 billion for military construction spending. That is $41 million below the level requested by the President, and $1.5 billion less than last year. As we have said over and over, even the gentleman from Michigan (Mr. KNOLLENBERG), the distinguished chairman of the subcommittee, called the bill woefully underfunded.

This amendment will help restore some of these desperately needed additional funds. It will provide an additional $958 million above the subcommittee's allocation. This would be offset by reducing the 2004 tax cut for 200,000 millionaires from $88,000 to $83,000. That is it.

Mr. Speaker, whether or not Members are Republicans or Democrats, they should be extremely concerned, in fact outraged, about the lack of adequate funding for the programs that help our men and women in the military. The Obey amendment would help fix that and do so with no additional cost to the deficit.

Our rhetoric is simply not enough, Mr. Speaker. If we want to honor our uniformed men and women then we should not be cutting their benefits and their programs. We should be providing them what they need.

So I will urge Members on both sides of the aisle to vote ''no'' on the previous question. Let me emphasize that a ''no'' vote will not stop the House from taking up the military construction appropriations bill. However, a ''yes'' vote will prevent the House from considering the Obey amendment to help restore funding for this important legislation.

Mr. Speaker, I ask unanimous consent to insert the text of the amendment and extraneous materials immediately prior to the vote on the previous question.

The SPEAKER pro tempore (Mr. LATOURETTE). Is there objection to the request of the gentleman from Massachusetts?

There was no objection.

Mr. MCGOVERN. Mr. Speaker, again, I urge my colleagues to vote ''no'' on the previous question, and I yield back the balance of my time.

The material previously referred to by the gentleman from Massachusetts is as follows:

PREVIOUS QUESTION FOR H. RES. 298—RULE ON H.R. 2559 FISCAL YEAR 2004 MILITARY CONSTRUCTION APPROPRIATIONS

At the end of the resolution, add the following:

''SEC. 2. Notwithstanding any other provision of this resolution, the amendment printed in section 3 shall be in order without intervention of any point of order and before any other amendment if offered by Representative Obey of Wisconsin or a designee. The amendment is not subject to amendment except for pro forma amendments or to a demand for a division of the question in the committee of the whole or in the House.

''SEC. 3. The amendment referred to in section 2 is as follows:

On page 2, line 13, under the heading ''Military Construction, Army'', delete the dollar amount and insert $1,726,660,000;

On page 3, line 13, under the heading ''Military Construction, Navy'', delete the dollar amount and insert $1,311,907,000;

On page 4, line 5, under the heading ''Military Construction, Air Force'', delete the dollar amount and insert $968,509,000;

On page 4, line 21, under the heading ''Military Construction, Defense-Wide'', delete the dollar amount and insert $872,110,000;

On page 5, line 20, under the heading ''Military Construction, Army National Guard, delete the dollar amount and insert $231,860,000;

On page 6, line 3, under the heading ''Military Construction Air National Guard'', delete the dollar amount and insert $95,605,000;

On page 7, line 19, under the heading ''Family Housing Construction, Army'', delete the dollar amount and insert $601,191,000;

On page 8, line 13, under the heading ''Family Housing Construction, Navy and Marine Corps'', delete the dollar amount and insert $288,193,000;

And on page 9, line 6, under the heading ''Family Housing Construction, Air Force'', delete the dollar amount and insert $841,065,000.

At the end of the bill, add the following:

Section . In the case of taxpayers with adjusted gross income tax excess of $1,000,000 for the tax year beginning in 2003, the amount of tax reduction resulting from enactment of the Jobs and Growth Tax Relief Reconciliation Act of 2003 shall be reduced by five percent.

Mrs. MYRICK. Mr. Speaker, I yield back the balance of my time, and I move the previous question on the resolution.

The SPEAKER pro tempore. The question is on ordering the previous question.

The question was taken; and the Speaker pro tempore announced that the ayes appeared to have it.

Mr. MCGOVERN. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

Pursuant to clause 9 of rule XX, the Chair will reduce to 5 minutes the minimum time for electronic voting, if ordered, on the question of adoption of the resolution.

The vote was taken by electronic device, and there were—yeas 220, nays 200, not voting 14, as follows:

[Roll No. 324]

YEAS—220

Aderholt
Akin
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Biggert
Bilirakis
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Carter
Castle
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Culberson
Cunningham
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Diaz-Balart, L.
Diaz-Balart, M.
Doolittle
Dreier
Duncan
Dunn
Ehlers
Emerson
English
Everett
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Franks (AZ)
Frelinghuysen
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gillmor
Gingrey
Goode
Goodlatte
Goss
Granger
Graves
Green (WI)
Greenwood
Gutknecht
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hefley
Hensarling
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
LaTourette
Leach
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
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
Sullivan
Sweeney
Tancredo
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Toomey
Turner (OH)
Upton
Vitter
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (FL)

NAYS—200

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
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Hall
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Hooley (OR)
Hoyer
Inslee
Israel
Jackson (IL)
Jackson-Lee (TX)
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
Waters
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—14

Brown-Waite, Ginny
Cubin
Dooley (CA)
Evans
Gephardt
Herger
Jefferson
Lewis (CA)
McInnis
Paul
Smith (WA)
Stearns
Watson
Young (AK)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LATOURETTE) (during the vote). Members are advised 2 minutes remain in this vote.

□ 1551

Mr. GORDON changed his vote from ''yea'' to ''nay.''

So the previous question was ordered.

The result of the vote was announced as above recorded.

The SPEAKER pro tempore. The question is on the resolution.

The resolution was agreed to.

A motion to reconsider was laid on the table.

PERMISSION FOR COMMITTEE ON APPROPRIATIONS TO HAVE UNTIL MIDNIGHT, JULY 3, 2003, TO FILE PRIVILEGED REPORT ON LEGISLATIVE BRANCH APPROPRIATIONS ACT, 2004

Mr. KINGSTON. Mr. Speaker, I ask unanimous consent that the Committee on Appropriations have until midnight, July 3, 2003, to file a privileged report, making appropriations for the Legislative Branch for the fiscal year ending September 30, 2004, and for other purposes.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Georgia?

There was no objection.

The SPEAKER pro tempore. Pursuant to clause 1 of rule XXI, all points of order are reserved on the bill.

GENERAL LEAVE

Mr. KNOLLENBERG. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks, and that I be permitted to include tabular and extraneous material on the bill, H.R. 2559.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Michigan?

There was no objection.

MILITARY CONSTRUCTION APPROPRIATIONS ACT, 2004

The SPEAKER pro tempore. Pursuant to House Resolution 298 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 2559.

□ 1553

IN THE COMMITTEE OF THE WHOLE

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 2559) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes, with Mr. BASS in the chair.

The Clerk read the title of the bill.

The CHAIRMAN. Pursuant to the rule, the bill is considered as having been read the first time.

Under the rule, the gentleman from Michigan (Mr. KNOLLENBERG) and the gentleman from Texas (Mr. EDWARDS) each will control 30 minutes.

The Chair recognizes the gentleman from Michigan (Mr. KNOLLENBERG).

Mr. KNOLLENBERG. Mr. Chairman, I yield myself such time as I may consume.

(Mr. KNOLLENBERG asked and was given permission to revise and extend his remarks.)

Mr. KNOLLENBERG. Mr. Chairman, it is my pleasure to present to the House H.R. 2559, the fiscal year 2004 military construction appropriations bill. This legislation provides funds for all types of construction projects on military installations here in the U.S. and abroad. Projects range from barracks and housing to training ranges and runways.

I would like to thank my ranking member, the gentleman from Texas (Mr. EDWARDS), for his advice and support and cooperation in producing this recommendation. He has been a good partner, and I appreciate having the gentleman there to work together on this bill.

I would also like to express my appreciation to all members of the subcommittee for their help in putting together this year's bill. I commend the good work done by the subcommittee staff, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldwin. This has made my transition to chairman an easy one. I want to thank my personal staff, Jeff Onizuk and Lieutenant Commander Scott Gray. I appreciate the long hours they have put in making this the best bill possible.

The bill presented today totals $9.196 billion, which complies with the 302(b) allocation for both budget authority and outlays. This recommendation is, however, $41 million below the President's request, a reduction of less than ½ of 1 percent. Excluding funds provided in response to the global war on terrorism and Operation Iraqi Freedom, the bill is $605 million or 6 percent below fiscal year 2003 enacted levels.

For the first time in recent memory, this subcommittee has produced a recommendation that is below the President's request. This is the hand that we were dealt under current budgetary constraints, and we have tried to deal with it in as fair a manner as possible.

I assure Members the committee did due diligence to find as much savings as possible for the bill, and I believe we left no stone unturned in this process. This bill continues the subcommittee's bipartisan tradition of quality of life first for our service men and women. This is our paramount goal, and I believe we have reached it.

As many Members are aware, the Department of Defense is undertaking a privatization effort for military housing. For those of us who have seen the results thus far, this is an exciting development. What it means for the family housing account of this bill is that less money does not mean less housing. It means that we are getting more bang for our buck. For example, take the Residential Communities Initiative at the Presidio of Monterey. Using only the basic allowance for housing, the BAH, 2,168 new homes will be built and 41 historic units will be renovated. In addition, the private contractor will build wider roads, playgrounds, amenities such as community centers and swimming pools, and so on. What had been substandard housing will become an enviable community for our military families, and it will come at no cost, no cost to the family housing account in this bill.

The bottom line is that the funding in this bill does not slow down the effort to revitalize our military family housing. In fact, that effort is accelerating because of this privatization initiative.

I would like to take a moment to highlight some key areas in the bill. First, $1.24 billion is provided for troop barracks. This is a $62 million increase from last year's level. This sends a positive message to our unaccompanied personnel stationed all around the world that their quality of life is a priority.

The bill includes $194 million for hospital and medical facilities, an increase of $25 million above last year's level. This is another positive quality-of-life message, one intended for all service members as well as their families.

$274 million is provided for community facilities, an increase of $45 million above the President's request. These facilities include child development centers, fire stations, schools, and physical fitness centers.

$465 million is provided for the Guard and Reserve components, an increase of $95 million above the President's request.

The bill fully funds the President's request of $1.2 billion for new family housing units and improvements to existing units, and $2.7 billion is provided for the operation and maintenance of existing family housing units.

□ 1600

I would like to highlight the overseas military construction program for just one moment. In support of a global repositioning effort, the President's amended budget submission and the recommendation before Members today rescinds and/or reduces overseas construction requirements by $327 million. Of these reductions, $279 million has been applied to construction requirements in the United States. It is my opinion additional cuts will adversely impact the quality of life and mission readiness of our troops living overseas, including those who are fighting the war against terrorism and also in Operation Iraqi Freedom. Therefore, I cannot recommend additional cuts in this area to my colleagues.

We have worked closely with the authorization committee in producing this legislation. I would like to take this opportunity to thank the gentleman from Colorado (Mr. HEFLEY) and his staff for their assistance.

In conclusion, we have focused our efforts on programs that directly support the men and women in our Armed Forces. We would like to do more. We always have and always will. But in my opinion, the recommendations in this bill are solid and fully fund projects that are vital to the security of the United States. The bottom line is this: with this bill, we meet the military's mission critical infrastructure needs and enable its efforts to improve the quality of life for our men and women in the Armed Forces. This is a fair bill. I encourage all my colleagues to support it.

Mr. Chairman, I include the following tabular material for the RECORD:

BUDGET AUTHORITY FOR 2003 AND BUDGET REQUESTS AND AMOUNTS RECOMMENDED IN THE BILL FOR 2004
(Amounts in thousands) (H.R. 2559)

	FY 2003 Enacted	FY 2004 Request	Bill	Bill vs. Enacted	Bill vs. Request
Military construction, Army	1,472,022	1,602,060	1,533,660	+61,638	-68,400
Defense emergency response fund (DERF)	211,688	---	---	-211,688	---
Subtotal	1,683,710	1,602,060	1,533,660	-150,050	-68,400
Rescission	-49,376	-66,050	-183,615	-134,239	-117,565
Supplemental appropriations (P.L. 108-11)	2,000	---	---	-2,000	---
Total	1,636,334	1,536,010	1,350,045	-286,289	-185,965
Military construction, Navy	1,095,698	1,147,537	1,211,077	+115,379	+63,540
Defense emergency response fund (DERF)	209,430	---	---	-209,430	---
Subtotal	1,305,128	1,147,537	1,211,077	-94,051	+63,540
Rescission	-1,340	-14,679	-39,322	-37,982	-24,643
Supplemental appropriations (P.L. 108-11)	48,100	---	---	-48,100	---
Total	1,351,888	1,132,858	1,171,755	-180,133	+38,897
Military construction, Air Force	891,650	830,671	896,136	+4,486	+65,465
Defense emergency response fund (DERF)	188,597	---	---	-188,597	---
Subtotal	1,080,247	830,671	896,136	-184,111	+65,465
Rescission	-13,281	---	---	+13,281	---
Rescission (P.L. 108-7)	-18,600	---	---	+18,600	---
Supplemental appropriations (P.L. 108-11)	152,900	---	---	-152,900	---
Total	1,201,266	830,671	896,136	-305,130	+65,465
Military construction, Defense-wide	836,345	815,113	813,613	-22,732	-1,500
Defense emergency response fund (DERF)	33,300	---	---	-33,300	---
Subtotal	869,645	815,113	813,613	-56,032	-1,500
Rescissions	-2,976	-997	-32,680	-29,704	-31,683
Total	866,669	814,116	780,933	-85,736	-33,183
Total, Active components	5,056,157	4,313,655	4,198,869	-857,288	-114,786
Military construction, Army National Guard	241,377	168,298	208,033	-33,344	+39,735
Military construction, Air National Guard	194,880	60,430	77,105	-117,775	+16,675
Defense emergency response fund (DERF)	8,933	---	---	-8,933	---
Total	203,813	60,430	77,105	-126,708	+16,675
Military construction, Army Reserve	100,554	68,478	84,569	-15,985	+16,091
Military construction, Naval Reserve	67,804	28,032	38,992	-28,812	+10,960
Defense emergency response fund (DERF)	7,117	---	---	-7,117	---
Total	74,921	28,032	38,992	-35,929	+10,960

BUDGET AUTHORITY FOR 2003 AND BUDGET REQUESTS AND AMOUNTS RECOMMENDED IN THE BILL FOR 2004
(Amounts in thousands) (H.R. 2559)

	FY 2003 Enacted	FY 2004 Request	Bill	Bill vs. Enacted	Bill vs. Request
Military construction, Air Force Reserve	63,650	44,312	56,212	-7,438	+11,900
Defense emergency response fund (DERF)	3,576	---	---	-3,576	---
Subtotal	67,226	44,312	56,212	-11,014	+11,900
Miscellaneous appropriations (P.L. 108-7)	18,600	---	---	-18,600	---
Total	85,826	44,312	56,212	-29,614	+11,900
Total, Reserve components	706,491	369,550	464,911	-241,580	+95,361
Total, Military construction	5,762,648	4,683,205	4,663,780	-1,098,868	-19,425
Appropriations	(5,185,580)	(4,764,931)	(4,919,397)	(-266,183)	(+154,466)
Defense emergency response fund	(662,641)	---	---	(-662,641)	---
Rescissions	(-85,573)	(-81,726)	(-255,617)	(-170,044)	(-173,891)
North Atlantic Treaty Organization Security Investment Program	167,200	169,300	169,300	+2,100	---
Family housing construction, Army	280,356	409,191	409,191	+128,835	---
Rescission	-4,920	-52,300	-52,300	-47,380	---
Total	275,436	356,891	356,891	+81,455	---
Family housing operation and maintenance, Army	1,106,007	1,043,026	1,043,026	-62,981	---
Family housing construction, Navy and Marine Corps	376,468	184,193	184,193	-192,275	---
Rescission	-2,652	---	-3,585	-933	-3,585
Total	373,816	184,193	180,608	-193,208	-3,585
Family housing operation and maintenance, Navy and Marine Corps	861,788	852,778	852,778	-9,010	---
Family housing construction, Air Force	684,824	657,065	657,065	-27,759	---
Rescission	-8,782	-19,347	-29,039	-20,257	-9,692
Total	676,042	637,718	628,026	-48,016	-9,692
Family housing operation and maintenance, Air Force	833,419	834,468	826,074	-7,345	-8,394
Defense emergency response fund (DERF)	29,631	---	---	-29,631	---
Subtotal	863,050	834,468	826,074	-36,976	-8,394
Supplemental appropriations (P.L. 108-11)	1,800	---	---	-1,800	---
Total	864,850	834,468	826,074	-38,776	-8,394
Family housing construction, Defense-wide	5,480	350	350	-5,130	---
Family housing operation and maintenance, Defense-wide	42,395	49,440	49,440	+7,045	---
Department of Defense Family Housing Improvement Fund	2,000	300	300	-1,700	---
Total, Family housing	4,207,814	3,959,164	3,937,493	-270,321	-21,671
Base realignment and closure account	561,138	370,427	370,427	-190,711	---
General provision (sec. 118)	---	55,000	55,000	+55,000	---
Grand total:					
New budget (obligational) authority	10,698,800	9,237,096	9,196,000	-1,502,800	-41,096
Appropriations	(10,108,455)	(9,390,469)	(9,536,541)	(-571,914)	(+146,072)
Defense emergency response fund	(692,272)	---	---	(-692,272)	---
Rescissions	(-101,927)	(-153,373)	(-340,541)	(-238,614)	(-187,168)

Mr. Chairman, I reserve the balance of my time.

Mr. EDWARDS. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I am going to vote for this military construction bill for one reason and for one reason alone. I believe the gentleman from Michigan, the chairman of our committee, has worked very hard and in a fair and bipartisan manner from day one on this bill. He and his capable staff have worked diligently and professionally to deal with a $1.5 billion military construction cut. This grossly inadequate funding level was not the decision of the gentleman from Michigan or myself. The gentleman from Michigan has a deep and genuine commitment to supporting a high quality of life for our servicemen and -women and their families. I know that firsthand. This decision was made above his pay grade and above mine. As the chairman and the ranking member of the Subcommittee on Military Construction, our responsibility is to take whatever funding level is given to us and invest those resources in a way that will fund the highest possible military construction priorities. I believe that is what the gentleman from Michigan, our subcommittee, and I have done; and that is why I will vote for this bill.

However, Mr. Chairman, I would be remiss and I believe it would be the height of irresponsibility for me not to speak honestly to our colleagues about what I consider to be the serious implications of cutting military construction funding by $1.5 billion. By the way, that is before the consideration of inflation. In my opinion, cutting military quality of life and military training investments during a time of war breaks faith with America's servicemen and -women and their families. I am deeply disappointed that the administration and the House leadership would say in effect that it is okay to salute our troops with our words while cutting critical military quality-of-life programs with our deeds. I believe it is wrong to salute our servicemen and -women with words while insulting them with our deeds. It is wrong in a time of war in Afghanistan for the administration in a separate bill to want to cut military education funds for military children by $173 million and to cut funds for military family housing, health care, day care and training in this bill by $1.5 billion.

Mr. Chairman, we are starting to see a pattern of respect to our servicemen and -women in time of war with our rhetoric and disrespect with our priorities and our actions. Frankly, in my opinion, we are reflecting the values of the majority leader of the House, the gentleman from Texas (Mr. DELAY), who said during the Iraqi war that in time of war, nothing is more important than cutting taxes. I would like to invite the majority leader to my district to explain that statement and that value to the 44,000 soldiers I represent at Fort Hood, 20,000 of whom are overseas in Iraq today.

I believe it adds insult to injury to make these cuts in military quality-of-life programs to help pay for an $88,000 tax cut for people in America living here safely, comfortably at home, not fighting in war, people making over $1 million a year. It is not just wrong; it is outrageous. As public officials, our spending priorities are a better reflection of our values than our speeches and our rhetoric. What does it say about our values in Congress when we ask Americans to go into combat in Iraq and then the administration is trying to cut those very servicemen's and -women's children's education funding by 14 percent? What does it say about our values when a person making $1 million in dividend income this year just received a $200,000 tax cut while a soldier in Iraq must read that the House has voted to cut military housing, quality-of-life and training facility projects by $1.5 billion? By the way, the House has voted to cut their future veterans benefits by $28 billion, a vote cast on March 21 just 8 minutes after we had overwhelmingly voted for a resolution saluting the service of our servicemen and -women in Iraq.

Mr. Chairman, in my opinion that type of priority makes a mockery of the American ideals of fairness and shared sacrifice during time of war. What do these cuts mean? It means that tens and tens of thousands of servicemen and -women living in inadequate housing will have to continue to do so. We have 83,000 new barracks that are needed to meet minimum DOD standards for our single servicemen and -women. We have a need for 128,860 new housing units for military families who sacrifice so much for our country. This bill does not meet those needs. Why? Not because of the values or priorities of the gentleman from Michigan, but because the top leadership of this House and the administration decided that we must cut military construction by $1.5 billion to help pay for that massive tax cut that we have already signed into law.

There is a lot of good in this bill, and the committee should be proud of its work. There are a lot of important priority programs funded. I salute the chairman and his very professional staff for, under very difficult circumstances, having to cut out important programs in order to adequately fund the highest-priority programs. I salute the gentleman from Michigan, his staff and the professional staff on both sides. This bill was put together without partisanship. It was put together under trying circumstances, with a last-minute decision by someone, I do not know and I do not know how, someone who said, we are going to have to cut our spending by $560 million below the amount authorized just a few weeks ago.

I support this bill for the many good things in it and the good work that was done to produce it; but I say to my colleagues, Mr. Chairman, we should be ashamed that we are asking our servicemen and -women to have their housing, their quality of life, their day care, their health clinics, their training facility programs cut by $1.5 billion in time of war. We should salute our servicemen and -women and their families with our deeds, not just with our words.

Mr. Chairman, I reserve the balance of my time.

Mr. KNOLLENBERG. Mr. Chairman, it is a pleasure for me to yield 3 minutes to the gentleman from Florida (Mr. YOUNG), the chairman of the Committee on Appropriations.

Mr. YOUNG of Florida. Mr. Chairman, I thank the gentleman for yielding me this time, and I rise for two purposes: one, to express strong support for the bill and to compliment Chairman KNOLLENBERG and Ranking Member EDWARDS for producing as good a bill as they could with what they had to work with. We have heard today as we heard during the Homeland Security appropriations bill earlier and I predict, Mr. Chairman, we will hear it from the other 11 appropriations bills, that they need more money, that they did not get enough money; that, as in this particular case, the bill is below the President's budget request.

Mr. Chairman, the budget resolution that this committee is required to deal with was below the President's budget request. Somebody tell me how we can go above the President's budget request with a budget resolution that is below the President's budget request. That would take a little magic. The gentleman from Wisconsin and I have sat together many times trying to figure out that magic. We have not found the right magic wand yet. But the committees and the subcommittees are doing the best they can with what they have to work with, and they are producing good bills.

The second part of my interest today is to say to our colleagues that, although there was a substantial delay in getting past some budgetary issues that were above the jurisdiction of the Committee on Appropriations, that 2 weeks ago when those issues were finally settled, your Committee on Appropriations has responded well. The Homeland Security bill was marked up, sent to the House, and it has gone on to the Senate. The military construction bill has been marked up, sent to the House and will go to the Senate today. The defense appropriations bill has been marked up. The labor, health and human services bill has been marked up. The interior appropriations bill has been marked up. The agriculture appropriations bill has been marked up, and the legislative branch bill has been marked up. So in that 2-week period, your committee has produced seven of the 13 bills. That is in addition to having completed 11 of last year's bills during this calendar year and one major wartime supplemental.

I am very proud of the Committee on Appropriations on both sides. I am

proud of the subcommittees and their leadership. But you cannot have more money to spend than the budget resolution provides, whether it is with the President's number, above the President's number, or below the President's number. We are given that number, and that is what we have to deal with.

Mr. EDWARDS. Mr. Chairman, I yield myself 3 minutes.

Mr. Chairman, I want to thank the gentleman from Florida (Mr. YOUNG) for his comments. There is no Member of this House, Democrat or Republican, over the years who has been more committed to our servicemen and -women. As critical as I am of the funding level in this bill, I know if anyone will work hard to see if we can find more money to more adequately show our respect to our servicemen and -women with our dollars in military construction, the gentleman from Florida will be the person to fight that fight and to lead that fight.

Mr. Chairman, I want to say to my colleagues that my comments, my critical comments about the funding level of this bill, not the way it was put together because the gentleman from Michigan did an excellent job and a fair job in doing that, but I want people to know this criticism does not just come from one Member of Congress. I would like to read an editorial dated June 30 of the ''Army Times.'' It says, ''Nothing But Lip Service.''

''In recent months, President Bush and the Republican-controlled Congress have missed no opportunity to heap richly deserved praise on the military. But talk is cheap and getting cheaper by the day, judging from the nickel-and-dime treatment the troops are getting lately.''

It goes on to say this:

''All of which brings us to the latest indignity, Bush's $9.2 billion military construction request for 2004, which was set a full $1.5 billion below this year's budget on the expectation that Congress, as has become tradition in recent years, would add funding as it drafted the construction appropriations bill.

''But Bush's tax cuts have left little elbow room in the 2004 Federal budget that is taking shape, and the squeeze is on across the board.

''The result: not only has the House appropriations military construction panel accepted Bush's proposed $1.5 billion cut, it voted to reduce construction spending by an additional $41 million next year.''

The editorial goes on after commending the gentleman from Wisconsin for his amendment to try to add nearly $1 billion to this bill to say this:

''Taken piecemeal, all these corner-cutting moves might be viewed as mere flesh wounds. But even flesh wounds are fatal if you suffer enough of them. It adds up to a troubling pattern that eventually will hurt morale, especially if the current breakneck operations tempo also rolls on unchecked and the tense situations in Iraq and Afghanistan do not ease.''

Mr. Chairman, that is a statement not from a Democrat or Republican in this House, but from the ''Army Times'' editorial. I think we should listen to the words and spirit of that editorial. I do not think our servicemen and -women are going to accept lip service. They give us dedicated service, including the risking of their lives. It is time for us to give them more than lip service when it comes to committing to making tough choices, committing to ensure that they can have a better quality of life, live in decent housing, have day care for their children and quality schools for their families.

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Mr. KNOLLENBERG. Mr. Chairman, I have no further requests for time, and I reserve the balance of my time.

Mr. EDWARDS. Mr. Chairman, I yield 6 minutes to the distinguished gentleman from Wisconsin (Mr. OBEY), the ranking Democrat on the full Committee on Appropriations who made an effort earlier this day to offer an amendment that was closed off by the Republican leadership to add nearly $1 billion of commitment to our servicemen and women's quality of life programs.

Mr. OBEY. Mr. Chairman, I thank the gentleman for yielding me this time.

I want to express my agreement with the comments made by the gentleman from Florida (Mr. YOUNG), the distinguished chairman of this committee.

And then I want to say this: Budgets are not just presentations of numbers. Budgets really reflect and define and exhibit our priorities and our values. And that is why this bill is such a sad commentary on the nature of this House.

When President Bush came into office, thanks to the fiscal discipline demonstrated by the previous administration, we expected to see at least $6 trillion worth of surpluses over the next decade. We were in the best shape that we had been fiscally in more than a generation. So the President decided that we could afford to provide very large tax cuts, and he estimated we would still have billions left over for other purposes, and the House passed those tax cuts.

My point is that then something happened that was totally unexpected. We got hit by 9/11 and the economic downturn that followed that. Any person of prudence in my view, having seen such a shocking change, would have been careful about the next step that they took, but this Congress and this White House, alas, was not. So despite the fact that the bottom was falling out of the economy and the bottom was falling out of Government revenues, the White House and this Congress decided they were going to push on with even larger tax cuts. They said that we needed to do it in order to create jobs.

But, not a single job has been created during the tenure of the Bush administration. In fact, we have lost almost 3 million jobs since President Bush took office. Part of that is not his responsibility; part of it in my view is, and the Congress's as well. My point is that when conditions change one would think that their approach and their remedies change, but they have not. We have gotten only one answer out of the administration in terms of dealing with the economy: Tax cuts, tax cuts, tax cuts, no matter how badly they are skewed to the upper reaches of the income ladders and no matter what they cost to the other people in this society. And this bill is one of the examples of what it costs.

When this House passes these tax cuts, it pretends that there is no cost to anyone else. Let me just spell out what some of the costs are. Those tax cuts mean that we will be paying $23 billion more in interest payments next year than we would otherwise be paying. Before these tax cuts play out we will be spending more on interest payments in the Federal budget than we will be spending on all domestic appropriation items reported by this committee, and it will be a gargantuan share of the Federal budget. We ought to be able to make better judgments than that.

But there are other costs as well. We passed the ''No Child Left Behind Act'' for education, sent mandates out to the States and said we would send cash out to help pay for those mandates. I've news for you, the appropriations bill that is going to come out will short sheet those education programs by $8 billion. Nobody knows that, but that is what is going to happen. And this is happening at a time when budget crunches all over the country are going to be squeezing States and squeezing schools. We are also having to squeeze down on what we provide in health care. There are thousands and thousands of families being pushed off health care in many States in the Union. And this bill represents what is going to happen to military families, because we are cutting $1.5 billion below the deliverable amount in the previous year's budget for military families under military construction. And we wind up making only token progress in improving the housing for military families and for single enlisted people.

The cost of the estate tax elimination, which this House just passed: For the cost of that money it took to take millionaires off the tax roll when we passed that estate tax change—that is going to cost $800 billion—for that $800 billion, we could close one-third of the gap in financing that will be existing in the Social Security system. We should have done that first. But we did not. We passed another huge tax cut for the high rollers.

So there are consequences, and there are costs to those tax cuts. The gentleman from Florida (Mr. YOUNG) is right. He cannot perform a miracle.

Neither can the gentleman from Michigan (Mr. KNOLLENBERG). Appropriations are the table scraps that are left over after this House has decided to plunge ahead, promising all of these out-sized tax cuts to the American people with a huge share of those tax cuts going to the most well off, and then we see what happens to the rest.

So that is why I am not pleased with this bill, not because of the work of the gentleman from Michigan (Mr. KNOLLENBERG) or the staff but because this House made a basic bad judgment to begin with and it is being compounded and illustrated and demonstrated with every other bill we bring to the floor.

That is the problem. There are consequences. The budget process is being handled in this House to try to hide those consequences. It is our responsibility to try to lay out what those consequences are, and that is why we have gone through this operation this afternoon.

Mr. KNOLLENBERG. Mr. Chairman, I continue to reserve the balance of my time.

Mr. EDWARDS. Mr. Chairman, I do not think there are any other speakers on this side. I yield myself 3 minutes.

Mr. Chairman, I never thought I in my 12 years in this House would come to the floor and speak out in favor of a military construction bill that cuts quality of life and training investments for servicemen and women even in time of war by $1.5 billion. I never thought I would ask my colleagues to vote for a bill that decreases Navy and Marine Corps family housing construction investment by $193 million compared to last year. I never thought I would ask my colleagues to vote for a bill that decreases family Air Force construction housing by $48 million compared to last year.

But I do ask my colleagues to vote for this bill because we had to do the best we could with the allocation given to us. Because of the needs, the important needs, military family needs that this bill meets, I will vote for it. Because of the needs that will remain unmet, I will not be proud that this House will go on record as saying in time of war to our servicemen and women thanks for risking their lives, thanks for fighting in Iraq, thanks for taking care of their children at home while they are wondering if their loved one will ever come home alive, while at the same time cutting their quality of life programs by $1.5 billion. I guess it is a testament to my respect for the gentleman from Michigan (Mr. KNOLLENBERG), his fairness, his dedication to our servicemen and women, his commitment to working as hard as any human could to see that we make the best with an unfair, horrible situation in this funding level, that I will vote for this bill. And I do want to pay a special thanks to the gentleman from Michigan (Mr. KNOLLENBERG) for standing up for people who often do not have someone speaking for them in this House, and that is our servicemen and women overseas, because I know there was an effort made to make additional cuts in some of those facilities. There is not much to be gained personally or politically by defending quality of life commitments overseas because those folks are not living in our districts at the time. The gentleman from Michigan (Mr. KNOLLENBERG) said no to that kind of cut because he knew that would have been the wrong thing to do. I salute him and I hope with his dedication and the gentleman from Florida's (Mr. YOUNG) and the gentleman from Wisconsin's (Mr. OBEY) and other Members of this House's dedication, we will see before this year ends we can pass a military construction bill that we can look our servicemen and women in the eye and say we are proud of them and we do salute them with more than just words.

So I ask my colleagues, despite my reservations, to support the tremendous effort and work of the gentleman from Michigan (Mr. KNOLLENBERG) and our subcommittee.

Mr. ORTIZ. Mr. Chairman, I rise this evening in support of our men and women in the Armed Services. For many weeks now, we have all declared our gratefulness to these warriors and their families of the sacrifices they have made on behalf of our Nation.

Besides their incredible efforts in fighting the War on Terrorism, these patriots and their families have had to learn to live without their fathers or mothers or spouses present on a daily basis because of numerous, long, and dangerous deployments, or even worse, if their loved one has paid the ultimate sacrifice. I, myself, have had more than my share of families in my district that have paid this price.

I have traveled extensively to our military facilities and have observed the substandard housing we force our military personnel and families to live in. We must address this situation.

We are all grateful for these sacrifices, but how will we show this gratefulness? Will we support the Ranking Member in his effort to scale back the tax cuts by a mere 5 percent for those who make over a million dollars a year, so we can restore funding and adequately house our forces?

Even though we are cutting military construction spending by $1.5 billion from last year's funding, we can still do the right thing at this time by voting for the Previous Question. We must support the Ranking Member's efforts and truly show our gratitude to our troops.

Mr. DICKS. Mr. Chairman, I would like to commend Chairman KNOLLENBERG and Ranking Member EDWARDS for their work on this bill. They have done their best with an unreasonable and unacceptable allocation. I know they share my deep disappointment over this level of funding, which is $1.5 billion less than was appropriated for Military Construction & Family Housing last year.

Unfortunately this cut makes a bad situation worse. When the Bush administration came into office, they found a Department of Defense where the recapitalization rates for facilities varied from 80 to over 100 years in the various services. They rightly condemned this situation. However, under this budget, the recapitalization rate for the active Air Force will increase to 183 years. The Navy recapitalization rate will increase to 140 years. The recapitalization rate for the Marines actually goes down, but is still an unacceptable 88 years. And the Army recapitalization rate in this budget increases to 144 years. The DOD goal is 67 years. I strongly support the effort by Mr. OBEY to increase funding for Military Construction and Family Housing in this bill by $1 billion. This funding, and much more, is sorely needed.

I would like to thank the Chairman and Ranking Member for working with me on the vital installations in Washington state. We will make a start in this bill on fixing a Navy pier at Puget Sound Naval Shipyard which today is not up to Navy standards for performing its mission, which is mooring nuclear powered aircraft carriers. And the bill includes several important projects to build barracks at Ft. Lewis, refurbish the Mission Support Center at McChord Air Force Base, and rebuild the service pier at Subase Bangor. Also, this bill continues to support the privatization of family housing at Ft. Lewis, WA. Mr. Chairman, beautiful new houses have been built and are under construction there, and this Congress can be proud about the new houses being built for military families through this innovative program.

I hope as this bill proceeds through the Congressional process, that additional funds can be found to make this a truly responsible piece of legislation. Having voiced my deep concerns, I will vote today in support of this bill in order to ensure that those important projects which do receive funding here are allowed to move forward.

Mr. SCHROCK. Mr. Chairman, America is indebted to the men and women of the armed forces. Their success in Iraq, Afghanistan and around the world give witness to their bravery and commitment. In order to maintain this dedicated, all-volunteer force and to ensure its readiness, we must be proactive in providing them adequate quality of life and training facilities.

The reality is that we are still correcting the spending deficiencies of the past. Even after years of funding plus-ups to the Department's military construction budget, service men and women continue to live and work in aging and inferior facilities. In fact, more than two-thirds of the services' current facilities are classified at ''C–3'' or ''C–4'' readiness levels. This signifies that their ability to carry out missions has been appreciably degraded.

I am glad that we are able to work across party lines to ensure that military construction is funded at the highest levels possible.

H.R. 2559 addresses many of the pressing construction and family housing needs facing the services. The bill would provide $1.2 billion for barracks, $16 million for child development centers, and $1.2 billion for new family housing units and improvements to existing ones.

I urge my colleagues to support H.R. 2559, because these new and improved facilities will enhance the quality of life for our service members while they are doing their jobs and training to defend America.

We must never let our military deteriorate as we have seen in the past, because, as recent events have demonstrated, we will never know when our nation's security will be challenged.

Mr. NUSSLE. Mr. Chairman, I rise today in support of H.R. 2559, the Military Construction

Appropriations Act for Fiscal Year 2004. It is the second bill we are considering pursuant to the 302(b) allocations adopted by the Appropriations Committee on June 17th. I am pleased to report that it is consistent with the levels established in H. Con. Res. 95, the House concurrent resolution on the budget for fiscal year 2004, which Congress adopted on April 10. The budget resolution provided $400.1 billion in discretionary budget authority for national defense. This bill funds the military construction and family housing portion of that commitment to our men and women in uniform.

H.R. 2559 provides $9.196 billion in new budget authority and $10.282 billion in outlays for fiscal year 2004. It is therefore identical to its 302(b) allocation to the House Subcommittee on Military Construction Appropriations. It does not contain emergency-designated new BA. It does include $340.5 million in rescissions of previously enacted BA. Although budget authority in the bill declines by 12.8 percent from the previous year, it is $81 million above the President's request. This mainly because H.R. 2559 contains a procurement appropriation of $120 million that, according to CBO, was part of the administration's request for the Defense appropriation bill rather than this bill.

The bill complies with section 302(f) of the Budget Act, which prohibits consideration of bills in excess of an appropriations subcommittee's 302(b) allocation of budget authority and outlays established in the budget resolution.

H.R. 2559 represents this House's solemn commitment to the quality of life of those who put their lives on the line for freedom. It not only addresses the long-term infrastructure problems at military bases, it sustains barracks, family housing, medical facilities, and child support centers across the country and overseas. It also provides infrastructure funding for National Guard and Reserve troops who now find themselves on the front lines of the war against terrorism. Finally, it incorporates the results of real-world national security policy changes: The redeployment south of U.S. military forces away from the North Korean border to better-protected bases, and the gradual drawdown of troops from some Central European bases.

In conclusion, I express my support for H.R. 2559.

Mr. FRELINGHUYSEN. Mr. Chairman, I rise in strong support of H.R. 2559, making appropriations for military construction for fiscal 2004. This legislation is a strong product for tough times and I want to commend the Subcommittee Chairman, the gentleman from Michigan, Mr. KNOLLENBERG, and the Gentleman from Texas, Mr. EDWARDS.

This legislation provides $9.2 billion in funding for military construction and family housing projects across the country.

While no one is satisfied with the bottom line on this bill and we all wish that we could not do more, this is a solid product. It satisfies our obligation to ensure that our men and women in uniform live in, train at, and deploy from adequate facilities. This bill shows our commitment to our service members by constructing and upgrading military installations, and military family housing in the United States and overseas.

Improving the quality of life for our men and women in uniform throughout the world is critically important. If we are asking these brave men and women to protect our national security, then we must ensure that they have the tools and the facilities to protect themselves.

America's armed forces have been charged with developing the capabilities to fight jointly and with coalition partners to secure victory across the full spectrum of warfare while continuing the transition to a more flexible, more agile, lighter and more lethal force.

In this context, I am pleased the Committee has included funding for a state-of-the-art explosives loading facility at the Army's ''Home of Lethality''—Picatinny Arsenal in New Jersey.

In Afghanistan and Iraq, the achievements of our young men and women in uniform are due in part to the incredible technological advances employed by our military, much of which has been researched and developed by Picatinny Arsenal—the only Army-owned, Army-operated facilities for the research and development of energetics materials (mines, armor, warheads, artillery, etc.) in the nation. The new facility will mark a substantial upgrade in safety, environmental protection and process controls that will benefit the other branches of the military that rely on Army research and development expertise.

Mr. Chairman, once again I commend Mr. KNOLLENBERG and Mr. YOUNG and I urge support for this bill.

Mr. FRANKS of Arizona. Mr. Chairman, today I urge your consideration of the authorization of $14.3 million for land acquisition to preserve access to the Barry M. Goldwater Range. This land acquisition would serve to prevent incompatible land uses and encroachment, and to increase the margin of safety in the Live Ordnance Departure Area located southwest of Luke Air Force Base.

The Barry M. Goldwater Range, a 2.7 million acre land and airspace area in southwest Arizona, is the crown jewel of all flight ranges, providing the Air Force with the space necessary to conduct live-fire training and simulating realistically the dimensions of a modern battlefield.

Luke Air Force Base-with its year-round idyllic weather-is the training home to the F–16 Fighting Falcon. With an average of 170 sorties flown each day, access to the Barry M. Goldwater Range is an essential part of the advanced training and practice required of the Air Force fighter pilots. The southern departure corridor from Luke Air Force Base is the only air corridor where live ordnance can be carried out by F–16 Fighters. The threat of advancement and increased pressure of residential development from what has traditionally been isolated farmland places the mission and the future of Luke Air Force Base at risk.

The Air Force has also made this $14.3 million request stating, ''Continued residential development of the departure corridors could impair Luke [Air Force Base's] ability to support sorties carrying live ordnance and to fully utilize the [Barry M. Goldwater Range] . . . [and] further encumbering Luke [Air Force Base's] access to the [Barry M. Goldwater Range] may adversely impact Luke's mission and result in a degradation to the national security.''

Mr. EDWARDS. Chairman, I yield back the balance of my time.

Mr. KNOLLENBERG. Mr. Chairman, I yield back the balance of my time.

The CHAIRMAN. All time for general debate has expired.

Pursuant to the rule, the bill shall be considered for amendment under the 5-minute rule. During consideration of the bill for amendment, the Chair may accord priority in recognition to a Member offering an amendment that has been printed in the designated place in the CONGRESSIONAL RECORD. Those amendments will be considered read.

The Clerk will read.

The Clerk read as follows:

H.R. 2559

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled, That the following sums are appropriated, out of any money in the Treasury not otherwise appropriated for military construction, family housing, and base realignment and closure functions administered by the Department of Defense, for the fiscal year ending September 30, 2004, and for other purposes, namely:

MILITARY CONSTRUCTION, ARMY

(INCLUDING RESCISSIONS)

For acquisition, construction, installation, and equipment of temporary or permanent public works, military installations, facilities, and real property for the Army as currently authorized by law, including personnel in the Army Corps of Engineers and other personal services necessary for the purposes of this appropriation, and for construction and operation of facilities in support of the functions of the Commander in Chief, $1,533,660,000, to remain available until September 30, 2008: *Provided,* That of this amount, not to exceed $122,710,000 shall be available for study, planning, design, architect and engineer services, and host nation support, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor: *Provided further,* That of the funds appropriated for ''Military Construction, Army'' under Public Law 107–249, $142,200,000 are rescinded: *Provided further,* That of the funds appropriated for ''Military Construction, Army'' under Public Law 107–64, $24,000,000 are rescinded: *Provided further,* That of the funds appropriated for ''Military Construction, Army'' under Public Law 106–246, $17,415,000 are rescinded.

AMENDMENT OFFERED BY MR. OBEY

Mr. OBEY. Mr. Chairman, I offer an amendment.

The Clerk read as follows:

Amendment offered by Mr. OBEY:

On page 2, line 13, under the heading ''Military Construction, Army'', delete the dollar amount and insert $1,726,660,000;

On page 3, line 13, under the heading ''Military Construction, Navy'', delete the dollar amount and insert $1,311,907,000;

On page 4, line 5, under the heading ''Military Construction, Air Force'', delete the dollar amount and insert $968,509,000;

On page 4, line 21, under the heading ''Military Construction, Defense-Wide'', delete the dollar amount and insert $872,110,000;

On page 5, line 20, under the heading ''Military Construction, Army National Guard'', delete the dollar amount and insert $231,860,000;

On page 6, line 3, under the heading ''Military Construction, Air National Guard'', delete the dollar amount and insert $95,605,000;

On page 7, line 19, under the heading ''Family Housing Construction, Army'', delete the dollar amount and insert $601,191,000;

On page 8, line 13, under the heading ''Family Housing Construction, Navy and

Marine Corps'', delete the dollar amount and insert $288,193,000;

And on page 9, line 6, under the heading ''Family Housing Construction, Air Force'', delete the dollar amount and insert $841,065,000.

At the end of the bill, add the following:

Section _____. In the case of taxpayers with adjusted gross income in excess of $1,000,000 for the tax beginning in 2003, the amount of tax reduction resulting from enactment of the Jobs and Growth Tax Relief Reconciliation Act of 2003 shall be reduced by five percent.

Mr. OBEY (during the reading). Mr. Chairman, I ask unanimous consent that the amendment be considered as read and printed in the RECORD.

The CHAIRMAN. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

Mr. KNOLLENBERG. Mr. Chairman, I reserve a point of order.

The CHAIRMAN. The point of order is reserved.

Mr. OBEY. Mr. Chairman, I have already explained to the House what the intention of this amendment is. This amendment would reinstate the $160 million in cuts from the President's budget for hangers, maintenance shops, office space, physical fitness facilities for the military that even the White House thought were crucial. It adds $480 million for family housing to help at least 2,500 military families. There are 134,000 inadequate units that service those families to date. It would add $318 million for new barracks. It would help get 5,300 single service personnel into decent housing. The Pentagon says there is a need for over 83,000 unit fix-ups. And it would pay for that by reducing the expected tax cut for those with adjusted gross incomes of more than $1 million dollars annually. We would adjust their tax cuts from $88,000 to $83,000, thus enabling them to keep 95 percent of their tax cut. That would free up enough money to meet these military needs, and I would urge the House, despite the action of the Committee on Rules, to allow this amendment to go forward.

POINT OF ORDER

The CHAIRMAN. Does the gentleman from Michigan (Mr. KNOLLENBERG) insist on his point of order?

Mr. KNOLLENBERG. Mr. Chairman, I do. I make a point of order against the amendment because it proposes to change existing law and constitutes legislation in an appropriations bill and therefore violates clause 2 of rule XXI, which states in part ''An amendment to a general appropriations bill shall not be in order if changing existing law.''

At this time I ask for a ruling from the Chair.

Mr. OBEY. Mr. Chairman, I would like to be heard on the point of order.

The CHAIRMAN. The gentleman from Wisconsin is recognized.

Mr. OBEY. Mr. Chairman, what has been happening in this House is that the Committee on Rules has routinely been waiving points of orders for the majority but denying those same waivers to the minority. That puts us in an uneven position on the House floor. We are in that kind of position on this amendment. I want to simply say in conceding the point of order that I will continue to make this motion on this bill. I will have it in my motion to recommit. I will try at every stage of the process to get this matter before the House so we can make these priority judgments, and it is up to the majority whether it wants to knock them off the floor or not.

The CHAIRMAN. The gentleman's point of order is conceded and sustained.

The Clerk will read.

Mr. KNOLLENBERG. Mr. Chairman, I ask unanimous consent that the remainder of the bill, through page 19, line 19 be considered as read, printed in the RECORD and open to amendment at any point.

The CHAIRMAN. Is there objection to the gentleman from Michigan?

There was no objection.

The text of the remainder of the bill, from page 3, line 5, though page 19, line 19 is as follows:

MILITARY CONSTRUCTION, NAVY

(INCLUDING RESCISSIONS)

For acquisition, construction, installation, and equipment of temporary or permanent public works, naval installations, facilities, and real property for the Navy as currently authorized by law, including personnel in the Naval Facilities Engineering Command and other personal services necessary for the purposes of this appropriation, $1,211,077,000, to remain available until September 30, 2008: *Provided*, That of this amount, not to exceed $65,612,000 shall be available for study, planning, design, architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor: *Provided further*, That of the funds appropriated for ''Military Construction, Navy'' under Public Law 107–249, $27,213,000 are rescinded: *Provided further*, That of the funds appropriated for ''Military Construction, Navy'' under Public Law 107–64, $12,109,000 are rescinded.

MILITARY CONSTRUCTION, AIR FORCE

For acquisition, construction, installation, and equipment of temporary or permanent public works, military installations, facilities, and real property for the Air Force as currently authorized by law, $896,136,000, to remain available until September 30, 2008: *Provided*, That of this amount, not to exceed $80,543,000 shall be available for study, planning, design, architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

MILITARY CONSTRUCTION, DEFENSE-WIDE

(INCLUDING RESCISSION AND TRANSFER OF FUNDS)

For acquisition, construction, installation, and equipment of temporary or permanent public works, installations, facilities, and real property for activities and agencies of the Department of Defense (other than the military departments), as currently authorized by law, $813,613,000, to remain available until September 30, 2008: *Provided*, That such amounts of this appropriation as may be determined by the Secretary of Defense may be transferred to such appropriations of the Department of Defense available for military construction or family housing as he may designate, to be merged with and to be available for the same purposes, and for the same time period, as the appropriation or fund to which transferred: *Provided further*, That of the amount appropriated, not to exceed $63,884,000 shall be available for study, planning, design, architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor: *Provided further*, That of the funds appropriated for ''Military Construction, Defense-wide'' under Public Law 107–249, $32,680,000 are rescinded.

MILITARY CONSTRUCTION, ARMY NATIONAL GUARD

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Army National Guard, and contributions therefor, as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $208,033,000, to remain available until September 30, 2008.

MILITARY CONSTRUCTION, AIR NATIONAL GUARD

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Air National Guard, and contributions therefor, as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $77,105,000, to remain available until September 30, 2008.

MILITARY CONSTRUCTION, ARMY RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Army Reserve as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $84,569,000, to remain available until September 30, 2008.

MILITARY CONSTRUCTION, NAVAL RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the reserve components of the Navy and Marine Corps as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $38,992,000, to remain available until September 30, 2008.

MILITARY CONSTRUCTION, AIR FORCE RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Air Force Reserve as authorized by chapter 1803 of title 10, United States Code, and Military Construction Authorization Acts, $56,212,000, to remain available until September 30, 2008.

NORTH ATLANTIC TREATY ORGANIZATION SECURITY INVESTMENT PROGRAM

For the United States share of the cost of the North Atlantic Treaty Organization Security Investment Program for the acquisition and construction of military facilities and installations (including international military headquarters) and for related expenses for the collective defense of the North Atlantic Treaty Area as authorized in Military Construction Authorization Acts and section 2806 of title 10, United States Code, $169,300,000, to remain available until expended.

FAMILY HOUSING CONSTRUCTION, ARMY

(INCLUDING RESCISSION)

For expenses of family housing for the Army for construction, including acquisition, replacement, addition, expansion, extension and alteration, as authorized by law, $409,191,000, to remain available until September 30, 2008: *Provided*, That of the funds appropriated for ''Family Housing Construction, Army'' under Public Law 107–249, $52,300,000 are rescinded.

FAMILY HOUSING OPERATION AND MAINTENANCE, ARMY

For expenses of family housing for the Army for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $1,043,026,000.

FAMILY HOUSING CONSTRUCTION, NAVY AND MARINE CORPS

(INCLUDING RESCISSION)

For expenses of family housing for the Navy and Marine Corps for construction, including acquisition, replacement, addition, expansion, extension and alteration, as authorized by law, $184,193,000, to remain available until September 30, 2008: *Provided*, That of the funds appropriated for ''Family Housing Construction, Navy and Marine Corps'' under Public Law 107–249, $3,585,000 are rescinded.

FAMILY HOUSING OPERATION AND MAINTENANCE, NAVY AND MARINE CORPS

For expenses of family housing for the Navy and Marine Corps for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $852,778,000.

FAMILY HOUSING CONSTRUCTION, AIR FORCE

(INCLUDING RESCISSIONS)

For expenses of family housing for the Air Force for construction, including acquisition, replacement, addition, expansion, extension and alteration, as authorized by law, $657,065,000, to remain available until September 30, 2008: *Provided*, That of the funds appropriated for ''Family Housing Construction, Air Force'' under Public Law 107–249, $19,347,000 are rescinded: *Provided further*, That of the funds appropriated for ''Family Housing Construction, Air Force'' under Public Law 105–237, $9,692,000 are rescinded.

FAMILY HOUSING OPERATION AND MAINTENANCE, AIR FORCE

For expenses of family housing for the Air Force for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $826,074,000.

FAMILY HOUSING CONSTRUCTION, DEFENSE-WIDE

For expenses of family housing for the activities and agencies of the Department of Defense (other than the military departments) for construction, including acquisition, replacement, addition, expansion, extension and alteration, as authorized by law, $350,000, to remain available until September 30, 2008.

FAMILY HOUSING OPERATION AND MAINTENANCE, DEFENSE-WIDE

For expenses of family housing for the activities and agencies of the Department of Defense (other than the military departments) for operation and maintenance, leasing, and minor construction, as authorized by law, $49,440,000.

DEPARTMENT OF DEFENSE FAMILY HOUSING IMPROVEMENT FUND

For the Department of Defense Family Housing Improvement Fund, $300,000, to remain available until expended, for family housing initiatives undertaken pursuant to section 2883 of title 10, United States Code, providing alternative means of acquiring and improving military family housing and supporting facilities.

BASE REALIGNMENT AND CLOSURE ACCOUNT

For deposit into the Department of Defense Base Closure Account 1990 established by section 2906(a)(1) of the Department of Defense Authorization Act, 1991 (Public Law 101–510), $370,427,000, to remain available until expended.

GENERAL PROVISIONS

SEC. 101. None of the funds appropriated in Military Construction Appropriations Acts shall be expended for payments under a cost-plus-a-fixed-fee contract for construction, where cost estimates exceed $25,000, to be performed within the United States, except Alaska, without the specific approval in writing of the Secretary of Defense setting forth the reasons therefor.

SEC. 102. Funds appropriated to the Department of Defense for construction shall be available for hire of passenger motor vehicles.

SEC. 103. Funds appropriated to the Department of Defense for construction may be used for advances to the Federal Highway Administration, Department of Transportation, for the construction of access roads as authorized by section 210 of title 23, United States Code, when projects authorized therein are certified as important to the national defense by the Secretary of Defense.

SEC. 104. None of the funds appropriated in this Act may be used to begin construction of new bases inside the continental United States for which specific appropriations have not been made.

SEC. 105. No part of the funds provided in Military Construction Appropriations Acts shall be used for purchase of land or land easements in excess of 100 percent of the value as determined by the Army Corps of Engineers or the Naval Facilities Engineering Command, except: (1) where there is a determination of value by a Federal court; (2) purchases negotiated by the Attorney General or his designee; (3) where the estimated value is less than $25,000; or (4) as otherwise determined by the Secretary of Defense to be in the public interest.

SEC. 106. None of the funds appropriated in Military Construction Appropriations Acts shall be used to: (1) acquire land; (2) provide for site preparation; or (3) install utilities for any family housing, except housing for which funds have been made available in annual Military Construction Appropriations Acts.

SEC. 107. None of the funds appropriated in Military Construction Appropriations Acts for minor construction may be used to transfer or relocate any activity from one base or installation to another, without prior notification to the Committees on Appropriations.

SEC. 108. No part of the funds appropriated in Military Construction Appropriations Acts may be used for the procurement of steel for any construction project or activity for which American steel producers, fabricators, and manufacturers have been denied the opportunity to compete for such steel procurement.

SEC. 109. None of the funds available to the Department of Defense for military construction or family housing during the current fiscal year may be used to pay real property taxes in any foreign nation.

SEC. 110. None of the funds appropriated in Military Construction Appropriations Acts may be used to initiate a new installation overseas without prior notification to the Committees on Appropriations.

SEC. 111. None of the funds appropriated in Military Construction Appropriations Acts may be obligated for architect and engineer contracts estimated by the Government to exceed $500,000 for projects to be accomplished in Japan, in any NATO member country, or in countries bordering the Arabian Sea, unless such contracts are awarded to United States firms or United States firms in joint venture with host nation firms.

SEC. 112. None of the funds appropriated in Military Construction Appropriations Acts for military construction in the United States territories and possessions in the Pacific and on Kwajalein Atoll, or in countries bordering the Arabian Sea, may be used to award any contract estimated by the Government to exceed $1,000,000 to a foreign contractor: *Provided*, That this section shall not be applicable to contract awards for which the lowest responsive and responsible bid of a United States contractor exceeds the lowest responsive and responsible bid of a foreign contractor by greater than 20 percent: *Provided further*, That this section shall not apply to contract awards for military construction on Kwajalein Atoll for which the lowest responsive and responsible bid is submitted by a Marshallese contractor.

SEC. 113. The Secretary of Defense is to inform the appropriate committees of Congress, including the Committees on Appropriations, of the plans and scope of any proposed military exercise involving United States personnel 30 days prior to its occurring, if amounts expended for construction, either temporary or permanent, are anticipated to exceed $100,000.

SEC. 114. Not more than 20 percent of the appropriations in Military Construction Appropriations Acts which are limited for obligation during the current fiscal year shall be obligated during the last 2 months of the fiscal year.

(TRANSFER OF FUNDS)

SEC. 115. Funds appropriated to the Department of Defense for construction in prior years shall be available for construction authorized for each such military department by the authorizations enacted into law during the current session of Congress.

SEC. 116. For military construction or family housing projects that are being completed with funds otherwise expired or lapsed for obligation, expired or lapsed funds may be used to pay the cost of associated supervision, inspection, overhead, engineering and design on those projects and on subsequent claims, if any.

SEC. 117. Notwithstanding any other provision of law, any funds appropriated to a military department or defense agency for the construction of military projects may be obligated for a military construction project or contract, or for any portion of such a project or contract, at any time before the end of the fourth fiscal year after the fiscal year for which funds for such project were appropriated if the funds obligated for such project: (1) are obligated from funds available for military construction projects; and (2) do not exceed the amount appropriated for such project, plus any amount by which the cost of such project is increased pursuant to law.

(TRANSFER OF FUNDS)

SEC. 118. During the 5-year period after appropriations available to the Department of Defense for military construction and family housing operation and maintenance and construction have expired for obligation, upon a determination that such appropriations will not be necessary for the liquidation of obligations or for making authorized adjustments to such appropriations for obligations incurred during the period of availability of such appropriations, unobligated balances of such appropriations may be transferred into

the appropriation ''Foreign Currency Fluctuations, Construction, Defense'' to be merged with and to be available for the same time period and for the same purposes as the appropriation to which transferred.

SEC. 119. The Secretary of Defense is to provide the Committees on Appropriations of the Senate and the House of Representatives with an annual report by February 15, containing details of the specific actions proposed to be taken by the Department of Defense during the current fiscal year to encourage other member nations of the North Atlantic Treaty Organization, Japan, Korea, and United States allies bordering the Arabian Sea to assume a greater share of the common defense burden of such nations and the United States.

(TRANSFER OF FUNDS)

SEC. 120. During the current fiscal year, in addition to any other transfer authority available to the Department of Defense, proceeds deposited to the Department of Defense Base Closure Account established by section 207(a)(1) of the Defense Authorization Amendments and Base Closure and Realignment Act (Public Law 100–526) pursuant to section 207(a)(2)(C) of such Act, may be transferred to the account established by section 2906(a)(1) of the Department of Defense Authorization Act, 1991, to be merged with, and to be available for the same purposes and the same time period as that account.

(TRANSFER OF FUNDS)

SEC. 121. Subject to 30 days prior notification to the Committees on Appropriations, such additional amounts as may be determined by the Secretary of Defense may be transferred to the Department of Defense Family Housing Improvement Fund from amounts appropriated for construction in ''Family Housing'' accounts, to be merged with and to be available for the same purposes and for the same period of time as amounts appropriated directly to the Fund: *Provided*, That appropriations made available to the Fund shall be available to cover the costs, as defined in section 502(5) of the Congressional Budget Act of 1974, of direct loans or loan guarantees issued by the Department of Defense pursuant to the provisions of subchapter IV of chapter 169, title 10, United States Code, pertaining to alternative means of acquiring and improving military family housing and supporting facilities.

SEC. 122. None of the funds appropriated or made available by this Act may be obligated for Partnership for Peace Programs in the New Independent States of the former Soviet Union.

(TRANSFER OF FUNDS)

SEC. 123. During the current fiscal year, in addition to any other transfer authority available to the Department of Defense, amounts may be transferred from the account established by section 2906(a)(1) of the Department of Defense Authorization Act, 1991, to the fund established by section 1013(d) of the Demonstration Cities and Metropolitan Development Act of 1966 (42 U.S.C. 3374) to pay for expenses associated with the Homeowners Assistance Program. Any amounts transferred shall be merged with and be available for the same purposes and for the same time period as the fund to which transferred.

SEC. 124. Notwithstanding this or any other provision of law, funds appropriated in Military Construction Appropriations Acts for operations and maintenance of family housing shall be the exclusive source of funds for repair and maintenance of all family housing units, including general or flag officer quarters: *Provided*, That not more than $35,000 per unit may be spent annually for the maintenance and repair of any general or flag officer quarters without 30 days advance prior notification to the appropriate committees of Congress, except that an after-the-fact notification shall be submitted if the limitation is exceeded solely due to costs associated with environmental remediation that could not be reasonably anticipated at the time of the budget submission: *Provided further*, That the Under Secretary of Defense (Comptroller) is to report annually to the Committees on Appropriations all operations and maintenance expenditures for each individual general or flag officer quarters for the prior fiscal year.

SEC. 125. None of the funds made available in this Act may be transferred to any department, agency, or instrumentality of the United States Government, except pursuant to a transfer made by, or transfer authority provided in, this Act or any other appropriation Act.

SEC. 126. None of the funds appropriated in this Act for the Department of the Army for military construction projects in the Republic of Korea may be obligated or expended for projects at Camp Humphreys in the Republic of Korea until the Secretary of Defense certifies and reports to the appropriate committees of Congress that the United States and the Republic of Korea have entered into an agreement on the availability and use of land sufficient for such projects. The certification must be presented to the committees no later than September 30, 2004, or the funds expire.

□ 1630

The CHAIRMAN. Are there any amendments?

If not, the Clerk will read.

The Clerk read as follows:

This Act may be cited as the ''Military Construction Appropriations Act, 2004''.

The CHAIRMAN. Are there further amendments?

If not, under the rule, the Committee rises.

Accordingly, the Committee rose; and the Speaker pro tempore, Mr. THORNBERRY, having assumed the chair, Mr. BASS, Chairman of the Committee of the Whole House on the State of the Union, reported that that Committee, having had under consideration the bill (H.R. 2559) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes, pursuant to House Resolution 298, he reported the bill back to the House.

The SPEAKER pro tempore. Under the rule, the previous question is ordered.

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. OBEY

Mr. OBEY. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. OBEY. Without the motion to recommit, yes.

Mr. KNOLLENBERG. Mr. Speaker, I reserve a point of order against the motion to recommit.

The SPEAKER pro tempore. A point of order is reserved.

The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. OBEY moves to recommit the bill, H.R. 2559, to the Committee on Appropriation with instructions to report the same forthwith with the following amendment:

On page 2, line 13, under the heading ''Military Construction, Army'', delete the dollar amount and insert $1,726,660,000;

On page 3, line 13, under the heading ''Military Construction, Navy'', delete the dollar amount and insert $1,311,907,000;

On page 4, line 5, under the heading ''Military Construction, Air Force'', delete the dollar amount and insert $968,509,000;

On page 4, line 21, under the heading ''Military Construction, Defense-Wide'', delete the dollar amount and insert $872,110,000;

On page 5, line 20, under the heading ''Military Construction, Army National Guard, delete the dollar amount and insert $231,860,000;

On page 6, line 3, under the heading ''Military Construction, Air National Guard'', delete the dollar amount and insert $95,605,000;

On page 7, line 19, under the heading ''Family Housing Construction, Army'', delete the dollar amount and insert $601,191,000;

On page 8, line 13, under the heading ''Family Housing Construction, Navy and Marine Corps'', delete the dollar amount and insert $288,193,000;

And on page 9, line 6, under the heading ''Family Housing Construction, Air Force'', delete the dollar amount and insert $841,065,000.

At the end of the bill, add the following:

SECTION ____. In the case of taxpayers with adjusted gross income in excess of $1,000,000 for the tax year beginning in 2003, the amount of tax reduction resulting from enactment of the Jobs and Growth Tax Relief Reconciliation Act of 2003 shall be reduced by five percent.

Mr. OBEY (during the reading). Mr. Speaker, I ask unanimous consent that the motion be considered as read and printed in the RECORD.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Wisconsin?

There was no objection.

The SPEAKER pro tempore. The Chair recognizes the gentleman from Wisconsin (Mr. OBEY) on his motion to recommit.

Mr. OBEY. Mr. Speaker, I will not take the 5 minutes. This is simply the same motion I offered before. If this House were operating on the basis of any degree of fairness today, it would be before the House, and I would simply ask that the majority refrain from offering the point of order against it. I know they have their marching orders. They have to do what they have to do, and I have to do what I have to do.

POINT OF ORDER

Mr. KNOLLENBERG. Mr. Chairman, I make a point of order against the motion to recommit because it proposes to change existing law and constitutes legislation in an appropriations bill, and, therefore, violates clause 2 of rule XXI.

The rule states, in pertinent part, ''An amendment to a general appropriation bill shall not be in order if changing existing law.''

The amendment proposes to alter the application of existing law.

The SPEAKER pro tempore. Does the gentleman from Wisconsin wish to be heard on the point of order?

Mr. OBEY. Yes, I do, Mr. Speaker.

As I said earlier, this is the same motion I made before. What is happening here is that because of a technical difference in the way the rules are being applied to the majority and the minority, we are being prevented from offering a motion which would strike a much better balance between the needs of our military and the needs of the most well-off people in this society.

With that, I concede the point of order.

The SPEAKER pro tempore. The gentleman from Wisconsin concedes the point of order. The point of order is sustained.

MOTION TO RECOMMIT OFFERED BY MR. OBEY

Mr. OBEY. Mr. Chairman, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the bill?

Mr. OBEY. I am, Mr. Speaker.

The SPEAKER pro tempore. The Clerk will report the motion to recommit.

The Clerk read as follows:

Mr. OBEY moves to recommit the bill, H.R. 2559, to the Committee on Appropriations.

The SPEAKER pro tempore. The motion is not debatable.

The question is on the motion to recommit offered by the gentleman from Wisconsin (Mr. OBEY).

The motion was rejected.

The SPEAKER pro tempore. The question is on the passage of the bill.

Under clause 10 of rule XX, the yeas and nays are ordered.

Pursuant to clauses 8 and 9 of rule XX, this 15-minute vote on passage of H.R. 2559 will be followed by 5-minute votes on suspending the rules and adopting House Resolution 277 and on agreeing to the Speaker's approval of the Journal.

The vote was taken by electronic device, and there were—yeas 428, nays 0, not voting 6, as follows:

[Roll No. 325]

YEAS—428

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
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
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
Cardin
Cardoza
Carson (IN)
Carson (OK)
Carter
Case
Castle
Chabot
Chocola
Clay
Clyburn
Coble
Cole
Collins
Conyers
Cooper
Costello
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
Dooley (CA)
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
Frank (MA)
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
LaTourette
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
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
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
Souder
Spratt
Stark
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)
Young (FL)

NOT VOTING—6

Brown-Waite, Ginny
Cox
Gephardt
McInnis
Paul
Smith (WA)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. THORNBERRY) (during the vote). Members are reminded less than 2 minutes remain in this vote.

□ 1654

Mr. ACKERMAN changed his vote from ''nay'' to ''yea''.

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

EXPRESSING SUPPORT FOR FREEDOM IN HONG KONG

The SPEAKER pro tempore. The unfinished business is the question of suspending the rules and agreeing to the resolution, H. Res. 277.

The Clerk read the title of the resolution.

The SPEAKER pro tempore. The question is on the motion offered by the gentleman from New Jersey (Mr. SMITH) that the House suspend the rules and agree to the resolution, H. Res. 277, on which the yeas and nays are ordered.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 426, nays 1, not voting 7, as follows:

[Roll No. 326]

YEAS—426

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
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
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Capps
Capuano
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)
DeFazio
DeGette

Delahunt
DeLauro
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Ehlers
Emanuel
Emerson
Engel
English
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Filner
Flake
Fletcher
Foley
Forbes
Ford
Fossella
Frank (MA)
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
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
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
LaTourette
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
Payne
Pearce
Pelosi
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
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
Souder
Spratt
Stark
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)
Young (FL)

NAYS—1

Paul

NOT VOTING—7

Brown-Waite, Ginny
Edwards
Gephardt
Herger
Jefferson
McInnis
Smith (WA)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised that 2 minutes remain in the vote.

□ 1703

So (two-thirds having voted in favor thereof) the rules were suspended and the resolution was agreed to.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

THE JOURNAL

The SPEAKER pro tempore (Mr. SWEENEY). Pursuant to clause 8 of rule XX, the pending business is the question of the Speaker's approval of the Journal of the last day's proceedings.

The question is on the Speaker's approval of the Journal, on which the yeas and nays are ordered.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 357, nays 68, not voting 9, as follows:

[Roll No. 327]

YEAS—357

Abercrombie
Ackerman
Akin
Alexander
Andrews
Baca
Bachus
Baker
Ballance
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Becerra
Bereuter
Berkley
Berman
Biggert
Bilirakis
Bishop (GA)
Bishop (NY)
Bishop (UT)
Blackburn
Blumenauer
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boswell
Boucher
Boyd
Bradley (NH)
Brady (TX)
Brown (SC)
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
Cox
Cramer
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.
Dicks
Dingell
Doggett
Dooley (CA)
Doolittle
Doyle
Dreier
Duncan
Dunn
Ehlers
Emanuel
Emerson
Engel
Eshoo
Etheridge
Evans
Everett
Farr
Fattah
Feeney
Ferguson
Flake
Fletcher
Foley
Forbes
Fossella
Frank (MA)
Franks (AZ)
Frelinghuysen
Frost
Gallegly
Garrett (NJ)
Gerlach
Gibbons
Gilchrest
Gingrey
Goode
Goodlatte
Gordon
Goss
Granger
Graves
Green (TX)
Green (WI)
Greenwood
Grijalva
Gutierrez
Hall
Harman
Harris
Hart
Hastings (WA)
Hayes
Hayworth
Hensarling
Herger
Hill
Hinojosa
Hobson
Hoeffel
Hoekstra
Holden
Holt
Honda
Hooley (OR)
Hostettler
Houghton
Hoyer
Hunter
Hyde
Inslee
Isakson
Israel
Issa
Istook
Jackson (IL)
Jackson-Lee (TX)
Janklow
Jenkins
John
Johnson (CT)
Johnson (IL)
Johnson, Sam
Jones (NC)
Jones (OH)
Kanjorski
Kaptur
Keller
Kelly
Kildee
Kilpatrick
Kind
King (IA)
King (NY)
Kingston
Kirk
Kleczka
Kline
Knollenberg
Kolbe
LaHood
Lampson
Langevin
Lantos
Larson (CT)
Latham
LaTourette
Leach
Lee
Lewis (CA)
Lewis (KY)
Linder
Lipinski
Lofgren
Lowey
Lucas (KY)
Lucas (OK)
Lynch
Majette
Maloney
Manzullo
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McCotter
McCrery
McHugh
McIntyre
McKeon
Meehan
Meek (FL)
Meeks (NY)
Menendez
Mica
Michaud
Millender-McDonald
Miller (FL)
Miller (MI)
Miller (NC)
Miller, Gary
Mollohan
Moran (KS)
Moran (VA)
Murphy
Murtha
Musgrave
Myrick
Nadler
Napolitano
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Ortiz
Osborne
Ose
Owens
Oxley
Pallone
Pascrell
Paul
Payne
Pearce
Pelosi
Pence
Peterson (PA)
Pickering
Pitts
Platts
Pombo
Pomeroy
Porter
Portman
Price (NC)
Pryce (OH)
Putnam
Quinn
Radanovich
Rahall
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)
Sanchez, Loretta
Sanders
Sandlin
Saxton
Schiff
Schrock
Scott (GA)
Scott (VA)
Sensenbrenner
Serrano
Sessions
Shaw
Shays
Sherman
Sherwood
Shimkus
Shuster
Simmons
Simpson
Skelton
Smith (NJ)
Smith (TX)
Snyder
Solis
Souder
Spratt
Stearns
Sullivan
Tancredo
Tanner
Tauscher
Tauzin
Taylor (NC)
Terry
Thomas
Thornberry
Tiahrt
Tiberi
Tierney
Turner (OH)
Turner (TX)
Udall (CO)
Upton
Van Hollen
Velazquez
Vitter
Walden (OR)
Walsh
Wamp
Watson
Watt
Waxman
Weiner
Weldon (FL)
Weldon (PA)
Wexler
Whitfield
Wilson (NM)
Wilson (SC)
Wolf
Woolsey
Young (AK)
Young (FL)

NAYS—68

Aderholt
Allen
Baird
Baldwin
Bell
Berry
Brady (PA)
Brown (OH)
Brown, Corrine
Capuano
Costello
Crane
DeFazio
English
Filner
Ford
Gillmor
Gutknecht
Hastings (FL)
Hefley
Hinchey
Hulshof
Johnson, E. B.
Kennedy (MN)
Kennedy (RI)
Kucinich
Larsen (WA)
Levin
Lewis (GA)
LoBiondo
Markey
Marshall
Matheson
McDermott
McGovern
McNulty
Miller, George
Moore
Neal (MA)
Oberstar
Obey
Olver
Otter
Pastor
Peterson (MN)
Ramstad
Sabo

Sanchez, Linda T.	Strickland	Udall (NM)
Schakowsky	Stupak	Visclosky
Shadegg	Sweeney	Waters
Slaughter	Taylor (MS)	Weller
Smith (MI)	Thompson (CA)	Wicker
Stark	Thompson (MS)	Wu
Stenholm	Toomey	
	Towns	

NOT VOTING—9

Brown-Waite, Ginny	Gonzalez	Smith (WA)
Edwards	Jefferson	Wynn
Gephardt	McInnis	
	Petri	

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (during the vote). Members are advised there are 2 minutes remaining.

□ 1711

So the Journal was approved.

The result of the vote was announced as above recorded.

FURTHER MESSAGE FROM THE SENATE

A further message from the Senate by Mr. Monahan, one of its clerks, announced that the Senate has passed a bill of the following title in which the concurrence of the House is requested:

S. 312. An act to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program.

MAKING IN ORDER ON TUESDAY, JULY 8, 2003, CONSIDERATION OF DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2004

Mr. LEWIS of California. Mr. Speaker, I ask unanimous consent that it be in order on Tuesday, July 8, 2003, for the Speaker, as though pursuant to clause 2(b) of rule XVIII, to declare the House resolved into the Committee of the Whole House on the State of the Union for consideration of a bill reported pursuant to section 6 of House Resolution 299 making appropriations for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes, which shall proceed according to the following order:

The first reading of the bill shall be dispensed with.

All points of order against consideration of the bill are waived.

General debate shall be confined to the bill and shall not exceed 1 hour equally divided and controlled by the chairman and ranking minority member of the Committee on Appropriations.

After general debate, the bill shall be considered for amendment under the 5-minute rule.

Points of order against provisions in the bill for failure to comply with clause 2 of rule XXI are waived.

During consideration of the bill for amendment, the Chairman of the Committee of the Whole may accord priority in recognition on the basis of whether the Member offering an amendment has caused it to be printed in the portion of the CONGRESSIONAL RECORD designated for that purpose in clause 8 of rule XVIII. Amendments so printed shall be considered as read.

At the conclusion of consideration of the bill for amendment, the Committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

HEALTH SAVINGS AND AFFORDABILITY ACT OF 2003

Mr. THOMAS. Mr. Speaker, pursuant to House Resolution 299, I call up the bill (H.R. 2596) to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes, and ask for its immediate consideration.

The Clerk read the title of the bill.

The text of H.R. 2596 is as follows:

H.R. 2596

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Health Savings and Affordability Act of 2003''.

SEC. 2. HEALTH SAVINGS SECURITY ACCOUNTS AND HEALTH SAVINGS ACCOUNTS.

(a) IN GENERAL.—Part VII of subchapter B of chapter 1 of the Internal Revenue Code of 1986 (relating to additional itemized deductions for individuals) is amended by redesignating section 223 as section 225 and by inserting after section 222 the following new sections:

''SEC. 223. HEALTH SAVINGS SECURITY ACCOUNTS.

''(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a health savings security account of such individual.

''(b) LIMITATIONS.—

''(1) IN GENERAL.—The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual.

''(2) MONTHLY LIMITATION.—The monthly limitation for any month is 1/12 of—

''(A) $2,000, in the case of an eligible individual who—

''(i) has self-only coverage under a minimum deductible plan as of the first day of such month, or

''(ii) is uninsured as of the first day of such month and is not described in subparagraph (B)(ii) with respect to the taxable year which includes such month,

''(B) $4,000, in the case of an eligible individual who—

''(i) has family coverage under a minimum deductible plan as of the first day of such month, or

''(ii) is uninsured as of the first day of such month and, with respect to the taxable year which includes such month—

''(I) is entitled to a deduction for a dependent under section 151(c) (or would be so entitled but for paragraph (2) or (4) of section 152(e)), or

''(II) files a joint return, and

''(C) zero in any other case.

''(3) ADDITIONAL CONTRIBUTIONS FOR INDIVIDUALS 55 OR OLDER.—

''(A) IN GENERAL.—In the case of an individual who has attained the age of 55 before the close of the taxable year, paragraph (2) shall be applied by increasing the $2,000 amount in paragraph (2)(A) and the $4,000 amount in paragraph (2)(B) by the additional contribution amount.

''(B) ADDITIONAL CONTRIBUTION AMOUNT.—For purposes of this section, the additional contribution amount is the amount determined in accordance with the following table:

''For taxable years beginning in:	**The additional** contribution amount is:
2004	$500
2005	$600
2006	$700
2007	$800
2008	$900
2009 and thereafter	$1,000.

''(4) LIMITATION BASED ON ADJUSTED GROSS INCOME.—

''(A) SELF-ONLY COVERAGE.—The dollar amount in paragraph (2)(A) (as increased under paragraph (3)) shall be reduced (but not below zero) by an amount which bears the same ratio to such dollar amount as—

''(i) the amount (if any) by which the taxpayer's adjusted gross income for such taxable year exceeds $75,000 ($150,000 in the case of a joint return), bears to

''(ii) $10,000 ($20,000 in the case of a joint return).

''(B) FAMILY COVERAGE.—The dollar amount in paragraph (2)(B) (as increased under paragraph (3)) shall be reduced (but not below zero) by an amount which bears the same ratio to such dollar amount as—

''(i) the amount (if any) by which the taxpayer's adjusted gross income for such taxable year exceeds $150,000, bears to

''(ii) $20,000.

''(C) NO REDUCTION BELOW $200 UNTIL COMPLETE PHASE-OUT.—No dollar amount shall be reduced below $200 under subparagraph (A) or (B) unless (without regard to this subparagraph) such limitation is reduced to zero.

''(D) ROUNDING.—Any amount determined under this paragraph which is not a multiple of $10 shall be rounded to the next lowest $10.

''(E) ADJUSTED GROSS INCOME.—For purposes of this paragraph, adjusted gross income shall be determined—

''(i) without regard to this section or section 911, and

''(ii) after application of sections 86, 135, 137, 219, 221, 222, and 469.

''(5) COORDINATION WITH OTHER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the sum of—

''(A) the aggregate amount paid during such taxable year to Archer MSAs of such individual,

''(B) the aggregate amount paid during such taxable year to health savings accounts of such individual, and

''(C) the aggregate amount paid during such taxable year to health savings security accounts of such individual by persons other than such individual.

''(6) SPECIAL RULES FOR MARRIED INDIVIDUALS, DEPENDENTS, AND MEDICARE ELIGIBLE INDIVIDUALS.—Rules similar to the rules of

paragraphs (3), (6), and (7) of section 220(b) shall apply for purposes of this section.

''(c) DEFINITIONS.—For purposes of this section—

''(1) ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual unless such individual is covered, as of the first day of such month, under any health plan which is not a minimum deductible plan.

''(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A) shall be applied without regard to—

''(i) coverage for any benefit provided by permitted insurance, and

''(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

''(2) MINIMUM DEDUCTIBLE PLAN.—

''(A) IN GENERAL.—The term 'minimum deductible plan' means a health plan—

''(i) in the case of self-only coverage, which has an annual deductible which is not less than $500, and

''(ii) in the case of family coverage, which has an annual deductible which is not less than twice the dollar amount in clause (i) (as increased under subparagraph (B)).

''(B) COST-OF-LIVING ADJUSTMENT FOR ANNUAL DEDUCTIBLES.—

''(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 2004, the $500 amount in subparagraph (A)(i) shall be increased by an amount equal to—

''(I) such dollar amount, multiplied by

''(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 2003' for 'calendar year 1992' in subparagraph (B) thereof.

''(ii) ROUNDING.—If any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

''(C) SPECIAL RULES.—

''(i) EXCLUSION OF CERTAIN PLANS.—Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

''(ii) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.—A plan shall not fail to be treated as a minimum deductible plan by reason of failing to have a deductible for preventive care.

''(3) UNINSURED.—An individual shall be treated as uninsured if such individual is not covered by insurance which constitutes medical care. The preceding sentence shall be applied without regard to the coverage described in paragraph (1)(B).

''(4) PERMITTED INSURANCE.—The term 'permitted insurance' has the meaning given such term in section 220(c)(3).

''(5) FAMILY COVERAGE.—The term 'family coverage' has the meaning given such term in section 220(c)(5).

''(6) ARCHER MSA.—The term 'Archer MSA' has the meaning given such term in section 220(d).

''(7) HEALTH SAVINGS ACCOUNT.—The term 'health savings account' has the meaning given such term in section 224(d).

''(d) HEALTH SAVINGS SECURITY ACCOUNT.—For purposes of this section—

''(1) IN GENERAL.—The term 'health savings security account' means a trust created or organized in the United States as a health savings security account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:

''(A) Except in the case of a rollover contribution from an Archer MSA, or a health savings security account, which is not includible in gross income, no contribution will be accepted—

''(i) unless it is in cash and is contributed by—

''(I) the account beneficiary,

''(II) a member of the family of the account beneficiary, or

''(III) an employer of the account beneficiary, and

''(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the highest annual limitation which could apply to an individual under subsection (b) for a taxable year beginning in such calendar year.

''(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

''(C) No part of the trust assets will be invested in life insurance contracts.

''(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(E) The interest of an individual in the balance in his account is nonforfeitable.

''(2) MEMBER OF THE FAMILY.—The term 'member of the family' has the meaning given such term in section 2032A(e)(2).

''(3) QUALIFIED MEDICAL EXPENSES.—The term 'qualified medical expenses' has the meaning given such term in section 220(d)(2), except that—

''(A) subparagraph (B)(i) thereof shall not apply to—

''(i) insurance which constitutes a minimum deductible plan if no portion of the cost of such insurance is paid by an employer or former employer of the account beneficiary or the spouse of such beneficiary, and

''(ii) any health insurance (other than health insurance substantially all of its coverage is coverage described in subsection (c)(1)(B)) if the account beneficiary has attained age 65, and

''(B) subparagraph (C) thereof shall not apply for purposes of this section.

''(4) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the individual on whose behalf the health savings security account was established.

''(5) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

''(A) Section 219(d)(2) (relating to no deduction for rollovers).

''(B) Section 219(f)(3) (relating to time when contributions deemed made).

''(C) Except as provided in section 106(d), section 219(f)(5) (relating to employer payments).

''(D) Section 408(g) (relating to community property laws).

''(E) Section 408(h) (relating to custodial accounts).

''(6) CONTRIBUTIONS FROM FLEXIBLE SPENDING ACCOUNTS TREATED AS MADE BY THE EMPLOYER.—Any contribution from a flexible spending account to a health savings security account which is not includible in the gross income of the employee by reason of section 125(h) shall be treated as a contribution made by the employer for purposes of this section.

''(e) TAX TREATMENT OF ACCOUNTS.—

''(1) IN GENERAL.—A health savings security account is exempt from taxation under this subtitle unless such account has ceased to be a health savings security account. Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

''(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to health savings security accounts, and any amount treated as distributed under such similar rules shall be treated as not used to pay qualified medical expenses.

''(f) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a health savings security account which is used exclusively to pay qualified medical expenses of any account beneficiary shall not be includible in gross income.

''(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—Any amount paid or distributed out of a health savings security account which is not used exclusively to pay the qualified medical expenses of the account beneficiary shall be included in the gross income of such beneficiary in the manner provided under section 72.

''(B) SPECIAL RULES FOR APPLYING SECTION 72.—For purposes of applying section 72 to any amount described in subparagraph (A)—

''(i) all health savings security accounts shall be treated as 1 contract,

''(ii) all distributions during any taxable year shall be treated as 1 distribution,

''(iii) the value of the contract, income on the contract, and investment in the contract shall be computed as of the close of the calendar year in which the taxable year begins, and

''(iv) such distributions shall be treated as made from contributions from members of the family of the account beneficiary to the extent that such distribution, when added to all previous distributions from the health savings security account taken into account under this clause, do not exceed the aggregate contributions from members of such family.

''(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—

''(A) IN GENERAL.—If any excess contribution is contributed for a taxable year to any health savings security account of an individual, paragraph (2) shall not apply to distributions from the health savings security accounts of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if—

''(i) such distribution is made on or before the last day prescribed by law (including extensions of time) for filing the account beneficiary's return for such taxable year,

''(ii) no deduction is allowed under this section with respect to such contribution,

''(iii) such distribution is accompanied by the amount of net income attributable to such excess contribution, and

''(iv) such distribution satisfies the requirements of subparagraph (B).

''(B) RULES RELATED TO ORDERING.—

''(i) DISTRIBUTIONS LIMITED TO CONTRIBUTIONS.—Subparagraph (A) shall apply to distributions to a person only to the extent of the contributions of such person to such accounts during such taxable year.

''(ii) CLASSES OF CONTRIBUTORS.—Subparagraph (A) shall apply only to distributions of such contributions which are made in the following order:

''(I) first, to members of the family of the account beneficiary,

''(II) second, to the account beneficiary,

''(III) third, to employers of the account beneficiary with respect to contributions under section 125(h), and

''(IV) fourth, to employers of the account beneficiary with respect to contributions under section 106(d).

''(iii) LAST-IN FIRST-OUT.—If distributions could be made to more than one person under any subclause of clause (ii), subparagraph (A) shall not apply to any such distribution unless such distribution is of the

most recent excess contribution which has not been distributed to the contributor.

''(C) TREATMENT OF NET INCOME.—Any net income described in subparagraph (A)(iii) shall be included in the gross income of the person receiving the distribution for the taxable year in which received.

''(D) EXCESS CONTRIBUTION.—For purposes of subparagraph (A), the term 'excess contribution' means any contribution (other than a rollover contribution from another health savings security account, or from an Archer MSA, which is not includible in gross income) to the extent such contribution results in the aggregate contributions to health savings security accounts of the account beneficiary for the taxable year to be in excess of the limitation under subsection (b) (determined without regard to paragraph (5)(C) thereof) which applies to such beneficiary for such year.

''(4) ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The tax imposed by this chapter on the account beneficiary for any taxable year in which there is a payment or distribution from a health savings security account of such beneficiary which is includible in gross income under paragraph (2) shall be increased by 15 percent of the amount which is so includible.

''(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

''(C) EXCEPTION FOR DISTRIBUTIONS AFTER MEDICARE ELIGIBILITY.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains the age specified in section 1811 of the Social Security Act.

''(5) ROLLOVER CONTRIBUTION.—

''(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a health savings security account to the account beneficiary to the extent the amount received is paid into a health savings security account, or a health savings account, for the benefit of such beneficiary not later than the 60th day after the day on which the beneficiary receives the payment or distribution.

''(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a health savings security account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a health savings security account which was not includible in the individual's gross income because of the application of this paragraph.

''(6) SPECIAL RULES.—Rules similar to the rules of paragraphs (6), (7), and (8) of section 220(f) shall apply for purposes of this section.

''(g) REPORTS.—The Secretary may require the trustee of a health savings security account to make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, and such other matters as the Secretary determines appropriate. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.

''(h) REGULATIONS.—The Secretary may issue regulations to carry out the purposes of this section, including regulations regarding the proper treatment of distributions described in subsection (f)(3) and nondeductible contributions by members of the family of the account beneficiary.

''SEC. 224. HEALTH SAVINGS ACCOUNTS.

''(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a health savings account of such individual.

''(b) LIMITATIONS.—

''(1) IN GENERAL.—The amount allowable as a deduction under subsection (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual.

''(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 1/12 of the annual deductible (as of the first day of such month) of the individual's coverage under the high deductible health plan.

''(3) COORDINATION WITH OTHER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the sum of—

''(A) the aggregate amount paid during such taxable year to Archer MSAs of such individual,

''(B) the aggregate amount paid during such taxable year to health savings security accounts of such individual, and

''(C) the aggregate amount paid during such taxable year to health savings accounts of such individual by persons other than such individual.

''(4) SPECIAL RULES FOR MARRIED INDIVIDUALS, DEPENDENTS, AND MEDICARE ELIGIBLE INDIVIDUALS.—Rules similar to the rules of paragraphs (3), (6), and (7) of section 220(b) shall apply for purposes of this section.

''(c) DEFINITIONS.—For purposes of this section—

''(1) ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—The term 'eligible individual' means, with respect to any month, any individual if—

''(i) such individual is covered under a high deductible health plan as of the 1st day of such month, and

''(ii) such individual is not, while covered under a high deductible health plan, covered under any health plan—

''(I) which is not a high deductible health plan, and

''(II) which provides coverage for any benefit which is covered under the high deductible health plan.

''(B) CERTAIN COVERAGE DISREGARDED.—Subparagraph (A)(ii) shall be applied without regard to—

''(i) coverage for any benefit provided by permitted insurance, and

''(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

''(2) HIGH DEDUCTIBLE HEALTH PLAN.—

''(A) IN GENERAL.—The term 'high deductible health plan' means a health plan—

''(i) in the case of self-only coverage, which has an annual deductible which is not less than $1,000 and not more than $2,250,

''(ii) in the case of family coverage, which has an annual deductible which is not less than $2,000 and not more than $4,500, and

''(iii) the annual out-of-pocket expenses required to be paid under the plan (other than for premiums) for covered benefits does not exceed—

''(I) $3,000 for self-only coverage, and

''(II) $5,500 for family coverage.

''(B) COST-OF-LIVING ADJUSTMENT.—

''(i) IN GENERAL.—In the case of any taxable year beginning in a calendar year after 1998, each dollar amount in subparagraph (A) shall be increased by an amount equal to—

''(I) such dollar amount, multiplied by

''(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 1997' for 'calendar year 1992' in subparagraph (B) thereof.

''(ii) SPECIAL RULES.—In the case of the $1,000 amount in subparagraph (A)(i) and the $2,000 amount in subparagraph (A)(ii), subclause (i)(II) shall be applied by substituting 'calendar year 2002' for 'calendar year 1997'.

''(iii) ROUNDING.—If any increase under clause (i) or (ii) is not a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

''(C) SPECIAL RULES.—

''(i) EXCLUSION OF CERTAIN PLANS.—Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

''(ii) SAFE HARBOR FOR ABSENCE OF PREVENTIVE CARE DEDUCTIBLE.— A plan shall not fail to be treated as a high deductible health plan by reason of failing to have a deductible for preventive care.

''(D) TREATMENT OF NETWORK SERVICES.—

''(i) IN GENERAL.—In the case of a health plan which is a preferred provider organization plan and which would (without regard to services provided outside such organization's network of providers described in clause (iii)(I)) be a high deductible health plan, such plan shall not fail to be a high deductible health plan because—

''(I) the annual deductible for services provided outside such network exceeds the applicable maximum dollar amount in clause (i) or (ii) of subparagraph (A), or

''(II) the annual out-of-pocket expenses required to be paid for services provided outside such network exceeds the applicable dollar amount in subparagraph (A)(iii).

''(ii) ANNUAL DEDUCTIBLE.—The annual deductible taken into account under subsection (b)(2) with respect to a plan which is a high deductible health plan by reason of clause (i) shall be the annual deductible for services provided within such network.

''(iii) PREFERRED PROVIDER ORGANIZATION PLAN DEFINED.—In this subparagraph, the term 'preferred provider organization plan' means a health 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 an organization that is not licensed or organized under State law as a health maintenance organization.

''(3) PERMITTED INSURANCE.—The term 'permitted insurance' has the meaning given such term in section 220(c)(3).

''(4) FAMILY COVERAGE.—The term 'family coverage' has the meaning given such term in section 220(c)(5).

''(5) ARCHER MSA.—The term 'Archer MSA' has the meaning given such term in section 220(d).

''(6) HEALTH SAVINGS SECURITY ACCOUNT.—The term 'health savings security account' has the meaning given such term in section 223(d).

''(d) HEALTH SAVINGS ACCOUNT.—For purposes of this section—

''(1) IN GENERAL.—The term 'health savings account' means a trust created or organized in the United States as a health savings account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, but only if the written governing instrument creating the trust meets the following requirements:

''(A) Except in the case of a rollover contribution from an Archer MSA, a health savings security account, or a health savings account, which is not includible in gross income, no contribution will be accepted—

''(i) unless it is in cash and is contributed by—

''(I) the account beneficiary, or

''(II) an employer of the account beneficiary, and

''(ii) to the extent such contribution, when added to previous contributions to the trust for the calendar year, exceeds the highest annual limitation which could apply to an individual under subsection (b) for a taxable year beginning in such calendar year.

''(B) The trustee is a bank (as defined in section 408(n)), an insurance company (as defined in section 816), or another person who demonstrates to the satisfaction of the Secretary that the manner in which such person will administer the trust will be consistent with the requirements of this section.

''(C) No part of the trust assets will be invested in life insurance contracts.

''(D) The assets of the trust will not be commingled with other property except in a common trust fund or common investment fund.

''(E) The interest of an individual in the balance in his account is nonforfeitable.

''(2) QUALIFIED MEDICAL EXPENSES.—The term 'qualified medical expenses' has the meaning given such term in section 220(d)(2).

''(3) ACCOUNT BENEFICIARY.—The term 'account beneficiary' means the individual on whose behalf the health savings account was established.

''(4) CERTAIN RULES TO APPLY.—Rules similar to the following rules shall apply for purposes of this section:

''(A) Section 219(d)(2) (relating to no deduction for rollovers).

''(B) Section 219(f)(3) (relating to time when contributions deemed made).

''(C) Except as provided in section 106(d), section 219(f)(5) (relating to employer payments).

''(D) Section 408(g) (relating to community property laws).

''(E) Section 408(h) (relating to custodial accounts).

''(6) CONTRIBUTIONS FROM FLEXIBLE SPENDING ACCOUNTS TREATED AS MADE BY THE EMPLOYER.—Any contribution from a flexible spending account to a health savings account which is not includible in the gross income of the employee by reason of section 125(h) shall be treated as a contribution made by the employer for purposes of this section.

''(e) TAX TREATMENT OF ACCOUNTS.—

''(1) IN GENERAL.—A health savings account is exempt from taxation under this subtitle unless such account has ceased to be a health savings account. Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (relating to imposition of tax on unrelated business income of charitable, etc. organizations).

''(2) ACCOUNT TERMINATIONS.—Rules similar to the rules of paragraphs (2) and (4) of section 408(e) shall apply to health savings accounts, and any amount treated as distributed under such rules shall be treated as not used to pay qualified medical expenses.

''(f) TAX TREATMENT OF DISTRIBUTIONS.—

''(1) AMOUNTS USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a health savings account which is used exclusively to pay qualified medical expenses of any account beneficiary shall not be includible in gross income.

''(2) INCLUSION OF AMOUNTS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—Any amount paid or distributed out of a health savings account which is not used exclusively to pay the qualified medical expenses of the account beneficiary shall be included in the gross income of such beneficiary.

''(3) EXCESS CONTRIBUTIONS RETURNED BEFORE DUE DATE OF RETURN.—

''(A) IN GENERAL.—If any excess contribution is contributed for a taxable year to any health savings account of an individual, paragraph (2) shall not apply to distributions from the health savings accounts of such individual (to the extent such distributions do not exceed the aggregate excess contributions to all such accounts of such individual for such year) if—

''(i) such distribution is made on or before the last day prescribed by law (including extensions of time) for filing the account beneficiary's return for such taxable year,

''(ii) no deduction is allowed under this section with respect to such contribution,

''(iii) such distribution is accompanied by the amount of net income attributable to such excess contribution, and

''(iv) such distribution satisfies the requirements of subparagraph (B).

''(B) RULES RELATED TO ORDERING.—

''(i) DISTRIBUTIONS LIMITED TO CONTRIBUTIONS.—Subparagraph (A) shall apply to distributions to a person only to the extent of the contributions of such person to such accounts during such taxable year.

''(ii) CLASSES OF CONTRIBUTORS.—Subparagraph (A) shall apply only to distributions of such contributions which are made in the following order:

''(I) first, to the account beneficiary,

''(II) second, to employers of the account beneficiary with respect to contributions under section 125(h), and

''(III) third, to employers of the account beneficiary with respect to contributions under section 106(d).

''(iii) LAST-IN FIRST-OUT.—If distributions could be made to more than one person under any subclause of clause (ii), subparagraph (A) shall not apply to any such distribution unless such distribution is of the most recent excess contribution which has not been distributed to the contributor.

''(C) TREATMENT OF NET INCOME.—Any net income described in subparagraph (A)(iii) shall be included in the gross income of the person receiving the distribution for the taxable year in which received.

''(D) EXCESS CONTRIBUTION.—For purposes of subparagraph (A), the term 'excess contribution' means any contribution (other than a rollover contribution from another health savings account, from a health savings security account, or from an Archer MSA, which is not includible in gross income) to the extent such contribution results in the aggregate contributions to health savings accounts of the account beneficiary for the taxable year to be in excess of the limitation under subsection (b) (determined without regard to paragraph (3)(C) thereof) which applies to such beneficiary for such year.

''(4) ADDITIONAL TAX ON DISTRIBUTIONS NOT USED FOR QUALIFIED MEDICAL EXPENSES.—

''(A) IN GENERAL.—The tax imposed by this chapter on the account beneficiary for any taxable year in which there is a payment or distribution from a health savings account of such beneficiary which is includible in gross income under paragraph (2) shall be increased by 15 percent of the amount which is so includible.

''(B) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

''(C) EXCEPTION FOR DISTRIBUTIONS AFTER MEDICARE ELIGIBILITY.—Subparagraph (A) shall not apply to any payment or distribution after the date on which the account beneficiary attains the age specified in section 1811 of the Social Security Act.

''(5) ROLLOVER CONTRIBUTION.—

''(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a health savings account to the account beneficiary to the extent the amount received is paid into a health savings account for the benefit of such beneficiary not later than the 60th day after the day on which the beneficiary receives the payment or distribution.

''(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) received by an individual from a health savings account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a health savings account which was not includible in the individual's gross income because of the application of this paragraph.

''(6) SPECIAL RULES.—Rules similar to the rules of paragraphs (6), (7), and (8) of section 220(f) shall apply for purposes of this section.

''(g) REPORTS.—The Secretary may require the trustee of a health savings account to make such reports regarding such account to the Secretary and to the account beneficiary with respect to contributions, distributions, and such other matters as the Secretary determines appropriate. The reports required by this subsection shall be filed at such time and in such manner and furnished to such individuals at such time and in such manner as may be required by the Secretary.''.

(b) DEDUCTION ALLOWED WHETHER OR NOT INDIVIDUAL ITEMIZES OTHER DEDUCTIONS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (18) the following new paragraphs:

''(19) HEALTH SAVINGS SECURITY ACCOUNTS.—The deduction allowed by section 223.

''(20) HEALTH SAVINGS ACCOUNTS.—The deduction allowed by section 224.''.

(c) COORDINATION WITH ARCHER MSAS.—

(1) ROLLOVERS FROM ARCHER MSAS PERMITTED.—Subparagraph (A) of section 220(f)(5) of such Code (relating to rollover contribution) is amended by inserting '', a health savings security account (as defined in section 223(d)), or a health savings account (as defined in section 224(d)),'' after ''paid into an Archer MSA''.

(2) REDUCTION IN ARCHER MSA LIMITATION FOR CONTRIBUTIONS TO HEALTH SAVINGS SECURITY ACCOUNTS AND HEALTH SAVINGS ACCOUNTS.—Subsection (b) of section 220 of such Code (relating to limitations) is amended by adding at the end the following new paragraph:

''(8) COORDINATION WITH HEALTH SAVINGS SECURITY ACCOUNTS AND HEALTH SAVINGS ACCOUNTS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the sum of—

''(A) the aggregate amount paid during such taxable year to health savings security accounts of such individual, and

''(B) the aggregate amount paid during such taxable year to health savings accounts of such individual.''.

(d) EXCLUSIONS FOR EMPLOYER CONTRIBUTIONS TO HEALTH SAVINGS SECURITY ACCOUNTS AND HEALTH SAVINGS ACCOUNTS.—

(1) EXCLUSION FROM INCOME TAX.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is amended by adding at the end the following new subsections:

''(d) CONTRIBUTIONS TO HEALTH SAVINGS SECURITY ACCOUNTS.—

''(1) IN GENERAL.—In the case of an employee who is an eligible individual, amounts contributed by such employee's employer to

any health savings security account of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 223(b) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

''(2) SPECIAL RULES.—Rules similar to the rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection.

''(3) DEFINITIONS.—For purposes of this subsection, the terms 'eligible individual' and 'health savings security account' have the respective meanings given to such terms by section 223.

''(4) CROSS REFERENCE.—

"For penalty on failure by employer to make comparable contributions to the health savings security accounts of comparable employees, see section 4980G.

''(e) CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—

''(1) IN GENERAL.—In the case of an employee who is an eligible individual, amounts contributed by such employee's employer to any health savings account of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amounts do not exceed the limitation under section 224(b) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

''(2) SPECIAL RULES.—Rules similar to the rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection.

''(3) DEFINITIONS.—For purposes of this subsection, the terms 'eligible individual' and 'health savings account' have the respective meanings given to such terms by section 224.

''(4) CROSS REFERENCE.—

"For penalty on failure by employer to make comparable contributions to the health savings accounts of comparable employees, see section 4980G.".

(2) EXCLUSION FROM EMPLOYMENT TAXES.—

(A) RAILROAD RETIREMENT TAX.—Subsection (e) of section 3231 of such Code is amended by adding at the end the following new paragraph:

''(11) HEALTH SAVINGS SECURITY ACCOUNT AND HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.—The term 'compensation' shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under subsection (d) or (e) of section 106.''.

(B) UNEMPLOYMENT TAX.—Subsection (b) of section 3306 of such Code is amended by striking ''or'' at the end of paragraph (16), by striking the period at the end of paragraph (17) and inserting ''; or'', and by inserting after paragraph (17) the following new paragraph:

''(18) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under subsection (d) or (e) of section 106.''.

(C) WITHHOLDING TAX.—Subsection (a) of section 3401 of such Code is amended by striking ''or'' at the end of paragraph (20), by striking the period at the end of paragraph (21) and inserting ''; or'', and by inserting after paragraph (21) the following new paragraph:

''(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under subsection (d) or (e) of section 106.''

(3) EMPLOYER CONTRIBUTIONS REQUIRED TO BE SHOWN ON W–2.—Subsection (a) of section 6051 of such Code is amended by striking ''and'' at the end of paragraph (10), by striking the period at the end of paragraph (11) and inserting a comma, and by inserting after paragraph (11) the following new paragraphs:

''(12) the amount contributed to any health savings security account (as defined in section 223(d)) of such employee or such employee's spouse, and

''(13) the amount contributed to any health savings account (as defined in section 224(d)) of such employee or such employee's spouse.''.

(4) PENALTY FOR FAILURE OF EMPLOYER TO MAKE COMPARABLE HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.—

(A) IN GENERAL.—Chapter 43 of such Code is amended by adding after section 4980F the following new section:

"SEC. 4980G. FAILURE OF EMPLOYER TO MAKE COMPARABLE HEALTH SAVINGS ACCOUNT CONTRIBUTIONS.

''(a) GENERAL RULE.—In the case of an employer who makes a contribution to the health savings security account or the health savings account of any employee during a calendar year, there is hereby imposed a tax on the failure of such employer to meet the requirements of subsection (b) for such calendar year.

''(b) RULES AND REQUIREMENTS.—Rules and requirements similar to the rules and requirements of section 4980E shall apply for purposes of this section.

''(c) REGULATIONS.—The Secretary shall issue regulations to carry out the purposes of this section, including regulations providing special rules for employers who make contributions to more than one of the following types of accounts during the calendar year:

''(1) An Archer MSA.

''(2) A health savings security account.

''(3) A health savings account.''.

(B) CLERICAL AMENDMENT.—The table of sections for chapter 43 of such Code is amended by adding after the item relating to section 4980F the following new item:

''Sec. 4980G. Failure of employer to make comparable health savings account contributions.''.

(e) TAX ON EXCESS CONTRIBUTIONS.—Section 4973 of such Code (relating to tax on excess contributions to certain tax-favored accounts and annuities) is amended—

(1) by striking ''or'' at the end of paragraph (3) of subsection (a),

(2) by inserting after paragraph (4) of subsection (a) the following new paragraphs:

''(5) a health savings security account (within the meaning of section 223(d)), or

''(6) a health savings account (within the meaning of section 224(d))'', and

(4) by adding at the end the following new subsections:

''(g) EXCESS CONTRIBUTIONS TO HEALTH SAVINGS SECURITY ACCOUNTS.—For purposes of this section, in the case of health savings security accounts (within the meaning of section 223(d)), the term 'excess contributions' means the sum of—

''(1) the aggregate amount contributed for the taxable year to the accounts (other than a rollover contribution from another health savings security account, or from an Archer MSA, which is not includible in gross income) which is in excess of the limitation under section 223(b) (determined without regard to paragraph (5)(C) thereof), and

''(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of—

''(A) the distributions out of the accounts which were included in gross income under section 223(f)(2), and

''(B) the excess (if any) of—

''(i) the sum of limitations described in paragraph (1), over

''(ii) the amount contributed to the accounts for the taxable year.

For purposes of this subsection, any contribution which is distributed out of the health savings security account in a distribution to which section 223(f)(3) applies shall be treated as an amount not contributed.

''(h) EXCESS CONTRIBUTIONS TO HEALTH SAVINGS ACCOUNTS.—For purposes of this section, in the case of health savings accounts (within the meaning of section 224(d)), the term 'excess contributions' means the sum of—

''(1) the aggregate amount contributed for the taxable year to the accounts (other than a rollover contribution from another health savings account, a health savings security account, or from an Archer MSA, which is not includible in gross income) which is in excess of the limitation under section 224(b) (determined without regard to paragraph (3)(C) thereof), and

''(2) the amount determined under this subsection for the preceding taxable year, reduced by the sum of—

''(A) the distributions out of the accounts which were included in gross income under section 224(f)(2), and

''(B) the excess (if any) of—

''(i) the sum of limitations described in paragraph (1), over

''(ii) the amount contributed to the accounts for the taxable year.

For purposes of this subsection, any contribution which is distributed out of the health savings account in a distribution to which section 224(f)(3) applies shall be treated as an amount not contributed.''.

(f) TAX ON PROHIBITED TRANSACTIONS.—

(1) Section 4975 of such Code (relating to tax on prohibited transactions) is amended by adding at the end of subsection (c) the following new paragraphs:

''(6) SPECIAL RULE FOR HEALTH SAVINGS SECURITY ACCOUNTS.—An individual for whose benefit a health savings security account (within the meaning of section 223(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a health savings security account by reason of the application of section 223(e)(2) to such account.

''(7) SPECIAL RULE FOR HEALTH SAVINGS ACCOUNTS.—An individual for whose benefit a health savings account (within the meaning of section 224(d)) is established shall be exempt from the tax imposed by this section with respect to any transaction concerning such account (which would otherwise be taxable under this section) if, with respect to such transaction, the account ceases to be a health savings account by reason of the application of section 224(e)(2) to such account.''.

(2) Paragraph (1) of section 4975(e) of such Code is amended by redesignating subparagraphs (E) and (F) as subparagraphs (G) and (H), respectively, and by inserting after subparagraph (D) the following new subparagraphs:

''(E) a health savings security account described in section 223(d),

''(F) a health savings account described in section 224(d),''.

(g) FAILURE TO PROVIDE REPORTS ON HEALTH SAVINGS ACCOUNTS.—Paragraph (2)

of section 6693(a) of such Code (relating to reports) is amended by redesignating subparagraphs (C) and (D) as subparagraphs (E) and (F), respectively, and by inserting after subparagraph (B) the following new subparagraphs:

''(C) section 223(g) (relating to health savings security accounts),

''(D) section 224(g) (relating to health savings accounts),''.

(h) EXCEPTION FROM CAPITALIZATION OF POLICY ACQUISITION EXPENSES.—Subparagraph (B) of section 848(e)(1) of such Code (defining specified insurance contract) is amended by striking ''and'' at the end of clause (iii), by striking the period at the end of clause (iv) and inserting a comma, and by adding at the end the following new clauses:

''(v) any contract which is a health savings security account (as defined in section 223(d)), and''.

''(vi) any contract which is a health savings account (as defined in section 224(d)).''.

(i) HEALTH SAVINGS SECURITY ACCOUNTS AND HEALTH SAVINGS ACCOUNTS MAY BE OFFERED UNDER CAFETERIA PLANS.—Paragraph (2) of section 125(d) (relating to cafeteria plan defined) is amended by adding at the end the following new subparagraph:

''(D) EXCEPTION FOR HEALTH SAVINGS ACCOUNTS.—Subparagraph (A) shall not apply to a plan to the extent of amounts which a covered employee may elect to have the employer pay as contributions to a health savings security account, or a health savings account, established on behalf of the employee.''.

(j) INFORMATION REPORTING BY PROVIDERS OF HEALTH INSURANCE.—Subpart B of part III of subchapter A of chapter 61 of such Code is amended by adding at the end the following new section:

''SEC. 6050U. RETURNS RELATING TO PROVIDERS OF HEALTH INSURANCE.

''(a) REQUIREMENT OF REPORTING.—Under regulations prescribed by the Secretary, every person who provides any individual with coverage under a plan which constitutes medical care shall, at such time as the Secretary may prescribe, make the return described in subsection (b) with respect to such individual.

''(b) FORM AND MANNER OF RETURNS.—A return is described in this subsection if such return—

''(1) is in such form as the Secretary may prescribe, and

''(2) contains such information as the Secretary prescribes.

''(c) STATEMENTS TO BE FURNISHED TO INDIVIDUALS WITH RESPECT TO WHOM INFORMATION IS REQUIRED.—Every person required to make a return under subsection (a) shall furnish to each individual whose name is required to be set forth in such return a written statement showing—

''(1) the name and address of the person required to make such return and the phone number of the information contact for such person, and

''(2) the information required to be shown on the return with respect to such individual.

The written statement required under the preceding sentence shall be furnished on or before January 31 of the year following the calendar year for which the return under subsection (a) is required to be made.''.

(k) CONFORMING AMENDMENTS.—

(1) The table of sections for part VII of subchapter B of chapter 1 of such Code is amended by striking the last item and inserting the following:

''Sec. 223. Health savings security accounts.
''Sec. 224. Health savings accounts.
''Sec. 225. Cross reference.''.

(2)(A) Sections 86(b)(2)(A), 135(c)(4)(A), 137(b)(3)(A), 219(g)(3)(A)(ii), and 221(b)(2)(C)(i) are each amended by inserting ''223,'' after ''222,''.

(B) Section 222(b)(2)(C)(i) is amended by inserting ''223,'' before ''911''.

(C) Section 469(i)(3)(F)(iii) is amended by striking ''and 222'' and inserting ''222, and 223''.

(l) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years beginning after December 31, 2003.

SEC. 3. DISPOSITION OF UNUSED HEALTH BENEFITS IN CAFETERIA PLANS AND FLEXIBLE SPENDING ARRANGEMENTS.

(a) IN GENERAL.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended by redesignating subsections (h) and (i) as subsections (i) and (j), respectively, and by inserting after subsection (g) the following:

''(h) CONTRIBUTIONS OF CERTAIN UNUSED HEALTH BENEFITS.—

''(1) IN GENERAL.—For purposes of this title, a plan or other arrangement shall not fail to be treated as a cafeteria plan solely because qualified benefits under such plan include a health flexible spending arrangement under which not more than $500 of unused health benefits may be—

''(A) carried forward to the succeeding plan year of such health flexible spending arrangement,

''(B) to the extent permitted by sections 223 and 224, contributed on behalf of the employee to a health savings security account (as defined in section 223(d)), or a health savings account (as defined in section 224(d)), maintained for the benefit of such employee, or

''(C) contributed to a qualified retirement plan (as defined in section 4974(c)), or an eligible deferred compensation plan (as defined in section 457(b)) of an eligible employer described in section 457(e)(1)(A), but only to the extent such amount would not be allowed as a deduction under—

''(i) section 223 if made directly by the employee to a health savings security account of the employee (determined without regard to any other contributions made by the employee), and

''(ii) section 224 if made directly by the employee to a health savings account of the employee (determined without regard to any other contributions made by the employee).

''(2) SPECIAL RULES FOR TREATMENT OF CONTRIBUTIONS TO RETIREMENT PLANS.—For purposes of this title, contributions under paragraph (1)(C)—

''(A) shall be treated as elective deferrals (as defined in section 402(g)(3)) in the case of contributions to a qualified cash or deferred arrangement (as defined in section 401(k)) or to an annuity contract described in section 403(b),

''(B) shall be treated as employer contributions to which the employee has a nonforfeitable right in the case of a plan (other than a plan described in subparagraph (A)) which is described in section 401(a) which includes a trust exempt from tax under section 501(a),

''(C) shall be treated as deferred compensation in the case of contributions to an eligible deferred compensation plan (as defined in section 457(b)), and

''(D) shall be treated in the manner designated for purposes of section 408 or 408A in the case of contributions to an individual retirement plan.

''(3) HEALTH FLEXIBLE SPENDING ARRANGEMENT.—For purposes of this subsection, the term 'health flexible spending arrangement' means a flexible spending arrangement (as defined in section 106(c)) that is a qualified benefit and only permits reimbursement for expenses for medical care (as defined in section 213(d)(1) (without regard to subparagraphs (C) and (D) thereof).

''(4) UNUSED HEALTH BENEFITS.—For purposes of this subsection, with respect to an employee, the term 'unused health benefits' means the excess of—

''(A) the maximum amount of reimbursement allowable to the employee during a plan year under a health flexible spending arrangement, taking into account any election by the employee, over

''(B) the actual amount of reimbursement during such year under such arrangement.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to taxable years beginning after December 31, 2003.

SEC. 4. EXCEPTION TO INFORMATION REPORTING REQUIREMENTS RELATED TO CERTAIN HEALTH ARRANGEMENTS.

(a) IN GENERAL.—Section 6041 (relating to information at source) is amended by adding at the end the following new subsection:

''(f) SECTION DOES NOT APPLY TO CERTAIN HEALTH ARRANGEMENTS.—This section shall not apply to any payment for medical care (as defined in section 213(d)) made under—

''(1) a flexible spending arrangement (as defined in section 106(c)(2)), or

''(2) a health reimbursement arrangement which is treated as employer-provided coverage under an accident or health plan for purposes of section 106.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to payments made after December 31, 2002.

□ 1715

The SPEAKER pro tempore (Mr. SWEENEY). Pursuant to House Resolution 299, the gentleman from California (Mr. THOMAS) and the gentleman from New York (Mr. RANGEL) each will control 30 minutes.

The Chair recognizes the gentleman from California (Mr. THOMAS).

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume.

This is an important day regarding all Americans' health care needs. Most people are focused on our seniors and the Medicare legislation, which will be before us shortly. We have before us now the Health Savings and Affordability Act, and I first want to thank my colleague, the gentleman from Illinois (Mr. LIPINSKI), for working with us in producing a bipartisan piece of legislation, which is extremely important to seniors accompanying the Medicare legislation, but really to all Americans, and especially those Americans who, through no fault of their own, today have no health insurance available to them.

This legislation creates two new savings accounts, a health savings account and a health savings security account. The basic idea is that people ought to be able to put their own money away, individuals, relatives, or otherwise who wish to help them put money away, and in particular instances, employers who adopt particular kinds of health care plans for their employees assist in putting money away for health care needs. These accounts will accumulate tax free and can be expended for any health needs.

Here is the really exciting and important new twist. There is no age limit at

which you have to make all of the contributions paid out of the health savings account. It is literally lifetime assistance. Why is that important? Because today, as we pass the new Medicare modernization with prescription drug program, we will add tremendous new benefits, but there are other costs associated with the bill, both in acquiring prescription drugs and in making sure that seniors can pay for those additional costs.

It is not right to say that every additional benefit provided to seniors should be paid for by taxpayers. We are already in the midst of the greatest intergenerational transfer of wealth in the history of the world. But it is also not fair to say to hardworking Americans that when they retire they should pay out of their own pockets if we have not provided an easily affordable method to accumulate those dollars.

That is exactly what we have in front of us today: A health savings account that has a multiple number of ways in which money can be placed in to be paid for health needs not only while you are working but when you retire. There is no absolute payout. And if there is money in it when the senior passes, then it becomes part of an estate and that money, in its transfer, is taxable. There is no possibility of gimmicking the system.

The real concern is that we have told Americans oftentimes that they have to pay for particular costs, and yet we do not provide an easy and affordable way for them to do so. One of the big concerns we have today is chronic or long-term care costs for seniors. Time value of money is the best way to address a problem that is going to face most Americans. That is exactly what health savings accounts allow you to do. It is clearly an affordable health care cost if you have planned for it.

Unfortunately, too often today's seniors did not plan. There was not a program convenient and easy for them to plan. This allows them, in a prudent way, to put money away. Oftentimes we may want to help our parents, senior children. This is a way, through a health savings account, that they can place money available for seniors to be readily used for health savings accounts that provide a positive, tax-free environment for accumulating those dollars.

In so many ways, Mr. Speaker, this particular program will blend not only with the Medicare changes that we are going to be making but in terms of meeting the needs of today's workers as well. It is completely portable, it is a fund that accumulates tax free, and it belongs to the individual. They can take it with them wherever they may want to work.

Mr. Speaker, I ask unanimous consent that the control of the balance of my time be by the gentleman from Wisconsin (Mr. RYAN).

The SPEAKER pro tempore. Without objection, the gentleman from Wisconsin (Mr. RYAN) will control the balance of the time.

There was no objection.

Mr. RYAN of Wisconsin. Mr. Speaker, I reserve the balance of my time.

Mr. RANGEL. Mr. Speaker, I yield myself such time as I may consume.

The chairman of the Committee on Ways and Means connected this bill with senior citizens' inability to plan for their future. Well, I am glad he is sending them a signal, because after what they intend to do with seniors with the Medicare bill, somebody might have planned for their futures.

I remember in the good old days when Republicans used to say that they were going to travel around the country and pull the Tax Code up by the roots. That meant they were going to close loopholes, get rid of shelters, and to have a system that people did not have to hire accountants and lawyers in order to know what their tax liability would be. I even volunteered to drive around with them on these buses to see just how they intended to put back a Code that was more equitable and fair and one could understand.

But while the gentleman from California (Mr. STARK) still thinks that some of them are on the level as relates to health, I asked for the opportunity to at least open up this debate just so that people who are not on the floor would understand that this has nothing to do with health. It has a heck of a lot to do with wealth and more to do with shelter. They have to find ways to make certain that the deficit gets larger and that there is no money in the Treasury to take care of the problems that we used to say was a Federal responsibility. How do you do it? Just being creative.

Why, they do not even need a chairman of a Committee on the Budget because there are no budget restrictions. Last night, this bill was supposed to be going over to the Committee on Rules at a cost of $71 billion over 10 years. What imagination. What creativity, when just overnight they found out that the bill really costs $171 billion. How can Republicans be so smart that just overnight, without hearings, without checking with Treasury, without talking with OMB they can find $100 billion?

Now, what is the cost of $171 billion? It is simple: It means that people who make up to $150,000 and are well do not have to pay taxes on storing away $4,000 in a tax shelter. So if you are working for someone and you make up to $150,000, you never have to pay taxes on the money, whether you are sick or whether or not you retire with the money. This is really just a tax-free grant to some of the people who are friendly to people on the other side.

But what about the people that do not have the $4,000? Now, that is the problem, because you are not eligible for this unless you do not have expenses that will be paid for for $1,000. So if an employer really cares for you and wants to have you eligible for this tax shelter, the best favor he can do for you is to take away your health insurance. And, of course, you make the killing on your savings by not paying taxes. And so once he does you this favor, he has to do it for the lesser-income people, and lo and behold, we will find that those who cannot afford to stash away this money, because they do not have disposable income, end up with no insurance and no savings account.

Oh, one might say this is cruel, but sensitivity never bothered the majority party, because at the end of the game they want to know how much of the people's money did you leave with them. Or to put it another way, how much did you take away from the Federal Government so that we cannot provide basic services.

So the gentleman from California (Mr. STARK) need not worry. This savings account has nothing to do with health. It has everything to do with shelter.

Mr. Speaker, I ask unanimous consent that the balance of my time be turned over to the gentleman from California (Mr. STARK) and that he be given the authority to allocate 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 California (Mr. STARK) reserves the balance of his time.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I just heard the ranking member say this is not a health bill, that this is a tax shelter. I beg to differ. Number one, what we are talking about here is really novel and revolutionary. We are saying that employers and employees can together contribute to their own savings account with pretax dollars, with tax- deductible dollars to purchase health care spending and to have a catastrophic plan.

The gentleman from New York said, what about the people who do not have $4,000 to put in their health security savings account? Well, their employer can put $4,000 into their account. The purpose of this reform, Mr. Speaker, is to get at some of the big issues that are really hurting this country, and that is the cost of health insurance, the affordability, and the accessibility of health insurance.

So what this reform does is it equips the individual in the family with the ability to go out into the health care marketplace with tax-deductible dollars to act like good consumers and buy their health insurance. It gives incentives. It actually requires, on health savings accounts, that employers provide catastrophic health insurance, or individuals who have their own health savings accounts have catastrophic health insurance. So it makes sure that people have health insurance if they really run into problems. But it allows people to manage their health care expenditures themselves.

You know, it is often said that we spend more time shopping for cars or

computers than we do for our own health insurance. Well, the reforms in this bipartisan Thomas-Lipinski bill give us those incentives to act like good consumers so we can watch our health care dollars. Health care inflation is out of control. Health care spending is out of control. Premium increases facing small businesses and individuals are out of control. We need to give consumers the ability to get it under control. That is what this legislation does.

I am also interested in the argument that this is somehow fiscally irresponsible. I find that kind of a unique argument, given the fact that the gentleman from New York is about to bring a prescription drug substitute amendment to the floor that spends $600 billion more than the Republican plan does; a trillion dollar bill that spends a trillion dollars on his prescription drug bill versus the $400 billion that was paid for in the House budget resolution, as is this health savings account legislation.

Mr. Speaker, I reserve the balance of my time so that the other side can yield time.

Mr. STARK. Mr. Speaker, I yield myself 3 minutes.

(Mr. STARK asked and was given permission to revise and extend his remarks.)

Mr. STARK. Mr. Speaker, I will start with an apology to all my Republican colleagues. For, oh, at least the 30 years or so I have been here, I have been accusing the Republicans of not being inclusive, just dealing with the rich and forgetting about the minorities and the working people in this country. With this bill they have become broadly inclusive. Later on tonight, they are going to take the first step in destroying health care for seniors, and then, because they are being so inclusive with this bill, they are going to screw everybody. They are going to destroy health care for the employees who get their health insurance from employers.

As the distinguished ranking member of our committee pointed out, $100 billion was added to this in the middle of the night, and the bill will be funded by borrowing, by increasing the national debt and worsening deficits. And all it really does, if you cut through all the Mickey Mouse that they have talked about, high-deductible insurance, is that it creates some new tax-exempt savings accounts. Tax shelters for the wealthy and the healthy. And it advances the objective of undercutting employer-provided health coverage.

It is no secret that the distinguished chairman of the Committee on Ways and Means has expressed his desire to dismantle the employment-linked health insurance system, and he has noted that he believes it encourages overutilization of health care because individuals are shielded from knowing the true cost.

□ 1730

Now, the argument that the bill will assist the uninsured is not true. Most of the uninsured have incomes too low to be eligible for any tax benefits contained in H.R. 2596. And as was stated earlier, few, if any, have the $4,000 a year in additional savings required to utilize the benefits contained. There is nothing in this bill that requires the employers to give the employees any money to make up for that gap that will be created by the higher deductibles. It merely gives them the opportunity, if they have any money, to add to savings accounts.

Not surprisingly, the same 6 million families who were deliberately excluded by the Republicans from the recent tax bill for child tax credit are the same families that they are excluding from benefiting in this bill. So for families with insurance, it provides tax benefits only if the insurance requires them to pay the first thousand dollars; and employers will be encouraged by this nonsense to increase health insurance deductibles, which lowers their costs and lowers the benefits for most of their employees' health insurance.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 2 minutes to the gentlewoman from Washington (Ms. DUNN), a member of the Committee on Ways and Means.

Ms. DUNN. Mr. Speaker, I am very happy that we have this bill on the floor finally. I think it serves a real need, and it provides total flexibility to people who want to provide for the coverage of their health care expenses.

One particular provision that appeals to me is one that we used to refer to as a catch-up health savings account contribution. We now call it a health savings security account, and these are accounts that are designed particularly for people who are age 55 or older. It gives them the right to contribute additional dollars every year into their health savings accounts because of particular situations they might have faced in the past.

The flexibility of HSAs is widely known. These dollars can be used for any health-related expense as long as it is not reimbursed. For example, they can be used to pay for long-term care or for health coverage policy or doctors' bills or for prescription drugs; but what is special about the health savings security accounts is in the way it applies to people like me. Many people, particularly women, during their child-raising years took time away from the workplace and often did not add money into accounts like IRAs, or actually Social Security accounts, and ended up with big goose eggs when the time came to calculate their benefits.

In this case, the health savings accounts provide for folks who took time off during their child-raising years, or to look after an ill parent; and it allows them to add up to 25 percent in additional dollars each year to their health savings accounts. This will begin in operation as soon as this bill is enacted. An individual age 55 or older can contribute $500 a year in addition to the total health savings account. That amount will grow to $1,000 in 2009, and I think it is a very sensitively written provision to help folks who have been away from the workforce or need this additional provision.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Michigan (Mr. LEVIN), a member of the Committee on Ways and Means who understands that with this $174 billion that we are wasting in this bill, we could help States maintain Medicaid coverage as they weather their fiscal crisis.

Mr. LEVIN. Mr. Speaker, this came out of the wee hours of this morning, but I want Members to realize how radical a move this is. We are going to have later today a radical effort to dismantle Medicare. What this is is a radical effort to dismantle our employer-based system in this country. So now we are going to take a step toward a kind of voucher for health insurance in the form of a tax credit. That is what we are going to do.

Those who can afford to use the tax credit will have that voucher, and they will go out into the marketplace. The consumer, each individual one, is going to try to swim as best as they can. But for those who do not have the money to put in this account, who have no benefit from the tax credit, they are going to continue not to swim as an individual consumer, but to sink. That is what is going to happen. That is why this is so radical.

Now, the other side of the aisle said we want to add money into Medicare in the prescription drug proposal. They are darn right. We did not create this deep deficit. Their answer to a deficit that is deep is to dig it deeper. In the middle of the night or early morning, you add $100 billion to the deficit; and I want to quickly read what this looks like.

We were supposed to have with the March baseline a deficit of $377 billion. We added $484 billion through what was called a technical reestimate. Then through legislation, we added what was it, 700 to $800 billion. Now the projected deficit, $1.5 trillion, four times what was projected a few months ago, and this does not include the bill that is going to be brought up later or additional military expenditures. It does not include this $100 billion. I tell the gentleman from Wisconsin (Mr. RYAN), this is fiscally irresponsible. You Republicans have zero fiscal responsibility in your political veins. Zero. This is radical because it is going to dismantle the employer-based system.

PARLIAMENTARY INQUIRY

Mr. HAYWORTH. Parliamentary inquiry, Mr. Speaker.

The SPEAKER pro tempore (Mr. SWEENEY). Does the gentleman from Michigan (Mr. LEVIN) yield for a parliamentary inquiry?

Mr. LEVIN. No, Mr. Speaker, I will not yield for a parliamentary inquiry.

Mr. Speaker, as I was saying, you are not only going to dismantle Medicare later as a first step, and now

try to dismantle the employer-based health care system in this country; but what you are doing is digging a deeper, deeper hole of debt in this country. This is a radical proposal on all accounts, and it should be rejected.

PARLIAMENTARY INQUIRY

Mr. HAYWORTH. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore. The gentleman will state it.

Mr. HAYWORTH. Mr. Speaker, is it appropriate for a Member to address his comments directly to another Member, or should those comments be directed through the Chair addressing the Member?

The SPEAKER pro tempore. All remarks should be directed through the Chair.

Mr. HAYWORTH. Was it true that the preceding gentleman addressed a Member directly?

The SPEAKER pro tempore. All remarks in debate should be directed to the Chair.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, to respond to a couple of comments from the last speaker, I would say, number one, we are going to keep hearing this rhetoric, that this undermines or destroys employer-sponsored health care. Actually, it is far from that. It is the opposite of that. This makes it easier for employers to offer health care to their employees. What this does is it makes it easier because employers can offer less-costly catastrophic coverage and give their employees money, pretax money in their accounts, to purchase health care. This will lower the cost of health insurance and make it cheaper for employers to offer health care.

Mr. Speaker, I yield 2½ minutes to the gentleman from Arizona (Mr. HAYWORTH), an esteemed member of the Committee on Ways and Means.

Mr. HAYWORTH. Mr. Speaker, again, as we come to the well this evening, we see a very vast difference in our visions of health care and visions of America.

Our friends on the left who later tonight will offer a $1 trillion government command-and-control approach to prescription drugs now take strong objection, to put it diplomatically, about a plan that, yes, initially is expensive. I would grant Members that billions are real dollars here, but it substantially supplements and expands the ability of people to have health insurance.

As the gentleman from Wisconsin (Mr. RYAN) mentioned, it gives employers more options to provide that type of insurance by embracing catastrophic plans and freeing up dollars to go to employees, and as we see in the case of health savings security accounts, and this is the key, and I would urge my colleagues to understand this, as so many have come to the well of this House on both sides of the aisle and lamented the numbers of uninsured Americans, not the medically indigent with whom we try to deal through Medicaid, but those who are working people who do not have insurance, this provides an option to those people to embrace insurance. To realize savings, yes, does require a modicum of personal responsibility, undoubtedly.

But, Mr. Speaker, certainly we have not degenerated to the point where we absolutely forsake a notion of personal responsibility in savings. What we do is offer options that will supplement health care; and despite the cat calls and poisonous partisan rhetoric, it is worth noting that this is bipartisan legislation.

So again a cautionary note to my friends on the left. If you believe you are indicting one party, stop and think; many of your colleagues who share both the party label and broad-based philosophy, as my friends on the left share in many different areas, join with us in this legislation because they understand it opens opportunity for health insurance, it opens opportunity for individuals, it opens opportunity for employers, and it will lead to more people seeking the insurance we all want to see them have. Vote ''yes'' on this legislation.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Washington (Mr. MCDERMOTT) who realizes that with this $176 billion we could insure every one of the 9 million uninsured children in this country.

(Mr. MCDERMOT asked and was given permission to revise and extend his remarks.)

Mr. MCDERMOTT. Mr. Speaker, I think it is important to realize that last night a miracle occurred in this body, a bill that left the committee costing $73 billion sometime after midnight suddenly became $173 billion. An actual miracle in the Committee on Rules.

The fact is Members have to understand why that happened. All Members make $150,000 a year. They were not covered by this bill. It only went up to $65,000; but in the Committee on Rules they said, let us put ourselves in this bill, so they raised it up to $150,000 so that we could take benefit of this. Now that was a thoughtful thing for them to be doing, but did they think about the people in your district?

My employees at Boeing, they get $65,000 a year. It is a pretty good paying job, and they get good benefits from their company. What is to stop their company tomorrow from saying, We are going to give you a $10,000 deductible policy, and we will put $500 into your account, you put $3,500 in, and you will have it all for yourself? They can do that. They can end a defined benefit package at Boeing tomorrow and give a defined contribution. Give employees a voucher, and say they are on their own. Do Members want them to strike over that?

Mr. Speaker, how about the woman making $30,000 teaching school. We all know those school teachers are rich people. You end the school program, the State governments are in trouble, they could say let us stop giving insurance to the teachers, let us just give them a $10,000 deductible policy, put $500 in their savings account and say to the $30,000-a-year teacher, they can come up with $3,500 to put into their account.

□ 1745

I love to hear people who make $150,000 talk about what it is like to be in this country making $30,000, which is the average pay. Or the people making $18,000. They work every day. They have no insurance. Do you think they have $3,500 to put into a savings account?

This is for rich people. That is why it went up $100 billion miraculously between a $65,000 income limit and $150,000. It only cost 74 for all the people at the bottom, but it cost 100 for us. This is a bad bill.

What it does, also, it says people are going to get out of the pool. People who are rich and healthy are going to get out of the pool, and they are going to leave the sick and the poor in the pool. And what happens to the premiums for the average person? They go up. The idea of insurance is to spread the risk, and you are letting the wealthy and healthy get out of the pool.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield myself 15 seconds to respond just briefly only to say that health care is voluntary by businesses. Mr. Speaker, Boeing could drop their health care right now, today, to their employees. And, Mr. Speaker, that is what is happening today. Millions of businesses are making those kinds of decisions to drop health care. We are trying to make it more affordable. We are trying to keep it so that businesses can still offer health insurance at an affordable price to their employees.

Mr. Speaker, I yield 2 minutes to the gentleman from California (Mr. ROYCE).

Mr. ROYCE. Mr. Speaker, I thank the gentleman for yielding me this time. This measure will make it easier for employers to offer health care to their employees. It is also going to help Americans save for their medical expenses, to gain greater access to quality health care. I particularly support the provision in this bill that would prevent a portion of the unused balances and flexible spending arrangements from being forfeited at the end of the year. Right now there is a use-it-or-lose-it provision that applies to workers. I have been working for several years to allow individuals to accumulate unused balances from their flexible spending arrangements to save for health care expenses. In this Congress I introduced H.R. 176 to allow individuals to accumulate $2,000 annually from these FSAs, as we call them.

Right now we have over 30 million workers in the United States that have these FSAs available to them. Employees and employers can set aside pretax

money which can be used to pay for out-of-pocket health care expenses and copayments and deductibles. Under the current system, unfortunately, employees forfeit money not used at the end of the year. Currently, this encourages wasteful health care spending because employees, knowing that they will forfeit unused account balances, engage in end-of-the-year spending sprees on services they may not need like extra eyeglasses, shades or unnecessary exams. So eliminating the use-it-or-lose-it provision solves this problem because then the employee will be able to roll over the balance from year to year. That is the attempt in this bill on that provision.

Preventing some forfeiture also increases the savings rate by increasing the disposable income of those employees in the program, and it also empowers them to make their own health care decisions. I urge my colleagues to pass this legislation.

Mr. STARK. Mr. Speaker, I yield myself 30 seconds. I have a couple of letters, one from the AFL-CIO which suggests that this legislation would establish an enormous tax shelter for wealthy individuals and at the same time undermine employer-based health coverage and shift costs onto workers. I have a letter from Families USA which, among other things, says that this bill also threatens the employer-provided health insurance system particularly among smaller employers who will be able to take deductions in the top brackets and who will then no longer be interested in providing coverage for their employees.

Mr. Speaker, I include both letters for the RECORD.

AMERICAN FEDERATION OF LABOR AND CONGRESS OF INDUSTRIAL ORGANIZATIONS,
Washington, DC, June 26, 2003.

DEAR REPRESENTATIVE: The AFL–CIO opposes H.R. 2351, the Health Savings Account Availability Act. This legislation would establish an enormous tax shelter for wealthy individuals and at the same time undermine employer-based health coverage and shift more cost onto workers. Despite proponents' claims, this bill would fail to expand coverage to the uninsured and would be especially harmful to those low-income, older and sicker workers who now have comprehensive coverage.

Under H.R. 2351, employers could offer Health Savings Accounts as long as they are provided in conjunction with high-deductible health insurance policies, defined as at least $500 for an individual policy and $1,000 for a family plan. This will encourage employers to abandon more generous coverage and offer instead less comprehensive policies that shift significant costs onto workers. The Joint Committee on Taxation has estimated that 30 million such accounts would be established by 2013 and the majority of employers would modify their health plans to meet the high-deductible guidelines of the legislation.

In addition, this shift in coverage would harm most those workers who need health care. Low-income workers who are the intended beneficiaries of these plans' preferred tax treatment are not likely to get back enough in taxes to offset the greater out-of-pocket costs they are likely to incur with these high-deductible plans.

Furthermore, those workers and other insured individuals who have traditional, more comprehensive coverage will see their premiums rise. Younger, healthier workers will likely choose the less-comprehensive coverage, leaving older and sicker workers and those who earn too little to pay taxes in traditional coverage. As a result, costs for this coverage will rise, leaving workers with no choice but to enroll in the high-deductible coverage this bill seeks to promote.

This legislation was slipped through the Ways and Means committee last week, and made worst late last night in the Rules Committee. Among the changes made in Rules, the income threshold has been raised to $175,000 for joint filers. The cost of the revised bill is estimated to be $174 over ten years—more than twice the estimated cost of the bill that passed Ways and Means last week—and makes clear that this legislation is first and foremost another tax shelter, not a bill to cover the uninsured.

H.R. 2351 was raised just last week with little notice and certainly without any hearings, despite the bill's far-reaching implications and significant cost. And now the House leadership has called for it to be joined with the Medicare prescription drug legislation before the House. I urge you to vote against H.R. 2351.

Sincerely,

WILLIAM SAMUEL,
Director, Department of Legislation.

FAMILIES USA
Washington, DC, June 26, 2003.

Hon. CHARLES RANGEL,
Rayburn House Office Building,
Washington, DC.

DEAR REPRESENTATIVE RANGEL, On behalf of Families USA, the national advocacy group for health care consumers, I am writing to oppose the Health Savings and Affordability act of 2003 (H.R. 2596). Implementation of the Health Savings Accounts (HSAs) and Health Savings Security Accounts (HSSAs) will do little to expand health insurance coverage to the 41 million Americans who are uninsured.

This bill creates two programs loosely modeled after existing Archer Medical Savings Accounts (MSAs). Rather than targeting limited federal funds to provide help for the lowest-income uninsured, this bill creates tax-free accounts, the HSSA's, which can be accessed by families with incomes up to $150,000 before starting to phase-out. The total cost of this bill is over $169 billion over ten years—a huge federal investment that will do little or nothing to cover the low-income uninsured. The people who deserved to be helped in any health legislation are being ignored by this legislation. If this huge commitment of resources were applied to an expansion of the Children's Health Insurance Program or to Medicaid, we could cover every uninsured child in America (about 8.5 million) with excellent care and have money left over to help their mothers! To casually, and with so little debate, spend these huge resources on so many higher-income individuals is a travesty of the legislative process.

This bill also threatens the employer-provided health insurance system, particularly among smaller employers who will be able to take deductions in the top brackets for their personal insurance and who will then no longer be interested in providing coverage for their employees.

We look forward to working under your leadership to reject this bill, and instead to work for real and meaningful mechanisms to expand coverage to the uninsured in this country. Thank you for your continued commitment to this issue and to reducing the number of uninsured Americans.

Sincerely,

RONALD E. POLLACK,
Executive Director.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the distinguished gentleman from Wisconsin (Mr. KLECZKA).

Mr. KLECZKA. Mr. Speaker, let me thank the gentleman from California for yielding me this time.

Mr. Speaker, I really do not know where to start, to start answering some of the critics and the proponents of this legislation. This bill started out about a week ago or so in the Committee on Ways and Means, which I serve on, and the cost was $14 billion. Then the day the bill came up, the cost rose to $72 billion. And then last night the cost went to $173 billion. Mr. Speaker, let us pass this bill quickly, because I am afraid it is going to continue to grow. But that does not make it a good bill.

What is going on here, my friends, is this is the demise of the employer-sponsored health care system in this country. The employers do not like it. They want to get out of it. Members of the committee, including the chairman, have indicated that their desire is to dismantle the employer-based health care system. This bill does it.

How does it do it? It gives the employer an option. It says, Mr. and Mrs. Employee, we are changing your health policy. I am going to give you one starting next month that will provide for a $2,000 deduction on your health care costs. Start saving, because the Congress passed a bill where you can save and then you pay the first $2,000.

It sounds fine in principle, but here is the problem, my friends. Working families in this country have to first of all pay the mortgage so they do not lose the home, pay for the car so he can get to work, feed the kids and clothe them and send them to school, and then this Congress has already told you that the past generation has been irresponsible, they did not plan for their future and you better. So put money away for your retirement in an IRA and a 401(k). And you say, yes, because Social Security probably will not be enough, I will do that. Then this Congress said, college education is going up, mom and dad, start saving for your kids' education. And so you say, yeah, I will put a couple of thousand away a year for Johnny's and Sally's education.

Now we are saying to you, after all this, we have got another one, start saving for your health care. Then you say, Mr. Republican Congressman, I am out of money. I do not make that much. I do not have any more disposable income. And so when your employer changes your health plan and you do not put the $2,000 or $4,000 away when you get sick, you are out of luck. That is what is going on here. Make no mistake about it.

Mr. STARK. Mr. Speaker, I yield 4 minutes to the distinguished gentleman from Texas (Mr. DOGGETT), a

member of the Committee on Ways and Means.

Mr. DOGGETT. Mr. Speaker, once again Republicans insist on a fiscally irresponsible bill that will benefit the wealthiest and in this case the healthiest at the cost of at least $174 billion added to our already soaring national debt.

Mr. Speaker, despite the bright sunshine outside, it really is a dark day for so many Americans who are working hard just to make ends meet. This bill is the natural companion to a measure written by the same folks that are presenting this bill, which previously denied a child tax credit to poor working folks. Tax cuts, no matter what the economic conditions, no matter how pressing are the other priorities we have in our country, such as protecting our families from terrorism, tax cuts, we are always told, can cure any ill in our society, unless of course you are poor and working, in which case your kids are not worthy of a child tax credit.

Thanks to the intransigence of the House Republican leadership, there are now 6 million working American families, they are folks like cafeteria workers and teachers' aides, nursing home employees, those working at our hospitals doing the tough work, they will receive no check for their children this year like other Americans. Their bid to gain a little economic independence, to share in the economic benefits of the American Dream, it will come and go on July 4 unfulfilled because of the refusal of this House Republican leadership and their desire to go on recess not only for July 4 but to continue their recess from reality.

For these same families that were deliberately excluded from the recent tax cut as well as for many other working families, House Republicans add more insult to injury by encouraging employers to terminate or to weaken any group health insurance coverage through which some of these employees may be covered. This bill is also the natural companion to the next bill that we are about to take up, the bill to repeal Medicare as we have known it, since President Lyndon B. Johnson signed it into law. We know this is not new. They have opposed Medicare since before President Johnson wrote his signature to make it a reality. Newt Gingrich wanted it to wither on the vine. Earlier this month, Mr. Gingrich declared, much as our colleagues are here today, using the very same words that they got from Newt Gingrich, that it was an ''obsolete government monopoly.''

Only yesterday we heard the same language from the sponsor of this measure: ''To those who say that the bill would end Medicare as we know it, our answer is, 'We certainly hope so.'''

''Old-fashioned Medicare isn't very good,'' said Bill Thomas, the sponsor of this legislation and the companion measure to repeal Medicare tonight.

Some of us think old-fashioned Medicare has worked pretty well for the millions of Americans that it has served since 1965, and we want to strengthen it, not see it undermined through into privatization.

The bill before us this afternoon does something very similar to what the later bill proposes to do to Medicare and, that is, to weaken, at great cost to our Treasury, our employer-based health care system. By totally excluding employees unless they are in plans that deny any assistance on at least the first $1,000 or $2,000 in medical bill coverage, this bill will encourage even higher deductibles. And it will be a struggle for a cafeteria worker to pay their first $1,000 or their first $2,000 or more-thousand under these new high-deductible plans.

The same plans will encourage more small employers to stop providing coverage at all and to protect themselves individually through these MSAs and to terminate costly health insurance for their other employees. It will encourage group health plans to reduce covered services, increase copayments.

In short, through these three bills, we see Republican indifference from cradle to grave for children, for workers, for seniors.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. ENGLISH) to talk about this legislation that we are debating, health savings accounts.

Mr. ENGLISH. Mr. Speaker, I really wish more of the American public were watching this debate because they would be able to fully appreciate how marginal the left has become to any serious debate about the problems facing this country. What we are going to be doing tonight is not voting to repeal Medicare, but instead voting to pass this bill, which is a bill that would provide more medical security for uninsured Americans as well as many low- and middle-income workers.

This legislation actually creates two new instruments to meet health care needs by rewarding Americans who open either type of account with tax advantages and maximum flexibility, so as the other side has noted, even the healthy can have a greater role in managing their own health care. Encouraging individuals to enroll in these new savings vehicles has multiple benefits. First, this is a big step to make health insurance more affordable and help reduce the growing number of Americans without health insurance. The tax-preferred nature of the health savings security accounts offers a powerful incentive for uninsured workers to take advantage of these accounts. The contributions to the accounts are deductible; the investment earnings within the accounts tax-free; and the distributions are also tax-free when used for health insurance. Many, including the self-employed, would find this enormously valuable. This results in significant savings on health insurance, an economic benefit that is certain to encourage many uninsured Americans to utilize these accounts.

Second, insured workers with high-deductible plans will also see similar incentives. Both savings vehicles give individuals a potent incentive to save for health care costs that do not fit within their deductible, giving them another option and perhaps some peace of mind about unanticipated medical expenses. The medical expenses that qualify for tax-free distributions are very far reaching and include expenses from preventive care to long-term care. When individuals use their own hard-earned dollars for health care, they will ask more questions, further inform themselves, and become better consumers of health care products. This bill undoubtedly promotes an educated and wise consumer of health care services and will result in all-around better health care decisions.

Our current Tax Code puts a punitive burden on working families who save their own money for medical and other expenses. The health savings accounts ease that burden by providing two simple and flexible savings mechanisms for working families.

□ 1800

This is commonsense legislation that makes health insurance and health care more affordable and tax advantaged for Americans. It does not destroy our health care system and it does not dismantle Medicare. Accordingly, I urge my colleagues to give workers control of their own health care and vote for the creation of health savings accounts.

The SPEAKER pro tempore (Mr. SWEENEY). The Chair advises Members that the gentleman from California (Mr. STARK) has 9 minutes remaining and the gentleman from Wisconsin (Mr. RYAN) has 12¼ minutes remaining.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. PALLONE), who understands that we could cover the parents of low-income children who are eligible for Medicaid and CHIP with the same amount of money.

Mr. PALLONE. Mr. Speaker, I just do not know how many tricks or hoaxes the Republican leadership is going to play on us tonight and on the American people. It is unbelievable. I listened to the gentleman from Pennsylvania. He said there is going to be Medicare reform tonight. There is not going to be Medicare reform. It is just going to be an effort to kill Medicare and destroy Medicare. And then they say they are going to bring up a prescription drug benefit tonight that really is not any meaningful benefit that forces one into HMOs, that denies them of choices of doctors and hospitals. And now this one, the ultimate trick, which I guess we did not really even know about until today, that basically tries to undercut employer-based health insurance.

When does it end? When are the Republicans going to end what they are trying to do to destroy the health care system?

Mr. Speaker, although we would like to provide health coverage for those who are uninsured, this bill does little or nothing to help the low-income uninsured. Individuals eligible for the tax credit under the Thomas bill would have to be uninsured or in high deductible plans, but according to the bill, starting in 2004, those individuals could set aside up to $2,000 tax free into a new health savings account to supposedly help pay for health insurance. But the argument that the bill will assist the uninsured is simply not true. Most uninsured have incomes that are too low to owe Federal income tax liability, let alone have $2,000 to set aside for this purpose. In addition, self-employed individuals, the other large segment of the uninsured, may already deduct 100 percent of the health insurance costs.

The only consequence of this bill is to undercut the provision of employer-sponsored health care coverage by encouraging employers to raise deductibles or potentially drop their coverage and raise the cost of health care for low income, older and sick workers with higher co-payments and premiums.

And, lastly, as many of the speakers on our side have said, this legislation will cost the government over $173 billion, another in a series of fiscally irresponsible tax cuts passed by the House. The entire cost of the bill will be funded by borrowing, increasing the national debt.

Where does this end? We have a national debt 4-, $500 billion. Where is it going to end?

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 2 minutes to the gentleman from Nebraska (Mr. TERRY).

(Mr. TERRY asked and was given permission to revise and extend his remarks.)

Mr. TERRY. Mr. Speaker, when will it end? I am saddened by the arguments from the left that fail to recognize that there are more people in America that want to have choices. They do not want just the offering of a government program one size fits all. Not everyone thinks that the government is the answer to everything. So I am proud to support bills that allow the market to provide opportunities and choices, and that is what tonight is about. I am wondering sitting here listening to the debate what some of our Founding Fathers would think of today's debate. Think about the people that started this country that left their countries to set sail on a venture unknown to come to a new land for what? Freedom. Trying to escape the government powers that were controlling their lives. And now 200 or 300 years later from those first people that landed on our shores, our debate is how far government is going to control their health and their lives. Not everybody wants bureaucrats running their health care. So I am proud to stand in favor of the HSAs.

Mr. Speaker, in today's world us baby boomers, and, yes, I am on the tail-end, there are a few others that are nearing their entry into Medicare, but we are facing a crisis too. Our parents need help in today's world. At the same time that we worry about our parents' health and their futures and what our role is as their children will be in helping them in their golden years, we are also raising our children, trying to save for their college and their future. This is one pro-family tax item. It allows me, as the child of a father who had a stroke last October, to help my parents with their health care costs. So this is one great pro-family tax measure, and I urge my colleagues to support it.

Mr. STARK. Mr. Speaker, I yield 1½ minutes to the gentleman from Illinois (Mr. EMANUEL).

Mr. EMANUEL. Mr. Speaker, I thank my colleague from California for yielding me this time.

Earlier the speaker before me talked about choice. In the prescription drug debate we are having, I have talked about choice and I have an amendment, a bipartisan amendment, to offer people choice between generic versus name brand drugs that would reduce prices so people could pick cheaper drugs. Also part of the provision allows individuals, government, private sector, to buy medications anywhere in the G–8 countries and have competition so they can get drugs cheaper in Germany or France or Canada or Italy. That would drive prices down.

I too agree with competition. The free market would drive prices down. So those of us who embrace the free market wonder why sometimes our colleagues on the other side are so scared of the free market. I have seen that the benefits of the free market work. I would like to see it come to the discussion we have on a prescription drug bill because if we bring that competition of the free market to the debate about prescription drugs, we will make medications more affordable to all Americans of all ages.

The interesting thing is there are two issues that are driving health care inflation at 25, 30 percent for the public. One is the cost of prescription drugs. Two is the 42 million uninsured who show up in our emergency rooms, driving up hospital costs which insurance companies pass on to employers and employers pass on to employees. And if we wanted to insure the uninsured, we can do it for a lot less money than this. Expand Kid Care. In Illinois we have a program known as Kid Care, insurance for the children of working parents, that expands the kid care to family care.

What is most interesting about this debate is that we have a prescription drug bill coverage for Members of Congress that is far more generous than the one that we are about to provide for our elderly. Those are the wrong values. Those are not the values that we came here to represent.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 30 seconds to the gentleman from Louisiana (Mr. MCCRERY), from the committee.

Mr. MCCRERY. Mr. Speaker, the immediate preceding speaker, the gentleman from Illinois (Mr. EMANUEL), spoke about the free market and letting free market forces work with respect to prescription drugs, and his solution is either import drugs from other countries and sell them here of course at lower prices or let us adopt the prices that are paid in those other countries here in our country, and he calls that the free market.

What he failed to point out is those drugs and those prices that he would be importing or adopting the prices out here are set by government price controls, not the free market.

Mr. EMANUEL. Mr. Speaker, will the gentleman yield?

Mr. MCCRERY. I yield to the gentleman from Illinois.

Mr. EMANUEL. Mr. Speaker, the fact is we would have competition. It is a Gutknecht-Emanuel bill with a number of the gentleman's colleagues on his side and a number of colleagues on my side. The three provisions to this bill, A, allow generics to come to market quicker so name brand pharmaceutical companies could not be involved in frivolous lawsuits.

Mr. MCCRERY. Mr. Speaker, reclaiming my time, the issue of generics is addressed in the underlying bill that we will be debating later tonight, but the gentleman spoke about bringing drugs in from other countries and selling them at prices that have been imposed by governments, not by the free market.

Mr. STARK. Mr. Speaker, I reserve the balance of my time.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. BURGESS).

Mr. BURGESS. Mr. Speaker, I thank the gentleman from Wisconsin for yielding me this time.

H.R. 2596 will increase access to consumer-based health coverage to all Americans regardless of income. Under H.R. 2596 the availability of health savings accounts will assist those that live without health coverage and give Americans more options when it comes to their health. Health savings accounts will promote savings and more direct health purchasing.

The character of these accounts will also simplify the doctor-patient relationship. As a physician, I know firsthand the difficulty some patients have working through their insurance companies and trying to figure out what services are covered by their policies. With a health savings account, patients can focus their attention on their medical care. They can discuss their needs with their doctors frankly and honestly, and they can proceed with appropriate medical treatments that they need.

My colleagues on the other side of the aisle are more prepared to force people into a one-size-fits-all solution instead of giving individuals the choice

or the purchasing power to make decisions for themselves.

I myself have had a medical saving account since 1997, that is, until I came to Congress, and it was coverage that I made available to everyone in my practice as a choice. It was not a requirement. If someone wanted the chance to be in charge of their medical decisions and a chance to build wealth in one of these accounts for future medical expenses, I thought it was only prudent as an employer to provide that opportunity.

Mr. Speaker, we talk about the evils of HMOs, and the Members on the other side of the aisle are frequently mentioning the evils of HMOs, but this is the anti-HMO. Put the purchasing power back in the hand of the patient.

These plans are centered on the concept of personal choice. These accounts make more money available to purchase health coverage. We need to be serious about the solutions when addressing the problems of the uninsured in this country. An individual will make rational decisions when they have the ability to spend their own money on their health services.

I ask my colleagues, I implore my colleagues, not to stand in the way. Give Americans the freedom to make this decision.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the gentleman from Washington (Mr. INSLEE).

(Mr. INSLEE asked and was given permission to revise and extend his remarks.)

Mr. INSLEE. Mr. Speaker, in regard to the Medicare bill we will be considering this evening, I thought about coming down to the House and asserting that this bill was a Trojan horse, but I think it is worse than a Trojan horse. I do not think it would be fair to the Trojan horse metaphor to call this a Trojan horse. And the reason is, is when the Athenians sent the horse to the Trojans, they did not announce in advance that the horse was full of soldiers that were going to attack the city. They kind of kept that a secret. But the Republicans have not kept any secrets about this horse at all because if we look at what the gentleman from California (Mr. THOMAS) said, ''To those who say that the Medicare bill would end Medicare as we know it, our answer is we certainly hope so.''

If the Athenians had announced that the gift, the alleged gift, they were sending was going to destroy the city they were attacking, no one would have bought that old nag. And it the same situation here. We should not buy this old nag of a bill with the expressed intent of destroying Medicare over the next 10 years. And, yes, it is complicated on how that is going to happen. And, yes, it is a little bit chaotic in explaining it. But the Members can rest assured that America's senior citizens are going to figure this out. They are going to figure out this is worse than a Trojan horse because they see it coming. We should reject this and adopt the Democratic substitute.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 2 minutes to the gentlewoman from Florida (Ms. HARRIS).

(Ms. HARRIS asked and was given permission to revise and extend her remarks.)

Ms. HARRIS. Mr. Speaker, today the House of Representative stands at the threshold of passing landmark legislation that protects and improves Medicare while providing our seniors with a real prescription drug benefit. While the debate remains properly focused upon this moral obligation to our seniors, I wish to highlight another exciting component of health care reform that we will address today.

H.R. 2596, the Health Savings and Affordability Act of 2003, authorizes the creation of health savings accounts which will enable every American to pay their basic medical expenses from tax-free money. In almost every purchase of goods and services except health care, individuals bargain directly with vendors and providers.

□ 1815

Assuming an adequately competitive market, suppliers will not charge more than buyers are willing and able to pay for very long.

The structure of our current health care system pushes consumers to the sidelines. Big insurance companies negotiate prices with big health care conglomerates, producing a distorted market and more expensive health care, prescription drugs, and health insurance premiums for the uninsured and self-employed.

H.R. 2596 allows Americans, particularly Medicare-eligible seniors, to use health care savings accounts to pay for medical expenses, prescription drug costs, retiree health insurance expenses, long-term care service, and COBRA coverage. It permits family members and employers to make tax-free contributions to these accounts.

The nature and uncertainty of health care expenses will always require critical programs such as Medicare and an efficiently-operating insurance industry. That is why the reforms that we will adopt in H.R. 1 are so vital.

Nevertheless, through the magic of the free market, H.R. 2596 will reduce costs that many Americans pay for the most basic health care needs, while forcing our entire health care system to become more efficient.

Mr. STARK. Mr. Speaker, I am delighted to yield the balance of our time to the distinguished gentleman from California (Mr. GEORGE MILLER), the ranking member of the Committee on Education and the Workforce.

Mr. GEORGE MILLER of California. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, in the next few hours, the Republicans in the Congress will engage in the greatest raid and diminishment on middle-class health care benefits in the history of this country. Benefits that have been built up over the last 50 or 60 years in this country that have enabled middle-class individuals to have some health security, to have some access to prescription drugs, to have access to the health care that they and their families need, will come under assault. It begins with this legislation, medical savings accounts, where millions of Americans who now have good health care plans, where they share the payment of those plans with their employers, between employers and employees, will find out that those plans are going to be substituted by high-threshold, high-cost, high-deductible plans, and the theory is that they can pay for that out of their medical savings accounts.

Millions of Americans are going to wake up and find out that the health care plans that they have available to them today will not be available to them tomorrow.

Just as with the passage of the Medicare bill, the prescription drug bill that we will do later tonight, some 30 percent of the people who have prescription drug benefits will wake up and find out that they will get a lesser benefit under the Medicare prescription drug benefit than they are currently getting today. Millions of senior citizens will discover that they have lost their prescription drug benefit as they know it, and they will have to accept something much less than that.

When we come back from the Fourth of July break, we will complete this trifecta assault on middle-class health care plans when the Committee on Education and the Workforce reports out the Association Health Care Plan proposal. Because the CBO, the Congressional Budget Office tells us that over 8 million Americans will lose the health care they have today, and what will be substituted will be a health care plan that is much less comprehensive than they have today. Mr. Speaker, 8 million Americans, 8 million middle-class Americans. And the answer that the Republicans suggest to us is we can all just save and pay for that ourselves.

Well, if we look who is paying into 401(k)s, we know that most Americans do not have that disposable income. That is why they have employer-based health care systems.

But starting tonight, that employer-based health care system, that system that has done so much to keep people healthy, to keep people out of poverty, to keep them from losing their homes, is about to be shredded; and the assault is complete and its comprehensive, and it runs from the seniors to new and young families trying to raise children. All of these people will find out. If my colleagues do not think it is going to happen, just look at the employers who are announcing that these cutbacks are going to come who are supporting the association health care plans, who are supporting medical savings accounts, these health savings accounts tonight, and who are supporting prescription drugs. Because they are lining up to get rid of their obligations for prescription drugs, for health care for young

families, health care for older families, all in the name of their cost savings. But that will dramatically change the middle class in this country and what they have come to know as health care security.

But for the elderly it is going to be even more dramatic. When we look at the prescription drug benefit, it is interesting that the largest elderly group in the country, AARP, everything that they say is essential to protect senior citizens, and a prescription drug benefit is not in this bill. Read their letter. It is not in this bill. They wish it was, they hope it will be, but it is not here tonight.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield myself the remaining time.

I would like to begin my closing by saying that the gentleman from California is a person who has worked in health care for many, many years; and I know that he is sincere in trying to do what he thinks is best to give access to people who need health care. I believe everyone who came to the floor and into the well who spoke on this bill today cares about health care.

Mr. Speaker, I am relatively new to this body; but one thing I have learned is that if you are running out of arguments, the oldest trick in the book is to impugn the other person's motives. Tell them that all we want to do is help the rich and hurt the poor, that what we are trying to do is destroy employer-sponsored health care.

Well, Mr. Speaker, two of the Nation's leading organizations who represent small employers, the people who are really facing these high premium hikes, the National Association of Manufacturers, the National Federation of Independent Businesses, this is one of their key priorities. They endorse this bill.

What this does, Mr. Speaker, is it makes it easier for employers to offer health care to their employees. It helps us continue employer-sponsored health care.

Another thing that we have been hearing, that this is fiscally irresponsible and adds to the deficit.

Mr. Speaker, what is fiscally irresponsible is the substitute prescription drug bill that the minority is bringing to the floor which costs $600 billion more than the budget resolution allows. The budget resolution that passed this House balances the budget within the term of the budget resolution, within 10 years. And this is paid for and budgeted for in the budget resolution.

Mr. Speaker, at the end of the day, after we have heard all of these arguments, it kind of comes down to two things, two different philosophies: socialism versus consumerism. They want socialized medicine. They want power to go to Washington where Washington can allocate the benefits, where Washington can ration the health care. We want power to go to the people. We want power to go to the consumers. We want people to have more choices. They want to restrict those choices.

This does not take anything away from anybody, Mr. Speaker. This gives people more choices. This says to people, if you are having a hard time saving for your health care, we are going to make it easier for you to do that. If you are a small business and you cannot afford health care for your employees right now, we are giving you a new option to do just that.

We are going to give employers the ability to say, look, you can put money in an account that you can deduct it from in your employee's name. Your employees contribute to this account. If you do it, you have to buy catastrophic health care coverage for them. So we are making sure with health care savings accounts that there is health insurance. And the beautiful part of this proposal, Mr. Speaker, is that this is the employee's money; it is their money that is at stake when they go out and buy health care. They are going to act like real consumers. They can take this money with them when they leave their job and go to another job. They can take this money with them into retirement throughout the rest of their life; and when they die, this money can go to their spouse. This money becomes the individual's money.

One of the big problems we have in health care today is we do not act like consumers. We have third-party payers paying the bills, and so when we go and pay for health care, someone else is paying the bills, so we really do not care how much it costs. That is one of the reasons why the costs of health care are going up through the roof.

This puts in place 280 million brains on behalf of bringing down health care costs and 280 million sets of eye balls watching this industry to make sure that doctors are charging the right kinds of prices, that hospitals are not overcharging, and that they are getting the best quality for their dollar.

Mr. Speaker, it is about giving power to consumers versus giving power to bureaucrats in Washington. Let us give Americans more freedom, let us give consumers more power, and let us help bring down health care costs.

Mr. Speaker, I urge passage of this bill.

Ms. JACKSON-LEE of Texas. Mr. Speaker, it used to be that the most challenging part of my job here was finding meaningful ways of improving quality of life for the people in my district. Now it seems the most challenging part is trying to figure out how the Republican leadership will next try to deny those same people the lives they and their families deserve. Today's bill is one of the more creative approaches I have seen by the Republicans to advance their goals of giving their rich political donors big tax cuts, and denying the poor and middle classes healthcare and the services they need.

This bill serves no one that really needs it, and will actually undermine the health insurance benefits received by millions of Americans now. It is confusing and complex, and makes a mess of a system that needs to be fine-tuned, not destroyed. The majority of Americans now receive health insurance through employers. This bill will offer a tax break to people who do not have health insurance coverage, and those whose coverage has a deductible of over $1,000. It sounds good, until you think about it. This bill will serve to encourage businesses to cut their health insurance programs, or raise deductibles on their employees. Low- to moderate-income employees and those who are uninsured pay all kinds of taxes: payroll taxes, sales taxes, property taxes. However, they tend to not pay enough income taxes to take advantage of this new Republican-give-to-the-rich scheme. So the exact people who are not being left out of our healthcare system, and who need relief, are being left out of this bill.

The underlying goal of this bill is to dismantle the employer-based health insurance system that the Chairman of the Ways and Means Committee hates. He has stated that he does not like employer-based health insurance because it shields people from the cost of healthcare and thus enables people to use healthcare too much. I don't see that Americans have made themselves too healthy. I want to increase access to care not decrease it, so I will vote against this bill.

Not only is this a bad bill, it is an expensive one. It will cost $71 billion over the next ten years—all money borrowed from our children and grandchildren. In the later years of the budget window, this bill will cost in excess of $10 billion per year, and will accelerate just at the time when the baby boom generation retires, denying resources to meet our commitments to the Social Security and Medicare systems.

Again, it seems this bill was crafted to specifically target and destroy the elements of our healthcare system that people know and trust: Medicare and Employer-sponsored coverage—and use the savings to give to CEOs, the healthy, and the wealthy. It is not surprising to find that due to the structure of this bill, the same people whose children were denied the benefits of a child tax credit, will also not receive any benefits from this bill.

Of course they will be allowed to help pay the interest on the booming debt that it adds to.

I will oppose this bill and encourage my colleagues to do the same.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield back the balance of my time.

The SPEAKER pro tempore (Mr. SWEENEY). All time for debate has expired.

Pursuant to House Resolution 299, the bill is considered read for amendment and the previous question is ordered.

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.

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.

Mr. STARK. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.

The SPEAKER pro tempore. Evidently a quorum is not present.

The Sergeant at Arms will notify absent Members.

The vote was taken by electronic device, and there were—yeas 237, nays 191, not voting 7, as follows:

[Roll No. 328]

YEAS—237

Aderholt
Akin
Alexander
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bereuter
Berkley
Biggert
Bilirakis
Bishop (GA)
Bishop (UT)
Blackburn
Blunt
Boehlert
Boehner
Bonilla
Bonner
Bono
Boozman
Boyd
Bradley (NH)
Brady (TX)
Brown (SC)
Burgess
Burns
Burr
Burton (IN)
Buyer
Calvert
Camp
Cannon
Cantor
Capito
Cardoza
Carter
Case
Chabot
Chocola
Coble
Cole
Collins
Cox
Crane
Crenshaw
Cubin
Culberson
Cunningham
Davis (TN)
Davis, Jo Ann
Davis, Tom
Deal (GA)
DeLay
DeMint
Deutsch
Diaz-Balart, L.
Diaz-Balart, M.
Dooley (CA)
Doolittle
Dreier
Duncan
Dunn
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
Hobson
Hoekstra
Hooley (OR)
Hostettler
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
LaTourette
Leach
Lewis (CA)
Lewis (KY)
Linder
Lipinski
LoBiondo
Lucas (KY)
Lucas (OK)
Manzullo
McCotter
McCrery
McHugh
McKeon
Mica
Miller (FL)
Miller (MI)
Miller, Gary
Moran (KS)
Murphy
Musgrave
Myrick
Nethercutt
Neugebauer
Ney
Northup
Norwood
Nunes
Nussle
Osborne
Ose
Otter
Oxley
Paul
Pearce
Pence
Peterson (MN)
Peterson (PA)
Petri
Pickering
Pitts
Platts
Pombo
Porter
Portman
Pryce (OH)
Putnam
Quinn
Radanovich
Ramstad
Regula
Rehberg
Renzi
Reynolds
Rogers (AL)
Rogers (KY)
Rogers (MI)
Rohrabacher
Royce
Ryan (WI)
Ryun (KS)
Saxton
Schrock
Scott (GA)
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
Walden (OR)
Walsh
Wamp
Weldon (FL)
Weldon (PA)
Weller
Whitfield
Wicker
Wilson (NM)
Wilson (SC)
Wolf
Young (AK)

NAYS—191

Abercrombie
Ackerman
Allen
Andrews
Baca
Baird
Baldwin
Ballance
Becerra
Bell
Berman
Berry
Bishop (NY)
Blumenauer
Boswell
Boucher
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Capuano
Cardin
Carson (IN)
Carson (OK)
Castle
Clay
Clyburn
Conyers
Cooper
Costello
Cramer
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
DeFazio
DeGette
Delahunt
DeLauro
Dicks
Dingell
Doggett
Doyle
Edwards
Emanuel
Engel
Eshoo
Etheridge
Evans
Farr
Fattah
Filner
Ford
Frank (MA)
Frost
Gonzalez
Gordon
Green (TX)
Grijalva
Gutierrez
Harman
Hastings (FL)
Hill
Hinchey
Hinojosa
Hoeffel
Holden
Holt
Honda
Houghton
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)
Lofgren
Lowey
Lynch
Majette
Maloney
Markey
Marshall
Matheson
Matsui
McCarthy (MO)
McCarthy (NY)
McCollum
McDermott
McGovern
McIntyre
McNulty
Meehan
Meek (FL)
Meeks (NY)
Menendez
Michaud
Millender-McDonald
Miller (NC)
Miller, George
Mollohan
Moore
Moran (VA)
Murtha
Nadler
Napolitano
Neal (MA)
Oberstar
Obey
Olver
Ortiz
Owens
Pallone
Pascrell
Pastor
Payne
Pelosi
Pomeroy
Price (NC)
Rahall
Rangel
Reyes
Rodriguez
Ross
Rothman
Roybal-Allard
Ruppersberger
Rush
Ryan (OH)
Sabo
Sanchez, Linda T.
Sanchez, Loretta
Sanders
Sandlin
Schakowsky
Schiff
Scott (VA)
Serrano
Sherman
Skelton
Slaughter
Snyder
Solis
Spratt
Stark
Stenholm
Strickland
Stupak
Tanner
Tauscher
Taylor (MS)
Thompson (CA)
Thompson (MS)
Tierney
Towns
Turner (TX)
Udall (CO)
Udall (NM)
Van Hollen
Velazquez
Visclosky
Waters
Watson
Watt
Waxman
Weiner
Wexler
Woolsey
Wu
Wynn

NOT VOTING—7

Brown-Waite, Ginny
Gephardt
McInnis
Ros-Lehtinen
Smith (WA)
Vitter
Young (FL)

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. SWEENEY) (during the vote). Members are advised that there are 2 minutes remaining in this vote.

□ 1855

Mr. STRICKLAND and Mr. GUTIERREZ changed their vote from ''yea'' to ''nay.''

Mr. BISHOP of Georgia changed his vote from ''nay'' to ''yea.''

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

EXTENDING AVAILABILITY OF SCHIP ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2001

Mr. TAUZIN. Mr. Speaker, I ask unanimous consent that the Committee on Energy and Commerce be discharged from further consideration of the bill (H.R. 531) to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children's Health Insurance Program (SCHIP), and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. SWEENEY). Is there objection to the request of the gentleman from Louisiana?

There was no objection.

The Clerk read the bill, as follows:

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. EXTENDING AVAILABILITY OF SCHIP ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2001.

(a) RETAINED AND REDISTRIBUTED ALLOTMENTS FOR FISCAL YEARS 1998 AND 1999.—Paragraphs (2)(A)(i) and (2)(A)(ii) of section 2104(g) of the Social Security Act (42 U.S.C. 1397dd(g)) are each amended by striking ''fiscal year 2002'' and inserting ''fiscal year 2004''.

(b) EXTENSION AND REVISION OF RETAINED AND REDISTRIBUTED ALLOTMENTS FOR FISCAL YEAR 2000.—

(1) PERMITTING AND EXTENDING RETENTION OF PORTION OF FISCAL YEAR 2000 ALLOTMENT.—Paragraph (2) of such section 2104(g) is amended—

(A) in the heading, by striking ''AND 1999'' and inserting ''THROUGH 2000''; and

(B) by adding at the end of subparagraph (A) the following:

''(iii) FISCAL YEAR 2000 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2000 that were not expended by the State by the end of fiscal year 2002, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2004.''.

(2) REDISTRIBUTED ALLOTMENTS.—Paragraph (1) of such section 2104(g) is amended—

(A) in subparagraph (A), by inserting ''or for fiscal year 2000 by the end of fiscal year 2002,'' after ''fiscal year 2001,'';

(B) in subparagraph (A), by striking ''1998 or 1999'' and inserting ''1998, 1999, or 2000'';

(C) in subparagraph (A)(i)—

(i) by striking ''or'' at the end of subclause (I),

(ii) by striking the period at the end of subclause (II) and inserting ''; or''; and

(iii) by adding at the end the following new subclause:

''(III) the fiscal year 2000 allotment, the amount specified in subparagraph (C)(i) (less the total of the amounts under clause (ii) for such fiscal year), multiplied by the ratio of the amount specified in subparagraph (C)(ii) for the State to the amount specified in subparagraph (C)(iii).'';

(D) in subparagraph (A)(ii), by striking ''or 1999'' and inserting '', 1999, or 2000'';

(E) in subparagraph (B), by striking ''with respect to fiscal year 1998 or 1999'';

(F) in subparagraph (B)(ii)—

(i) by inserting ''with respect to fiscal year 1998, 1999, or 2000,'' after ''subsection (e),''; and

(ii) by striking ''2002'' and inserting ''2004''; and

(G) by adding at the end the following new subparagraph:

''(C) AMOUNTS USED IN COMPUTING REDISTRIBUTIONS FOR FISCAL YEAR 2000.—For purposes of subparagraph (A)(i)(III)—

''(i) the amount specified in this clause is the amount specified in paragraph (2)(B)(i)(I) for fiscal year 2000, less the total amount remaining available pursuant to paragraph (2)(A)(iii);

''(ii) the amount specified in this clause for a State is the amount by which the State's

expenditures under this title in fiscal years 2000, 2001, and 2002 exceed the State's allotment for fiscal year 2000 under subsection (b); and

''(iii) the amount specified in this clause is the sum, for all States entitled to a redistribution under subparagraph (A) from the allotments for fiscal year 2000, of the amounts specified in clause (ii).''.

(3) CONFORMING AMENDMENTS.—Such section 2104(g) is further amended—

(A) in its heading, by striking ''AND 1999'' and inserting '', 1999, AND 2000''; and

(B) in paragraph (3)—

(i) by striking ''or fiscal year 1999'' and inserting '', fiscal year 1999, or fiscal year 2000''; and

(ii) by striking ''or November 30, 2001'' and inserting ''November 30, 2001, or November 30, 2002'', respectively.

(c) EXTENSION AND REVISION OF RETAINED AND REDISTRIBUTED ALLOTMENTS FOR FISCAL YEAR 2001.—

(1) PERMITTING AND EXTENDING RETENTION OF PORTION OF FISCAL YEAR 2001 ALLOTMENT.—Paragraph (2) of such section 2104(g), as amended in subsection (b)(1)(B), is further amended—

(A) in the heading, by striking ''2000'' and inserting ''2001''; and

(B) by adding at the end of subparagraph (A) the following:

''(iv) FISCAL YEAR 2001 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2001 that were not expended by the State by the end of fiscal year 2003, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2005.''.

(2) REDISTRIBUTED ALLOTMENTS.—Paragraph (1) of such section 2104(g), as amended in subsection (b)(2), is further amended—

(A) in subparagraph (A), by inserting ''or for fiscal year 2001 by the end of fiscal year 2003,'' after ''fiscal year 2002,'';

(B) in subparagraph (A), by striking ''1999, or 2000'' and inserting ''1999, 2000, or 2001'';

(C) in subparagraph (A)(i)—

(i) by striking ''or'' at the end of subclause (II),

(ii) by striking the period at the end of subclause (III) and inserting ''; or''; and

(iii) by adding at the end the following new subclause:

''(IV) the fiscal year 2001 allotment, the amount specified in subparagraph (D)(i) (less the total of the amounts under clause (ii) for such fiscal year), multiplied by the ratio of the amount specified in subparagraph (D)(ii) for the State to the amount specified in subparagraph (D)(iii).'';

(D) in subparagraph (A)(ii), by striking ''or 2000'' and inserting ''2000, or 2001'';

(E) in subparagraph (B)—

(i) by striking ''and'' at the end of clause (ii);

(ii) by redesignating clause (iii) as clause (iv); and

(iii) by inserting after clause (ii) the following new clause:

''(iii) notwithstanding subsection (e), with respect to fiscal year 2001, shall remain available for expenditure by the State through the end of fiscal year 2005; and''; and

(F) by adding at the end the following new subparagraph:

''(D) AMOUNTS USED IN COMPUTING REDISTRIBUTIONS FOR FISCAL YEAR 2001.—For purposes of subparagraph (A)(i)(IV)—

''(i) the amount specified in this clause is the amount specified in paragraph (2)(B)(i)(I) for fiscal year 2001, less the total amount remaining available pursuant to paragraph (2)(A)(iv);

''(ii) the amount specified in this clause for a State is the amount by which the State's expenditures under this title in fiscal years 2001, 2002, and 2003 exceed the State's allotment for fiscal year 2001 under subsection (b); and

''(iii) the amount specified in this clause is the sum, for all States entitled to a redistribution under subparagraph (A) from the allotments for fiscal year 2001, of the amounts specified in clause (ii).''.

(3) CONFORMING AMENDMENTS.—Such section 2104(g) is further amended—

(A) in its heading, by striking ''AND 2000'' and inserting ''2000, AND 2001''; and

(B) in paragraph (3)—

(i) by striking ''or fiscal year 2000'' and inserting ''fiscal year 2000, or fiscal year 2001''; and

(ii) by striking ''or November 30, 2002,'' and inserting ''November 30, 2002, or November 30, 2003,'', respectively.

(d) EFFECTIVE DATE.—This section, and the amendments made by this section, shall be effective as if this section had been enacted on September 30, 2002, and amounts under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) from allotments for fiscal years 1998 through 2000 are available for expenditure on and after October 1, 2002, under the amendments made by this section as if this section had been enacted on September 30, 2002.

The bill was ordered to be engrossed and read a third time, was read the third time, and passed, and a motion to reconsider was laid on the table.

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. 531, the bill just passed.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana?

There was no objection.

MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003

Mr. THOMAS. Mr. Speaker, pursuant to House Resolution 299, I call up the bill (H.R. 1) to amend title XVIII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes, and ask for its immediate consideration.

The Clerk read the title of the bill.

The SPEAKER pro tempore (Mr. LAHOOD). Pursuant to House Resolution 299, the bill is considered read for amendment.

The text of H.R. 1 is as follows:

H.R. 1

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; AMENDMENTS TO SOCIAL SECURITY ACT; REFERENCES TO BIPA AND SECRETARY; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Medicare 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 DRUG BENEFIT

Sec. 101. Establishment of a medicare prescription drug benefit.

''PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

''Sec. 1860D–1. Benefits; eligibility; enrollment; and coverage period.

''Sec. 1860D–2. Requirements for qualified prescription drug coverage.

''Sec. 1860D–3. Beneficiary protections for qualified prescription drug coverage.

''Sec. 1860D–4. Requirements for and contracts with prescription drug plan (PDP) sponsors.

''Sec. 1860D–5. Process for beneficiaries to select qualified prescription drug coverage.

''Sec. 1860D–6. Submission of bids and premiums.

''Sec. 1860D–7. Premium and cost-sharing subsidies for low-income individuals.

''Sec. 1860D–8. Subsidies for all medicare beneficiaries for qualified prescription drug coverage.

''Sec. 1860D–9. Medicare Prescription Drug Trust Fund.

''Sec. 1860D–10. Definitions; application to medicare advantage and EFFS programs; treatment of references to provisions in part C.

Sec. 102. Offering of qualified prescription drug coverage under Medicare Advantage and enhanced fee-for-service (EFFS) program.

Sec. 103. Medicaid amendments.

Sec. 104. Medigap transition.

Sec. 105. Medicare prescription drug discount card and assistance program.

Sec. 106. Disclosure of return information for purposes of carrying out medicare catastrophic prescription drug program.

Sec. 107. State Pharmaceutical Assistance Transition Commission.

Sec. 108. Additional requirements for annual financial report and oversight on medicare program, including prescription drug spending.

TITLE II—MEDICARE ENHANCED FEE-FOR-SERVICE AND MEDICARE ADVANTAGE PROGRAMS; MEDICARE COMPETITION

Sec. 200. Medicare modernization and revitalization.

Subtitle A—Medicare Enhanced Fee-for-Service Program

Sec. 201. Establishment of enhanced fee-for-service (EFFS) program under medicare.

''PART E—ENHANCED FEE-FOR-SERVICE PROGRAM

''Sec. 1860E–1. Offering of enhanced fee-for-service plans throughout the United States.

''Sec. 1860E–2. Offering of enhanced fee-for-service (EFFS) plans.

''Sec. 1860E–3. Submission of bids; beneficiary savings; payment of plans.
''Sec. 1860E–4. Premiums; organizational and financial requirements; establishment of standards; contracts with EFFS organizations.

Subtitle B—Medicare Advantage Program

CHAPTER 1—IMPLEMENTATION OF PROGRAM

Sec. 211. Implementation of medicare advantage program.
Sec. 212. Medicare advantage improvements.

CHAPTER 2—IMPLEMENTATION OF COMPETITION PROGRAM

Sec. 221. Competition program beginning in 2006.

CHAPTER 3—ADDITIONAL REFORMS

Sec. 231. Making permanent change in medicare advantage reporting deadlines and annual, coordinated election period.
Sec. 232. Avoiding duplicative State regulation.
Sec. 233. Specialized medicare advantage plans for special needs beneficiaries.
Sec. 234. Medicare MSAs.
Sec. 235. Extension of reasonable cost contracts.
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Sec. 1121. Importation of prescription drugs.

TITLE I—MEDICARE PRESCRIPTION DRUG BENEFIT

SEC. 101. ESTABLISHMENT OF A MEDICARE PRESCRIPTION DRUG BENEFIT.

(a) IN GENERAL.—Title XVIII is amended—

(1) by redesignating part D as part F; and

(2) by inserting after part C the following new part:

''PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM

''SEC. 1860D–1. BENEFITS; ELIGIBILITY; ENROLLMENT; AND COVERAGE PERIOD.

''(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—Subject to the succeeding provisions of this part, each individual who is entitled to benefits under part A or is enrolled under part B is entitled to obtain qualified prescription drug coverage (described in section 1860D–2(a)) as follows:

''(1) MEDICARE-RELATED PLANS.—

''(A) MEDICARE ADVANTAGE.—If the individual is eligible to enroll in a Medicare Advantage plan that provides qualified prescription drug coverage under section 1851(j), the individual may enroll in such plan and obtain coverage through such plan.

''(B) EFFS PLANS.—If the individual is eligible to enroll in an EFFS plan that provides qualified prescription drug coverage under part E under section 1860E–2(d), the individual may enroll in such plan and obtain coverage through such plan.

''(C) MA-EFFS PLAN; MA-EFFS RX PLAN.—For purposes of this part, the term 'MA-EFFS plan' means a Medicare Advantage plan under part C and an EFFS plan under part E and the term 'MA-EFFS Rx plan' means a MA-EFFS plan insofar as such plan provides qualified prescription drug coverage.

''(2) PRESCRIPTION DRUG PLAN.—If the individual is not enrolled in a MA-EFFS plan, the individual may enroll under this part in a prescription drug plan (as defined in section 1860D–10(a)(5)).

Such individuals shall have a choice of such plans under section 1860D–5(d).

''(b) GENERAL ELECTION PROCEDURES.—

''(1) IN GENERAL.—An individual eligible to make an election under subsection (a) may elect to enroll in a prescription drug plan under this part, or elect the option of qualified prescription drug coverage under a MA-EFFS Rx plan under part C or part E, and to change such election only in such manner and form as may be prescribed by regulations of the Administrator of the Medicare Benefits Administration (appointed under section 1809(b)) (in this part referred to as the 'Medicare Benefits Administrator') and only during an election period prescribed in or under this subsection.

''(2) ELECTION PERIODS.—

''(A) IN GENERAL.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the Medicare Advantage and EFFS programs under section 1851(e), including—

''(i) annual coordinated election periods; and

''(ii) special election periods.

In applying the last sentence of section 1851(e)(4) (relating to discontinuance of an election during the first year of eligibility) under this subparagraph, in the case of an election described in such section in which the individual had elected or is provided qualified prescription drug coverage at the time of such first enrollment, the individual shall be permitted to enroll in a prescription drug plan under this part at the time of the election of coverage under the original fee-for-service plan.

''(B) INITIAL ELECTION PERIODS.—

''(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of October 1, 2005, there shall be an initial election period of 6 months beginning on that date.

''(ii) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who is first entitled to benefits under part A or enrolled under part B after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

''(C) ADDITIONAL SPECIAL ELECTION PERIODS.—The Administrator shall establish special election periods—

''(i) in cases of individuals who have and involuntarily lose prescription drug coverage described in subsection (c)(2)(C);

''(ii) in cases described in section 1837(h) (relating to errors in enrollment), in the same manner as such section applies to part B;

''(iii) in the case of an individual who meets such exceptional conditions (including conditions provided under section 1851(e)(4)(D)) as the Administrator may provide; and

''(iv) in cases of individuals (as determined by the Administrator) who become eligible for prescription drug assistance under title XIX under section 1935(d).

''(3) INFORMATION ON PLANS.—Information described in section 1860D–3(b)(1) on prescription drug plans and MA-EFFS Rx plans shall be made available during election periods.

''(4) ADDITIONAL INFORMATION.—In order to promote the efficient marketing of prescription drug plans and MA-EFFS plans, the Administrator may provide information to the sponsors and organizations offering such plans about individuals eligible to enroll in such plans.

''(c) GUARANTEED ISSUE; COMMUNITY RATING; AND NONDISCRIMINATION.—

''(1) GUARANTEED ISSUE.—

''(A) IN GENERAL.—An eligible individual who is eligible to elect qualified prescription drug coverage under a prescription drug plan or MA-EFFS Rx plan at a time during which elections are accepted under this part with respect to the plan shall not be denied enrollment based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

''(B) MEDICARE ADVANTAGE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to PDP sponsors under this subsection.

''(2) COMMUNITY-RATED PREMIUM.—

''(A) IN GENERAL.—In the case of an individual who enrolls under a prescription drug plan or in a MA-EFFS Rx plan during the individual's initial enrollment period under this part or maintains (as determined under subparagraph (C)) continuous prescription drug coverage since the date the individual first qualifies to elect prescription drug coverage under this part, a PDP sponsor or entity offering a prescription drug plan or MA-EFFS Rx plan and in which the individual is enrolled may not deny, limit, or condition the coverage or provision of covered prescription drug benefits or vary or increase the premium under the plan based on any

health status-related factor described in section 2702(a)(1) of the Public Health Service Act or any other factor.

''(B) LATE ENROLLMENT PENALTY.—In the case of an individual who does not maintain such continuous prescription drug coverage (as described in subparagraph (C)), a PDP sponsor or an entity offering a MA-EFFS Rx plan may (notwithstanding any provision in this title) adjust the premium otherwise applicable with respect to qualified prescription drug coverage in a manner that reflects additional actuarial risk involved. Such a risk shall be established through an appropriate actuarial opinion of the type described in subparagraphs (A) through (C) of section 2103(c)(4). The Administrator shall provide a mechanism for assisting such sponsors and entities in identifying eligible individuals who have (or have not) maintained such continuous prescription drug coverage.

''(C) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that as of such date the individual is covered under any of the following prescription drug coverage and before the date that is the last day of the 63-day period that begins on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage):

''(i) COVERAGE UNDER PRESCRIPTION DRUG PLAN OR MA-EFFS RX PLAN.—Qualified prescription drug coverage under a prescription drug plan or under a MA-EFFS Rx plan.

''(ii) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, or through a demonstration project under part C 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.

''(iii) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan as defined in section 1860D–8(f)(1), but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(iv) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)), but only if the policy was in effect on January 1, 2006, and if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(v) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(vi) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans under chapter 17 of title 38, United States Code, but only if (subject to subparagraph (E)(ii)) the coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(D) CERTIFICATION.—For purposes of carrying out this paragraph, the certifications of the type described in sections 2701(e) of the Public Health Service Act and in section 9801(e) of the Internal Revenue Code shall also include a statement for the period of coverage of whether the individual involved had prescription drug coverage described in subparagraph (C).

''(E) DISCLOSURE.—

''(i) IN GENERAL.—Each entity that offers coverage of the type described in clause (iii), (iv), (v), or (vi) of subparagraph (C) shall provide for disclosure, consistent with standards established by the Administrator, of whether such coverage provides benefits at least equivalent to the benefits under a qualified prescription drug plan.

''(ii) WAIVER OF LIMITATIONS.—An individual may apply to the Administrator to waive the requirement that coverage of such type provide benefits at least equivalent to the benefits under a qualified prescription drug plan, if the individual establishes that the individual was not adequately informed that such coverage did not provide such level of benefits.

''(F) CONSTRUCTION.—Nothing in this section shall be construed as preventing the disenrollment of an individual from a prescription drug plan or a MA-EFFS Rx plan based on the termination of an election described in section 1851(g)(3), including for non-payment of premiums or for other reasons specified in subsection (d)(3), which takes into account a grace period described in section 1851(g)(3)(B)(i).

''(3) NONDISCRIMINATION.—A PDP sponsor that offers a prescription drug plan in an area designated under section 1860D–4(b)(5) shall make such plan available to all eligible individuals residing in the area without regard to their health or economic status or their place of residence within the area.

''(d) EFFECTIVE DATE OF ELECTIONS.—

''(1) IN GENERAL.—Except as provided in this section, the Administrator shall provide that elections under subsection (b) take effect at the same time as the Administrator provides that similar elections under section 1851(e) take effect under section 1851(f).

''(2) NO ELECTION EFFECTIVE BEFORE 2006.—In no case shall any election take effect before January 1, 2006.

''(3) TERMINATION.—The Administrator shall provide for the termination of an election in the case of—

''(A) termination of coverage under both part A and part B; and

''(B) termination of elections described in section 1851(g)(3) (including failure to pay required premiums).

''SEC. 1860D–2. REQUIREMENTS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) REQUIREMENTS.—

''(1) IN GENERAL.—For purposes of this part and part C and part E, the term 'qualified prescription drug coverage' means either of the following:

''(A) STANDARD COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard coverage (as defined in subsection (b)) and access to negotiated prices under subsection (d).

''(B) ACTUARIALLY EQUIVALENT COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Coverage of covered outpatient drugs which meets the alternative coverage requirements of subsection (c) and access to negotiated prices under subsection (d), but only if it is approved by the Administrator, as provided under subsection (c).

''(2) PERMITTING ADDITIONAL OUTPATIENT PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered outpatient drugs that exceeds the coverage required under paragraph (1), but any such additional coverage shall be limited to coverage of covered outpatient drugs.

''(B) DISAPPROVAL AUTHORITY.—The Administrator shall review the offering of qualified prescription drug coverage under this part or part C or E. If the Administrator finds, in the case of a qualified prescription drug coverage under a prescription drug plan or a MA-EFFS Rx plan, that the organization or sponsor offering the coverage is engaged in activities intended to discourage enrollment of classes of eligible medicare beneficiaries obtaining coverage through the plan on the basis of their higher likelihood of utilizing prescription drug coverage, the Administrator may terminate the contract with the sponsor or organization under this part or part C or E.

''(3) APPLICATION OF SECONDARY PAYOR PROVISIONS.—The provisions of section 1852(a)(4) shall apply under this part in the same manner as they apply under part C.

''(b) STANDARD COVERAGE.—For purposes of this part, the 'standard coverage' is coverage of covered outpatient drugs (as defined in subsection (f)) that meets the following requirements:

''(1) DEDUCTIBLE.—The coverage has an annual deductible—

''(A) for 2006, that is equal to $250; or

''(B) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (5) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''(2) 80:20 BENEFIT STRUCTURE.—

''(A) 20 PERCENT COINSURANCE.—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—

''(i) equal to 20 percent; or

''(ii) is actuarially equivalent (using processes established under subsection (e)) to an average expected payment of 20 percent of such costs.

''(B) USE OF TIERS.—Nothing in this part shall be construed as preventing a PDP sponsor from applying tiered copayments, so long as such tiered copayments are consistent with subparagraph (A).

''(3) INITIAL COVERAGE LIMIT.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes—

''(A) for 2006, that is equal to $2,000; or

''(B) for a subsequent year, that is equal to the amount specified in this paragraph for the previous year, increased by the annual percentage increase described in paragraph (5) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $25 shall be rounded to the nearest multiple of $25.

''(4) CATASTROPHIC PROTECTION.—

''(A) IN GENERAL.—Notwithstanding paragraph (3), the coverage provides benefits with no cost-sharing after the individual has incurred costs (as described in subparagraph (C)) for covered outpatient drugs in a year equal to the annual out-of-pocket threshold specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET THRESHOLD.—

''(i) IN GENERAL.—For purposes of this part, the 'annual out-of-pocket threshold' specified in this subparagraph is equal to $3,500 (subject to adjustment under clause (ii) and subparagraph (D)).

''(ii) INFLATION INCREASE.—For a year after 2006, the dollar amount specified in clause (i)

shall be increased by the annual percentage increase described in paragraph (5) for the year involved. Any amount determined under the previous sentence that is not a multiple of $100 shall be rounded to the nearest multiple of $100.

''(C) APPLICATION.—In applying subparagraph (A)—

''(i) incurred costs shall only include costs incurred for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3); and

''(ii) such costs shall be treated as incurred only if they are paid by the individual (or by another individual, such as a family member, on behalf of the individual), under section 1860D–7, under title XIX, or under a State pharmaceutical assistance program and the individual (or other individual) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement (other than under such title or such program) for such costs.

''(D) ADJUSTMENT OF ANNUAL OUT-OF-POCKET THRESHOLDS.—

''(i) IN GENERAL.—Subject to clause (vii), for each enrollee in a prescription drug plan or in a MA-EFFS Rx plan whose adjusted gross income exceeds the income threshold as defined in clause (ii) for a year, the annual out-of-pocket threshold otherwise determined under subparagraph (B) for such year shall be increased by an amount equal to the percentage specified in clause (iii), multiplied by the lesser of—

''(I) the amount of such excess; or

''(II) the amount by which the income threshold limit exceeds the income threshold.

Any amount determined under the previous sentence that is not a multiple of $100 shall be rounded to the nearest multiple of $100.

''(ii) INCOME THRESHOLD.—For purposes of clause (i)—

''(I) IN GENERAL.—Subject to subclause (II), the term 'income threshold' means $60,000 and the term 'income threshold limit' means $200,000.

''(II) INCOME INFLATION ADJUSTMENT.—In the case of a year beginning after 2006, each of the dollar amounts in subclause (I) shall be increased by an amount equal to such dollar amount multiplied by the cost-of-living adjustment determined under section 1(f)(3) of the Internal Revenue Code of 1986 for such year, determined by substituting 'calendar year 2005' for 'calendar year 1992'. If any amount increased under the previous sentence is not a multiple of $100, such amount shall be rounded to the nearest multiple of $100.

''(iii) PERCENTAGE.—The percentage specified in this clause for a year is a fraction (expressed as a percentage) equal to—

''(I) the annual out-of-pocket threshold for a year under subparagraph (B) (determined without regard to this subparagraph), divided by

''(II) the income threshold under clause (ii) for that year.

If any percentage determined under the previous sentence that is not a multiple of 1/10th of 1 percentage point, such percentage shall be rounded to the nearest multiple of 1/10th of 1 percentage point.

''(iv) USE OF MOST RECENT RETURN INFORMATION.—For purposes of clause (i) for an enrollee for a year, except as provided in clause (v), the adjusted gross income of an individual shall be based on the most recent information disclosed to the Secretary under section 6109(l)(19) of the Internal Revenue Code of 1986 before the beginning of that year.

''(v) INDIVIDUAL ELECTION TO PRESENT MOST RECENT INFORMATION REGARDING INCOME.—The Secretary shall provide, in coordination with the Secretary of the Treasury, a procedure under which, for purposes of applying this subparagraph for a calendar year, instead of using the information described in clause (iv), an enrollee may elect to use more recent information, including information with respect to a taxable year ending in such calendar year. Such process shall—

''(I) require the enrollee to provide the Secretary with a copy of the relevant portion of the more recent return to be used under this clause;

''(II) provide for the Medicare Beneficiary Ombudsman (under section 1810) offering assistance to such enrollees in presenting such information and the toll-free number under such section being a point of contact for beneficiaries to inquire as to how to present such information;

''(III) provide for the verification of the information in such return by the Secretary of the Treasury under section 6103(l)(19) of the Internal Revenue Code of 1986; and

''(IV) provide for the payment by the Secretary (in a manner specified by the Secretary) to the enrollee of an amount equal to the excess of the benefit payments that would have been payable under the plan if the more recent return information were used, over the benefit payments that were made under the plan.

In the case of a payment under subclause (III) for an enrollee under a prescription drug plan, the PDP sponsor of the plan shall pay to the Secretary the amount so paid, less the applicable reinsurance amount that would have applied under section 1860D–8(c)(1)(B) if such payment had been treated as an allowable cost under such section. Such plan payment shall be deposited in the Treasury to the credit of the Medicare Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund (under section 1841).

''(vi) DISSEMINATION OF INFORMATION ON PROCESS.—The Secretary shall provide, through the annual medicare handbook under section 1804(a), for a general description of the adjustment of annual out-of-pocket thresholds provided under this subparagraph, including the process for adjustment based upon more recent information and the confidentiality provisions of subparagraph (F), and shall provide for dissemination of a table for each year that sets forth the amount of the adjustment that is made under clause (i) based on the amount of an enrollee's adjusted gross income.

''(vii) ENROLLEE OPT-OUT.—The Secretary shall provide a procedure whereby, if an enrollee elects to have the maximum annual out-of-pocket threshold applied under this subparagraph for a year, the Secretary shall not request any information regarding the enrollee under subparagraph (E) for that year.

''(E) REQUESTING INFORMATION ON ENROLLEES.—

''(i) IN GENERAL.—The Secretary shall, periodically as required to carry out subparagraph (D), transmit to the Secretary of the Treasury a list of the names and TINs of enrollees in prescription drug plans (or in MA-EFFS Rx plans) and request that such Secretary disclose to the Secretary information under subparagraph (A) of section 6103(l)(19) of the Internal Revenue Code of 1986 with respect to those enrollees for a specified taxable year for application in a particular calendar year.

''(ii) DISCLOSURE TO PLAN SPONSORS.—In the case of a specified taxpayer (as defined in section 6103(l)(19)(B) of the Internal Revenue Code of 1986) who is enrolled in a prescription drug plan or in an MA-EFFS Rx plan or an individual who makes an election under subparagraph (D)(vii), the Secretary shall disclose to the entity that offers the plan the annual out-of-pocket threshold applicable to such individual under subparagraph (D).

''(F) MAINTAINING CONFIDENTIALITY OF INFORMATION.—

''(i) IN GENERAL.—The amount of any increase in an annual out-of-pocket threshold under subparagraph (D) may not be disclosed by the Secretary except to a PDP sponsor or entity that offers a MA-EFFS Rx plan to the extent necessary to carry out this part.

''(ii) CRIMINAL AND CIVIL PENALTIES FOR UNAUTHORIZED DISCLOSURE.—A person who makes an unauthorized disclosure of information disclosed under section 6103(l)(19) of the Internal Revenue Code of 1986 (including disclosure of any increase in an annual out-of-pocket threshold under subparagraph (D)) shall be subject to penalty to the extent provided under—

''(I) section 7213 of such Code (relating to criminal penalty for unauthorized disclosure of information);

''(II) section 7213A of such Code (relating to criminal penalty for unauthorized inspection of returns or return information);

''(III) section 7431 of such Code (relating to civil damages for unauthorized inspection or disclosure of returns and return information);

''(IV) any other provision of the Internal Revenue Code of 1986; or

''(V) any other provision of law.

''(iii) APPLICATION OF ADDITIONAL CIVIL MONETARY PENALTY FOR UNAUTHORIZED DISCLOSURES.—In addition to any penalty otherwise provided under law, any person who makes an unauthorized disclosure of such information shall be subject to a civil monetary penalty of not to exceed $10,000 for each such unauthorized disclosure. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil money penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A(a).

''(G) 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 sponsors and organization that offer the plans in which such individuals are enrolled about such reimbursement arrangements. A PDP sponsor or Medicare Advantage or EFFS organization may also periodically ask individuals enrolled in a prescription drug plan or MA-EFFS Rx plan offered by the sponsor or organization 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–1(d)(3).

''(5) ANNUAL PERCENTAGE INCREASE.—For purposes of this part, the annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures for covered outpatient drugs in the United States for medicare beneficiaries, as determined by the Administrator for the 12-month period ending in July of the previous year.

''(c) ALTERNATIVE COVERAGE REQUIREMENTS.—A prescription drug plan or MA-

EFFS Rx plan may provide a different prescription drug benefit design from the standard coverage described in subsection (b) so long as the Administrator determines (based on an actuarial analysis approved by the Administrator) that the following requirements are met and the plan applies for, and receives, the approval of the Administrator for such benefit design:

''(1) ASSURING AT LEAST ACTUARIALLY EQUIVALENT COVERAGE.—

''(A) ASSURING EQUIVALENT VALUE OF TOTAL COVERAGE.—The actuarial value of the total coverage (as determined under subsection (e)) is at least equal to the actuarial value (as so determined) of standard coverage.

''(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (e)) exceeds the actuarial value of the subsidy payments under section 1860D–8 with respect to such coverage.

''(C) ASSURING STANDARD PAYMENT FOR COSTS AT INITIAL COVERAGE LIMIT.—The coverage is designed, based upon an actuarially representative pattern of utilization (as determined under subsection (e)), to provide for the payment, with respect to costs incurred that are equal to the initial coverage limit under subsection (b)(3), of an amount equal to at least the product of—

''(i) the amount by which the initial coverage limit described in subsection (b)(3) exceeds the deductible described in subsection (b)(1); and

''(ii) 100 percent minus the cost-sharing percentage specified in subsection (b)(2)(A)(i).

''(2) CATASTROPHIC PROTECTION.—The coverage provides for beneficiaries the catastrophic protection described in subsection (b)(4).

''(d) ACCESS TO NEGOTIATED PRICES.—

''(1) IN GENERAL.—Under qualified prescription drug coverage offered by a PDP sponsor or an entity offering a MA-EFFS Rx plan, the sponsor or entity shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of cost-sharing or an initial coverage limit (described in subsection (b)(3)). Insofar as a State elects to provide medical assistance under title XIX to a beneficiary enrolled under such title and under a prescription drug plan or MA-EFFS Rx plan for a drug based on the prices negotiated by a prescription drug plan or MA-EFFS Rx plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated by a prescription drug plan under this part, by a MA-EFFS Rx plan with respect to covered outpatient drugs, or by a qualified retiree prescription drug plan (as defined in section 1860D–8(f)(1)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

''(2) DISCLOSURE.—The PDP sponsor or entity offering a MA-EFFS Rx plan shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts or rebates or other remuneration or price concessions made available to the sponsor or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Administrator under this paragraph in the same manner as such provisions apply to information disclosed under such section.

''(3) 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–4(b)(3)(C), the Administrator may periodically audit the financial statements and records of PDP sponsor or entities offering a MA-EFFS Rx plan.

''(e) ACTUARIAL VALUATION; DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

''(1) PROCESSES.—For purposes of this section, the Administrator shall establish processes and methods—

''(A) for determining the actuarial valuation of prescription drug coverage, including—

''(i) an actuarial valuation of standard coverage and of the reinsurance subsidy payments under section 1860D–8;

''(ii) the use of generally accepted actuarial principles and methodologies; and

''(iii) applying the same methodology for determinations of alternative coverage under subsection (c) as is used with respect to determinations of standard coverage under subsection (b); and

''(B) for determining annual percentage increases described in subsection (b)(5).

Such methods for determining actuarial valuation shall take into account effects of alternative coverage on drug utilization.

''(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), PDP sponsors and entities offering MA-EFFS Rx plans may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values, but the Administrator shall determine whether such actuarial values meet the requirements under subsection (c)(1).

''(f) COVERED OUTPATIENT DRUGS DEFINED.—

''(1) IN GENERAL.—Except as provided in this subsection, for purposes of this part, the term 'covered outpatient drug' means—

''(A) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i) or (A)(ii) of section 1927(k)(2); or

''(B) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section and medical supplies associated with the injection of insulin (as defined in regulations of the Secretary)

and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

''(2) EXCLUSIONS.—

''(A) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

''(B) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

''(3) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully appealed under section 1860D–3(f)(2).

''(4) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A prescription drug plan or MA-EFFS Rx plan may exclude from qualified prescription drug coverage any covered outpatient drug—

''(A) for which payment would not be made if section 1862(a) applied to part D; or

''(B) which are not prescribed in accordance with the plan or this part.

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860D–3(f).

''SEC. 1860D–3. BENEFICIARY PROTECTIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) GUARANTEED ISSUE, COMMUNITY-RATED PREMIUMS, ACCESS TO NEGOTIATED PRICES, AND NONDISCRIMINATION.—For provisions requiring guaranteed issue, community-rated premiums, access to negotiated prices, and nondiscrimination, see sections 1860D–1(c)(1), 1860D–1(c)(2), 1860D–2(d), and 1860D–6(b), respectively.

''(b) DISSEMINATION OF INFORMATION.—

''(1) GENERAL INFORMATION.—A PDP sponsor shall disclose, in a clear, accurate, and standardized form to each enrollee with a prescription drug plan offered by the sponsor under this part at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

''(A) Access to specific covered outpatient drugs, including access through pharmacy networks.

''(B) How any formulary used by the sponsor functions, including the drugs included in the formulary.

''(C) Co-payments and deductible requirements, including the identification of the tiered or other co-payment level applicable to each drug (or class of drugs).

''(D) Grievance and appeals procedures.

Such information shall also be made available upon request to prospective enrollees.

''(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll under a prescription drug plan, the PDP sponsor shall provide the information described in section 1852(c)(2) (other than subparagraph (D)) to such individual.

''(3) RESPONSE TO BENEFICIARY QUESTIONS.—Each PDP sponsor offering a prescription drug plan shall have a mechanism for providing specific information to enrollees upon request. The sponsor shall make available on a timely basis, through an Internet website and in writing upon request, information on specific changes in its formulary.

''(4) CLAIMS INFORMATION.—Each PDP sponsor offering a prescription drug plan must furnish to each enrollee in a form easily understandable to such enrollees an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice of the benefits in relation to initial coverage limit and the annual out-of-pocket threshold applicable to such enrollee for the current year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(c) ACCESS TO COVERED BENEFITS.—

''(1) ASSURING PHARMACY ACCESS.—

''(A) PARTICIPATION OF ANY WILLING PHARMACY.—A PDP sponsor and an entity offering a MA-EFFS Rx plan shall permit the participation of any pharmacy that meets terms and conditions that the plan has established.

''(B) DISCOUNTS ALLOWED FOR NETWORK PHARMACIES.—A prescription drug plan and a MA-EFFS Rx plan may, notwithstanding subparagraph (A), reduce coinsurance or copayments for its enrolled beneficiaries below the level otherwise provided for covered outpatient drugs dispensed through in-network pharmacies, but in no case shall such a reduction result in an increase in payments made by the Administrator under section 1860D–8 to a plan.

''(C) CONVENIENT ACCESS FOR NETWORK PHARMACIES.—The PDP sponsor of the prescription drug plan and the entity offering a MA-EFFS Rx 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 (consistent with rules of the Administrator). The Administrator shall establish convenient access rules under this subparagraph that are no less favorable to enrollees than the rules for convenient access to pharmacies of the Secretary of Defense established as of June 1, 2003, for purposes of the TRICARE Retail Pharmacy (TRRx) program. Such rules shall include adequate emergency access for enrolled beneficiaries.

''(D) LEVEL PLAYING FIELD.—Such a sponsor shall permit enrollees to receive benefits (which may include a 90-day supply of drugs or biologicals) through a community pharmacy, rather than through mail order, with any differential in charge paid by such enrollees.

''(E) NOT REQUIRED TO ACCEPT INSURANCE RISK.—The terms and conditions under subparagraph (A) may not require participating pharmacies to accept insurance risk as a condition of participation.

''(2) USE OF STANDARDIZED TECHNOLOGY.—

''(A) IN GENERAL.—The PDP sponsor of a prescription drug plan and an entity offering a MA-EFFS Rx plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrollee to assure access to negotiated prices under section 1860D–2(d) for the purchase of prescription drugs for which coverage is not otherwise provided under the plan.

''(B) STANDARDS.—

''(i) DEVELOPMENT.—The Administrator shall provide for the development or utilization of uniform standards relating to a standardized format for the card or other technology referred to in subparagraph (A). Such standards shall be compatible with standards established under part C of title XI.

''(ii) APPLICATION OF ADVISORY TASK FORCE.—The advisory task force established under subsection (d)(3)(B)(ii) shall provide recommendations to the Administrator under such subsection regarding the standards developed under clause (i).

''(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a PDP sponsor of a prescription drug plan or an entity offering a MA-EFFS Rx plan uses a formulary, the following requirements must be met:

''(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The sponsor or entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least one practicing physician and at least one practicing pharmacist independent and free of conflict with respect to the committee both with expertise in the care of elderly or disabled persons and a majority of its members shall consist of individuals who are practicing physicians or practicing pharmacists (or both).

''(B) FORMULARY DEVELOPMENT.—In developing and reviewing the formulary, the committee shall—

''(i) 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; and

''(ii) shall take into account whether including in the formulary particular covered outpatient drugs has therapeutic advantages in terms of safety and efficacy.

''(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs (although not necessarily for all drugs within such categories and classes). In establishing such classes, the committee shall take into account the standards published in the United States Pharmacopeia-Drug Information. The committee shall make available to the enrollees under the plan through the Internet or otherwise the bases for the exclusion of coverage of any drug from the formulary.

''(D) PROVIDER AND PATIENT EDUCATION.—The committee shall establish policies and procedures to educate and inform health care providers and enrollees concerning the formulary.

''(E) NOTICE BEFORE REMOVING DRUG FROM FORMULARY FOR CHANGING PREFERRED OR TIER STATUS OF DRUG.—Any removal of a covered outpatient drug from a formulary and any change in the preferred or tier cost-sharing status of such a drug shall take effect only after appropriate notice is made available to beneficiaries and physicians.

''(F) PERIODIC EVALUATION OF PROTOCOLS.—In connection with the formulary, a prescription drug plan shall provide for the periodic evaluation and analysis of treatment protocols and procedures.

''(G) GRIEVANCES AND APPEALS RELATING TO APPLICATION OF FORMULARIES.—For provisions relating to grievances and appeals of coverage, see subsections (e) and (f).

''(d) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(1) IN GENERAL.—The PDP sponsor or entity offering a MA-EFFS Rx plan shall have in place, directly or through appropriate arrangements, with respect to covered outpatient drugs—

''(A) an effective cost and drug utilization management program, including medically appropriate incentives to use generic drugs and therapeutic interchange, when appropriate;

''(B) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including side-effects, and improve medication use, including a medication therapy management program described in paragraph (2) and for years beginning with 2007, an electronic prescription program described in paragraph (3); and

''(C) a program to control fraud, abuse, and waste.

Nothing in this section shall be construed as impairing a PDP sponsor or entity from utilizing 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 may be furnished by a pharmacy provider and that is designed to assure, with respect to beneficiaries at risk for potential medication problems, such as beneficiaries with complex or chronic diseases (such as diabetes, asthma, hypertension, and congestive heart failure) or multiple prescriptions, that covered outpatient drugs under the prescription drug plan are appropriately used to optimize therapeutic outcomes through improved medication use and reduce the risk of adverse events, including adverse drug interactions. Such programs may distinguish between services in ambulatory and institutional settings.

''(B) ELEMENTS.—Such program may include—

''(i) enhanced beneficiary understanding to promote the appropriate use of medications by beneficiaries and to reduce the risk of potential adverse events associated with medications, through beneficiary education, counseling, case management, disease state management programs, and other appropriate means;

''(ii) increased beneficiary adherence with prescription medication regimens through medication refill reminders, special packaging, and other compliance programs and other appropriate means; and

''(iii) detection of patterns of overuse and underuse of prescription drugs.

''(C) DEVELOPMENT OF PROGRAM IN COOPERATION WITH LICENSED PHARMACISTS.—The program shall be developed in cooperation with licensed and practicing pharmacists and physicians.

''(D) CONSIDERATIONS IN PHARMACY FEES.—The PDP sponsor of a prescription drug program and an entity offering a MA-EFFS Rx 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. Each such sponsor or entity shall disclose to the Administrator upon request the amount of any such management or dispensing fees and such fees shall be confidential in the same manner as provided under section 1927(b)(3)(D) for information disclosed under section 1927(b)(3)(A).

''(3) ELECTRONIC PRESCRIPTION PROGRAM.—

''(A) IN GENERAL.—An electronic prescription drug program described in this paragraph is a program that includes at least the following components, consistent with uniform standards established under subparagraph (B):

''(i) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—Prescriptions must be written and transmitted electronically (other than by facsimile), except in emergency cases and other exceptional circumstances recognized by the Administrator.

''(ii) PROVISION OF INFORMATION TO PRESCRIBING HEALTH CARE PROFESSIONAL.—The program provides for the electronic transmittal to the prescribing health care professional of information that includes—

''(I) information (to the extent available and feasible) on the drug or drugs being prescribed for that patient and other information relating to the medical history or condition of the patient that may be relevant to the appropriate prescription for that patient;

''(II) cost-effective alternatives (if any) for the use of the drug prescribed; and

''(III) information on the drugs included in the applicable formulary.

To the extent feasible, such program shall permit the prescribing health care professional to provide (and be provided) related information on an interactive, real-time basis.

''(B) STANDARDS.—

''(i) DEVELOPMENT.—The Administrator shall provide for the development of uniform standards relating to the electronic prescription drug program described in subparagraph (A). Such standards shall be compatible with standards established under part C of title XI.

''(ii) ADVISORY TASK FORCE.—In developing such standards and the standards described in subsection (c)(2)(B)(i) the Administrator shall establish a task force that includes representatives of physicians, hospitals, pharmacies, beneficiaries, pharmacy benefit managers, individuals with expertise in information technology, and pharmacy benefit experts of the Departments of Veterans Affairs and Defense and other appropriate Federal agencies to provide recommendations to the Administrator on such standards, including recommendations relating to the following:

''(I) The range of available computerized prescribing software and hardware and their costs to develop and implement.

''(II) The extent to which such standards and systems reduce medication errors and can be readily implemented by physicians, pharmacies, and hospitals.

''(III) Efforts to develop uniform standards and a common software platform for the secure electronic communication of medication history, eligibility, benefit, and prescription information.

''(IV) Efforts to develop and promote universal connectivity and interoperability for the secure electronic exchange of such information.

''(V) The cost of implementing such systems in the range of hospital and physician office settings and pharmacies, including hardware, software, and training costs.

''(VI) Implementation issues as they relate to part C of title XI, and current Federal and State prescribing laws and regulations and their impact on implementation of computerized prescribing.

''(iii) DEADLINES.—

''(I) The Administrator shall constitute the task force under clause (ii) by not later than April 1, 2004.

''(II) Such task force shall submit recommendations to Administrator by not later than January 1, 2005.

''(III) The Administrator shall provide for the development and promulgation, by not later than January 1, 2006, of national standards relating to the electronic prescription drug program described in clause (ii). Such standards shall be issued by a standards organization accredited by the American National Standards Institute (ANSI) and shall be compatible with standards established under part C of title XI.

''(4) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to prescription drug plans under this part with respect to the following requirements, in the same manner as they apply to plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

''(A) Paragraph (1) (including quality assurance), including medication therapy management program under paragraph (2).

''(B) Subsection (c)(1) (relating to access to covered benefits).

''(C) Subsection (g) (relating to confidentiality and accuracy of enrollee records).

''(5) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each PDP sponsor and each entity offering a MA-EFFS Rx plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered outpatient drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost available generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

''(e) GRIEVANCE MECHANISM, COVERAGE DETERMINATIONS, AND RECONSIDERATIONS.—

''(1) IN GENERAL.—Each PDP sponsor shall provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the sponsor provides covered benefits) and enrollees with prescription drug plans of the sponsor under this part in accordance with section 1852(f).

''(2) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—A PDP sponsor shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug plan it offers under this part in the same manner as such requirements apply to an organization with respect to benefits it offers under a plan under part C.

''(3) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug plan offered by a PDP sponsor or a MA-EFFS Rx plan 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 non-preferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

''(f) APPEALS.—

''(1) IN GENERAL.—Subject to paragraph (2), a PDP sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs (including a determination related to the application of tiered cost-sharing described in subsection (e)(3)) in the same manner as such requirements apply to an organization with respect to benefits it offers under a plan under part C.

''(2) FORMULARY DETERMINATIONS.—An individual who is enrolled in a prescription drug plan offered by a PDP sponsor or in a MA-EFFS Rx plan may appeal to obtain coverage for a covered outpatient drug that is not on a formulary of the sponsor or entity offering the plan if the prescribing physician determines that the formulary drug for treatment of the same condition either would not be as effective for the individual or would have adverse effects for the individual or both.

''(g) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—A PDP sponsor that offers a prescription drug plan shall meet the requirements of section 1852(h) with respect to enrollees under the plan in the same manner as such requirements apply to an organization with respect to enrollees under part C. A PDP sponsor shall be treated as a business associate for purposes of the provisions of subpart E of part 164 of title 45, Code of Federal Regulations, adopted pursuant to the authority of the Secretary under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S. C. 1320d-2 note).

''SEC. 1860D–4. REQUIREMENTS FOR AND CONTRACTS WITH PRESCRIPTION DRUG PLAN (PDP) SPONSORS.

''(a) GENERAL REQUIREMENTS.—Each PDP sponsor of a prescription drug plan shall meet the following requirements:

''(1) LICENSURE.—Subject to subsection (c), the sponsor is organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State in which it offers a prescription drug plan.

''(2) ASSUMPTION OF FINANCIAL RISK FOR UNSUBSIDIZED COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B) and section 1860D–5(d)(2), the entity assumes full financial risk on a prospective basis for qualified prescription drug coverage that it offers under a prescription drug plan and that is not covered under section 1860D–8.

''(B) REINSURANCE PERMITTED.—The entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrollee.

''(3) SOLVENCY FOR UNLICENSED SPONSORS.—In the case of a sponsor that is not described in paragraph (1), the sponsor shall meet solvency standards established by the Administrator under subsection (d).

''(b) CONTRACT REQUIREMENTS.—

''(1) IN GENERAL.—The Administrator shall not permit the election under section 1860D–1 of a prescription drug plan offered by a PDP sponsor under this part, and the sponsor shall not be eligible for payments under section 1860D–7 or 1860D–8, unless the Administrator has entered into a contract under this subsection with the sponsor with respect to the offering of such plan. Such a contract with a sponsor may cover more than one prescription drug plan. Such contract shall provide that the sponsor agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(2) NEGOTIATION REGARDING TERMS AND CONDITIONS.—The Administrator shall have the same authority to negotiate the terms and conditions of prescription drug plans under this part as the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code. In negotiating the terms and conditions regarding premiums for which information is submitted under section 1860D–6(a)(2), the Administrator shall take into account the subsidy payments under section 1860D–8.

''(3) INCORPORATION OF CERTAIN MEDICARE ADVANTAGE CONTRACT REQUIREMENTS.—The following provisions of section 1857 shall apply, subject to subsection (c)(5), to contracts under this section in the same manner as they apply to contracts under section 1857(a):

''(A) MINIMUM ENROLLMENT.—Paragraphs (1) and (3) of section 1857(b), except that the requirement of such paragraph (1) shall be waived during the first contract year with respect to an organization in a region.

''(B) CONTRACT PERIOD AND EFFECTIVENESS.—Paragraphs (1) through (3) and (5) of section 1857(c).

''(C) PROTECTIONS AGAINST FRAUD AND BENEFICIARY PROTECTIONS.—Section 1857(d).

''(D) ADDITIONAL CONTRACT TERMS.—Section 1857(e); except that in applying section 1857(e)(2) under this part—

''(i) such section shall be applied separately to costs relating to this part (from costs under part C and part E);

''(ii) in no case shall the amount of the fee established under this subparagraph for a plan exceed 20 percent of the maximum amount of the fee that may be established under subparagraph (B) of such section; and

''(iii) no fees shall be applied under this subparagraph with respect to MA-EFFS Rx plans.

''(E) INTERMEDIATE SANCTIONS.—Section 1857(g).

''(F) PROCEDURES FOR TERMINATION.—Section 1857(h).

''(4) RULES OF APPLICATION FOR INTERMEDIATE SANCTIONS.—In applying paragraph (3)(E)—

''(A) the reference in section 1857(g)(1)(B) to section 1854 is deemed a reference to this part; and

''(B) the reference in section 1857(g)(1)(F) to section 1852(k)(2)(A)(ii) shall not be applied.

''(5) SERVICE AREA REQUIREMENT.—For purposes of this part, the Administrator shall designate at least 10 areas covering the entire United States and to the extent practicable shall be consistent with EFFS regions established under section 1860E–1(a)(2).

''(c) WAIVER OF CERTAIN REQUIREMENTS TO EXPAND CHOICE.—

''(1) IN GENERAL.—In the case of an entity that seeks to offer a prescription drug plan in a State, the Administrator shall waive the requirement of subsection (a)(1) that the entity be licensed in that State if the Administrator determines, based on the application and other evidence presented to the Administrator, that any of the grounds for approval of the application described in paragraph (2) have been met.

''(2) GROUNDS FOR APPROVAL.—The grounds for approval under this paragraph are the grounds for approval described in subparagraph (B), (C), and (D) of section 1855(a)(2), and also include the application by a State of any grounds other than those required under Federal law.

''(3) APPLICATION OF WAIVER PROCEDURES.—With respect to an application for a waiver (or a waiver granted) under this subsection, the provisions of subparagraphs (E), (F), and (G) of section 1855(a)(2) shall apply.

''(4) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) does not deem the entity to meet other requirements imposed under this part for a PDP sponsor.

''(5) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying provisions of section 1855(a)(2) under this subsection to prescription drug plans and PDP sponsors—

''(A) any reference to a waiver application under section 1855 shall be treated as a reference to a waiver application under paragraph (1); and

''(B) any reference to solvency standards shall be treated as a reference to solvency standards established under subsection (d).

''(d) SOLVENCY STANDARDS FOR NON-LICENSED SPONSORS.—

''(1) ESTABLISHMENT.—The Administrator shall establish, by not later than October 1, 2004, financial solvency and capital adequacy standards that an entity that does not meet the requirements of subsection (a)(1) must meet to qualify as a PDP sponsor under this part.

''(2) COMPLIANCE WITH STANDARDS.—Each PDP sponsor that is not licensed by a State under subsection (a)(1) and for which a waiver application has been approved under subsection (c) shall meet solvency and capital adequacy standards established under paragraph (1). The Administrator shall establish certification procedures for such PDP sponsors with respect to such solvency standards in the manner described in section 1855(c)(2).

''(e) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency, except as provided in subsection (d)) with respect to prescription drug plans which are offered by PDP sponsors under this part.

''(2) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to premiums paid to PDP sponsors for prescription drug plans under this part, or with respect to any payments made to such a sponsor by the Administrator under this part.

''SEC. 1860D–5. PROCESS FOR BENEFICIARIES TO SELECT QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) IN GENERAL.—The Administrator shall establish a process for the selection of the prescription drug plan or MA-EFFS Rx plan through which eligible individuals elect qualified prescription drug coverage under this part.

''(b) ELEMENTS.—Such process shall include the following:

''(1) Annual, coordinated election periods, in which such individuals can change the qualifying plans through which they obtain coverage, in accordance with section 1860D–1(b)(2).

''(2) Active dissemination of information to promote an informed selection among qualifying plans based upon price, quality, and other features, in the manner described in (and in coordination with) section 1851(d), including the provision of annual comparative information, maintenance of a toll-free hotline, and the use of non-Federal entities.

''(3) Coordination of elections through filing with the entity offering a MA-EFFS Rx plan or a PDP sponsor, in the manner described in (and in coordination with) section 1851(c)(2).

''(4) Informing each enrollee before the beginning of each year of the annual out-of-pocket threshold applicable to the enrollee for that year under section 1860D–2(b)(4) at such time.

''(c) MA-EFFS RX ENROLLEE MAY ONLY OBTAIN BENEFITS THROUGH THE PLAN.—An individual who is enrolled under a MA-EFFS Rx plan may only elect to receive qualified prescription drug coverage under this part through such plan.

''(d) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

''(1) CHOICE OF AT LEAST TWO PLANS IN EACH AREA.—

''(A) IN GENERAL.—The Administrator shall assure that each individual who is entitled to benefits under part A or enrolled under part B and who is residing in an area in the United States has available, consistent with subparagraph (B), a choice of enrollment in at least two qualifying plans (as defined in paragraph (5)) in the area in which the individual resides, at least one of which is a prescription drug plan.

''(B) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in subparagraph (A) is not satisfied with respect to an area if only one PDP sponsor or one entity that offers a MA-EFFS Rx plan offers all the qualifying plans in the area.

''(2) GUARANTEEING ACCESS TO COVERAGE.—In order to assure access under paragraph (1) and consistent with paragraph (3), the Administrator may provide partial underwriting of risk for a PDP sponsor to expand the service area under an existing prescription drug plan to adjoining or additional areas or to establish such a plan (including offering such a plan on a regional or nationwide basis), but only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

''(3) LIMITATION ON AUTHORITY.—In exercising authority under this subsection, the Administrator—

''(A) shall not provide for the full underwriting of financial risk for any PDP sponsor; and

''(B) shall seek to maximize the assumption of financial risk by PDP sponsors or entities offering a MA-EFFS Rx plan.

''(4) REPORTS.—The Administrator shall, in each annual report to Congress under section 1809(f), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to minimize the exercise of such authority, including minimizing the assumption of financial risk.

''(5) QUALIFYING PLAN DEFINED.—For purposes of this subsection, the term 'qualifying plan' means a prescription drug plan or a MA-EFFS Rx plan.

''SEC. 1860D–6. SUBMISSION OF BIDS AND PREMIUMS.

''(a) SUBMISSION OF BIDS, PREMIUMS, AND RELATED INFORMATION.—

''(1) IN GENERAL.—Each PDP sponsor shall submit to the Administrator the information described in paragraph (2) in the same manner as information is submitted by an organization under section 1854(a)(1).

''(2) INFORMATION SUBMITTED.—The information described in this paragraph is the following:

''(A) COVERAGE PROVIDED.—Information on the qualified prescription drug coverage to be provided.

''(B) ACTUARIAL VALUE.—Information on the actuarial value of the coverage.

''(C) BID AND PREMIUM.—Information on the bid and the premium for the coverage, including an actuarial certification of—

''(i) the actuarial basis for such bid and premium;

''(ii) the portion of such bid and premium attributable to benefits in excess of standard coverage;

''(iii) the reduction in such bid resulting from the reinsurance subsidy payments provided under section 1860D–8(a)(2); and

''(iv) the reduction in such premium resulting from the direct and reinsurance subsidy payments provided under section 1860D–8.

''(D) ADDITIONAL INFORMATION.—Such other information as the Administrator may require to carry out this part.

''(3) REVIEW OF INFORMATION; NEGOTIATION AND APPROVAL OF PREMIUMS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Administrator shall review the information filed under paragraph (2) for the purpose of conducting negotiations under section 1860D–4(b)(2) (relating to using OPM-like authority under the FEHBP). The Administrator, using the information provided (including the actuarial certification under paragraph (2)(C)) shall approve the premium submitted under this subsection only if the premium accurately reflects both (i) the actuarial value of the benefits provided, and (ii) the 73 percent average subsidy provided under section 1860D–8 for the standard benefit. The Administrator shall apply actuarial principles to approval of a premium under this part in a manner similar to the manner in which those principles are applied in establishing the monthly part B premium under section 1839.

''(B) EXCEPTION.—In the case of a plan described in section 1851(a)(2)(C), the provisions of subparagraph (A) shall not apply and the provisions of paragraph (5)(B) of section 1854(a), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply to the negotiation and rejection of the monthly bid amounts and proportion referred to in subparagraph (A).

''(b) UNIFORM BID AND PREMIUM.—

''(1) IN GENERAL.—The bid and premium for a prescription drug plan under this section may not vary among enrollees in the plan in the same service area.

''(2) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing the imposition of a late enrollment penalty under section 1860D–1(c)(2)(B).

''(c) COLLECTION.—

''(1) BENEFICIARY'S OPTION OF PAYMENT THROUGH WITHHOLDING FROM SOCIAL SECURITY PAYMENT OR USE OF ELECTRONIC FUNDS TRANSFER MECHANISM.—In accordance with regulations, a PDP sponsor shall permit each enrollee, at the enrollee's option, to make payment of premiums under this part to the sponsor through withholding from benefit payments in the manner provided under section 1840 with respect to monthly premiums under section 1839 or through an electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account) or otherwise. All premium payments that are withheld under this paragraph shall be

credited to the Medicare Prescription Drug Trust Fund and shall be paid to the PDP sponsor involved.

''(2) OFFSETTING.—Reductions in premiums for coverage under parts A and B as a result of a selection of a MA-EFFS Rx plan may be used to reduce the premium otherwise imposed under paragraph (1).

''(d) ACCEPTANCE OF REFERENCE PREMIUM AMOUNT AS FULL PREMIUM FOR SUBSIDIZED LOW-INCOME INDIVIDUALS IF NO STANDARD (OR EQUIVALENT) COVERAGE IN AN AREA.—

''(1) IN GENERAL.—If there is no standard prescription drug coverage (as defined in paragraph (2)) offered in an area, in the case of an individual who is eligible for a premium subsidy under section 1860D–7 and resides in the area, the PDP sponsor of any prescription drug plan offered in the area (and any entity offering a MA-EFFS Rx plan in the area) shall accept the reference premium amount (under paragraph (3)) as payment in full for the premium charge for qualified prescription drug coverage.

''(2) STANDARD PRESCRIPTION DRUG COVERAGE DEFINED.—For purposes of this subsection, the term 'standard prescription drug coverage' means qualified prescription drug coverage that is standard coverage or that has an actuarial value equivalent to the actuarial value for standard coverage.

''(3) REFERENCE PREMIUM AMOUNT DEFINED.—For purposes of this subsection, the term 'reference premium amount' means, with respect to qualified prescription drug coverage offered under—

''(A) a prescription drug plan that—

''(i) provides standard coverage (or alternative prescription drug coverage the actuarial value is equivalent to that of standard coverage), the plan's PDP premium; or

''(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the plan's PDP premium multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage;

''(B) an EFFS plan, the EFFS monthly prescription drug beneficiary premium (as defined in section 1860E–4(a)(3)(B)); or

''(C) a Medicare Advantage, the Medicare Advantage monthly prescription drug beneficiary premium (as defined in section 1854(b)(2)(B)).

For purposes of subparagraph (A), the term 'PDP premium' means, with respect to a prescription drug plan, the premium amount for enrollment under the plan under this part (determined without regard to any low-income subsidy under section 1860D–7 or any late enrollment penalty under section 1860D–1(c)(2)(B)).

''SEC. 1860D–7. PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS.

''(a) INCOME-RELATED SUBSIDIES FOR INDIVIDUALS WITH INCOME BELOW 150 PERCENT OF FEDERAL POVERTY LEVEL.—

''(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR INDIVIDUALS WITH INCOME BELOW 135 PERCENT OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual (as defined in paragraph (4)) who is determined to have income that does not exceed 135 percent of the Federal poverty level, the individual is entitled under this section—

''(A) to an income-related premium subsidy equal to 100 percent of the amount described in subsection (b)(1); and

''(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860D–2(b) (up to the initial coverage limit specified in paragraph (3) of such section) of amounts that do not exceed $2 for a multiple source or generic drug (as described in section 1927(k)(7)(A)) and $5 for a non-preferred drug.

''(2) SLIDING SCALE PREMIUM SUBSIDY FOR INDIVIDUALS WITH INCOME ABOVE 135, BUT BELOW 150 PERCENT, OF FEDERAL POVERTY LEVEL.—In the case of a subsidy eligible individual who is determined to have income that exceeds 135 percent, but does not exceed 150 percent, of the Federal poverty level, the individual is entitled under this section to an income-related premium subsidy determined on a linear sliding scale ranging from 100 percent of the amount described in subsection (b)(1) for individuals with incomes at 135 percent of such level to 0 percent of such amount for individuals with incomes at 150 percent of such level.

''(3) CONSTRUCTION.—Nothing in this section shall be construed as preventing a PDP sponsor or entity offering a MA-EFFS Rx plan from reducing to 0 the cost-sharing otherwise applicable to generic drugs.

''(4) DETERMINATION OF ELIGIBILITY.—

''(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, subject to subparagraph (D), the term 'subsidy eligible individual' means an individual who—

''(i) is eligible to elect, and has elected, to obtain qualified prescription drug coverage under this part;

''(ii) has income below 150 percent of the Federal poverty line; and

''(iii) meets the resources requirement described in subparagraph (D).

''(B) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy eligible individual and the amount of such individual's income shall be determined under the State medicaid plan for the State under section 1935(a) or by the Social Security Administration. In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Administrator. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this subparagraph.

''(C) INCOME DETERMINATIONS.—For purposes of applying this section—

''(i) income shall be determined in the manner described in section 1905(p)(1)(B); and

''(ii) the term 'Federal poverty line' means the official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(D) RESOURCE STANDARD APPLIED TO BE BASED ON THREE TIMES SSI RESOURCE STANDARD.—The resource requirement of this subparagraph is that an individual's resources (as determined under section 1613 for purposes of the supplemental security income program) do not exceed—

''(i) for 2006 three times the maximum amount of resources that an individual may have and obtain benefits under that program; and

''(ii) for a subsequent year the resource limitation established under this clause for the previous year increased by the annual percentage increase in the consumer price index (all items; U.S. city average) as of September of such previous year.

Any resource limitation established under clause (ii) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''(E) TREATMENT OF TERRITORIAL RESIDENTS.—In the case of an individual who is not a resident of the 50 States or the District of Columbia, the individual is not eligible to be a subsidy eligible individual but may be eligible for financial assistance with prescription drug expenses under section 1935(e).

''(F) TREATMENT OF CONFORMING MEDIGAP POLICIES.—For purposes of this section, the term 'qualified prescription drug coverage' includes a medicare supplemental policy described in section 1860D–8(b)(4).

''(5) INDEXING DOLLAR AMOUNTS.—

''(A) FOR 2007.—The dollar amounts applied under paragraphs (1)(B) for 2007 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860D–2(b)(5) for 2007.

''(B) FOR SUBSEQUENT YEARS.—The dollar amounts applied under paragraph (1)(B) for a year after 2007 shall be the amounts (under this paragraph) applied under paragraph (1)(B) for the preceding year increased by the annual percentage increase described in section 1860D–2(b)(5) (relating to growth in medicare prescription drug costs per beneficiary) for the year involved.

''(b) PREMIUM SUBSIDY AMOUNT.—

''(1) IN GENERAL.—The premium subsidy amount described in this subsection for an individual residing in an area is the benchmark premium amount (as defined in paragraph (2)) for qualified prescription drug coverage offered by the prescription drug plan or the MA-EFFS Rx plan in which the individual is enrolled.

''(2) BENCHMARK PREMIUM AMOUNT DEFINED.—For purposes of this subsection, the term 'benchmark premium amount' means, with respect to qualified prescription drug coverage offered under—

''(A) a prescription drug plan that—

''(i) provides standard coverage (or alternative prescription drug coverage the actuarial value of which is equivalent to that of standard coverage), the premium amount for enrollment under the plan under this part (determined without regard to any subsidy under this section or any late enrollment penalty under section 1860D–1(c)(2)(B)); or

''(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the premium amount described in clause (i) multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage; or

''(B) a MA-EFFS Rx plan, the portion of the premium amount that is attributable to statutory drug benefits (described in section 1853(a)(1)(A)(ii)(II)).

''(c) RULES IN APPLYING COST-SHARING SUBSIDIES.—

''(1) IN GENERAL.—In applying subsection (a)(1)(B), nothing in this part shall be construed as preventing a plan or provider from waiving or reducing the amount of cost-sharing otherwise applicable.

''(2) LIMITATION ON CHARGES.—In the case of an individual receiving cost-sharing subsidies under subsection (a)(1)(B), the PDP sponsor or entity offering a MA-EFFS Rx plan may not charge more than $5 per prescription.

''(3) APPLICATION OF INDEXING RULES.—The provisions of subsection (a)(5) shall apply to the dollar amount specified in paragraph (2) in the same manner as they apply to the dollar amounts specified in subsections (a)(1)(B).

''(d) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator shall provide a process whereby, in the case of an individual who is determined to be a subsidy eligible individual and who is enrolled in prescription drug plan or is enrolled in a MA-EFFS Rx plan—

''(1) the Administrator provides for a notification of the PDP sponsor or the entity offering the MA-EFFS Rx plan involved that the individual is eligible for a subsidy and the amount of the subsidy under subsection (a);

''(2) the sponsor or entity involved reduces the premiums or cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Administrator information on the amount of such reduction; and

''(3) the Administrator periodically and on a timely basis reimburses the sponsor or entity for the amount of such reductions.

The reimbursement under paragraph (3) with respect to cost-sharing subsidies may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

''(e) RELATION TO MEDICAID PROGRAM.—

''(1) IN GENERAL.—For provisions providing for eligibility determinations, and additional financing, under the medicaid program, see section 1935.

''(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for prescribed drugs provided under the medicaid program under title XIX consistent with section 1935(d)(1).

''(3) COORDINATION.—The Administrator shall develop and implement a plan for the coordination of prescription drug benefits under this part with the benefits provided under the medicaid program under title XIX, with particular attention to insuring coordination of payments and prevention of fraud and abuse. In developing and implementing such plan, the Administrator shall involve the Secretary, the States, the data processing industry, pharmacists, and pharmaceutical manufacturers, and other experts.

''SEC. 1860D–8. SUBSIDIES FOR ALL MEDICARE BENEFICIARIES FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

''(a) SUBSIDY PAYMENT.—In order to reduce premium levels applicable to qualified prescription drug coverage for all medicare beneficiaries consistent with an overall subsidy level of 73 percent, to reduce adverse selection among prescription drug plans and MA-EFFS Rx plans, and to promote the participation of PDP sponsors under this part, the Administrator shall provide in accordance with this section for payment to a qualifying entity (as defined in subsection (b)) of the following subsidies:

''(1) DIRECT SUBSIDY.—In the case of an enrollee enrolled for a month in a prescription drug plan or a MA-EFFS Rx plan, a direct subsidy equal to 43 percent of the national average monthly bid amount (computed under subsection (g)) for that month.

''(2) SUBSIDY THROUGH REINSURANCE.—In the case of an enrollee enrolled for a month in a prescription drug plan or a MA-EFFS Rx plan, the reinsurance payment amount (as defined in subsection (c)), which in the aggregate is 30 percent of the total payments made by qualifying entities for standard coverage under the respective plan, for excess costs incurred in providing qualified prescription drug coverage—

''(A) for enrollees with a prescription drug plan under this part; and

''(B) for enrollees with a MA-EFFS Rx plan.

''(3) EMPLOYER AND UNION FLEXIBILITY.—In the case of an individual who is a participant or beneficiary in a qualified retiree prescription drug plan (as defined in subsection (f)(1)) and who is not enrolled in a prescription drug plan or in a MA-EFFS Rx plan, the special subsidy payments under subsection (f)(3).

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

''(b) QUALIFYING ENTITY DEFINED.—For purposes of this section, the term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

''(1) A PDP sponsor offering a prescription drug plan under this part.

''(2) An entity that offers a MA-EFFS Rx plan.

''(3) The sponsor of a qualified retiree prescription drug plan (as defined in subsection (f)).

''(c) REINSURANCE PAYMENT AMOUNT.—

''(1) IN GENERAL.—Subject to subsection (d)(1)(B) and paragraph (4), the reinsurance payment amount under this subsection for a qualifying covered individual (as defined in paragraph (5)) for a coverage year (as defined in subsection (h)(2)) is equal to the sum of the following:

''(A) REINSURANCE BETWEEN INITIAL REINSURANCE THRESHOLD AND THE INITIAL COVERAGE LIMIT.—For the portion of the individual's gross covered prescription drug costs (as defined in paragraph (3)) for the year that exceeds the initial reinsurance threshold specified in paragraph (4), but does not exceed the initial coverage limit specified in section 1860D–2(b)(3), an amount equal to 20 percent of the allowable costs (as defined in paragraph (2)) attributable to such gross covered prescription drug costs.

''(B) REINSURANCE ABOVE ANNUAL OUT-OF-POCKET THRESHOLD.—For the portion of the individual's gross covered prescription drug costs for the year that exceeds the annual out-of-pocket threshold specified in 1860D–2(b)(4)(B), an amount equal to 80 percent of the allowable costs attributable to such gross covered prescription drug costs.

''(2) ALLOWABLE COSTS.—For purposes of this section, the term 'allowable costs' means, with respect to gross covered prescription drug costs under a plan described in subsection (b) offered by a qualifying entity, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

''(3) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term 'gross covered prescription drug costs' means, with respect to an enrollee with a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan (including costs attributable to administrative costs) for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

''(4) INITIAL REINSURANCE THRESHOLD.—The initial reinsurance threshold specified in this paragraph—

''(A) for 2006, is equal to $1,000; or

''(B) for a subsequent year, is equal to the payment threshold specified in this paragraph for the previous year, increased by the annual percentage increase described in section 1860D–2(b)(5) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

''(5) QUALIFYING COVERED INDIVIDUAL DEFINED.—For purposes of this subsection, the term 'qualifying covered individual' means an individual who—

''(A) is enrolled with a prescription drug plan under this part; or

''(B) is enrolled with a MA-EFFS Rx plan.

''(d) ADJUSTMENT OF PAYMENTS.—

''(1) ADJUSTMENT OF REINSURANCE PAYMENTS TO ASSURE 30 PERCENT LEVEL OF SUBSIDY THROUGH REINSURANCE.—

''(A) ESTIMATION OF PAYMENTS.—The Administrator shall estimate—

''(i) the total payments to be made (without regard to this subsection) during a year under subsections (a)(2) and (c); and

''(ii) the total payments to be made by qualifying entities for standard coverage under plans described in subsection (b) during the year.

''(B) ADJUSTMENT.—The Administrator shall proportionally adjust the payments made under subsections (a)(2) and (c) for a coverage year in such manner so that the total of the payments made under such subsections for the year is equal to 30 percent of the total payments described in subparagraph (A)(ii).

''(2) RISK ADJUSTMENT FOR DIRECT SUBSIDIES.—To the extent the Administrator determines it appropriate to avoid risk selection, the payments made for direct subsidies under subsection (a)(1) are subject to adjustment based upon risk factors specified by the Administrator. Any such risk adjustment shall be designed in a manner as to not result in a change in the aggregate payments made under such subsection.

''(e) PAYMENT METHODS.—

''(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

''(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Medicare Prescription Drug Trust Fund.

''(f) RULES RELATING TO QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—

''(1) DEFINITION.—For purposes of this section, the term 'qualified retiree prescription drug plan' means employment-based retiree health coverage (as defined in paragraph (4)(A)) if, with respect to an individual who is a participant or beneficiary under such coverage and is eligible to be enrolled in a prescription drug plan or a MA-EFFS Rx plan under this part, the following requirements are met:

''(A) ACTUARIAL EQUIVALENCE TO STANDARD COVERAGE.—The Administrator determines (based on an actuarial analysis approved by the Administrator) that coverage provides at least the same actuarial value as standard coverage. Such determination may be made on an annual basis.

''(B) AUDITS.—The sponsor (or the administrator, if designated by the sponsor) and the plan shall maintain, and afford the Administrator access to, such records as the Administrator may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made.

''(C) PROVISION OF CERTIFICATION OF PRESCRIPTION DRUG COVERAGE.—The sponsor of the plan shall provide for issuance of certifications of the type described in section 1860D–1(c)(2)(D).

''(2) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to a participant or beneficiary in a qualified retiree prescription drug plan unless the individual is—

''(A) is covered under the plan; and

''(B) is eligible to obtain qualified prescription drug coverage under section 1860D–1 but did not elect such coverage under this part (either through a prescription drug plan or through a MA-EFFS Rx plan).

''(3) EMPLOYER AND UNION SPECIAL SUBSIDY AMOUNTS.—

''(A) IN GENERAL.—For purposes of subsection (a), the special subsidy payment amount under this paragraph for a qualifying covered retiree(as defined in paragraph (6)) for a coverage year (as defined in subsection (h)) enrolled in a qualifying entity described in subsection (b)(3) under a qualified retiree prescription drug plan is, for the portion of the individual's gross covered prescription drug costs for the year that exceeds the deductible amount specified in subparagraph (B), an amount equal to, subject to subparagraph (D), 28 percent of the allowable costs attributable to such gross covered prescription drug costs, but only to the extent such costs exceed the deductible under subparagraph (B) and do not exceed the cost limit under such subparagraph in the case of any such individual for the plan year.

''(B) DEDUCTIBLE AND COST LIMIT APPLICABLE.—Subject to subparagraph (C)—

''(i) the deductible under this subparagraph is equal to $250 for plan years that end in 2006; and

''(ii) the cost limit under this subparagraph is equal to $5,000 for plan years that end in 2006.

''(C) INDEXING.—The deductible and cost limit amounts specified in subparagraphs (B) for a plan year that ends after 2006 shall be adjusted in the same manner as the annual deductible under section 1860D–2(b)(1) is annually adjusted under such section.

''(4) RELATED DEFINITIONS.—As used in this section:

''(A) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage of health care costs for individuals eligible to enroll in a prescription drug plan or MA-EFFS Rx plan under this part (or for such individuals and their spouses and dependents) under a group health plan (including such a plan that is established or maintained under or pursuant to one or more collective bargaining agreements or that is offered under chapter 89 of title 5, United States Code) based on their status as retired participants in such plan.

''(B) QUALIFYING COVERED RETIREE.—The term 'qualifying covered retiree' means an individual who is eligible to obtain qualified prescription drug coverage under section 1860D–1 but did not elect such coverage under this part (either through a prescription drug plan or through a MA-EFFS Rx plan) but is covered under a qualified retiree prescription drug plan.

''(C) SPONSOR.—The term 'sponsor' means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

''(5) CONSTRUCTION.—Nothing in this subsection shall be construed as—

''(A) precluding an individual who is covered under employment-based retiree health coverage from enrolling in a prescription drug plan or in a MA-EFFS plan;

''(B) precluding such employment-based retiree health coverage or an employer or other person from paying all or any portion of any premium required for coverage under such a prescription drug plan or MA-EFFS plan on behalf of such an individual; or

''(C) preventing such employment-based retiree health coverage from providing coverage for retirees—

''(i) who are covered under a qualified retiree prescription plan that is better than standard coverage; or

''(ii) who are not covered under a qualified retiree prescription plan but who are enrolled in a prescription drug plan or a MA-EFFS Rx plan, that is supplemental to the benefits provided under such prescription drug plan or MA-EFFS Rx plan, except that any such supplemental coverage (not including payment of any premium referred to in subparagraph (B)) shall be treated as primary coverage to which section 1862(b)(2)(A)(i) is deemed to apply.

''(g) COMPUTATION OF NATIONAL AVERAGE MONTHLY BID AMOUNT.—

''(1) IN GENERAL.—For each year (beginning with 2006) the Administrator shall compute a national average monthly bid amount equal to the average of the benchmark bid amounts for each prescription drug plan and for each MA-EFFS Rx plan (as computed under paragraph (2), but excluding plans described in section 1851(a)(2)(C))) adjusted under paragraph (4) to take into account reinsurance payments.

''(2) BENCHMARK BID AMOUNT DEFINED.—For purposes of this subsection, the term 'benchmark bid amount' means, with respect to qualified prescription drug coverage offered under—

''(A) a prescription drug plan that—

''(i) provides standard coverage (or alternative prescription drug coverage the actuarial value of which is equivalent to that of standard coverage), the PDP bid; or

''(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the PDP bid multiplied by the ratio of (I) the actuarial value of standard coverage, to (II) the actuarial value of the alternative coverage; or

''(B) a MA-EFFS Rx plan, the portion of the bid amount that is attributable to statutory drug benefits (described in section 1853(a)(1)(A)(ii)(II)).

For purposes of subparagraph (A), the term 'PDP bid' means, with respect to a prescription drug plan, the bid amount for enrollment under the plan under this part (determined without regard to any low-income subsidy under section 1860D–7 or any late enrollment penalty under section 1860D–1(c)(2)(B)).

''(3) WEIGHTED AVERAGE.—

''(A) IN GENERAL.—The monthly national average monthly bid amount 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) SPECIAL RULE FOR 2006.—For purposes of applying this subsection for 2006, the Administrator shall establish procedures for determining the weighted average under subparagraph (A) for 2005.

''(4) ADJUSTMENT TO ADD BACK IN VALUE OF REINSURANCE SUBSIDIES.—The adjustment under this paragraph, to take into account reinsurance payments under subsection (c) making up 30 percent of total payments, is such an adjustment as will make the national average monthly bid amount represent represent 100 percent, instead of representing 70 percent, of average payments under this part.

''(h) COVERAGE YEAR DEFINED.—For purposes of this section, the term 'coverage year' means a calendar year in which covered outpatient drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

"SEC. 1860D–9. MEDICARE PRESCRIPTION DRUG TRUST FUND.

''(a) IN GENERAL.—There is created on the books of the Treasury of the United States a trust fund to be known as the 'Medicare Prescription Drug Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, such fund as provided in this part. Except as otherwise provided in this section, the provisions of subsections (b) through (i) of section 1841 shall apply to the Trust Fund in the same manner as they apply to the Federal Supplementary Medical Insurance Trust Fund under such section.

''(b) PAYMENTS FROM TRUST FUND.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Trust Fund such amounts as the Administrator certifies are necessary to make—

''(A) payments under section 1860D–7 (relating to low-income subsidy payments);

''(B) payments under section 1860D–8 (relating to subsidy payments); and

''(C) payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TRANSFERS TO MEDICAID ACCOUNT FOR INCREASED ADMINISTRATIVE COSTS.—The Managing Trustee shall transfer from time to time from the Trust Fund to the Grants to States for Medicaid account amounts the Administrator certifies are attributable to increases in payment resulting from the application of a higher Federal matching percentage under section 1935(b).

''(c) DEPOSITS INTO TRUST FUND.—

''(1) LOW-INCOME TRANSFER.—There is hereby transferred to the Trust Fund, from amounts appropriated for Grants to States for Medicaid, amounts equivalent to the aggregate amount of the reductions in payments under section 1903(a)(1) attributable to the application of section 1935(c).

''(2) APPROPRIATIONS TO COVER GOVERNMENT CONTRIBUTIONS.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Trust Fund, an amount equivalent to the amount of payments made from the Trust Fund under subsection (b), reduced by the amount transferred to the Trust Fund under paragraph (1).

''(d) RELATION TO SOLVENCY REQUIREMENTS.—Any provision of law that relates to the solvency of the Trust Fund under this part shall take into account the Trust Fund and amounts receivable by, or payable from, the Trust Fund.

"SEC. 1860D–10. DEFINITIONS; APPLICATION TO MEDICARE ADVANTAGE AND EFFS PROGRAMS; TREATMENT OF REFERENCES TO PROVISIONS IN PART C.

''(a) DEFINITIONS.—For purposes of this part:

''(1) COVERED OUTPATIENT DRUGS.—The term 'covered outpatient drugs' is defined in section 1860D–2(f).

''(2) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means such limit as established under section 1860D–2(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

''(3) MEDICARE PRESCRIPTION DRUG TRUST FUND.—The term 'Medicare Prescription Drug Trust Fund' means the Trust Fund created under section 1860D–9(a).

''(4) PDP SPONSOR.—The term 'PDP sponsor' means an entity that is certified under this part as meeting the requirements and standards of this part for such a sponsor.

''(5) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' means health benefits coverage that—

''(A) is offered under a policy, contract, or plan by a PDP sponsor pursuant to, and in accordance with, a contract between the Administrator and the sponsor under section 1860D–4(b);

''(B) provides qualified prescription drug coverage; and

''(C) meets the applicable requirements of the section 1860D–3 for a prescription drug plan.

''(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' is defined in section 1860D–2(a).

''(7) STANDARD COVERAGE.—The term 'standard coverage' is defined in section 1860D–2(b).

''(8) INSURANCE RISK.—The term 'insurance risk' means, with respect to a participating pharmacy, risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to reflect performance-based measures of activities within the control of the pharmacy, such as formulary compliance and generic drug substitution.

''(b) OFFER OF QUALIFIED PRESCRIPTION DRUG COVERAGE UNDER MEDICARE ADVANTAGE AND EFFS PROGRAMS.—

''(1) AS PART OF MEDICARE ADVANTAGE PLAN.—Medicare Advantage organizations are required to offer Medicare Advantage plans that include qualified prescription drug coverage under part C pursuant to section 1851(j).

''(2) AS PART OF EFFS PLAN.—EFFS organizations are required to offer EFFS plans that include qualified prescription drug coverage under part E pursuant to section 1860E–2(d).

''(c) APPLICATION OF PART C PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a prescription drug plan and a PDP sponsor, unless otherwise provided in this part such provisions shall be applied as if—

''(1) any reference to a Medicare Advantage or other plan included a reference to a prescription drug plan;

''(2) any reference to a provider-sponsored organization included a reference to a PDP sponsor;

''(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D–4(b); and

''(4) any reference to part C included a reference to this part.

''(d) REPORT ON PHARMACY SERVICES PROVIDED TO LONG-TERM CARE FACILITY PATIENTS.—

''(1) REVIEW.—Within 6 months after the date of the enactment of this section, the Secretary shall review the current standards of practice for pharmacy services provided to patients in nursing facilities and other long-term care facilities.

''(2) EVALUATIONS AND RECOMMENDATIONS.—Specifically in the review under paragraph (1), the Secretary shall—

''(A) assess the current standards of practice, clinical services, and other service requirements generally utilized for pharmacy services in the long-term care setting;

''(B) evaluate the impact of those standards with respect to patient safety, reduction of medication errors and quality of care; and

''(C) recommend (in the Secretary's report under paragraph (3)) necessary actions and appropriate reimbursement to ensure the provision of prescription drugs to medicare beneficiaries residing in nursing facilities and other long-term care facilities in a manner consistent with existing patient safety and quality of care standards under applicable State and Federal laws.

''(3) REPORT.—The Secretary shall submit a report to the Congress on the Secretary's findings and recommendations under this subsection, including a detailed description of the Secretary's plans to implement this part in a manner consistent with applicable State and Federal laws designed to protect the safety and quality of care of patients of nursing facilities and other long-term care facilities.''.

(b) ADDITIONAL CONFORMING CHANGES.—

(1) CONFORMING REFERENCES TO PREVIOUS PART D.—Any reference in law (in effect before the date of the enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

(2) CONFORMING AMENDMENT PERMITTING WAIVER OF COST-SHARING.—Section 1128B(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

(A) by striking ''and'' at the end of subparagraph (E);

(B) by striking the period at the end of subparagraph (F) and inserting ''; and''; and

(C) by adding at the end the following new subparagraph:

''(G) the waiver or reduction of any cost-sharing imposed under part D of title XVIII.''.

(3) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this subtitle.

(c) STUDY ON TRANSITIONING PART B PRESCRIPTION DRUG COVERAGE.—Not later than January 1, 2005, the Medicare Benefits Administrator shall submit a report to Congress that makes recommendations regarding methods for providing benefits under part D of title XVIII of the Social Security Act for outpatient prescription drugs for which benefits are provided under part B of such title.

SEC. 102. OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE UNDER MEDICARE ADVANTAGE AND ENHANCED FEE-FOR-SERVICE (EFFS) PROGRAM.

(a) MEDICARE ADVANTAGE.—Section 1851 (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

''(j) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS AND SUBSIDIES.—

''(1) OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—A Medicare Advantage organization on and after January 1, 2006—

''(A) may not offer a Medicare Advantage plan described in section 1851(a)(2)(A) in an area unless either that plan (or another Medicare Advantage plan offered by the organization in that area) includes qualified prescription drug coverage; and

''(B) may not offer the prescription drug coverage (other than that required under parts A and B) to an enrollee under a Medicare Advantage plan, unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

''(2) REQUIREMENT FOR ELECTION OF PART D COVERAGE TO OBTAIN QUALIFIED PRESCRIPTION DRUG COVERAGE.—For purposes of this part, an individual who has not elected qualified prescription drug coverage under section 1860D–1(b) shall be treated as being ineligible to enroll in a Medicare Advantage plan under this part that offers such coverage.

''(3) COMPLIANCE WITH CERTAIN ADDITIONAL BENEFICIARY PROTECTIONS FOR PRESCRIPTION DRUG COVERAGE.—With respect to the offering of qualified prescription drug coverage by a Medicare Advantage organization under this part on and after January 1, 2006, the organization and plan shall meet the requirements of subsections (a) through (d) of section 1860D–3 in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D and shall submit to the Administrator the information described in section 1860D–6(a)(2). The Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

''(4) AVAILABILITY OF PREMIUM AND COST-SHARING SUBSIDIES.—In the case of low-income individuals who are enrolled in a Medicare Advantage plan that provides qualified prescription drug coverage, premium and cost-sharing subsidies are provided for such coverage under section 1860D–7.

''(5) AVAILABILITY OF DIRECT AND REINSURANCE SUBSIDIES TO REDUCE BIDS AND PREMIUMS.—Medicare Advantage organizations are provided direct and reinsurance subsidy payments for providing qualified prescription drug coverage under this part under section 1860D–8.

''(6) CONSOLIDATION OF DRUG AND NON-DRUG PREMIUMS.—In the case of a Medicare Advantage plan that includes qualified prescription drug coverage, with respect to an enrollee in such plan there shall be a single premium for both drug and non-drug coverage provided under the plan.

''(7) TRANSITION IN INITIAL ENROLLMENT PERIOD.—Notwithstanding any other provision of this part, the annual, coordinated election period under subsection (e)(3)(B) for 2006 shall be the 6-month period beginning with November 2005.

''(8) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in section 1860D–2.

''(9) SPECIAL RULES FOR PRIVATE FEE-FOR-SERVICE PLANS.— With respect to a Medicare Advantage plan described in section 1851(a)(2)(C) that offers qualified prescription drug coverage—

''(A) REQUIREMENTS REGARDING NEGOTIATED PRICES.—Subsections (a)(1) and (d)(1) of section 1860D–2 shall not be construed to require the plan to negotiate prices or discounts but shall apply to the extent the plan does so.

''(B) MODIFICATION OF PHARMACY PARTICIPATION REQUIREMENT.—If the plan provides access, without charging additional copayments, to all pharmacies without regard to whether they are participating pharmacies in a network, section 1860D-3(c)(1)(A)(iii) shall not apply to the plan.

''(C) DRUG UTILIZATION MANAGEMENT PROGRAM NOT REQUIRED.—The requirements of section 1860D-3(d)(1)(A) shall not apply to the plan.

''(D) NON-PARTICIPATING PHARMACY DISCLOSURE EXCEPTION.—If the plan provides coverage for drugs purchased from all pharmacies, without entering into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, section 1860D-3(d)(5) shall not apply to the plan.''.

(b) APPLICATION TO EFFS PLANS.—Subsection (d) of section 1860E–2, as added by section 201(a), is amended to read as follows:

''(d) AVAILABILITY OF PRESCRIPTION DRUG BENEFITS AND SUBSIDIES.—

''(1) OFFERING OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—An EFFS organization—

''(A) may not offer an EFFS plan in an area unless either that plan (or another EFFS plan offered by the organization in that area) includes qualified prescription drug coverage; and

''(B) may not offer the prescription drug coverage (other than that required under parts A and B) to an enrollee under an EFFS plan, unless such drug coverage is at least qualified prescription drug coverage and unless the requirements of this subsection with respect to such coverage are met.

''(2) REQUIREMENT FOR ELECTION OF PART D COVERAGE TO OBTAIN QUALIFIED PRESCRIPTION DRUG COVERAGE.—For purposes of this part, an individual who has not elected qualified prescription drug coverage under section 1860D–1(b) shall be treated as being ineligible

to enroll in an EFFS plan under this part that offers such coverage.

''(3) COMPLIANCE WITH CERTAIN ADDITIONAL BENEFICIARY PROTECTIONS FOR PRESCRIPTION DRUG COVERAGE.—With respect to the offering of qualified prescription drug coverage by an EFFS organization under this part, the organization and plan shall meet the requirements of subsections (a) through (d) of section 1860D–3 in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D and shall submit to the Administrator the information described in section 1860D–6(a)(2). The Administrator shall waive such requirements to the extent the Administrator determines that such requirements duplicate requirements otherwise applicable to the organization or plan under this part.

''(4) AVAILABILITY OF PREMIUM AND COST-SHARING SUBSIDIES.—In the case of low-income individuals who are enrolled in an EFFS plan that provides qualified prescription drug coverage, premium and cost-sharing subsidies are provided for such coverage under section 1860D–7.

''(5) AVAILABILITY OF DIRECT AND REINSURANCE SUBSIDIES TO REDUCE BIDS AND PREMIUMS.—EFFS organizations are provided direct and reinsurance subsidy payments for providing qualified prescription drug coverage under this part under section 1860D–8.

''(6) CONSOLIDATION OF DRUG AND NON-DRUG PREMIUMS.—In the case of an EFFS plan that includes qualified prescription drug coverage, with respect to an enrollee in such plan there shall be a single premium for both drug and non-drug coverage provided under the plan.

''(7) QUALIFIED PRESCRIPTION DRUG COVERAGE; STANDARD COVERAGE.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in section 1860D–2.''.

(c) CONFORMING AMENDMENTS.—Section 1851 (42 U.S.C. 1395w–21) is amended—

(1) in subsection (a)(1)—

(A) by inserting ''(other than qualified prescription drug benefits)'' after ''benefits'';

(B) by striking the period at the end of subparagraph (B) and inserting a comma; and

(C) by adding after and below subparagraph (B) the following:

''and may elect qualified prescription drug coverage in accordance with section 1860D–1.''; and

(2) in subsection (g)(1), by inserting ''and section 1860D–1(c)(2)(B)'' after ''in this subsection''.

(d) EFFECTIVE DATE.—The amendments made by this section apply to coverage provided on or after January 1, 2006.

SEC. 103. MEDICAID AMENDMENTS.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—

(1) REQUIREMENT.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) by striking ''and'' at the end of paragraph (64);

(B) by striking the period at the end of paragraph (65) and inserting ''; and''; and

(C) by inserting after paragraph (65) the following new paragraph:

''(66) provide for making eligibility determinations under section 1935(a).''.

(2) NEW SECTION.—Title XIX is further amended—

(A) by redesignating section 1935 as section 1936; and

(B) by inserting after section 1934 the following new section:

''SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

''SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall—

''(1) make determinations of eligibility for premium and cost-sharing subsidies under (and in accordance with) section 1860D–7;

''(2) inform the Administrator of the Medicare Benefits Administration of such determinations in cases in which such eligibility is established; and

''(3) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860D–7).

''(b) PAYMENTS FOR ADDITIONAL ADMINISTRATIVE COSTS.—

''(1) IN GENERAL.—The amounts expended by a State in carrying out subsection (a) are, subject to paragraph (2), expenditures reimbursable under the appropriate paragraph of section 1903(a); except that, notwithstanding any other provision of such section, the applicable Federal matching rates with respect to such expenditures under such section shall be increased as follows (but in no case shall the rate as so increased exceed 100 percent):

''(A) For expenditures attributable to costs incurred during 2005, the otherwise applicable Federal matching rate shall be increased by 6-⅔ percent of the percentage otherwise payable (but for this subsection) by the State.

''(B)(i) For expenditures attributable to costs incurred during 2006 and each subsequent year through 2018, the otherwise applicable Federal matching rate shall be increased by the applicable percent (as defined in clause (ii)) of the percentage otherwise payable (but for this subsection) by the State.

''(ii) For purposes of clause (i), the 'applicable percent' for—

''(I) 2006 is 13-⅓ percent; or

''(II) a subsequent year is the applicable percent under this clause for the previous year increased by 6-⅔ percentage points.

''(C) For expenditures attributable to costs incurred after 2018, the otherwise applicable Federal matching rate shall be increased to 100 percent.

''(2) COORDINATION.—The State shall provide the Administrator with such information as may be necessary to properly allocate administrative expenditures described in paragraph (1) that may otherwise be made for similar eligibility determinations.''.

(b) PHASED-IN FEDERAL ASSUMPTION OF MEDICAID RESPONSIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES FOR DUALLY ELIGIBLE INDIVIDUALS.—

(1) IN GENERAL.—Section 1903(a)(1) (42 U.S.C. 1396b(a)(1)) is amended by inserting before the semicolon the following: '', reduced by the amount computed under section 1935(c)(1) for the State and the quarter''.

(2) AMOUNT DESCRIBED.—Section 1935, as inserted by subsection (a)(2), is amended by adding at the end the following new subsection:

''(c) FEDERAL ASSUMPTION OF MEDICAID PRESCRIPTION DRUG COSTS FOR DUALLY-ELIGIBLE BENEFICIARIES.—

''(1) IN GENERAL.—For purposes of section 1903(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2005) the amount computed under this subsection is equal to the product of the following:

''(A) MEDICARE SUBSIDIES.—The total amount of payments made in the quarter under section 1860D–7 (relating to premium and cost-sharing prescription drug subsidies for low-income medicare beneficiaries) that are attributable to individuals who are residents of the State and are entitled to benefits with respect to prescribed drugs under the State plan under this title (including such a plan operating under a waiver under section 1115).

''(B) STATE MATCHING RATE.—A proportion computed by subtracting from 100 percent the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State and the quarter.

''(C) PHASE-OUT PROPORTION.—The phase-out proportion (as defined in paragraph (2)) for the quarter.

''(2) PHASE-OUT PROPORTION.—For purposes of paragraph (1)(C), the 'phase-out proportion' for a calendar quarter in—

''(A) 2006 is 93⅓ percent;

''(B) a subsequent year before 2021, is the phase-out proportion for calendar quarters in the previous year decreased by 6-⅔ percentage points; or

''(C) a year after 2020 is 0 percent.''.

(c) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—Section 1935, as so inserted and amended, is further amended by adding at the end the following new subsection:

''(d) ADDITIONAL PROVISIONS.—

''(1) MEDICAID AS SECONDARY PAYOR.—In the case of an individual who is entitled to qualified prescription drug coverage under a prescription drug plan under part D of title XVIII (or under a MA-EFFS Rx plan under part C or E of such title) and medical assistance for prescribed drugs under this title, medical assistance shall continue to be provided under this title (other than for copayment amounts specified in section 1860D–7(a)(1)(B), notwithstanding section 1916) for prescribed drugs to the extent payment is not made under the prescription drug plan or MA-EFFS Rx plan selected by the individual.

''(2) CONDITION.—A State may require, as a condition for the receipt of medical assistance under this title with respect to prescription drug benefits for an individual eligible to obtain qualified prescription drug coverage described in paragraph (1), that the individual elect qualified prescription drug coverage under section 1860D–1.''.

(d) TREATMENT OF TERRITORIES.—

(1) IN GENERAL.—Section 1935, as so inserted and amended, is further amended—

(A) in subsection (a) in the matter preceding paragraph (1), by inserting ''subject to subsection (e)'' after ''section 1903(a)'';

(B) in subsection (c)(1), by inserting ''subject to subsection (e)'' after ''1903(a)(1)''; and

(C) by adding at the end the following new subsection:

''(e) TREATMENT OF TERRITORIES.—

''(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

''(A) the previous provisions of this section shall not apply to residents of such State; and

''(B) if the State establishes a plan described in paragraph (2) (for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be increased by the amount specified in paragraph (3).

''(2) PLAN.—The plan described in this paragraph is a plan that—

''(A) provides medical assistance with respect to the provision of covered outpatient drugs (as defined in section 1860D–2(f)) to low-income medicare beneficiaries; and

''(B) assures that additional amounts received by the State that are attributable to the operation of this subsection are used only for such assistance.

''(3) INCREASED AMOUNT.—

''(A) IN GENERAL.—The amount specified in this paragraph for a State for a year is equal to the product of—

''(i) the aggregate amount specified in subparagraph (B); and

''(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

''(B) AGGREGATE AMOUNT.—The aggregate amount specified in this subparagraph for—

''(i) 2006, is equal to $25,000,000; or

''(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by annual percentage increase specified in section 1860D–2(b)(5) for the year involved.

''(4) REPORT.—The Administrator shall submit to Congress a report on the application of this subsection and may include in the report such recommendations as the Administrator deems appropriate.''.

(2) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting ''and section 1935(e)(1)(B)'' after ''Subject to subsection (g)''.

(e) AMENDMENT TO BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended—

(1) by striking ''and'' at the end of subclause (III);

(2) by striking the period at the end of subclause (IV) and inserting ''; and''; and

(3) by adding at the end the following new subclause:

''(V) any prices charged which are negotiated by a prescription drug plan under part D of title XVIII, by a MA-EFFS Rx plan under part C or E of such title with respect to covered outpatient drugs, or by a qualified retiree prescription drug plan (as defined in section 1860D–8(f)(1)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B of such title.''.

SEC. 104. MEDIGAP TRANSITION.

(a) IN GENERAL.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) COVERAGE OF PRESCRIPTION DRUGS.—

''(1) IN GENERAL.—Notwithstanding any other provision of law, except as provided in paragraph (3) no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under this section on or after January 1, 2006, to an individual unless it replaces a medicare supplemental policy that was issued to that individual and that provided some coverage of expenses for prescription drugs. Nothing in this subsection shall be construed as preventing the policy holder of a medicare supplemental policy issued before January 1, 2006, from continuing to receive benefits under such policy on and after such date.

''(2) ISSUANCE OF SUBSTITUTE POLICIES FOR BENEFICIARIES ENROLLED WITH A PLAN UNDER PART D.—

''(A) IN GENERAL.—The issuer of a medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as 'A', 'B', 'C', 'D', 'E', 'F', or 'G' (under the standards established under subsection (p)(2)) and that is offered and is available for issuance to new enrollees by such issuer;

''(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the date of termination or disenrollment along with the application for such medicare supplemental policy.

''(B) INDIVIDUAL COVERED.—An individual described in this subparagraph is an individual who—

''(i) enrolls in a prescription drug plan under part D; and

''(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as 'H', 'I', or 'J' under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

''(C) ENFORCEMENT.—The provisions of paragraph (4) of subsection (s) shall apply with respect to the requirements of this paragraph in the same manner as they apply to the requirements of such subsection.

''(3) NEW STANDARDS.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Medicare Prescription Drug and Modernization Act of 2003, with respect to policies issued to individuals who are enrolled in a plan under part D, the changes in standards shall only provide for substituting (for the benefit packages described in paragraph (2)(B)(ii) that included coverage for prescription drugs) two benefit packages that may provide for coverage of cost-sharing (other than the prescription drug deductible) with respect to qualified prescription drug coverage under such part. The two benefit packages shall be consistent with the following:

''(A) FIRST NEW POLICY.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

''(i) Coverage of 50 percent of the cost-sharing otherwise applicable under parts A and B, except coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

''(ii) No coverage of the part B deductible.

''(iii) Coverage for all hospital coinsurance for long stays (as in the current core benefit package).

''(iv) A limitation on annual out-of-pocket expenditures under parts A and B to $4,000 in 2005 (or, in a subsequent year, to such limitation for the previous year increased by an appropriate inflation adjustment specified by the Secretary).

''(B) SECOND NEW POLICY.—The policy described in this subparagraph has the same benefits as the policy described in subparagraph (A), except as follows:

''(i) Substitute '75 percent' for '50 percent' in clause (i) of such subparagraph.

''(ii) Substitute '$2,000' for '$4,000' in clause (iv) of such subparagraph.

''(4) CONSTRUCTION.—Any provision in this section or in a medicare supplemental policy relating to guaranteed renewability of coverage shall be deemed to have been met through the offering of other coverage under this subsection.''.

(b) NAIC REPORT TO CONGRESS ON MEDIGAP MODERNIZATION.—The Secretary shall request the National Association of Insurance Commissioners to submit to Congress, not later than 18 months after the date of the enactment of this Act, a report that includes recommendations on the modernization of coverage under the medigap program under section 1882 of the Social Security Act (42 U.S.C. 1395ss).

SEC. 105. MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND ASSISTANCE PROGRAM.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1806 the following new sections:

''MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT AND ASSISTANCE PROGRAM

''SEC. 1807. (a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—The Secretary shall establish a program—

''(A) to endorse prescription drug discount card programs (each such program referred to as an 'endorsed program') that meet the requirements of this section in order to provide access to prescription drug discounts through eligible entities for medicare beneficiaries throughout the United States; and

''(B) to provide for prescription drug accounts and public contributions into such accounts.

The Secretary shall make available to medicare beneficiaries information regarding endorsed programs and accounts under this section.

''(2) LIMITED PERIOD OF OPERATION.—The Secretary shall begin—

''(A) the card endorsement part of the program under paragraph (1)(A) as soon as possible, but in no case later than 90 days after the date of the enactment of this section; and

''(B) the prescription drug account part of the program under paragraph (1)(B) as soon as possible, but in no case later than September 2004.

''(3) TRANSITION.—The program under this section shall continue through 2005 throughout the United States. The Secretary shall provide for an appropriate transition and termination of such program on January 1, 2006.

''(4) VOLUNTARY NATURE OF PROGRAM.—Nothing in this section shall be construed as requiring an eligible beneficiary to enroll in the program under this section.

''(b) ELIGIBLE BENEFICIARY; ELIGIBLE ENTITY; PRESCRIPTION DRUG ACCOUNT.—For purposes of this section:

''(1) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is eligible for benefits under part A or enrolled under part B and who is not enrolled in a Medicare Advantage plan that offers qualified prescription drug coverage.

''(2) ELIGIBLE ENTITY.—The term 'eligible entity' means any entity that the Secretary determines to be appropriate to provide the benefits under this section, including—

''(A) pharmaceutical benefit management companies;

''(B) wholesale and retail pharmacy delivery systems;

''(C) insurers;

''(D) Medicare Advantage organizations;

''(E) other entities; or

''(F) any combination of the entities described in subparagraphs (A) through (E).

''(3) PRESCRIPTION DRUG ACCOUNT.—The term 'prescription drug account' means, with respect to an eligible beneficiary, an account established for the benefit of that beneficiary under section 1807A.

''(c) ENROLLMENT IN ENDORSED PLAN.—

''(1) ESTABLISHMENT OF PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary may make an election to enroll under this section with an endorsed program.

''(B) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this section for a year in order to be eligible to receive the benefits under this section for that year.

''(C) LIMITATION ON ENROLLMENT.—

''(i) IN GENERAL.—Except as provided under this subparagraph and under such exceptional circumstances as the Secretary may provide, an eligible individual shall have the opportunity to enroll under this section during an initial, general enrollment period as soon as possible after the date of the enactment of this section and annually thereafter.

The Secretary shall specify the form, manner, and timing of such election but shall permit the exercise of such election at the time the individual is eligible to enroll. The annual open enrollment periods shall be coordinated with those provided under the Medicare Advantage program under part C.

''(ii) REELECTION AFTER TERMINATION OF ENROLLMENT IN A MEDICARE ADVANTAGE PLAN.—In the case of an individual who is enrolled under this section and who subsequently enrolls in a Medicare Advantage plan that provides qualified prescription drug coverage under part C, the individual shall be given the opportunity to reenroll under this section at the time the individual discontinues the enrollment under such part.

''(iii) LATE ENROLLMENT.—The Secretary shall permit individuals to elect to enroll under this section at times other than as permitted under the previous provisions of this paragraph.

''(D) TERMINATION OF ENROLLMENT.—An enrollee under this section shall be disenrolled—

''(i) upon enrollment in a Medicare Advantage plan under part C that provides qualified prescription drug coverage;

''(ii) upon failure to pay the applicable enrollment fee under subsection (f);

''(iii) upon termination of coverage under part A or part B; or

''(iv) upon notice submitted to the Secretary in such form, manner, and time as the Secretary shall provide.

Terminations of enrollment under this subparagraph shall be effective as specified by the Secretary in regulations.

''(2) ENROLLMENT PERIODS.—

''(A) IN GENERAL.—Except as provided under this paragraph, an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary's initial enrollment period under part B (as determined under section 1837).

''(B) OPEN ENROLLMENT PERIOD FOR CURRENT BENEFICIARIES.—The Secretary shall establish a period, which shall begin on the date on which the Secretary first begins to accept elections for enrollment under this section and shall end not earlier than 3 months later, during which any eligible beneficiary may enroll under this section.

''(C) SPECIAL ENROLLMENT PERIOD IN CASE OF TERMINATION OF COVERAGE UNDER A GROUP HEALTH PLAN.—The Secretary shall provide for a special enrollment period under this section in the same manner as is provided under section 1837(i) with respect to part B, except that for purposes of this subparagraph any reference to 'by reason of the individual's (or the individual's spouse's) current employment status' shall be treated as being deleted.

''(3) PERIOD OF COVERAGE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B) and subject to subparagraph (C), an eligible beneficiary's coverage under the program under this section shall be effective for the period provided under section 1838, as if that section applied to the program under this section.

''(B) ENROLLMENT DURING OPEN AND SPECIAL ENROLLMENT.—Subject to subparagraph (C), an eligible beneficiary who enrolls under the program under this section under subparagraph (B) or (C) of paragraph (2) shall be entitled to the benefits under this section beginning on the first day of the month following the month in which such enrollment occurs.

''(d) SELECTION OF AN ELIGIBLE ENTITY FOR ACCESS TO NEGOTIATED PRICES.—

''(1) PROCESS.—

''(A) IN GENERAL.—The Secretary shall establish a process through which an eligible beneficiary who is enrolled under this section shall select any eligible entity, that has been awarded a contract under this section and serves the State in which the beneficiary resides, to provide access to negotiated prices under subsection (i).

''(B) RULES.—In establishing the process under subparagraph (A), the Secretary shall use rules similar to the rules for enrollment and disenrollment with a Medicare Advantage plan under section 1851 (including the special election periods under subsection (e)(4) of such section), including that—

''(i) an individual may not select more than one eligible entity at any time; and

''(ii) an individual shall only be permitted (except for unusual circumstances) to change the selection of the entity once a year.

In carrying out clause (ii), the Secretary may consider a change in residential setting (such as placement in a nursing facility) to be an unusual circumstance.

''(C) DEFAULT SELECTION.—In establishing such process, the Secretary shall provide an equitable method for selecting an eligible entity for individuals who enroll under this section and fail to make such a selection.

''(2) COMPETITION.—Eligible entities with a contract under this section shall compete for beneficiaries on the basis of discounts, formularies, pharmacy networks, and other services provided for under the contract.

''(e) PROVIDING ENROLLMENT, SELECTION, AND COVERAGE INFORMATION TO BENEFICIARIES.—

''(1) ACTIVITIES.—The Secretary shall provide for activities under this section to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding enrollment under this section, the selection of eligible entities, and the prescription drug coverage made available by eligible entities with a contract under this section.

''(2) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—To the extent practicable, the activities described in paragraph (1) shall ensure that eligible beneficiaries are provided with such information at least 60 days prior to the first enrollment period described in subsection (c).

''(f) ENROLLMENT FEE.—

''(1) AMOUNT.—Except as provided in paragraph (3), enrollment under the program under this section is conditioned upon payment of an annual enrollment fee of $30. Such fee for 2004 shall include any portion of 2003 in which the program is implemented under this section.

''(2) COLLECTION OF ENROLLMENT FEE.—The annual enrollment fee shall be collected and credited to the Federal Supplementary Medical Insurance Trust Fund in the same manner as the monthly premium determined under section 1839 is collected and credited to such Trust Fund under section 1840, except that it shall be collected only 1 time per year.

''(3) PAYMENT OF ENROLLMENT FEE BY STATE FOR CERTAIN BENEFICIARIES.—

''(A) IN GENERAL.—The Secretary shall establish an arrangement under which a State may provide for payment of some or all of the enrollment fee for some or all low income enrollees in the State, as specified by the State under the arrangement. Insofar as such a payment arrangement is made with respect to an enrollee, the amount of the enrollment fee shall be paid directly by the State and shall not be collected under paragraph (2). In carrying out this paragraph, the Secretary may apply procedures similar to that applied under state agreements under section 1843.

''(B) NO FEDERAL MATCHING AVAILABLE UNDER MEDICAID OR SCHIP.—Expenditures made by a State described in subparagraph (A) shall not be treated as State expenditures for purposes of Federal matching payments under titles XIX and XXI insofar as such expenditures are for an enrollment fee under this subsection.

''(4) DISTRIBUTION OF PORTION OF ENROLLMENT FEE.—Of the enrollment fee collected by the Secretary under this subsection with respect to a beneficiary, ⅔ of that fee shall be made available to the eligible entity selected by the eligible beneficiary.

''(g) ISSUANCE OF CARD AND COORDINATION.—Each eligible entity shall—

''(1) issue, in a uniform standard format specified by the Secretary, to each enrolled beneficiary a card and an enrollment number that establishes proof of enrollment and that can be used in a coordinated manner—

''(A) to identify the eligible entity selected to provide access to negotiated prices under subsection (i); and

''(B) to make deposits to and withdrawals from a prescription drug account under section 1807A; and

''(2) provide for electronic methods to coordinate with the accounts established under section 1807A.

''(h) ENROLLEE PROTECTIONS.—

''(1) GUARANTEED ISSUE AND NONDISCRIMINATION.—

''(A) GUARANTEED ISSUE.—

''(i) IN GENERAL.—An eligible beneficiary who is eligible to select an eligible entity under subsection (b) for prescription drug coverage under this section at a time during which selections are accepted under this section with respect to the coverage shall not be denied selection based on any health status-related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor and may not be charged any selection or other fee as a condition of such acceptance.

''(ii) MEDICARE ADVANTAGE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment) of section 1851(g) (relating to priority and limitation on termination of election) shall apply to selection of eligible entities under this paragraph.

''(B) NONDISCRIMINATION.—An eligible entity offering prescription drug coverage under this section shall not establish a service area in a manner that would discriminate based on health or economic status of potential enrollees.

''(C) COVERAGE OF ALL PORTIONS OF A STATE.—If an eligible entity with a contract under this section serves any part of a State it shall serve the entire State.

''(2) DISSEMINATION OF INFORMATION.—

''(A) GENERAL INFORMATION.—An eligible entity with a contract under this section shall disclose, in a clear, accurate, and standardized form to each eligible beneficiary who has selected the entity to provide access to negotiated prices under this section at the time of selection and at least annually thereafter, the information described in section 1852(c)(1) relating to such prescription drug coverage. Such information includes the following (in a manner designed to permit and promote competition among eligible entities):

''(i) Summary information regarding negotiated prices (including discounts) for covered outpatient drugs.

''(ii) Access to such prices through pharmacy networks.

''(iii) How any formulary used by the eligible entity functions.

''(B) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an eligible beneficiary, the eligible entity shall provide the information described in section 1852(c)(2) (other than subparagraph (D)) to such beneficiary.

''(C) RESPONSE TO BENEFICIARY QUESTIONS.—Each eligible entity offering prescription drug coverage under this section shall have a mechanism (including a toll-free telephone number) for providing upon request specific information (such as negotiated prices, including discounts) to individuals who have selected the entity. The entity shall make available, through an Internet website and in writing upon request, information on specific changes in its formulary.

''(D) COORDINATION WITH PRESCRIPTION DRUG ACCOUNT BENEFITS.—Each such eligible entity shall provide for coordination of such information as the Secretary may specify to carry out section 1807A.

''(3) ACCESS TO COVERED BENEFITS.—

''(A) ENSURING PHARMACY ACCESS.—The provisions of subsection (c)(1) of section 1860D–3 (other than payment provisions under section 1860D–8 with respect to sponsors under such subsection) shall apply to an eligible entity under this section in the same manner as they apply to a PDP sponsor under such section.

''(B) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—For requirements relating to the access of an eligible beneficiary to negotiated prices (including applicable discounts), see subsection (i).

''(C) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—Insofar as an eligible entity with a contract under this part uses a formulary, the entity shall comply with the requirements of section 1860D–3(c)(3), insofar as the Secretary determines that such requirements can be implemented on a timely basis.

''(4) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(A) IN GENERAL.—For purposes of providing access to negotiated benefits under subsection (i), the eligible entity shall have in place the programs and measure described in section 1860D–3(d), including an effective cost and drug utilization management program, quality assurance measures and systems, and a program to control fraud, abuse, and waste, insofar as the Secretary determines that such provisions can be implemented on a timely basis.

''(B) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to the requirements for an endorsed program under this section with respect to the following requirements, in the same manner as they apply to Medicare Advantage plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

''(i) Paragraph (3)(A) (relating to access to covered benefits).

''(ii) Paragraph (7) (relating to confidentiality and accuracy of enrollee records).

''(5) GRIEVANCE MECHANISM.—Each eligible entity shall provide meaningful procedures for hearing and resolving grievances between the organization consistent with the requirements of section 1860D–3(e) insofar as they relate to PDP sponsors of prescription drug plans.

''(6) BENEFICIARY SERVICES.—An eligible entity shall provide for its enrollees pharmaceutical support services, such as education and counseling, and services to prevent adverse drug interactions.

''(7) COVERAGE DETERMINATIONS AND RECONSIDERATIONS.—An eligible entity shall meet the requirements of paragraphs (1) through (3) of section 1852(g) with respect to covered benefits under the prescription drug coverage it offers under this section in the same manner as such requirements apply to a Medicare Advantage organization with respect to benefits it offers under a Medicare Advantage plan under part C.

''(8) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—An eligible entity shall meet the requirements of section 1852(h) with respect to enrollees under this section in the same manner as such requirements apply to a Medicare Advantage organization with respect to enrollees under part C. The eligible entity shall implement policies and procedures to safeguard the use and disclosure of enrollees' individually identifiable health information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996. The eligible entity shall be treated as a covered entity for purposes of the provisions of subpart E of part 164 of title 45, Code of Federal Regulations, adopted pursuant to the authority of the Secretary under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S. C. 1320d-2 note).

''(9) PERIODIC REPORTS AND OVERSIGHT.—The eligible entity shall submit to the Secretary periodic reports on performance, utilization, finances, and such other matters as the Secretary may specify. The Secretary shall provide appropriate oversight to ensure compliance of eligible entities with the requirements of this subsection, including verification of the discounts and services provided.

''(10) ADDITIONAL BENEFICIARY PROTECTIONS.—The eligible entity meets such additional requirements as the Secretary identifies to protect and promote the interest of enrollees, including requirements that ensure that enrollees are not charged more than the lower of the negotiated retail price or the usual and customary price.

''(i) BENEFITS UNDER THE PROGRAM THROUGH SAVINGS TO ENROLLEES THROUGH NEGOTIATED PRICES.—

''(1) IN GENERAL.—Subject to paragraph (2), each eligible entity with a contract under this section shall provide each eligible beneficiary enrolled with the entity with access to negotiated prices (including applicable discounts). For purposes of this paragraph, the term 'prescription drugs' is not limited to covered outpatient drugs, but does not include any over-the-counter drug that is not a covered outpatient drug. The prices negotiated by an eligible entity under this paragraph 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) FORMULARY RESTRICTIONS.—Insofar as an eligible entity with a contract under this part uses a formulary, the negotiated prices (including applicable discounts) for prescription drugs shall only be available for drugs included in such formulary.

''(3) PROHIBITION ON APPLICATION ONLY TO MAIL ORDER.—The negotiated prices under this subsection shall apply to prescription drugs that are available other than solely through mail order.

''(4) PROHIBITION ON CHARGES FOR REQUIRED SERVICES.—An eligible entity (and any pharmacy contracting with such entity for the provision of a discount under this section) may not charge a beneficiary any amount for any services required to be provided by the entity under this section.

''(5) DISCLOSURE.—The eligible entity offering the endorsed program shall disclose to the Secretary (in a manner specified by the Secretary) the extent to which discounts or rebates or other remuneration or price concessions made available to the entity 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 Secretary under this paragraph in the same manner as such provisions apply to information disclosed under such section.

''(6) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—Each eligible entity shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered outpatient drug in connection with its endorsed program shall inform the enrollee in that program 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 available generic drug covered under the program that is therapeutically equivalent and bioequivalent.

''(j) CONTRIBUTION INTO PRESCRIPTION DRUG ACCOUNT.—

''(1) IN GENERAL.—In the case of an individual enrolled under this section, the Secretary shall—

''(A) establish a prescription drug account for the individual under section 1807A; and

''(B) subject to paragraph (5), deposit into such account on a monthly or other periodic basis an amount that, on an annual basis, is equivalent to the annual Federal contribution amount specified in paragraph (2) for the enrollee involved.

''(2) ANNUAL FEDERAL CONTRIBUTION AMOUNT.—Subject to paragraph (3), in the case of an accountholder whose income is—

''(A) not more than 135 percent of the poverty line, the annual Federal contribution amount for a year is $800;

''(B) more than 135 percent, but not more than 150 percent, of the poverty line, the annual Federal contribution amount for a year is $500; or

''(C) more than 150 percent of the poverty line, the annual Federal contribution amount for a year is $100.

''(3) INCOME ELIGIBILITY DETERMINATIONS.—The determination of whether an individual residing in a State is a eligible for a contribution under paragraph (1) shall be determined under the State medicaid plan for the State under section 1935(a) or by the Social Security Administration. In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Secretary. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this paragraph.

''(4) PARTIAL YEAR.—Insofar as the provisions of this subsection and section 1807A are not implemented for all months in 2004, the annual contribution amount under this subsection for 2004 shall be prorated to reflect the portion of that year in which such provisions are in effect.

''(5) RESTRICTION ON CONTRIBUTIONS.—There shall only be an annual Federal contribution under paragraph (1) for an individual if the individual is not eligible for coverage of, or assistance for, outpatient prescription drugs under any of the following:

''(A) A medicaid plan under title XIX (including under any waiver approved under section 1115).

''(B) Enrollment under a group health plan or health insurance coverage.

''(C) Enrollment under a medicare supplemental insurance policy.

''(D) Chapter 55 of title 10, United States Code (relating to medical and dental care for members of the uniformed services).

''(E) Chapter 17 of title 38, United States Code (relating to Veterans' medical care).

''(F) Enrollment under a plan under chapter 89 of title 5, United States Code (relating to the Federal employees' health benefits program).

''(G) The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).

''(6) APPROPRIATION TO COVER NET PROGRAM EXPENDITURES.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Federal Supplementary Medical Insurance Trust Fund established under section 1841, an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this section exceed the sum of the portion of the enrollment fees retained by the Secretary.

''(k) DEFINITIONS.—In this part and section 1807A:

''(1) COVERED OUTPATIENT DRUG.—

''(A) IN GENERAL.—Except as provided in this paragraph, for purposes of this section, the term 'covered outpatient drug' means—

''(i) a drug that may be dispensed only upon a prescription and that is described in subparagraph (A)(i) or (A)(ii) of section 1927(k)(2); or

''(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section or insulin described in subparagraph (C) of such section and medical supplies associated with the injection of insulin (as defined in regulations of the Secretary),

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.—

''(i) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this section shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

''(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this section shall not be so considered under an endorsed program if the eligible entity offering the program excludes the drug under a formulary and a review of such exclusion is not successfully resolved under subsection (h)(5).

''(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—An eligible entity offering an endorsed program may exclude from qualified prescription drug coverage any covered outpatient 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 program or this section.

Such exclusions are determinations subject to review pursuant to subsection (h)(5).

''(2) POVERTY LINE.—The term 'poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 673(2) of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

''(l) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as may be necessary to carry out this section and section 1807A.

''(e) INTERIM, FINAL REGULATORY AUTHORITY.—In order to carry out this section and section 1807A in a timely manner, the Secretary may promulgate regulations that take effect on an interim basis, after notice and pending opportunity for public comment.

''PRESCRIPTION DRUG ACCOUNTS

''SEC. 1807A. ''(a) ESTABLISHMENT OF ACCOUNTS.—

''(1) IN GENERAL.—The Secretary shall establish and maintain for each eligible beneficiary who is enrolled under section 1807 at the time of enrollment a prescription drug account (in this section and section 1807 referred to as an 'account').

''(2) RESERVE ACCOUNTS.—In cases described in subsections (b)(3)(A), (b)(3)(B)(i), and (b)(3)(B)(ii)(I), the Secretary shall establish and maintain for each surviving spouse who is not enrolled under section 1807 a reserve prescription drug account (in this section referred to as an 'reserve account').

''(3) ACCOUNTHOLDER DEFINED.—In this section and section 1807A, the term 'accountholder' means an individual for whom an account or reserve account has been established under this section.

''(4) EXPENDITURES FROM ACCOUNT.—Nothing in this section shall be construed as requiring the Federal Government to obligate funds for amounts in any account until such time as a withdrawal from such account is authorized under this section.

''(b) USE OF ACCOUNTS.—

''(1) APPLICATION OF ACCOUNT.—Except as provided in this subsection, amounts credited to an account shall only be used for the purchase of covered outpatient drugs for the accountholder. Any amounts remaining at the end of a year remain available for expenditures in succeeding years.

''(2) ACCOUNT RULES FOR PUBLIC AND PRIVATE CONTRIBUTIONS.—The Secretary shall establish a ongoing process for the determination of the amount in each account that is attributable to public and private contributions (including spousal rollover contributions) based on the following rules:

''(A) TREATMENT OF EXPENDITURES.—Expenditures from the account shall—

''(i) first be counted against any public contribution; and

''(ii) next be counted against private contributions.

''(B) TREATMENT OF SPOUSAL ROLLOVER CONTRIBUTIONS.—With respect to any spousal rollover contribution, the portions of such contribution that were attributable to public and private contributions at the time of its distribution under subsection (b)(3) shall be treated under this paragraph as if it were a direct public or private contribution, respectively, into the account of the spouse.

''(3) DEATH OF ACCOUNTHOLDER.—In the case of the death of an accountholder, the balance in any account (taking into account liabilities accrued before the time of death) shall be distributed as follows:

''(A) TREATMENT OF PUBLIC CONTRIBUTIONS.—If the accountholder is married at the time of death, the amount in the account that is attributable to public contributions shall be credited to the account (if any) of the surviving spouse of the accountholder (or, if the surviving spouse is not an eligible beneficiary, into a reserve account to be held for when that spouse becomes an eligible beneficiary).

''(B) TREATMENT OF PRIVATE CONTRIBUTIONS.—The amount in the account that is attributable to private contributions shall be distributed as follows:

''(i) DESIGNATION OF DISTRIBUTEE.—If the accountholder has made a designation, in a form and manner specified by the Secretary, for the distribution of some or all of such amount, such amount shall be distributed in accordance with the designation. Such designation may provide for the distribution into an account (including a reserve account) of a surviving spouse.

''(ii) ABSENCE OF DESIGNATION.—Insofar as the accountholder has not made such a designation—

''(I) SURVIVING SPOUSE.—If the accountholder was married at the time of death, the remainder shall be credited to an account (including a reserve account) of the accountholder's surviving spouse.

''(II) NO SURVIVING SPOUSE.—If the accountholder was not so married, the remainder shall be distributed to the estate of the accountholder and distributed as provided by law.

''(4) USE OF ACCOUNT FOR PREMIUMS FOR ENROLLMENT IN A MEDICARE ADVANTAGE PLAN.—During any period in which an accountholder is enrolled in a Medicare Advantage plan under part C, the balance in the account may be used and applied only to reimburse the amount of the premium (if any) established for enrollment under the plan.

''(5) APPLICATION TO MEDICAID EXPENSES IN CERTAIN CASES.—

''(A) IN GENERAL.—Except as provided in this paragraph, an account shall be treated as an asset for purposes of establishing eligibility for medical assistance under title XIX.

''(B) APPLICATION TOWARDS SPENDDOWN.—In the case of an accountholder who is applying for such medical assistance and who would, but for the application of subparagraph (A), be eligible for such assistance—

''(i) subparagraph (A) shall not apply; and

''(ii) the account shall be available (in accordance with a procedure established by the Secretary) to the State to reimburse the State for any expenditures made under the plan for such medical assistance.

''(c) AMOUNTS CREDITED IN ACCOUNT.—The Secretary shall credit to a prescription drug account of an eligible beneficiary the following amounts:

''(1) PUBLIC CONTRIBUTIONS.—The following contributions (each referred to in this section as a 'public contribution'):

''(A) FEDERAL CONTRIBUTIONS.—Federal contributions provided under subsection (d).

''(B) STATE CONTRIBUTIONS.—Contributions made by a State under subsection (f).

''(2) SPOUSAL ROLLOVER CONTRIBUTION.—A distribution from a deceased spouse under subsection (b)(3) (referred to in this section as a 'spousal rollover contribution').

''(3) PRIVATE CONTRIBUTIONS.—The following contributions (each referred to in this section as a 'private contribution'):

''(A) EMPLOYER AND INDIVIDUAL CONTRIBUTIONS.—Contributions made under subsection (e).

''(B) OTHER INDIVIDUAL CONTRIBUTIONS.—Contributions made by accountholder other than under subsection (e).

''(C) CONTRIBUTIONS BY NONPROFIT ORGANIZATIONS.—Contributions made by a charitable, not-for-profit organization (that may be a religious organization).

Except as provided in this subsection, no amounts may be contributed to, or credited to, a prescription drug account.

''(d) FEDERAL CONTRIBUTION.—For Federal contributions in the case of accountholders, see section 1807(j).

''(e) EMPLOYER AND INDIVIDUAL CONTRIBUTIONS.—

''(1) EMPLOYMENT-RELATED CONTRIBUTION.—

''(A) IN GENERAL.—In the case of any accountholder who is a beneficiary or participant in a group health plan (including a multi-employer plan), whether as an employee, former employee or otherwise, including as a dependent of an employee or former employee, the plan may make a contribution into the accountholder's account (but not into a reserve account of the accountholder).

''(B) LIMITATION.—The total amount that may be contributed under subparagraph (A) under a plan to an account during any year may not exceed $5,000.

''(C) CONDITION.—A group health plan may condition a contribution with respect to an

accountholder under this paragraph on the accountholder's enrollment under section 1807 with an eligible entity that is recognized or approved by that plan.

''(2) OTHER INDIVIDUALS.—

''(A) IN GENERAL.—Any individual may also contribute to the account of that individual or the account of any other individual under this subsection.

''(B) LIMITATION.—The total amount that may be contributed to an account under subparagraph (A) during any year may not exceed $5,000, regardless of who makes such contribution.

''(3) NO CONTRIBUTION PERMITTED TO RESERVE ACCOUNT.—No contribution may be made under this subsection to a reserve account.

''(4) FORM AND MANNER OF CONTRIBUTION.—The Secretary shall specify the form and manner of contributions under this subsection.

''(f) STATE CONTRIBUTIONS.—

''(1) IN GENERAL.—A State may enter into arrangements with the Secretary for the crediting of amounts for accountholders.

''(2) FORM AND MANNER OF CONTRIBUTION.—The Secretary shall specify the form and manner of contributions under this subsection.

''(3) MEDICAID TREATMENT.—Amounts credited under this subsection shall not be treated as medical assistance for purposes of title XIX or child health assistance for purposes of title XXI for individuals who are not qualifying low income enrollees.''.

(b) EXCLUSION OF COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(g) (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 Voluntary Medicare Outpatient Prescription Drug Discount and Security Program under sections 1807 and 1807A.''.

(c) STATE ELIGIBILITY DETERMINATIONS.—Section 1935, as added by section 103(a)(2), is amended—

(1) in subsection (a)(1), by inserting ''and of eligibility for an annual Federal contribution amount under section 1807A(j)(2)'' before the semicolon; and

(2) in subsection (a)(3), by inserting ''and sections 1807 and 1807A'' after ''1860D–7)''.

(d) REPORT ON PROGRESS IN IMPLEMENTATION OF PRESCRIPTION DRUG BENEFIT.—Not later than March 1, 2005, the Administrator shall submit a report to Congress on the progress that has been made in implementing the prescription drug benefit under this title. The Administrator shall include in the report specific steps that have been taken, and that need to be taken, to ensure a timely start of the program on January 1, 2006.

SEC. 106. DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF CARRYING OUT MEDICARE CATASTROPHIC PRESCRIPTION DRUG PROGRAM.

(a) DISCLOSURE.—

(1) IN GENERAL.—Subsection (l) of section 6103 of the Internal Revenue Code of 1986 (relating to disclosure of returns and return information for purposes other than tax administration) is amended by adding at the end the following new paragraph:

''(19) DISCLOSURE OF RETURN INFORMATION FOR PURPOSES OF CARRYING OUT MEDICARE CATASTROPHIC PRESCRIPTION DRUG PROGRAM.—

''(A) IN GENERAL.—The Secretary may, upon written request from the Secretary of Health and Human Services under section 1860D–2(b)(4)(E)(i) of the Social Security Act, disclose to officers and employees of the Department of Health and Human Services with respect to a specified taxpayer for the taxable year specified by the Secretary of Health and Human Services in such request—

''(i) the taxpayer identity information with respect to such taxpayer, and

''(ii) the adjusted gross income of such taxpayer for the taxable year (or, if less, the income threshold limit specified in section 1860D–2(b)(4)(D)(ii) for the calendar year specified by such Secretary in such request).

''(B) SPECIFIED TAXPAYER.—For purposes of this paragraph, the term 'specified taxpayer' means any taxpayer who—

''(i) is identified by the Secretary of Health and Human Services in the request referred to in subparagraph (A), and

''(ii) either—

''(I) has an adjusted gross income for the taxable year referred to in subparagraph (A) in excess of the income threshold specified in section 1860D–2(b)(4)(D)(ii) of such Act for the calendar year referred to in such subparagraph, or

''(II) is identified by such Secretary under subparagraph (A) as being an individual who elected to use more recent information under section 1860D–2(b)(4)(D)(v) of such Act.

''(C) JOINT RETURNS.—In the case of a joint return, the Secretary shall, for purposes of applying this paragraph, treat each spouse as a separate taxpayer having an adjusted gross income equal to one-half of the adjusted gross income determined with respect to such return.

''(D) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Department of Health and Human Services only for the purpose of administering the prescription drug benefit under title XVIII of the Social Security Act. Such officers and employees may disclose the annual out-of-pocket threshold which applies to an individual under such part to the entity that offers the plan referred to in section 1860D–2(b)(4)(E)(ii) of such Act in which such individual is enrolled. Such sponsor may use such information only for purposes of administering such benefit.''.

(2) JOINT RETURN PERMITTED IN CASE OF SURVIVING SPOUSES.—Under section 6103(a)(3) of the Internal Revenue Code of 1986, a surviving spouse may file a joint return for the taxable year in which one spouse dies.

(b) CONFIDENTIALITY.—Paragraph (3) of section 6103(a) of such Code is amended by striking ''or (16)'' and inserting ''(16), or (19)''.

(c) PROCEDURES AND RECORDKEEPING RELATED TO DISCLOSURES.—Subsection (p)(4) of section 6103 of such Code is amended by striking ''any other person described in subsection (l)(16) or (17)'' each place it appears and inserting ''any other person described in subsection (l)(16), (17), or (19)''.

(d) UNAUTHORIZED DISCLOSURE.—Paragraph (2) of section 7213(a) of such Code is amended by striking ''or (16)'' and inserting ''(16), or (19)''.

(e) UNAUTHORIZED INSPECTION.—Subparagraph (B) of section 7213A(a)(1) of such Code is amended by inserting ''or (19)'' after ''subsection (l)(18)''.

SEC. 107. 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 Advantage 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).

SEC. 108. ADDITIONAL REQUIREMENTS FOR ANNUAL FINANCIAL REPORT AND OVERSIGHT ON MEDICARE PROGRAM, INCLUDING PRESCRIPTION DRUG SPENDING.

(a) IN GENERAL.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(l) COMBINED REPORT ON OPERATION AND STATUS OF THE TRUST FUND, THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, AND MEDICARE PRESCRIPTION DRUG TRUST FUND.—

''(1) IN GENERAL.—In addition to the duty of the Board of Trustees to report to Congress under subsection (b), on the date the Board submits the report required under subsection (b)(2), the Board shall submit to Congress a report on the operation and status of the Trust Fund, the Federal Supplementary Medical Insurance Trust Fund established under section 1841, and the Medicare Prescription Drug Trust Fund under section 1860D–9(a) (in this subsection collectively referred to as the 'Trust Funds'). Such report shall included the following information:

''(A) OVERALL SPENDING FROM THE GENERAL FUND OF THE TREASURY.—A statement of total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury to the Trust Funds for payment for benefits covered under this title, stated in terms of the total amount and in terms of the percentage such amount bears to all other amounts obligated from such General Revenues during such fiscal year.

''(B) HISTORICAL OVERVIEW OF SPENDING.—From the date of the inception of the program of insurance under this title through the fiscal year involved, a statement of the total amounts referred to in subparagraph (A).

''(C) 10-YEAR AND 75-YEAR PROJECTIONS.—An estimate of total amounts referred to in subparagraph (A) required to be obligated for payment for benefits covered under this title for each of the 10 fiscal years succeeding the fiscal year involved and for the 75-year period beginning with the succeeding fiscal year.

''(D) RELATION TO GDP GROWTH.—A comparison of the rate of growth of the total amounts referred to in subparagraph (A) to the rate of growth in the gross domestic product for the same period.

''(2) PUBLICATION.—Each report submitted under paragraph (1) shall be published jointly by the Committee on Ways and Means and the Committee on Energy and Commerce as a public document and shall be made available by such Committees on the Internet.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to fiscal years beginning on or after the date of the enactment of this Act.

TITLE II—MEDICARE ENHANCED FEE-FOR-SERVICE AND MEDICARE ADVANTAGE PROGRAMS; MEDICARE COMPETITION

SEC. 200. MEDICARE MODERNIZATION AND REVITALIZATION.

This title provides for—

(1) establishment of the medicare enhanced fee-for-service (EFFS) program under which medicare beneficiaries are provided access to a range of enhanced fee-for-service (EFFS) plans that may use preferred provider networks to offer an enhanced range of benefits;

(2) establishment of a Medicare Advantage program that offers improved managed care plans with coordinated care; and

(3) competitive bidding, in the style of the Federal Employees Health Benefits program (FEHBP), among enhanced fee-for-service plans and Medicare Advantage plans in order to promote greater efficiency and responsiveness to medicare beneficiaries.

Subtitle A—Medicare Enhanced Fee-for-Service Program

SEC. 201. ESTABLISHMENT OF ENHANCED FEE-FOR-SERVICE (EFFS) PROGRAM UNDER MEDICARE.

(a) IN GENERAL.—Title XVIII, as amended by section 101(a), is amended—

(1) by redesignating part E as part F; and

(2) by inserting after part D the following new part:

''PART E—ENHANCED FEE-FOR-SERVICE PROGRAM

''OFFERING OF ENHANCED FEE-FOR-SERVICE PLANS THROUGHOUT THE UNITED STATES

''SEC. 1860E–1. (a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—The Administrator shall establish under this part beginning January 1, 2006, an enhanced fee-for-service program under which enhanced fee-for-service plans (as defined in subsection (b)) are offered to EFFS-eligible individuals (as so defined) in EFFS regions throughout the United States.

''(2) EFFS REGIONS.—For purposes of this part the Administrator shall establish EFFS regions throughout the United States by dividing the entire United States into at least 10 such regions. Before establishing such regions, the Administrator shall conduct a market survey and analysis, including an examination of current insurance markets, to determine how the regions should be established. The regions shall be established in a manner to take into consideration maximizing full access for all EFFS-eligible individuals, especially those residing in rural areas.

''(b) DEFINITIONS.—For purposes of this part:

''(1) EFFS ORGANIZATION.—The 'EFFS organization' means an entity that the Administrator certifies as meeting the requirements and standards applicable to such organization under this part.

''(2) ENHANCED FEE-FOR-SERVICE PLAN; EFFS PLAN.—The terms 'enhanced fee-for-service plan' and 'EFFS plan' mean health benefits coverage offered under a policy, contract, or plan by an EFFS organization pursuant to and in accordance with a contract pursuant to section 1860E–4(c), but only if the plan provides either fee-for-service coverage described in the following subparagraph (A) or preferred provider coverage described in the following subparagraph (B):

''(A) FEE-FOR-SERVICE COVERAGE.—The plan—

''(i) reimburses hospitals, physicians, and other providers at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk;

''(ii) does not vary such rates for such a provider based on utilization relating to such provider; and

''(iii) does not restrict the selection of providers among those who are lawfully authorized to provide the covered services and agree to accept the terms and conditions of payment established by the plan.

''(B) PREFERRED PROVIDER COVERAGE.—The plan—

''(i) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan; and

''(ii) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers.

''(3) EFFS ELIGIBLE INDIVIDUAL.—The term 'EFFS eligible individual' means an eligible individual described in section 1851(a)(3).

''(4) EFFS REGION.—The term 'EFFS region' means a region established under subsection (a)(2).

''(c) APPLICATION OF CERTAIN ELIGIBILITY, ENROLLMENT, ETC. REQUIREMENTS.—The provisions of section 1851 (other than subsection (h)(4)(A)) shall apply to EFFS plans offered by an EFFS organization in an EFFS region, including subsection (g) (relating to guaranteed issue and renewal).

''OFFERING OF ENHANCED FEE-FOR-SERVICE (EFFS) PLANS

''SEC. 1860E–2. (a) PLAN REQUIREMENTS.—No EFFS plan may be offered under this part in an EFFS region unless the requirements of this part are met with respect to the plan and EFFS organization offering the plan.

''(b) AVAILABLE TO ALL EFFS BENEFICIARIES IN THE ENTIRE REGION.—With respect to an EFFS plan offered in an EFFS region—

''(1) IN GENERAL.—The plan must be offered to all EFFS-eligible individuals residing in the region.

''(2) ASSURING ACCESS TO SERVICES.—The plan shall comply with the requirements of section 1852(d)(4).

''(c) BENEFITS.—

''(1) IN GENERAL.—Each EFFS plan shall provide to members enrolled in the plan under this part benefits, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

''(A) for the items and services described in section 1852(a)(1);

''(B) that are uniform for the plan for all EFFS eligible individuals residing in the same EFFS region;

''(C) that include a single deductible applicable to benefits under parts A and B and include a catastrophic limit on out-of-pocket expenditures for such covered benefits; and

''(D) that include benefits for prescription drug coverage for each enrollee who elects under part D to be provided qualified prescription drug coverage through the plan.

''(2) DISAPPROVAL AUTHORITY.—The Administrator shall not approve a plan of an EFFS organization if the Administrator determines (pursuant to the last sentence of section 1852(b)(1)(A)) that the benefits are designed to substantially discourage enrollment by certain EFFS eligible individuals with the organization.

''(d) OUTPATIENT PRESCRIPTION DRUG COVERAGE.—For rules concerning the offering of prescription drug coverage under EFFS plans, see the amendment made by section 102(b) of the Medicare Prescription Drug and Modernization Act of 2003.

''(e) OTHER ADDITIONAL PROVISIONS.—The provisions of section 1852 (other than subsection (a)(1)) shall apply under this part to EFFS plans. For the application of chronic care improvement provisions, see the amendment made by section 722(b).

''SUBMISSION OF BIDS; BENEFICIARY SAVINGS; PAYMENT OF PLANS

''SEC. 1860E–3. (a) SUBMISSION OF BIDS.—

''(1) REQUIREMENT.—

''(A) EFFS MONTHLY BID AMOUNT.—For each year (beginning with 2006), an EFFS organization shall submit to the Administrator an EFFS monthly bid amount for each EFFS plan offered in each region. Each such bid is referred to in this section as the 'EFFS monthly bid amount'.

''(B) FORM.—Such bid amounts shall be submitted for each such plan and region in a form and manner and time specified by the Administrator, and shall include information described in paragraph (3)(A).

''(2) UNIFORM BID AMOUNTS.—Each EFFS monthly bid amount submitted under paragraph (1) by an EFFS organization under this part for an EFFS plan in an EFFS region may not vary among EFFS eligible individuals residing in the EFFS region involved.

''(3) SUBMISSION OF BID AMOUNT INFORMATION BY EFFS ORGANIZATIONS.—

''(A) INFORMATION TO BE SUBMITTED.—The information described in this subparagraph is as follows:

''(i) The EFFS monthly bid amount for provision of all items and services under this

part, which amount shall be based on average costs for a typical beneficiary residing in the region, and the actuarial basis for determining such amount.

''(ii) The proportions of such bid amount that are attributable to—

''(I) the provision of statutory non-drug benefits (such portion referred to in this part as the 'unadjusted EFFS statutory non-drug monthly bid amount');

''(II) the provision of statutory prescription drug benefits; and

''(III) the provision of non-statutory benefits;

and the actuarial basis for determining such proportions.

''(iii) Such additional information as the Administrator may require to verify the actuarial bases described in clauses (i) and (ii).

''(B) STATUTORY BENEFITS DEFINED.—For purposes of this part:

''(i) The term 'statutory non-drug benefits' means benefits under section 1852(a)(1).

''(ii) The term 'statutory prescription drug benefits' means benefits under part D.

''(iii) The term 'statutory benefits' means statutory prescription drug benefits and statutory non-drug benefits.

''(C) ACCEPTANCE AND NEGOTIATION OF BID AMOUNTS.—The Administrator has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportion described in subparagraph (A)(ii)), and for such purpose, the Administrator has negotiation authority that the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code. The Administrator may reject such a bid amount or proportion if the Administrator determines that such amount or proportion is not supported by the actuarial bases provided under subparagraph (A).

''(D) CONTRACT AUTHORITY.—The Administrator may, taking into account the unadjusted EFFS statutory non-drug monthly bid amounts accepted under subparagraph (C), enter into contracts for the offering of EFFS plans by up to 3 EFFS organizations in any region.

''(b) PROVISION OF BENEFICIARY SAVINGS FOR CERTAIN PLANS.—

''(1) BENEFICIARY REBATE RULE.—

''(A) REQUIREMENT.—The EFFS plan shall provide to the enrollee a monthly rebate equal to 75 percent of the average per capita savings (if any) described in paragraph (2) applicable to the plan and year involved.

''(B) FORM OF REBATE.—A rebate required under this paragraph shall be provided—

''(i) through the crediting of the amount of the rebate towards the EFFS monthly prescription drug beneficiary premium (as defined in section 1860E–4(a)(3)(B)) and the EFFS monthly supplemental beneficiary premium (as defined in section 1860E–4(a)(3)(C));

''(ii) through a direct monthly payment (through electronic funds transfer or otherwise); or

''(iii) through other means approved by the Medicare Benefits Administrator,

or any combination thereof.

''(2) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—For purposes of paragraph (1)(A), the average per capita monthly savings referred to in such paragraph for an EFFS plan and year is computed as follows:

''(A) DETERMINATION OF REGION-WIDE AVERAGE RISK ADJUSTMENT.—

''(i) IN GENERAL.—The Medicare Benefits Administrator shall determine, at the same time rates are promulgated under section 1853(b)(1) (beginning with 2006), for each EFFS region the average of the risk adjustment factors described in subsection (c)(3) to be applied to enrollees under this part in that region. In the case of an EFFS region in which an EFFS plan was offered in the previous year, the Administrator may compute such average based upon risk adjustment factors applied under subsection (c)(3) in that region in a previous year.

''(ii) TREATMENT OF NEW REGIONS.—In the case of a region in which no EFFS plan was offered in the previous year, the Administrator shall estimate such average. In making such estimate, the Administrator may use average risk adjustment factors applied to comparable EFFS regions or applied on a national basis.

''(B) DETERMINATION OF RISK ADJUSTED BENCHMARK AND RISK-ADJUSTED BID.—For each EFFS plan offered in an EFFS region, the Administrator shall—

''(i) adjust the EFFS region-specific non-drug monthly benchmark amount (as defined in paragraph (3)) by the applicable average risk adjustment factor computed under subparagraph (A); and

''(ii) adjust the unadjusted EFFS statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

''(C) DETERMINATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—The average per capita monthly savings described in this subparagraph is equal to the amount (if any) by which—

''(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i), exceeds

''(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

''(3) COMPUTATION OF EFFS REGION-SPECIFIC NON-DRUG MONTHLY BENCHMARK AMOUNT.—For purposes of this part, the term 'EFFS region-specific non-drug monthly benchmark amount' means, with respect to an EFFS region for a month in a year, an amount equal to 1/12 of the average (weighted by number of EFFS eligible individuals in each payment area described in section 1853(d)) of the annual capitation rate as calculated under section 1853(c)(1) for that area.

''(c) PAYMENT OF PLANS BASED ON BID AMOUNTS.—

''(1) NON-DRUG BENEFITS.—Under a contract under section 1860E–4(c) and subject to section 1853(g) (as made applicable under subsection (d)), the Administrator shall make monthly payments under this subsection in advance to each EFFS organization, with respect to coverage of an individual under this part in an EFFS region for a month, in an amount determined as follows:

''(A) PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in subsection (b)(2)(C), the payment under this subsection is equal to the unadjusted EFFS statutory non-drug monthly bid amount, adjusted under paragraphs (3) and (4), plus the amount of the monthly rebate computed under subsection (b)(1)(A) for that plan and year.

''(B) PLANS WITH BIDS AT OR ABOVE BENCHMARK.—In the case of a plan for which there are no average per capita monthly savings described in subsection (b)(2)(C), the payment amount under this subsection is equal to the EFFS region-specific non-drug monthly benchmark amount, adjusted under paragraphs (3) and (4).

''(2) FOR FEDERAL DRUG SUBSIDIES.—In the case in which an enrollee who elects under part D to be provided qualified prescription drug coverage through the plan, the EFFS organization offering such plan also is entitled—

''(A) to direct subsidy payment under section 1860D–8(a)(1);

''(B) to reinsurance subsidy payments under section 1860D–8(a)(2); and

''(C) to reimbursement for premium and cost-sharing reductions for low-income individuals under section 1860D–7(c)(3).

''(3) DEMOGRAPHIC RISK ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—The Administrator shall adjust under paragraph (1)(A) the unadjusted EFFS statutory non-drug monthly bid amount and under paragraph (1)(B) the EFFS region-specific non-drug monthly benchmark amount for such risk factors as age, disability status, gender, institutional status, and such other factors as the Administrator determines to be appropriate, including adjustment for health status under section 1853(a)(3) (as applied under subsection (d)), so as to ensure actuarial equivalence. The Administrator may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

''(4) ADJUSTMENT FOR INTRA-REGIONAL GEOGRAPHIC VARIATIONS.—The Administrator shall also adjust such amounts in a manner to take into account variations in payments rates under part C among the different payment areas under such part included in each EFFS region.

''(d) APPLICATION OF ADDITIONAL PAYMENT RULES.—The provisions of section 1853 (other than subsections (a)(1)(A), (d), and (e)) shall apply to an EFFS plan under this part, except as otherwise provided in this section.

''PREMIUMS; ORGANIZATIONAL AND FINANCIAL REQUIREMENTS; ESTABLISHMENT OF STANDARDS; CONTRACTS WITH EFFS ORGANIZATIONS

''SEC. 1860E–4. (a) PREMIUMS.—

''(1) IN GENERAL.—The provisions of section 1854 (other than subsections (a)(6)(C) and (h)), including subsection (b)(5) relating to the consolidation of drug and non-drug beneficiary premiums and subsection (c) relating to uniform bids and premiums, shall apply to an EFFS plan under this part, subject to paragraph (2).

''(2) CROSS-WALK.—In applying paragraph (1), any reference in section 1854(b)(1)(A) or 1854(d) to—

''(A) a Medicare Advantage monthly basic beneficiary premium is deemed a reference to the EFFS monthly basic beneficiary premium (as defined in paragraph (3)(A));

''(B) a Medicare Advantage monthly prescription drug beneficiary premium is deemed a reference to the EFFS monthly prescription drug beneficiary premium (as defined in paragraph (3)(B)); and

''(C) a Medicare Advantage monthly supplemental beneficiary premium is deemed a reference to the EFFS monthly supplemental beneficiary premium (as defined in paragraph (3)(C)).

''(3) DEFINITIONS.—For purposes of this part:

''(A) EFFS MONTHLY BASIC BENEFICIARY PREMIUM.—The term 'EFFS monthly basic beneficiary premium' means, with respect to an EFFS plan—

''(i) described in section 1860E–3(c)(1)(A) (relating to plans providing rebates), zero; or

''(ii) described in section 1860E–3(c)(1)(B), the amount (if any) by which the unadjusted EFFS statutory non-drug monthly bid amount exceeds the EFFS region-specific non-drug monthly benchmark amount (as defined in section 1860E–3(b)(3)).

''(B) EFFS MONTHLY PRESCRIPTION DRUG BENEFICIARY PREMIUM.—The term 'EFFS monthly prescription drug beneficiary premium' means, with respect to an EFFS plan, the portion of the aggregate monthly bid amount submitted under clause (i) of section 1860E–3(a)(3)(A) for the year that is attributable under such section to the provision of statutory prescription drug benefits.

''(C) EFFS MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term 'EFFS monthly supplemental beneficiary premium' means, with respect to an EFFS plan, the portion of the aggregate monthly bid amount submitted under clause (i) of section 1860E–

3(a)(3)(A) for the year that is attributable under such section to the provision of non-statutory benefits.

''(b) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS.—The provisions of section 1855 shall apply to an EFFS plan offered by an EFFS organization under this part.

''(c) STANDARDS.—The provisions of paragraphs (1), (3), and (4) of section 1856(b) shall apply to an EFFS plan offered by an EFFS organization under this part.

''(d) CONTRACTS WITH EFFS ORGANIZATIONS.—The provisions of section 1857 shall apply to an EFFS plan offered by an EFFS organization under this part, except that any reference in such section to part C is deemed a reference to this part.''.

(b) APPLICATION OF MEDIGAP PROVISIONS TO EFFS PLANS.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) shall be administered as if any reference to a Medicare+Choice organization offering a Medicare+Choice plan under part C of title XVIII of such Act were a reference both to a Medicare Advantage organization offering a Medicare Advantage plan under such part and an EFFS organization offering an EFFS plan under part E of such title.

Subtitle B—Medicare Advantage Program

CHAPTER 1—IMPLEMENTATION OF PROGRAM

SEC. 211. IMPLEMENTATION OF MEDICARE ADVANTAGE PROGRAM.

(a) IN GENERAL.—There is hereby established the Medicare Advantage program. The Medicare Advantage program shall consist of the program under part C of title XVIII of the Social Security Act, as amended by this title.

(b) REFERENCES.—Any reference to the program under part C of title XVIII of the Social Security Act shall be deemed a reference to the Medicare Advantage program and, with respect to such part, any reference to ''Medicare+Choice'' is deemed a reference to ''Medicare Advantage''.

SEC. 212. MEDICARE ADVANTAGE 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 Advantage 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 Advantage 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) CHANGE IN BUDGET NEUTRALITY FOR BLEND.—Section 1853(c) (42 U.S.C. 1395w–23(c)) is amended—

(1) in paragraph (1)(A), by inserting ''(for a year other than 2004)'' after ''multiplied''; and

(2) in paragraph (5), by inserting ''(other than 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 (A), by striking ''The sum'' and inserting ''For a year before 2005, the sum'';

(B) in subparagraph (B)(iv), by striking ''and each succeeding year'' and inserting '', 2003, and 2004'';

(C) in subparagraph (C)(iv), by striking ''and each succeeding year'' and inserting ''and 2003''; and

(D) 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 Advantage capitation rate under this paragraph for the area for the previous year; or

''(II) the annual Medicare Advantage capitation rate under this paragraph for the area for the previous year increased by the national per capita Medicare Advantage 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 Advantage 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 ADVANTAGE 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 Advantage plans in different areas and its impact on lowering premiums and increasing benefits under such plans.

(h) ANNOUNCEMENT OF REVISED MEDICARE ADVANTAGE PAYMENT RATES.—Within 6 weeks after the date of the enactment of this Act, the Secretary shall determine, and shall announce (in a manner intended to provide notice to interested parties) Medicare Advantage capitation rates under section 1853 of the Social Security Act (42 U.S.C. 1395w–23) for 2004, revised in accordance with the provisions of this section.

CHAPTER 2—IMPLEMENTATION OF COMPETITION PROGRAM

SEC. 221. COMPETITION PROGRAM BEGINNING IN 2006.

(a) SUBMISSION OF EFFS-LIKE BIDDING INFORMATION BEGINNING IN 2006.—Section 1854 (42 U.S.C. 1395w–24) is amended—

(1) by amending the section heading to read as follows:

''PREMIUMS AND BID AMOUNT'';

(2) in subsection (a)(1)(A)—

(A) by striking ''(A)'' and inserting ''(A)(i) if the following year is before 2006,''; and

(B) by inserting before the semicolon at the end the following: ''or (ii) if the following year is 2006 or later, the information described in paragraph (3) or (6)(A) for the type of plan involved''; and

(3) by adding at the end of subsection (a) the following:

''(6) SUBMISSION OF BID AMOUNTS BY MEDICARE ADVANTAGE ORGANIZATIONS.—

''(A) INFORMATION TO BE SUBMITTED.—The information described in this subparagraph is as follows:

''(i) The monthly aggregate bid amount for provision of all items and services under this part, which amount shall be based on average costs for a typical beneficiary residing in the area, and the actuarial basis for determining such amount.

''(ii) The proportions of such bid amount that are attributable to—

''(I) the provision of statutory non-drug benefits (such portion referred to in this part as the 'unadjusted Medicare Advantage statutory non-drug monthly bid amount');

''(II) the provision of statutory prescription drug benefits; and

''(III) the provision of non-statutory benefits;

and the actuarial basis for determining such proportions.

''(iii) Such additional information as the Administrator may require to verify the actuarial bases described in clauses (i) and (ii).

''(B) STATUTORY BENEFITS DEFINED.—For purposes of this part:

''(i) The term 'statutory non-drug benefits' means benefits under section 1852(a)(1).

''(ii) The term 'statutory prescription drug benefits' means benefits under part D.

''(iii) The term 'statutory benefits' means statutory prescription drug benefits and statutory non-drug benefits.

''(C) ACCEPTANCE AND NEGOTIATION OF BID AMOUNTS.—

''(i) IN GENERAL.—Subject to clause (ii)—

''(I) the Administrator has the authority to negotiate regarding monthly bid amounts submitted under subparagraph (A) (and the proportion described in subparagraph (A)(ii)), and for such purpose and subject to such clause, the Administrator has negotiation authority that the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code; and

''(II) the Administrator may reject such a bid amount or proportion if the Administrator determines that such amount or proportion is not supported by the actuarial bases provided under subparagraph (A).

''(ii) EXCEPTION.—In the case of a plan described in section 1851(a)(2)(C), the provisions of clause (i) shall not apply and the provisions of paragraph (5)(B), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply to the negotiation and rejection of the monthly bid amounts and proportion referred to in subparagraph (A).''.

(b) PROVIDING FOR BENEFICIARY SAVINGS FOR CERTAIN PLANS.—

(1) IN GENERAL.—Section 1854(b) (42 U.S.C. 1395w–24(b)) is amended—

(A) by adding at the end of paragraph (1) the following new subparagraph:

''(C) BENEFICIARY REBATE RULE.—

''(i) REQUIREMENT.—The Medicare Advantage plan shall provide to the enrollee a monthly rebate equal to 75 percent of the average per capita savings (if any) described in paragraph (3) applicable to the plan and year involved.

''(iii) FORM OF REBATE.—A rebate required under this subparagraph shall be provided—

''(I) through the crediting of the amount of the rebate towards the Medicare Advantage monthly supplementary beneficiary premium or the premium imposed for prescription drug coverage under part D;

''(II) through a direct monthly payment (through electronic funds transfer or otherwise); or

''(III) through other means approved by the Medicare Benefits Administrator,

or any combination thereof.''; and

(B) by adding at the end the following new paragraphs:

''(3) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—For purposes of paragraph (1)(C)(i), the average per capita monthly savings referred to in such paragraph for a Medicare Advantage plan and year is computed as follows:

''(A) DETERMINATION OF STATE-WIDE AVERAGE RISK ADJUSTMENT.—

''(i) IN GENERAL.—The Medicare Benefits Administrator shall determine, at the same time rates are promulgated under section 1853(b)(1) (beginning with 2006), for each State the average of the risk adjustment factors to be applied under section 1853(a)(1)(A) to payment for enrollees in that State. In the case of a State in which a Medicare Advantage plan was offered in the previous year, the Administrator may compute such average based upon risk adjustment factors applied in that State in a previous year.

''(ii) TREATMENT OF NEW STATES.—In the case of a State in which no Medicare Advantage plan was offered in the previous year, the Administrator shall estimate such average. In making such estimate, the Administrator may use average risk adjustment factors applied to comparable States or applied on a national basis.

''(B) DETERMINATION OF RISK ADJUSTED BENCHMARK AND RISK-ADJUSTED BID.—For each Medicare Advantage plan offered in a State, the Administrator shall—

''(i) adjust the Medicare Advantage area-specific non-drug monthly benchmark amount (as defined in subsection (j)) by the applicable average risk adjustment factor computed under subparagraph (A); and

''(ii) adjust the unadjusted Medicare Advantage statutory non-drug monthly bid amount by such applicable average risk adjustment factor.

''(C) DETERMINATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—The average per capita monthly savings described in this subparagraph is equal to the amount (if any) by which—

''(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i), exceeds

''(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

''(D) AUTHORITY TO DETERMINE RISK ADJUSTMENT FOR AREAS OTHER THAN STATES.—The Administrator may provide for the determination and application of risk adjustment factors under this paragraph on the basis of areas other than States.

''(4) BENEFICIARY'S OPTION OF PAYMENT THROUGH WITHHOLDING FROM SOCIAL SECURITY PAYMENT OR USE OF ELECTRONIC FUNDS TRANSFER MECHANISM.—In accordance with regulations, a Medicare Advantage organization shall permit each enrollee, at the enrollee's option, to make payment of premiums under this part to the organization indirectly through withholding from benefit payments in the manner provided under section 1840 with respect to monthly premiums under section 1839 or through an electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account) or otherwise. All premium payments that are withheld under this paragraph that are credited to the Federal Supplementary Medical Insurance Drug Trust Fund shall be paid to the Medicare Advantage organization involved.''.

(2) PROVISION OF SINGLE CONSOLIDATED PREMIUM.—Section 1854(b) (42 U.S.C. 1395w–24(b)), as amended by paragraph (1), is further amended by adding at the end the following new paragraph:

''(5) SINGLE CONSOLIDATED PREMIUM.—In the case of an enrollee in a Medicare Advantage plan who elects under part D to be provided qualified prescription drug coverage through the plan, the Administrator shall provide a mechanism for the consolidation of the beneficiary premium amount for non-drug benefits under this part with the premium amount for prescription drug coverage under part D provided through the plan.''.

(3) COMPUTATION OF MEDICARE ADVANTAGE AREA-SPECIFIC NON-DRUG BENCHMARK.—Section 1853 (42 U.S.C. 1395w–23) is amended by adding at the end the following new subsection:

''(j) COMPUTATION OF MEDICARE ADVANTAGE AREA-SPECIFIC NON-DRUG MONTHLY BENCHMARK AMOUNT.—For purposes of this part, the term 'Medicare Advantage area-specific non-drug monthly benchmark amount' means, with respect to a Medicare Advantage payment area for a month in a year, an amount equal to 1/12 of the annual Medicare Advantage capitation rate under section 1853(c)(1) for the area for the year.''.

(c) PAYMENT OF PLANS BASED ON BID AMOUNTS.—

(1) IN GENERAL.—Section 1853(a)(1)(A) (42 U.S.C. 1395w–23) is amended by striking ''in an amount'' and all that follows and inserting the following: ''in an amount determined as follows:

''(i) PAYMENT BEFORE 2006.—For years before 2006, the payment amount shall be equal to 1/12 of the annual Medicare Advantage capitation rate (as calculated under subsection (c)(1)) with respect to that individual for that area, reduced by the amount of any reduction elected under section 1854(f)(1)(E) and adjusted under clause (iv).

''(ii) PAYMENT FOR STATUTORY NON-DRUG BENEFITS BEGINNING WITH 2006.—For years beginning with 2006—

''(I) PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C), the payment under this subsection is equal to the unadjusted Medicare Advantage statutory non-drug monthly bid amount, adjusted under clause (iv), plus the amount of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year.

''(II) PLANS WITH BIDS AT OR ABOVE BENCHMARK.—In the case of a plan for which there are no average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the Medicare Advantage area-specific non-drug monthly benchmark amount, adjusted under clause (iv).

''(iii) FOR FEDERAL DRUG SUBSIDIES.—In the case in which an enrollee who elects under part D to be provided qualified prescription drug coverage through the plan, the Medicare Advantage organization offering such plan also is entitled—

''(I) to direct subsidy payment under section 1860D–8(a)(1);

''(II) to reinsurance subsidy payments under section 1860D–8(a)(2); and

''(III) to reimbursement for premium and cost-sharing reductions for low-income individuals under section 1860D–7(c)(3).

''(iv) DEMOGRAPHIC ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—The Administrator shall adjust the payment amount under clause (i), the unadjusted Medicare Advantage statutory non-drug monthly bid amount under clause (ii)(I), and the Medicare Advantage area-specific non-drug monthly benchmark amount under clause (ii)(II) for such risk factors as age, disability status, gender, institutional status, and such other factors as the Administrator determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Administrator may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.''.

(d) CONFORMING AMENDMENTS.—

(1) PROTECTION AGAINST BENEFICIARY SELECTION.—Section 1852(b)(1)(A) (42 U.S.C. 1395w–22(b)(1)(A)) is amended by adding at the end the following: ''The Administrator shall not approve a plan of an organization if the Administrator determines that the benefits are designed to substantially discourage enrollment by certain Medicare Advantage eligible individuals with the organization.''.

(2) CONFORMING AMENDMENT TO PREMIUM TERMINOLOGY.—Section 1854(b)(2) (42 U.S.C. 1395w–24(b)(2)) is amended by redesignating subparagraph (C) as subparagraph (D) and by striking subparagraphs (A) and (B) and inserting the following:

''(A) MEDICARE ADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM.—The term 'Medicare Advantage monthly basic beneficiary premium' means, with respect to a Medicare Advantage plan—

''(i) described in section 1853(a)(1)(A)(ii)(I) (relating to plans providing rebates), zero; or

''(ii) described in section 1853(a)(1)(A)(ii)(II), the amount (if any) by which the unadjusted Medicare Advantage statutory non-drug monthly bid amount exceeds the Medicare Advantage area-specific non-drug monthly benchmark amount.

''(B) MEDICARE ADVANTAGE MONTHLY PRESCRIPTION DRUG BENEFICIARY PREMIUM.—The term 'Medicare Advantage monthly prescription drug beneficiary premium' means, with respect to a Medicare Advantage plan, that portion of the bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under such section to the provision of statutory prescription drug benefits.

''(C) MEDICARE ADVANTAGE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term 'Medicare Advantage monthly supplemental beneficiary premium' means, with respect to a Medicare Advantage plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under such section to the provision of nonstatutory benefits.''.

(3) REQUIREMENT FOR UNIFORM PREMIUM AND BID AMOUNTS.—Section 1854(c) (42 U.S.C. 1395w–24(c)) is amended to read as follows:

''(c) UNIFORM PREMIUM AND BID AMOUNTS.—The Medicare Advantage monthly bid amount submitted under subsection (a)(6), the Medicare Advantage monthly basic, prescription drug, and supplemental beneficiary premiums, and the Medicare Advantage monthly MSA premium charged under subsection (b) of a Medicare Advantage organization under this part may not vary among individuals enrolled in the plan.''.

(4) PERMITTING BENEFICIARY REBATES.—

(A) Section 1851(h)(4)(A) (42 U.S.C. 1395w–21(h)(4)(A)) is amended by inserting ''except as provided under section 1854(b)(1)(C)'' after ''or otherwise''.

(B) Section 1854(d) (42 U.S.C. 1395w–24(d)) is amended by inserting '', except as provided under subsection (b)(1)(C),'' after ''and may not provide''.

(5) OTHER CONFORMING AMENDMENTS RELATING TO BIDS.—Section 1854 (42 U.S.C. 1395w–24) is amended—

(A) in the heading of subsection (a), by inserting ''AND BID AMOUNTS'' after ''PREMIUMS''; and

(B) in subsection (a)(5)(A), by inserting ''paragraphs (2), (3), and (4) of'' after ''filed under''.

(e) ADDITIONAL CONFORMING AMENDMENTS.—

(1) ANNUAL DETERMINATION AND ANNOUNCEMENT OF CERTAIN FACTORS.—Section 1853(b)(1) (42 U.S.C. 1395w–23(b)(1)) is amended by striking ''the respective calendar year'' and all that follows and inserting the following: ''the calendar year concerned with respect to each Medicare Advantage payment area, the following:

''(A) PRE-COMPETITION INFORMATION.—For years before 2006, the following:

''(i) MEDICARE ADVANTAGE CAPITATION RATES.—The annual Medicare Advantage capitation rate for each Medicare Advantage payment area for the year.

''(ii) ADJUSTMENT FACTORS.—The risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year.

''(B) COMPETITION INFORMATION.—For years beginning with 2006, the following:

''(i) BENCHMARK.—The Medicare Advantage area-specific non-drug benchmark under section 1853(j).

''(ii) ADJUSTMENT FACTORS.—The adjustment factors applied under section 1853(a)(1)(A)(iv) (relating to demographic adjustment), section 1853(a)(1)(B) (relating to adjustment for end-stage renal disease), and section 1853(a)(3) (relating to health status adjustment).''.

(2) REPEAL OF PROVISIONS RELATING TO ADJUSTED COMMUNITY RATE (ACR).—

(A) IN GENERAL.—Subsections (e) and (f) of section 1854 (42 U.S.C. 1395w–24) are repealed.

(B) CONFORMING AMENDMENTS.—(i) Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking '', and to reflect'' and all that follows and inserting a period.

(ii) Section 1852(a)(1) (42 U.S.C. 1395w–22(a)(1)) is amended by striking ''title XI'' and all that follows and inserting the following: ''title XI 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.''.

(iii) Section 1857(d)(1) (42 U.S.C. 1395w–27(d)(1)) is amended by striking '', costs, and computation of the adjusted community rate'' and inserting ''and costs''.

(f) REFERENCES UNDER PART E.—Section 1859 (42 U.S.C. 1395w–29) is amended by adding at the end the following new subsection:

''(f) APPLICATION UNDER PART E.—In the case of any reference under part E to a requirement or provision of this part in the relation to an EFFS plan or organization under such part, except as otherwise specified any such requirement or provision shall be applied to such organization or plan in the same manner as such requirement or provision applies to a Medicare Advantage private fee-for-service plan (and the Medicare Advantage organization that offers such plan) under this part.''.

(g) EFFECTIVE DATE.—The amendments made by this section shall apply to payments and premiums for months beginning with January 2006.

CHAPTER 3—ADDITIONAL REFORMS

SEC. 231. MAKING PERMANENT CHANGE IN MEDICARE ADVANTAGE 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''.

(d) REQUIRING PROVISION OF AVAILABLE INFORMATION COMPARING PLAN OPTIONS.—The first sentence of section 1851(d)(2)(A)(ii) (42 U.S.C. 1395w–21(d)(2)(A)(ii)) is amended by inserting before the period the following: ''to the extent such information is available at the time of preparation of materials for the mailing''.

SEC. 232. AVOIDING DUPLICATIVE STATE REGULATION.

(a) IN GENERAL.—Section 1856(b)(3) (42 U.S.C. 1395w–26(b)(3)) is amended to read as follows:

''(3) RELATION TO STATE LAWS.—The standards established under this subsection shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to Medicare Advantage plans which are offered by Medicare Advantage organizations under this part.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

SEC. 233. SPECIALIZED MEDICARE ADVANTAGE 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 Advantage plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.''.

(b) SPECIALIZED MEDICARE ADVANTAGE 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 ADVANTAGE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—

''(A) IN GENERAL.—The term 'specialized Medicare Advantage plan for special needs beneficiaries' means a Medicare Advantage plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

''(B) SPECIAL NEEDS BENEFICIARY.—The term 'special needs beneficiary' means a Medicare Advantage 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 Advantage 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 ADVANTAGE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare Advantage 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) AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MEDICARE ADVANTAGE PLANS.—In promulgating regulations to carry out the last sentence of section 1851(a)(2)(A) of the Social Security Act (as added by subsection (a)) and section 1859(b)(4) of such Act (as added by subsection (b)), the Secretary may provide (notwithstanding section 1859(b)(4)(A) of such Act) for the offering of specialized Medicare Advantage plans by Medicare Advantage plans that disproportionately serve special needs beneficiaries who are frail, elderly medicare beneficiaries.

(e) 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 Advantage 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).

(f) 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 shall issue interim 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. 234. MEDICARE MSAS.

(a) EXEMPTION FROM REPORTING ENROLLEE ENCOUNTER DATA.—

(1) IN GENERAL.—Section 1852(e)(1) (42 U.S.C. 1395w–22(e)(1)) is amended by inserting ''(other than MSA plans)'' after ''plans''.

(2) CONFORMING AMENDMENTS.—Section 1852 (42 U.S.C. 1395w–22) is amended—

(A) in subsection (c)(1)(I), by inserting before the period at the end the following: ''if required under such section''; and

(B) in subparagraphs (A) and (B) of subsection (e)(2), by striking '', a non-network MSA plan,'' and '', NON-NETWORK MSA PLANS,'' each place it appears.

(b) MAKING PROGRAM PERMANENT AND ELIMINATING CAP.—Section 1851(b)(4) (42 U.S.C. 1395w–21(b)(4)) is amended—

(1) in the heading, by striking ''ON A DEMONSTRATION BASIS'';

(2) by striking the first sentence of subparagraph (A); and

(3) by striking the second sentence of subparagraph (C).

(c) APPLYING LIMITATIONS ON BALANCE BILLING.—Section 1852(k)(1) (42 U.S.C. 1395w–22(k)(1)) is amended by inserting ''or with an organization offering a MSA plan'' after ''section 1851(a)(2)(A)''.

(d) ADDITIONAL AMENDMENT.—Section 1851(e)(5)(A) (42 U.S.C. 1395w–21(e)(5)(A)) is amended—

(1) by adding ''or'' at the end of clause (i);

(2) by striking '', or'' at the end of clause (ii) and inserting a semicolon; and

(3) by striking clause (iii).

SEC. 235. 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 Advantage 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. 236. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

Section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as amended by section 6135 of the Omnibus Budget Reconciliation Act of 1989, section 13557 of the Omnibus Budget Reconciliation Act of 1993, section 4017 of BBA, section 534 of BBRA (113 Stat. 1501A–390), and section 633 of BIPA, is amended by striking ''December 31, 2004'' and inserting ''December 31, 2009''.

SEC. 237. STUDY OF PERFORMANCE-BASED PAYMENT SYSTEMS.

(a) IN GENERAL.—The Secretary shall request the Institute of Medicine of the National Academy of Sciences to—

(1) conduct a study that reviews and evaluates public and private sector experiences in establishing performance measures and payment incentives under the medicare program and linking performance to payment; and

(2) submit a report to the Secretary and Congress, not later than 18 months after the date of the enactment of this Act, regarding such study.

(b) STUDY.—The study under subsection (a)(1) shall—

(1) include a review and evaluation of incentives that have been or could be used to encourage quality performance, including those aimed at health plans and their enrollees, providers and their patients, and other incentives that encourage quality-based health care purchasing and collaborative efforts to improve performance; and

(2) examine how these measures and incentives might be applied in the Medicare Advantage program, the Enhanced Fee-For-Service (EFFS) program, and traditional fee-for-service programs.

(c) REPORT RECOMMENDATIONS.—The report under subsection (a)(2) shall—

(1) include recommendations regarding appropriate performance measures for use in assessing and paying for quality; and

(2) identify options for updating performance measures.

Subtitle C—Application of FEHBP-Style Competitive Reforms

SEC. 241. APPLICATION OF FEHBP-STYLE COMPETITIVE REFORM BEGINNING IN 2010.

(a) IDENTIFICATION OF COMPETITIVE EFFS REGIONS; COMPUTATION OF COMPETITIVE EFFS NON-DRUG BENCHMARKS UNDER EFFS PROGRAM.—

(1) IN GENERAL.—Section 1860E–3, as added by section 201(a), is amended by adding at the end the following new subsection:

''(e) APPLICATION OF COMPETITION.—

''(1) DETERMINATION OF COMPETITIVE EFFS REGIONS.—

''(A) IN GENERAL.—For purposes of this part, the term 'competitive EFFS region' means, for a year beginning with 2010, an EFFS region that the Administrator finds—

''(i) there will be offered in the region during the annual, coordinated election period under section 1851(e)(3)(B) (as applied under section 1860E–1(c)) before the beginning of the year at least 2 EFFS plans (in addition to the fee-for-service program under parts A and B), each offered by a different EFFS organization and each of which met the minimum enrollment requirements of paragraph (1) of section 1857(b) (as applied without regard to paragraph (3) thereof) as of March of the previous year; and

''(ii) during March of the previous year at least the percentage specified in subparagraph (C) of the number of EFFS eligible individuals who reside in the region were enrolled in an EFFS plan.

''(B) PERCENTAGE SPECIFIED.—

''(i) IN GENERAL.—For purposes of subparagraph (A), subject to clause (ii), the percentage specified in this subparagraph for a year is equal the lesser of 20 percent or to the sum of—

''(I) the percentage, as estimated by the Administrator, of EFFS eligible individuals in the United States who are enrolled in EFFS plans during March of the previous year; and

''(II) the percentage, as estimated by the Administrator, of Medicare Advantage eligible individuals in the United States who are enrolled in Medicare Advantage plans during March of the previous year.

''(ii) EXCEPTION.—In the case of an EFFS region that was a competitive EFFS region for the previous year, the Medicare Benefits Administrator may continue to treat the region as meeting the requirement of subparagraph (A)(ii) if the region would meet such requirement but for a de minimis reduction below the percentage specified in clause (i).

''(2) COMPETITIVE EFFS NON-DRUG MONTHLY BENCHMARK AMOUNT.—For purposes of this part, the term 'competitive EFFS non-drug monthly benchmark amount' means, with respect to an EFFS region for a month in a year and subject to paragraph (8), the sum of the 2 components described in paragraph (3) for the region and year. The Administrator shall compute such benchmark amount for each competitive EFFS region before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2010) in which it is designated as such a region.

''(3) 2 COMPONENTS.—For purposes of paragraph (2), the 2 components described in this paragraph for an EFFS region and a year are the following:

''(A) EFFS COMPONENT.—The product of the following:

''(i) WEIGHTED AVERAGE OF PLAN BIDS IN REGION.—The weighted average of the EFFS plan bids for the region and year (as determined under paragraph (4)(A)).

''(ii) NON-FFS MARKET SHARE.—1 minus the fee-for-service market share percentage determined under paragraph (5) for the region and the year.

''(B) FEE-FOR-SERVICE COMPONENT.—The product of the following:

''(i) FEE-FOR-SERVICE REGION-SPECIFIC NON-DRUG AMOUNT.—The fee-for-service region-specific non-drug amount (as defined in paragraph (6)) for the region and year.

''(ii) FEE-FOR-SERVICE MARKET SHARE.—The fee-for-service market share percentage (determined under paragraph (5)) for the region and the year.

''(4) DETERMINATION OF WEIGHTED AVERAGE EFFS PLAN BIDS FOR A REGION.—

''(A) IN GENERAL.—For purposes of paragraph (3)(A)(i), the weighted average of EFFS plan bids for an EFFS region and a year is the sum of the following products for EFFS plans described in subparagraph (C) in the region and year:

''(i) UNADJUSTED EFFS STATUTORY NON-DRUG MONTHLY BID AMOUNT.—The unadjusted EFFS statutory non-drug monthly bid amount (as defined in subsection (a)(3)(A)(ii)(I)) for the region and year.

''(ii) PLAN'S SHARE OF EFFS ENROLLMENT IN REGION.—The number of individuals described in subparagraph (B), divided by the total number of such individuals for all EFFS plans described in subparagraph (C) for that region and year.

''(B) COUNTING OF INDIVIDUALS.—The Administrator shall count, for each EFFS plan described in subparagraph (C) for an EFFS region and year, the number of individuals who reside in the region and who were enrolled under such plan under this part during March of the previous year.

''(C) EXCLUSION OF PLANS NOT OFFERED IN PREVIOUS YEAR.—For an EFFS region and year, the EFFS plans described in this subparagraph are plans that are offered in the region and year and were offered in the region in March of the previous year.

''(5) COMPUTATION OF FEE-FOR-SERVICE MARKET SHARE PERCENTAGE.—The Administrator shall determine, for a year and an EFFS region, the proportion (in this subsection referred to as the 'fee-for-service market share percentage') of the EFFS eligible individuals who are residents of the region during March

of the previous year, of such individuals who were not enrolled in an EFFS plan or in a Medicare Advantage plan (or, if greater, such proportion determined for individuals nationally).

''(6) FEE-FOR-SERVICE REGION-SPECIFIC NON-DRUG AMOUNT.—

''(A) IN GENERAL.—For purposes of paragraph (3)(B)(i) and section 1839(h)(2)(A), subject to subparagraph (C), the term 'fee-for-service region-specific non-drug amount' means, for a competitive EFFS region and a year, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for such region for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under this part who are not enrolled in an EFFS plan under part E or a Medicare Advantage plan under part C for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

''(B) USE OF FULL RISK ADJUSTMENT TO STANDARDIZE FEE-FOR-SERVICE COSTS TO TYPICAL BENEFICIARY.—In determining the adjusted average per capita cost for a region and year under subparagraph (A), such costs shall be adjusted to fully take into account the demographic and health status risk factors established under subsection (c)(3) so that such per capita costs reflect the average costs for a typical beneficiary residing in the region.

''(C) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under subparagraph (A) for a year, such cost shall be adjusted to include the Administrator's estimate, on a per capita basis, of the amount of additional payments that would have been made in the region 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.

''(7) APPLICATION OF COMPETITION.—In the case of an EFFS region that is a competitive EFFS region for a year, for purposes of applying subsections (b) and (c)(1) and section 1860E–4(a), any reference to an EFFS region-specific non-drug monthly benchmark amount shall be treated as a reference to the competitive EFFS non-drug monthly benchmark amount under paragraph (2) for the region and year.

''(8) PHASE-IN OF BENCHMARK FOR EACH REGION.—

''(A) USE OF BLENDED BENCHMARK.—In the case of a region that has not been a competitive EFFS region for each of the previous 4 years, the competitive EFFS non-drug monthly benchmark amount shall be equal to the sum of the following:

''(i) NEW COMPETITIVE COMPONENT.—The product of—

''(I) the weighted average phase-in proportion for that area and year, as specified in subparagraph (B); and

''(II) the competitive EFFS non-drug monthly benchmark amount for the region and year, determined under paragraph (2) without regard to this paragraph.

''(ii) OLD COMPETITIVE COMPONENT.—The product of—

''(I) 1 minus the weighted average phase-in proportion for that region and year; and

''(II) the EFFS region-specific non-drug benchmark amount for the region and the year.

''(B) COMPUTATION OF WEIGHTED AVERAGE PHASE-IN PROPORTION.—For purposes of this paragraph, the 'weighted average phase-in proportion' for an EFFS region for a year shall be determined as follows:

''(i) FIRST YEAR (AND REGION NOT COMPETITIVE REGION IN PREVIOUS YEAR).—If the area was not a competitive EFFS region in the previous year, the weighted average phase-in proportion for the region for the year is equal to ⅕.

''(ii) COMPETITIVE REGION IN PREVIOUS YEAR.—If the region was a competitive EFFS region in the previous year, the weighted average phase-in proportion for the region for the year is equal to the weighted average phase-in proportion determined under this subparagraph for the region for the previous year plus ⅕, but in no case more than 1.''.

(2) CONFORMING AMENDMENTS.—

(A) Such section 1860E–3 is further amended—

(i) in subsection (b), by adding at the end the following new paragraph:

''(4) APPLICATION IN COMPETITIVE REGIONS.—For special rules applying this subsection in competitive EFFS regions, see subsection (e)(7).'';

(ii) in subsection (c)(1), by inserting ''and subsection (e)(7)'' after ''(as made applicable under subsection (d))''; and

(iii) in subsection (d) , by striking ''and (e)'' and inserting ''(e), and (k) ''.

(B) Section 1860E–4(a)(1), as inserted by section 201(a)(2), is amended by inserting '', except as provided in section 1860E–3(e)(7)'' after ''paragraph (2)''.

(b) IDENTIFICATION OF COMPETITIVE MEDICARE ADVANTAGE AREAS; APPLICATION OF COMPETITIVE MEDICARE ADVANTAGE NON-DRUG BENCHMARKS UNDER MEDICARE ADVANTAGE PROGRAM.—

(1) IN GENERAL.—Section 1853, as amended by section 221(b)(3), is amended by adding at the end the following new subsection:

''(k) APPLICATION OF COMPETITION.—

''(1) DETERMINATION OF COMPETITIVE MEDICARE ADVANTAGE AREAS.—

''(A) IN GENERAL.—For purposes of this part, the terms 'competitive Medicare Advantage area' and 'CMA area' mean, for a year beginning with 2010, an area (which is a metropolitan statistical area or other area with a substantial number of Medicare Advantage enrollees) that the Administrator finds—

''(i) there will be offered during the annual, coordinated election period under section 1851(e)(3)(B) under this part before the beginning of the year at least 2 Medicare Advantage plans (in addition to the fee-for-service program under parts A and B), each offered by a different Medicare Advantage organization and each of which met the minimum enrollment requirements of paragraph (1) of section 1857(b) (as applied without regard to paragraph (3) thereof) as of March of the previous year with respect to the area; and

''(ii) during March of the previous year at least the percentage specified in subparagraph (B) of the number of Medicare Advantage eligible individuals who reside in the area were enrolled in a Medicare Advantage plan.

''(B) PERCENTAGE SPECIFIED.—

''(i) IN GENERAL.—For purposes of subparagraph (A), subject to clause (ii), the percentage specified in this subparagraph for a year is equal the lesser of 20 percent or to the sum of—

''(I) the percentage, as estimated by the Administrator, of EFFS eligible individuals in the United States who are enrolled in EFFS plans during March of the previous year; and

''(II) the percentage, as estimated by the Administrator, of Medicare Advantage eligible individuals in the United States who are enrolled in Medicare Advantage plans during March of the previous year.

''(ii) EXCEPTION.—In the case of an area that was a competitive area for the previous year, the Medicare Benefits Administrator may continue to treat the area as meeting the requirement of subparagraph (A)(ii) if the area would meet such requirement but for a de minimis reduction below the percentage specified in clause (i).

''(2) COMPETITIVE MEDICARE ADVANTAGE NON-DRUG MONTHLY BENCHMARK AMOUNT.—For purposes of this part, the term 'competitive Medicare Advantage non-drug monthly benchmark amount' means, with respect to a competitive Medicare Advantage area for a month in a year subject to paragraph (8), the sum of the 2 components described in paragraph (3) for the area and year. The Administrator shall compute such benchmark amount for each competitive Medicare Advantage area before the beginning of each annual, coordinated election period under section 1851(e)(3)(B) for each year (beginning with 2010) in which it is designated as such an area.

''(3) 2 COMPONENTS.—For purposes of paragraph (2), the 2 components described in this paragraph for a competitive Medicare Advantage area and a year are the following:

''(A) MEDICARE ADVANTAGE COMPONENT.—The product of the following:

''(i) WEIGHTED AVERAGE OF MEDICARE ADVANTAGE PLAN BIDS IN AREA.—The weighted average of the plan bids for the area and year (as determined under paragraph (4)(A)).

''(ii) NON-FFS MARKET SHARE.—1 minus the fee-for-service market share percentage, determined under paragraph (5) for the area and year.

''(B) FEE-FOR-SERVICE COMPONENT.—The product of the following:

''(i) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG AMOUNT.—The fee-for-service area-specific non-drug amount (as defined in paragraph (6)) for the area and year.

''(ii) FEE-FOR-SERVICE MARKET SHARE.—The fee-for-service market share percentage, determined under paragraph (5) for the area and year.

''(4) DETERMINATION OF WEIGHTED AVERAGE MEDICARE ADVANTAGE BIDS FOR AN AREA.—

''(A) IN GENERAL.—For purposes of paragraph (3)(A)(i), the weighted average of plan bids for an area and a year is the sum of the following products for Medicare Advantage plans described in subparagraph (C) in the area and year:

''(i) MONTHLY MEDICARE ADVANTAGE STATUTORY NON-DRUG BID AMOUNT.—The unadjusted Medicare Advantage statutory non-drug monthly bid amount.

''(ii) PLAN'S SHARE OF MEDICARE ADVANTAGE ENROLLMENT IN AREA.—The number of individuals described in subparagraph (B), divided by the total number of such individuals for all Medicare Advantage plans described in subparagraph (C) for that area and year.

''(B) COUNTING OF INDIVIDUALS.—The Administrator shall count, for each Medicare Advantage plan described in subparagraph (C) for an area and year, the number of individuals who reside in the area and who were enrolled under such plan under this part during March of the previous year.

''(C) EXCLUSION OF PLANS NOT OFFERED IN PREVIOUS YEAR.—For an area and year, the Medicare Advantage plans described in this subparagraph are plans described in the first sentence of section 1851(a)(2)(A) that are offered in the area and year and were offered in the area in March of the previous year.

''(5) COMPUTATION OF FEE-FOR-SERVICE MARKET SHARE PERCENTAGE.—The Administrator shall determine, for a year and a competitive Medicare Advantage area, the proportion (in this subsection referred to as the 'fee-for-service market share percentage') of Medicare Advantage eligible individuals residing in the area who during March of the previous year were not enrolled in a Medicare Advantage plan or in an EFFS plan (or, if greater, such proportion determined for individuals nationally).

''(6) FEE-FOR-SERVICE AREA-SPECIFIC NON-DRUG AMOUNT.—

''(A) IN GENERAL.—For purposes of paragraph (3)(B)(i) and section 1839(h)(1)(A), subject to subparagraph (C), the term 'fee-for-service area-specific non-drug amount' means, for a competitive Medicare Advantage area and a year, the adjusted average per capita cost for the year involved, determined under section 1876(a)(4) for such area for services covered under parts A and B for individuals entitled to benefits under part A and enrolled under this part who are not enrolled in a Medicare Advantage plan under part C or an EFFS plan under part E for the year, but adjusted to exclude costs attributable to payments under section 1886(h).

''(B) USE OF FULL RISK ADJUSTMENT TO STANDARDIZE FEE-FOR-SERVICE COSTS TO TYPICAL BENEFICIARY.—In determining the adjusted average per capita cost for an area and year under subparagraph (A), such costs shall be adjusted to fully take into account the demographic and health status risk factors established under subsection (a)(1)(A)(iv) so that such per capita costs reflect the average costs for a typical beneficiary residing in the area.

''(C) INCLUSION OF COSTS OF VA AND DOD MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the adjusted average per capita cost under subparagraph (A) for a year, such cost shall be adjusted to include the Administrator'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.

''(7) APPLICATION OF COMPETITION.—In the case of an area that is a competitive Medicare Advantage area for a year, for purposes of applying subsection (a)(1)(A)(ii) and sections 1854(b)(2)(A)(ii) and 1854(b)(3)(B)(i), any reference to a Medicare Advantage area-specific non-drug monthly benchmark amount shall be treated as a reference to the competitive Medicare Advantage non-drug monthly benchmark amount under paragraph (2) for the area and year.

''(8) PHASE-IN OF BENCHMARK FOR EACH AREA.—

''(A) USE OF BLENDED BENCHMARK.—In the case of an area that has not been a competitive Medicare Advantage area for each of the previous 4 years, the competitive Medicare Advantage non-drug monthly benchmark amount shall be equal to the sum of the following:

''(i) NEW COMPETITIVE COMPONENT.—The product of—

''(I) the weighted average phase-in proportion for that area and year, as specified in subparagraph (B); and

''(II) the competitive Medicare Advantage non-drug monthly benchmark amount for the area and year, determined under paragraph (2) without regard to this paragraph.

''(ii) OLD COMPETITIVE COMPONENT.—The product of—

''(I) 1 minus the weighted average phase-in proportion for that area and year; and

''(II) the Medicare Advantage area-wide non-drug benchmark amount for the area and the year.

''(B) COMPUTATION OF WEIGHTED AVERAGE PHASE-IN PROPORTION.—For purposes of this paragraph, the 'weighted average phase-in proportion' for a Medicare Advantage payment area for a year shall be determined as follows:

''(i) FIRST YEAR (AND AREA NOT COMPETITIVE AREA IN PREVIOUS YEAR).—If the area was not a Medicare Advantage competitive area in the previous year, the weighted average phase-in proportion for the area for the year is equal to ⅕.

''(ii) COMPETITIVE AREA IN PREVIOUS YEAR.—If the area was a competitive Medicare Advantage area in the previous year, the weighted average phase-in proportion for the area for the year is equal to the weighted average phase-in proportion determined under this subparagraph for the area for the previous year plus ⅕, but in no case more than 1.

''(C) MEDICARE ADVANTAGE AREA-WIDE NON-DRUG BENCHMARK AMOUNT.—For purposes of subparagraph (A)(ii)(II), the term 'Medicare Advantage area-wide non-drug benchmark amount' means, for an area and year, the weighted average of the amounts described in section 1853(j) for Medicare Advantage payment area or areas included in the area (based on the number of traditional fee-for-service enrollees in such payment area or areas) and year.''.

(2) APPLICATION.—Section 1854 (42 U.S.C. 1395w–24) is amended—

(A) in subsection (b)(1)(C)(i), as added by section 221(b)(1)(A), by striking ''(i) REQUIREMENT.—The'' and inserting ''(i) REQUIREMENT FOR NON-COMPETITIVE AREAS.—In the case of a Medicare Advantage payment area that is not a competitive Medicare Advantage area designated under section 1853(k)(1), the'';

(B) in subsection (b)(1)(C), as so added, by inserting after clause (i) the following new clause:

''(ii) REQUIREMENT FOR COMPETITIVE MEDICARE ADVANTAGE AREAS.—In the case of a Medicare Advantage payment area that is designated as a competitive Medicare Advantage area under section 1853(k)(1), if there are average per capita monthly savings described in paragraph (6) for a Medicare Advantage plan and year, the Medicare Advantage plan shall provide to the enrollee a monthly rebate equal to 75 percent of such savings.''; and

(C) by adding at the end of subsection (b), as amended by sections 221(b)(1)(B) and 221(b)(2), the following new paragraph:

''(6) COMPUTATION OF AVERAGE PER CAPITA MONTHLY SAVINGS FOR COMPETITIVE MEDICARE ADVANTAGE AREAS.—For purposes of paragraph (1)(C)(ii), the average per capita monthly savings referred to in such paragraph for a Medicare Advantage plan and year shall be computed in the same manner as the average per capita monthly savings is computed under paragraph (3) except that the reference to the Medicare Advantage area-specific non-drug monthly benchmark amount in paragraph (3)(B)(i) (or to the benchmark amount as adjusted under paragraph (3)(C)(i)) is deemed to be a reference to the competitive Medicare Advantage non-drug monthly benchmark amount (or such amount as adjusted in the manner described in paragraph (3)(B)(i)).''.

(3) ADDITIONAL CONFORMING AMENDMENTS.—

(A) PAYMENT OF PLANS.—Section 1853(a)(1)(A)(ii), as amended by section 221(c)(1), is amended—

(i) in subclauses (I) and (II), by inserting ''(or, insofar as such payment area is a competitive Medicare Advantage area, described in section 1854(b)(6))'' after ''section 1854(b)(3)(C)''; and

(ii) in subclause (II), by inserting ''(or, insofar as such payment area is a competitive Medicare Advantage area, the competitive Medicare Advantage non-drug monthly benchmark amount)'' after ''Medicare Advantage area-specific non-drug monthly benchmark amount''; and

(B) DISCLOSURE OF INFORMATION.—Section 1853(b)(1)(B), as amended by section 221(e)(1), is amended to read as follows:

''(B) COMPETITION INFORMATION.—For years beginning with 2006, the following:

''(i) BENCHMARKS.—The Medicare Advantage area-specific non-drug benchmark under section 1853(j) and, if applicable, the competitive Medicare Advantage non-drug benchmark under section 1853(k)(2), for the year and competitive Medicare Advantage area involved and the national fee-for-service market share percentage for the area and year.

''(ii) ADJUSTMENT FACTORS.—The adjustment factors applied under section 1853(a)(1)(A)(iv) (relating to demographic adjustment), section 1853(a)(1)(B) (relating to adjustment for end-stage renal disease), and section 1853(a)(3) (relating to health status adjustment).

''(iii) CERTAIN BENCHMARKS AND AMOUNTS.—In the case of a competitive Medicare Advantage area, the Medicare Advantage area-wide non-drug benchmark amount (as defined in subsection (k)(8)(C)) and the fee-for-service area-specific non-drug amount (as defined in section 1853(k)(6)) for the area.

''(iv) INDIVIDUALS.—The number of individuals counted under subsection (k)(4)(B) and enrolled in each Medicare Advantage plan in the area.''.

(C) DEFINITION OF MONTHLY BASIC PREMIUM.—Section 1854(b)(2)(A)(ii), as amended by section 221(d)(2), is amended by inserting ''(or, in the case of a competitive Medicare Advantage area, the competitive Medicare Advantage non-drug monthly benchmark amount or, in applying this paragraph under part E in the case of a competitive EFFS region, the competitive EFFS non-drug monthly benchmark amount)'' after ''benchmark amount''.

(c) PREMIUM ADJUSTMENT.—

(1) IN GENERAL.—Section 1839 (42 U.S.C. 1395r) is amended by adding at the end the following new subsection:

''(h)(1)(A) In the case of an individual who resides in a competitive Medicare Advantage area under section 1853(k)(1) (regardless of whether such area is in a competitive EFFS region under section 1860E–3(e)) and who is not enrolled in a Medicare Advantage plan under part C or in an EFFS plan under part E, the monthly premium otherwise applied under this part (determined without regard to subsections (b) and (f) or any adjustment under this subsection) shall be adjusted as follows: If the fee-for-service area-specific non-drug amount (as defined in section 1853(k)(6)) for the competitive Medicare Advantage area in which the individual resides for a month—

''(i) does not exceed the competitive Medicare Advantage non-drug benchmark (as determined under paragraph (2) of section 1853(k), without regard to paragraph (8) thereof) for such area, the amount of the premium for the individual for the month shall be reduced by an amount equal to the product of the adjustment factor under subparagraph (C) and 75 percent of the amount by which such competitive benchmark exceeds such fee-for-service area-specific non-drug amount; or

''(ii) exceeds such competitive Medicare Advantage non-drug benchmark, the amount of the premium for the individual for the month shall be adjusted to ensure, subject to subparagraph (B), that—

''(I) the sum of the amount of the adjusted premium and the competitive Medicare Advantage non-drug benchmark for the area, is equal to

''(II) the sum of the unadjusted premium plus amount of the fee-for-service area-specific non-drug amount for the area.

''(B) In no case shall the actual amount of an adjustment under subparagraph (A)(ii) exceed the product of the adjustment factor under subparagraph (C) and the amount of the adjustment otherwise computed under

subparagraph (A)(ii) without regard to this subparagraph.

''(C) The adjustment factor under this subparagraph for an area for a year is equal to—

''(i) the number of consecutive years (in the 5-year period ending with the year involved) in which such area was a competitive Medicare Advantage area; divided by

''(ii) 5.

''(2)(A) In the case of an individual who resides in an area that is within a competitive EFFS region under section 1860E–3(e) but is not within a competitive Medicare Advantage area under section 1853(k)(1) and who is not enrolled in a Medicare Advantage plan under part C or in an EFFS plan under part E, the monthly premium otherwise applied under this part (determined without regard to subsections (b) and (f) or any adjustment under this subsection) shall be adjusted as follows: If the fee-for-service region-specific non-drug amount (as defined in section 1860E–3(e)(6)) for a region for a month—

''(i) does not exceed the competitive EFFS non-drug monthly benchmark amount (as determined under paragraph (2) of section 1860E–3(e), without regard to paragraph (8) thereof) for such region, the amount of the premium for the individual for the month shall be reduced by an amount equal to the product of the adjustment factor under subparagraph (C) and 75 percent of the amount by which such competitive benchmark amount exceeds such fee-for-service region-specific non-drug benchmark amount; or

''(ii) exceeds such competitive EFFS non-drug monthly benchmark amount, the amount of the premium for the individual for the month shall be adjusted to ensure, subject to subparagraph (B), that—

''(I) the sum of the amount of the adjusted premium and the competitive EFFS non-drug monthly benchmark amount for the region, is equal to

''(II) the sum of the unadjusted premium plus the amount of the EFFS region-specific non-drug monthly bidfor the region.

''(B) In no case shall the actual amount of an adjustment under subparagraph (A)(ii) exceed the product of the adjustment factor under subparagraph (C) and the amount of the adjustment otherwise computed under subparagraph (A)(ii) without regard to this subparagraph.

''(C) The adjustment factor under this subparagraph for an EFFS region for a year is equal to—

''(i) the number of consecutive years (in the 5-year period ending with the year involved) in which such region was a competitive EFFS region; divided by

''(ii) 5.

''(3) Nothing in this subsection shall be construed as preventing a reduction under paragraph (1)(A) or paragraph (2)(A) in the premium otherwise applicable under this part to zero or from requiring the provision of a rebate to the extent such premium would otherwise be required to be less than zero.

''(4) The adjustment in the premium under this subsection shall be effected in such manner as the Medicare Benefits Administrator determines appropriate.

''(5) In order to carry out this subsection (insofar as it is effected through the manner of collection of premiums under 1840(a)), the Medicare Benefits Administrator shall transmit to the Commissioner of Social Security—

''(A) at the beginning of each year, the name, social security account number, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year; and

''(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.''.

(2) NO CHANGE IN MEDICARE'S DEFINED BENEFIT PACKAGE.—Nothing in this part (or the amendments made by this part) shall be construed as changing the entitlement to defined benefits under parts A and B of title XVIII of the Social Security Act.

(3) CONFORMING AMENDMENT.—Section 1844(c) (42 U.S.C. 1395w(c)) is amended by inserting ''and without regard to any premium adjustment effected under section 1839(h)'' before the period at the end.

(d) EFFECTIVE DATE.—The amendments made by this section shall take effect on January 1, 2010.

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 2005; and

''(II) at least ⅔ of such areas in 2006; 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, 2004, 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).

''(iii) CONSTRUCTION.—Nothing in this subparagraph shall be construed as delaying the effective date of the implementation of the competitive acquisition program under this section.

''(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, 2005; 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.

(d) GAO STUDY ON SAFE AND EFFECTIVE HOME INFUSION AND INHALATION THERAPY; STANDARDS.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study of the standards, professional services, and related functions necessary for the provision of safe and effective home infusion therapy and home inhalation therapy.

(2) REPORT.—Not later than May 1, 2004, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

(3) USE OF FINDINGS IN DEVELOPING STANDARDS.—In promulgating regulations to carry out section 1847 of the Social Security Act, as amended by subsection (a), the Secretary shall ensure that quality standards developed under subsection (b)(2)(B) of such section reflect the findings of the Comptroller General set forth in the report under paragraph (2).

SEC. 303. COMPETITIVE ACQUISITION OF COVERED OUTPATIENT DRUGS AND BIOLOGICALS.

(a) ADJUSTMENT TO PHYSICIAN FEE SCHEDULE.—

(1) ADJUSTMENT IN 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 of subparagraph (B), the following new clause:

''(iv) EXCEPTION TO BUDGET NEUTRALITY.—The additional expenditures attributable to clauses (ii) and (iii) of subparagraph (H) shall not be taken into account in applying clause (ii)(II) for 2005.''; and

(B) by adding at the end the following new subparagraph:

''(H) ADJUSTMENTS IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR 2005.—

''(i) IN GENERAL.—As part of the annual process of establishing the physician fee schedule under subsection (b) for 2005, the Secretary shall increase the practice expense relative value units for 2005 consistent with clauses (ii) and (iii).

''(ii) USE OF SUPPLEMENTAL SURVEY DATA.—For 2005 for any specialty that submitted survey data that included expenses for the administration of drugs and biologicals for which payment is made under section 1842(o) (or section 1847A), the Secretary shall use such supplemental survey data in carrying out this subparagraph insofar as they are collected and provided by entities and organizations consistent with the criteria established by the Secretary pursuant to section 212(a) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 and insofar as such data are submitted to the Secretary by December 31, 2004.

''(iii) PROVISIONS FOR APPROPRIATE REPORTING AND BILLING FOR PHYSICIANS' SERVICES ASSOCIATED WITH THE ADMINISTRATION OF COVERED OUTPATIENT DRUGS AND BIOLOGICALS.—

''(I) EVALUATION OF CODES.—The Secretary shall promptly evaluate existing codes for physicians' services associated with the administration of covered outpatient drugs and biologicals (as defined in section 1847A(a)(2)(A)) to ensure accurate reporting and billing for such services.

''(II) USE OF EXISTING PROCESSES.—In carrying out subclause (I), the Secretary shall use existing processes for the consideration of coding changes and, to the extent coding changes are made, shall use such processes in establishing relative values for such services.

''(III) IMPLEMENTATION.—In carrying out subclause (I), the Secretary shall consult with representatives of physician specialties affected by the implementation of section 1847A or section 1847B, and shall take such steps within the Secretary's authority to expedite such considerations under subclause (II).

''(iv) SUBSEQUENT, BUDGET NEUTRAL ADJUSTMENTS PERMITTED.—Nothing in this subparagraph shall be construed as preventing the Secretary from providing for adjustments in practice expense relative value units under (and consistent with) subparagraph (B) for years after 2005.

''(v) CONSULTATION.—Before publishing the notice of proposed rulemaking to carry out this subparagraph, the Secretary shall consult with the Comptroller General of the United States and with groups representing the physician specialties involved.

''(vi) TREATMENT AS CHANGE IN LAW AND REGULATION IN SUSTAINABLE GROWTH RATE DETERMINATION.—The enactment of subparagraph (B)(iv) and this subparagraph shall be treated as a change in law for purposes of applying subsection (f)(2)(D).''.

(2) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL REVIEW.—Section 1848(i)(1) (42 U.S.C. 1395w–4(i)(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 new subparagraph:

''(F) adjustments in practice expense relative value units for 2005 under subsection (c)(2)(H).''.

(3) TREATMENT OF OTHER SERVICES CURRENTLY IN THE NON-PHYSICIAN WORK POOL.—The Secretary shall make adjustments to the non-physician work pool methodology (as such term is used in the regulations promulgated by the Secretary in the Federal Register as of December 31, 2002) for determination of practice expense relative value units under the physician fee schedule described in section 1848(c)(2)(C)(ii) of the Social Security Act so that the practice expense relative value units for services determined under such methodology are not affected relative to the practice expense relative value units of other services not determined under such non-physician work pool methodology, as the result of amendments made by paragraph (1).

(b) PAYMENT BASED ON COMPETITION.—Title XVIII is amended by inserting after section 1847 (42 U.S.C. 1395w–3), as amended by section 302, the following new sections:

''COMPETITIVE ACQUISITION OF COVERED OUTPATIENT DRUGS AND BIOLOGICALS

''SEC. 1847A. (a) IMPLEMENTATION OF COMPETITIVE ACQUISITION.—

''(1) IMPLEMENTATION OF PROGRAM.—

''(A) IN GENERAL.—The Secretary shall establish and implement a competitive acquisition program under which—

''(i) competitive acquisition areas are established throughout the United States for contract award purposes for acquisition of and payment for categories of covered outpatient drugs and biologicals (as defined in paragraph (2)) under this part;

''(ii) each physician is given the opportunity annually to elect to obtain drugs and biologicals under the program or under section 1847B; and

''(iii) each physician who elects to obtain drugs and biologicals under the program makes an annual selection under paragraph (5) of the contractor through which drugs and biologicals within a category of drugs and biologicals will be acquired and delivered to the physician under this part.

''(B) IMPLEMENTATION.—The Secretary shall implement the program so that the program applies to—

''(i) the oncology category beginning in 2005; and

''(ii) the non-oncology category beginning in 2006.

This section shall not apply in the case of a physician who elects section 1847B to apply.

''(C) WAIVER OF CERTAIN PROVISIONS.—In order to promote competition, efficient service, and product quality, in carrying out the program 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.

''(D) EXCLUSION AUTHORITY.—The Secretary may exclude covered outpatient drugs and biologicals (including a class of such drugs and biologicals) from the competitive bidding system under this section if the drugs or biologicals (or class) are not appropriate for competitive bidding due to low volume of utilization by beneficiaries under this part or a unique mode or method of delivery or similar reasons.

''(2) COVERED OUTPATIENT DRUGS AND BIOLOGICALS, CATEGORIES, PROGRAM DEFINED.—For purposes of this section—

''(A) COVERED OUTPATIENT DRUGS AND BIOLOGICALS DEFINED.—The term 'covered outpatient drugs and biologicals' means drugs and biologicals to which section 1842(o) applies and which are not covered under section 1847 (relating to competitive acquisition for items of durable medical equipment). Such term does not include the following:

''(i) Blood clotting factors.

''(ii) Drugs and biologicals furnished to individuals in connection with the treatment of end stage renal disease.

''(iii) Radiopharmaceuticals.

''(iv) Vaccines.

''(B) 2 CATEGORIES.—Each of the following shall be a separate category of covered outpatient drugs and biologicals, as identified by the Secretary:

''(i) ONCOLOGY CATEGORY.—A category (in this section referred to as the 'oncology category') consisting of those covered outpatient drugs and biologicals that, as determined by the Secretary, are typically primarily billed by oncologists or are otherwise used to treat cancer.

''(ii) NON-ONCOLOGY CATEGORIES.—Such numbers of categories (in this section referred to as the 'non-oncology categories') consisting of covered outpatient drugs and biologicals not described in clause (i), and appropriate subcategories of such drugs and biologicals as the Secretary may specify.

''(C) PROGRAM.—The term 'program' means the competitive acquisition program under this section.

''(D) COMPETITIVE ACQUISITION AREA; AREA.—The terms 'competitive acquisition area' and 'area' mean an appropriate geographic region established by the Secretary under the program.

''(E) CONTRACTOR.—The term 'contractor' means an entity that has entered into a contract with the Secretary under this section.

''(3) APPLICATION OF PROGRAM PAYMENT METHODOLOGY.—With respect to covered outpatient drugs and biologicals which are supplied under the program in an area and which are prescribed by a physician who has not elected section 1847B to apply—

''(A) the claim for such drugs and biologicals shall be submitted by the contractor that supplied the drugs and biologicals;

''(B) collection of amounts of any deductible and coinsurance applicable with respect to such drugs and biologicals shall be the responsibility of such contractor and shall not be collected unless the drug or biological is administered to the beneficiary involved; and

''(C) the payment under this section (and related coinsurance amounts) for such drugs and biologicals—

''(i) shall be made only to such contractor;

''(ii) shall be conditioned upon the administration of such drugs and biologicals; and

''(iii) shall be based on the average of the bid prices for such drugs and biologicals in the area, as computed under subsection (d).

The Secretary shall provide a process for recoupment in the case in which payment is made for drugs and biologicals which were billed at the time of dispensing but which were not actually administered.

''(4) CONTRACT REQUIRED.—

''(A) IN GENERAL.—Payment may not be made under this part for covered outpatient drugs and biologicals prescribed by a physician who has not elected section 1847B to apply within a category and a competitive acquisition area with respect to which the program applies unless—

''(i) the drugs or biologicals are supplied by a contractor with a contract under this section for such category of drugs and biologicals and area; and

''(ii) the physician has elected such contractor under paragraph (5) for such category and area.

''(B) PHYSICIAN CHOICE.—Subparagraph (A) shall not apply for a category of drugs for an area if the physician prescribing the covered outpatient drug in such category and area has elected to apply section 1847B instead of this section.

''(5) CONTRACTOR SELECTION PROCESS.—

''(A) IN GENERAL.—The Secretary shall provide a process for the selection of a contractor, on an annual basis and in such exigent circumstances as the Secretary may provide and with respect to each category of covered outpatient drugs and biologicals for an area, by physicians prescribing such drugs and biologicals in the area of the contractor under this section that will supply the drugs and biologicals within that category and area. Such selection shall also include the election described in section 1847B(a).

''(B) INFORMATION ON CONTRACTORS.—The Secretary shall make available to physicians on an ongoing basis, through a directory posted on the Department's Internet website or otherwise and upon request, a list of the contractors under this section in the different competitive acquisition areas.

''(C) SELECTING PHYSICIAN DEFINED.—For purposes of this section, the term 'selecting physician' means, with respect to a contractor and category and competitive acquisition area, a physician who has not elected section 1847B to apply and has selected to apply under this section such contractor for such category and area.

''(b) PROGRAM REQUIREMENTS.—

''(1) CONTRACT FOR COVERED OUTPATIENT DRUGS AND BIOLOGICALS.—The Secretary shall conduct a competition among entities for the acquisition of a covered outpatient drug or biological within each HCPCS code within each category for each competitive acquisition area.

''(2) CONDITIONS FOR AWARDING CONTRACT.—

''(A) IN GENERAL.—The Secretary may not award a contract to any entity under the competition conducted in a competitive acquisition area pursuant to paragraph (1) with respect to the acquisition of covered outpatient drugs and biologicals within a category unless the Secretary finds that the entity meets all of the following with respect to the contract period involved:

''(i) CAPACITY TO SUPPLY COVERED OUTPATIENT DRUG OR BIOLOGICAL WITHIN CATEGORY.—

''(I) IN GENERAL.—The entity has sufficient arrangements to acquire and to deliver covered outpatient drugs and biologicals within such category in the area specified in the contract at the bid price specified in the contract for all physicians that may elect such entity.

''(II) SHIPMENT METHODOLOGY.—The entity has arrangements in effect for the shipment at least 5 days each week of covered outpatient drugs and biologicals under the contract and for the timely delivery (including for emergency situations) of such drugs and biologicals in the area under the contract.

''(ii) QUALITY, SERVICE, FINANCIAL PERFORMANCE AND SOLVENCY STANDARDS.—The entity meets quality, service, financial performance, and solvency standards specified by the Secretary, including—

''(I) the establishment of procedures for the prompt response and resolution of physician and beneficiary complaints and inquiries regarding the shipment of covered outpatient drugs and biologicals; and

''(II) a grievance process for the resolution of disputes.

''(B) ADDITIONAL CONSIDERATIONS.—The Secretary may refuse to award a contract under this section, and may terminate such a contract, with an entity based upon—

''(i) the suspension or revocation, by the Federal Government or a State government, of the entity's license for the distribution of drugs or biologicals (including controlled substances); or

''(ii) the exclusion of the entity under section 1128 from participation under this title.

''(C) APPLICATION OF MEDICARE PROVIDER OMBUDSMAN.—For provision providing for a program-wide Medicare Provider Ombudsman to review complaints, see section 1868(b), as added by section 923 of the Medicare Prescription Drug and Modernization Act of 2003.

''(3) AWARDING MULTIPLE CONTRACTS FOR A CATEGORY AND AREA.—In order to provide a choice of at least 2 contractors in each competitive acquisition area for a category of drugs and biologicals, the Secretary may limit (but not below 2) the number of qualified entities that are awarded such contracts for any category and area. The Secretary shall select among qualified entities based on the following:

''(A) The bid prices for covered outpatient drugs and biologicals within the category and area.

''(B) Bid price for distribution of such drugs and biologicals.

''(C) Ability to ensure product integrity.

''(D) Customer service.

''(E) Past experience in the distribution of drugs and biologicals, including controlled substances.

''(F) Such other factors as the Secretary may specify.

''(4) TERMS OF CONTRACTS.—

''(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 consistent with this section.

''(B) PERIOD OF CONTRACTS.—A contract under this section shall be for a term of 2 years, but may be terminated by the Secretary or the entity with appropriate, advance notice.

''(C) INTEGRITY OF DRUG AND BIOLOGICAL DISTRIBUTION SYSTEM.—The Secretary—

''(i) shall require that for all drug and biological products distributed by a contractor under this section be acquired directly from the manufacturer or from a distributor that has acquired the products directly from the manufacturer; and

''(ii) may require, in the case of such products that are particularly susceptible to counterfeit or diversion, that the contractor comply with such additional product integrity safeguards as may be determined to be necessary.

''(D) IMPLEMENTATION OF ANTI-COUNTERFEITING, QUALITY, SAFETY, AND RECORD KEEPING REQUIREMENTS.—The Secretary shall require each contractor to implement (through its officers, agents, representatives, and employees) requirements relating to the storage and handling of covered outpatient drugs and biologicals and for the establishment and maintenance of distribution records for such drugs and biologicals. A contract under this section may include requirements relating to the following:

''(i) Secure facilities.

''(ii) Safe and appropriate storage of drugs and biologicals.

''(iii) Examination of drugs and biologicals received and dispensed.

''(iv) Disposition of damaged and outdated drugs and biologicals.

''(v) Record keeping and written policies and procedures.

''(vi) Compliance personnel.

''(E) COMPLIANCE WITH CODE OF CONDUCT AND FRAUD AND ABUSE RULES.—Under the contract—

''(i) the contractor shall comply with a code of conduct, specified or recognized by the Secretary, that includes standards relating to conflicts of interest; and

''(ii) the contractor shall comply with all applicable provisions relating to prevention of fraud and abuse, including compliance with applicable guidelines of the Department of Justice and the Inspector General of the Department of Health and Human Services.

''(F) DIRECT DELIVERY OF DRUGS AND BIOLOGICALS TO PHYSICIANS.—Under the contract the contractor shall only supply covered outpatient drugs and biologicals directly to the selecting physicians and not directly to beneficiaries, except under circumstances and settings where a beneficiary currently receives a drug or biological in the beneficiary's home or other non-physician office setting as the Secretary may provide. The contractor shall not deliver drugs and biologicals to a selecting physician except upon receipt of a prescription for such drugs and biologicals, and such necessary data as may be required by the Secretary to carry out this section. This section does not—

''(i) require a physician to submit a prescription for each individual treatment; or

''(ii) change a physician's flexibility in terms of writing a prescription for drugs for a single treatment or a course of treatment.

''(5) PERMITTING ACCESS TO DRUGS AND BIOLOGICALS.—The Secretary shall establish rules under this section under which drugs and biologicals which are acquired through a contractor under this section may be used to resupply inventories of such drugs and biologicals which are administered consistent with safe drug practices and with adequate safeguards against fraud and abuse. The previous sentence shall apply if the physicians can demonstrate to the Secretary all of the following:

''(A) The drugs or biologicals are required immediately.

''(B) The physician could not have reasonably anticipated the immediate requirement for the drugs or biologicals.

''(C) The contractor could not deliver to the physician the drugs or biologicals in a timely manner.

''(D) The drugs or biologicals were administered in an emergency situation.

''(6) CONSTRUCTION.—Nothing in this section shall be construed as waiving applicable State requirements relating to licensing of pharmacies.

''(c) BIDDING PROCESS.—

''(1) IN GENERAL.—In awarding a contract for a category of drugs and biologicals in an area under the program, the Secretary shall consider with respect to each entity seeking to be awarded a contract the prices bid to acquire and supply the covered outpatient drugs and biologicals for that category and area and the other factors referred to in subsection (b)(3).

''(2) PRICES BID.—The prices bid by an entity under paragraph (1) shall be the prices in effect and available for the supply of contracted drugs and biologicals in the area through the entity for the contract period.

''(3) REJECTION OF CONTRACT OFFER.—The Secretary shall reject the contract offer of an entity with respect to a category of drugs and biologicals for an area if the Secretary estimates that the prices bid, in the aggregate on average, would exceed 100 percent of the average sales price (as determined under section 1847B).

''(4) BIDDING ON A NATIONAL OR REGIONAL BASIS.—Nothing in this section shall be construed as precluding a bidder from bidding for contracts in all areas of the United States or as requiring a bidder to submit a bid for all areas of the United States.

''(5) UNIFORMITY OF BIDS WITHIN AREA.—The amount of the bid submitted under a contract offer for any covered outpatient drug or biological for an area shall be the same for that drug or biological for all portions of that area.

''(6) CONFIDENTIALITY OF BIDS.—The provisions of subparagraph (D) of section 1927(b)(3) shall apply to a bid submitted in a contract offer for a covered outpatient drug or biological under this section in the same manner as it applies to information disclosed under such section, except that any reference—

''(A) in that subparagraph to a 'manufacturer or wholesaler' is deemed a reference to a 'bidder' under this section;

''(B) in that section to 'prices charged for drugs' is deemed a reference to a 'bid' submitted under this section; and

''(C) in clause (i) of that section to 'this section', is deemed a reference to 'part B of title XVIII'.

''(7) INCLUSION OF COSTS.—The bid price submitted in a contract offer for a covered outpatient drug or biological shall—

''(A) include all costs related to the delivery of the drug or biological to the selecting physician (or other point of delivery); and

''(B) include the costs of dispensing (including shipping) of such drug or biological and management fees, but shall not include any costs related to the administration of the drug or biological, or wastage, spillage, or spoilage.

''(8) PRICE ADJUSTMENTS DURING CONTRACT PERIOD; DISCLOSURE OF COSTS.—Each contract awarded shall provide for—

''(A) disclosure to the Secretary the contractor's reasonable, net acquisition costs for periods specified by the Secretary, not more often than quarterly, of the contract; and

''(B) appropriate price adjustments over the period of the contract to reflect significant increases or decreases in a contractor's reasonable, net acquisition costs, as so disclosed.

''(d) COMPUTATION OF AVERAGE BID PRICES FOR A CATEGORY AND AREA.—

''(1) IN GENERAL.—For each year or other contract period for each covered outpatient drug or biological and area with respect to which a competition is conducted under the program, the Secretary shall compute an area average of the bid prices submitted, in contract offers accepted for the category and area, for that year or other contract period.

''(2) SPECIAL RULES.—The Secretary shall establish rules regarding the use under this section of the alternative payment amount provided under section 1847B to the use of a price for specific covered outpatient drugs and biologicals in the following cases:

''(A) NEW DRUGS AND BIOLOGICALS.—A covered outpatient drug or biological for which an average bid price has not been previously determined.

''(B) OTHER CASES.—Such other exceptional cases as the Secretary may specify in regulations, such as oral drugs under section 1861(s)(2)(Q) and immmunosuppressives under section 1861(s)(2)(J).

''(e) COINSURANCE.—

''(1) IN GENERAL.—Coinsurance under this part with respect to a covered outpatient drug or biological for which payment is payable under this section shall be based on 20 percent of the payment basis under this section.

''(2) COLLECTION.—Such coinsurance shall be collected by the contractor that supplies the drug or biological involved and, subject to subsection (a)(3)(B), in the same manner as coinsurance is collected for durable medical equipment under this part.

''(f) SPECIAL PAYMENT RULES.—

''(1) IN GENERAL.—The Secretary may not provide for an adjustment to reimbursement for covered outpatient drugs and biologicals unless adjustments to the practice expense payment adjustment are made on the basis of supplemental surveys under section 1848(c)(2)(H)(ii) of the Social Security Act, as added by subsection (a)(1)(B).

''(2) USE IN EXCLUSION CASES.—If the Secretary excludes a drug or biological (or class of drugs or biologicals) under subsection (a)(1)(D), the Secretary may provide for reimbursement to be made under this part for such drugs and biologicals (or class) using the payment methodology under section 1847B.

''(3) COORDINATION RULES.—The provisions of section 1842(h)(3) shall apply to a contractor with respect to covered outpatients drugs and biologicals supplied by that contractor in the same manner as they apply to a participating supplier. In order to administer this section, the Secretary may condition payment under this part to a person for the administration of a drug or biological supplied under this section upon person's provision of information on such administration.

''(4) APPLICATION OF REQUIREMENT FOR ASSIGNMENT.—For provision requiring assignment of claims for covered outpatient drugs and biologicals, see section 1842(o)(3).

''(5) PROTECTION FOR BENEFICIARY IN CASE OF MEDICAL NECESSITY DENIAL.—For protection of beneficiaries against liability in the case of medical necessity determinations, see section 1842(b)(3)(B)(ii)(III).

''(6) PHYSICIAN ROLE IN APPEALS PROCESS.—The Secretary shall establish a procedure under which a physician who prescribes a drug or biological for which payment is made under this section has appeal rights that are similar to those provided to a physician who prescribes durable medical equipment or a laboratory test.

''(g) ADVISORY COMMITTEE.—The Secretary shall establish an advisory committee that includes representatives of parties affected by the program under this section, including physicians, specialty pharmacies, distributors, manufacturers, and beneficiaries. The committee shall advise the Secretary on issues relating to the effective implementation of this section.

''(h) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual report in each of 2005, 2006, and 2007, on the program. Each such report shall include information on savings, reductions in cost-sharing, access to covered outpatient drugs and biologicals, the range of choices of contractors available to providers, and beneficiary and provider satisfaction.

''OPTIONAL USE OF AVERAGE SALES PRICE PAYMENT METHODOLOGY

''SEC. 1847B. (a) IN GENERAL.—

''(1) ELECTION.—In connection with the annual election made by a physician under section 1847A(a)(5), the physician may elect to apply this section to the payment for covered outpatient drugs and biologicals instead of the payment methodology under section 1847A.

''(2) IMPLEMENTATION.—This section shall be implemented with respect to categories of covered outpatient drugs and biologicals described in section 1847A(a)(2)(B).

''(3) COVERED OUTPATIENT DRUGS AND BIOLOGICALS DEFINED.—For purposes of this section, the term 'covered outpatient drugs and biologicals' has the meaning given such term in section 1847A(a)(2)(A).

''(b) COMPUTATION OF PAYMENT AMOUNT.—

''(1) IN GENERAL.—If this section applies with respect to a covered outpatient drug or biological, the amount payable for the drug or biological (based on a minimum dosage unit) is, subject to applicable deductible and coinsurance—

''(A) in the case of a multiple source drug (as defined in subsection (c)(6)(C)), 100 percent (or in the case of covered outpatient drugs and biologicals furnished during 2005 and 2006, 112 percent) of the amount determined under paragraph (3); or

''(B) in the case of a single source drug (as defined in subsection (c)(6)(D)), 100 percent (or in the case of covered outpatient drugs and biologicals furnished during 2005 and 2006, 112 percent) of the amount determined under paragraph (4).

''(2) SPECIFICATION OF UNIT.—

''(A) SPECIFICATION BY MANUFACTURER.—The manufacturer of a covered outpatient drug shall specify the unit associated with each National Drug Code as part of the submission of data under section 1927(b)(3)(A)(iii).

''(B) UNIT DEFINED.—In this section, the term 'unit' means, with respect to a covered outpatient drug, the lowest identifiable quantity (such as a capsule or tablet, milligram of molecules, or grams) of the drug that is dispensed, exclusive of any diluent without reference to volume measures pertaining to liquids.

''(3) MULTIPLE SOURCE DRUG.—For all drug products included within the same multiple source drug, the amount specified in this paragraph is the volume-weighted average of the average sales prices reported under section 1927(b)(3)(A)(iii) computed as follows:

''(A) Compute the sum of the products (for each national drug code assigned to such drug products) of—

''(i) the manufacturer's average sales price (as defined in subsection (c)); and

''(ii) the total number of units specified under paragraph (2) sold, as reported under section 1927(b)(3)(A)(iii).

''(B) Divide the sum computed under subparagraph (A) by the sum of the total number of units under subparagraph (A)(ii) for all national drug codes assigned to such drug products.

''(4) SINGLE SOURCE DRUG.—The amount specified in this paragraph for a single source drug is the lesser of the following:

''(A) MANUFACTURER'S AVERAGE SALES PRICE.—The manufacturer's average sales price for a national drug code, as computed using the methodology applied under paragraph (3).

''(B) WHOLESALE ACQUISITION COST (WAC).—The wholesale acquisition cost (as defined in subsection (c)(6)(B)) reported for the single source drug.

''(5) BASIS FOR DETERMINATION.—The payment amount shall be determined under this subsection based on information reported under subsection (e) and without regard to any special packaging, labeling, or identifiers on the dosage form or product or package.

''(c) MANUFACTURER'S AVERAGE SALES PRICE.—

''(1) IN GENERAL.—For purposes of this subsection, subject to paragraphs (2) and (3), the manufacturer's 'average sales price' means, of a covered outpatient drug for a NDC code for a calendar quarter for a manufacturer for a unit—

''(A) the manufacturer's total sales (as defined by the Secretary in regulations for purposes of section 1927(c)(1)) in the United States for such drug in the calendar quarter; divided by

''(B) the total number of such units of such drug sold by the manufacturer in such quarter.

''(2) CERTAIN SALES EXEMPTED FROM COMPUTATION.—In calculating the manufacturer's average sales price under this subsection, the following sales shall be excluded:

''(A) SALES EXEMPT FROM BEST PRICE.—Sales exempt from the inclusion in the determination of 'best price' under section 1927(c)(1)(C)(i).

''(B) SALES AT NOMINAL CHARGE.—Such other sales as the Secretary identifies by regulation as sales to an entity that are nominal in price or do not reflect a market price paid by an entity to which payment is made under this section.

''(3) SALE PRICE NET OF DISCOUNTS.—In calculating the manufacturer's average sales price under this subsection, such price shall be determined taking into account volume discounts, prompt pay discounts, cash discounts, the free goods that are contingent on any purchase requirement, chargebacks, and rebates (other than rebates under section 1927), that result in a reduction of the cost to the purchaser. A rebate to a payor or other entity that does not take title to a covered outpatient drug shall not be taken into account in determining such price unless the manufacturer has an agreement with the payor or other entity under which the purchaser's price for the drug is reduced as a consequence of such rebate.

''(4) AUTHORITY TO DISREGARD AVERAGE SALES PRICE DURING FIRST QUARTER OF SALES.—In the case of a covered outpatient drug during an initial period (not to exceed a full calendar quarter) in which data on the prices for sales for the drug is not sufficiently available from the manufacturer to compute an average sales price for the drug, the Secretary may determine the amount payable under this section for the drug without considering the manufacturer's average sales price of that manufacturer for that drug.

''(5) FREQUENCY OF DETERMINATIONS.—

''(A) IN GENERAL ON A QUARTERLY BASIS.—The manufacturer's average sales price, for a covered outpatient drug of a manufacturer, shall be determined by such manufacturer under this subsection on a quarterly basis. In making such determination insofar as there is a lag in the reporting of the information on rebates and chargebacks under paragraph (3) so that adequate data are not available on a timely basis, the manufacturer shall apply a methodology established by the Secretary based on a 12-month rolling average for the manufacturer to estimate costs attributable to rebates and chargebacks.

''(B) UPDATES IN RATES.—The payment rates under subsection (b)(1) and (b)(2)(A) shall be updated by the Secretary on a quarterly basis and shall be applied based upon the manufacturer's average sales price determined for the most recent calendar quarter.

''(C) USE OF CONTRACTORS; IMPLEMENTATION.—The Secretary may use a carrier, fiscal intermediary, or other contractor to determine the payment amount under subsection (b). Notwithstanding any other provision of law, the Secretary may implement, by program memorandum or otherwise, any of the provisions of this section.

''(6) DEFINITIONS AND OTHER RULES.—In this section:

''(A) MANUFACTURER.—The term 'manufacturer' means, with respect to a covered outpatient drug, the manufacturer (as defined in section 1927(k)(5)) whose national drug code appears on such drug.

''(B) WHOLESALE ACQUISITION COST.—The term 'wholesale acquisition cost' means, with respect to a covered outpatient drug, the manufacturer's list price for the drug to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug pricing data.

''(C) MULTIPLE SOURCE DRUG.—The term 'multiple source drug' means, for a calendar quarter, a covered outpatient drug for which there are 2 or more drug products which—

''(i) are rated as therapeutically equivalent (under the Food and Drug Administration's most recent publication of 'Approved Drug Products with Therapeutic Equivalence Evaluations'),

''(ii) except as provided in subparagraph (E), are pharmaceutically equivalent and bioequivalent, as determined under subparagraph (F) and as determined by the Food and Drug Administration, and

''(iii) are sold or marketed in the United States during the quarter.

''(D) SINGLE SOURCE DRUG.—The term 'single source drug' means a covered outpatient drug which is not a multiple source drug and which is produced or distributed under an original new drug application approved by the Food and Drug Administration, including a drug product marketed by any cross-licensed producers or distributors operating under the new drug application, or which is a biological.

''(E) EXCEPTION FROM PHARMACEUTICAL EQUIVALENCE AND BIOEQUIVALENCE REQUIREMENT.—Subparagraph (C)(ii) shall not apply if the Food and Drug Administration changes by regulation the requirement that, for purposes of the publication described in subparagraph (C)(i), in order for drug products to be rated as therapeutically equivalent, they must be pharmaceutically equivalent and bioequivalent, as defined in subparagraph (F).

''(F) DETERMINATION OF PHARMACEUTICAL EQUIVALENCE AND BIOEQUIVALENCE.—For purposes of this paragraph—

''(i) drug products are pharmaceutically equivalent if the products contain identical amounts of the same active drug ingredient in the same dosage form and meet compendial or other applicable standards of strength, quality, purity, and identity; and

''(ii) drugs are bioequivalent if they do not present a known or potential bioequivalence problem, or, if they do present such a problem, they are shown to meet an appropriate standard of bioequivalence.

''(G) INCLUSION OF VACCINES.—In applying provisions of section 1927 under this section, 'other than a vaccine' is deemed deleted from section 1927(k)(2)(B).

''(d) AUTHORITY TO USE ALTERNATIVE PAYMENT IN RESPONSE TO PUBLIC HEALTH EMERGENCY.—In the case of a public health emergency under section 319 of the Public Health Service Act in which there is a documented inability to access covered outpatient drugs and biologicals, and a concomitant increase in the price, of a drug or biological which is not reflected in the manufacturer's average sales price for one or more quarters, the Secretary may use the wholesale acquisition cost (or other reasonable measure of drug price) instead of the manufacturer's average sales price for such quarters and for subsequent quarters until the price and availability of the drug or biological has stabilized and is substantially reflected in the applicable manufacturer's average sales price.

''(e) REPORTS.—

''(1) QUARTERLY REPORT ON AVERAGE SALES PRICE.—For requirements for reporting the manufacturer's average sales price (and, if required to make payment, the manufacturer's wholesale acquisition cost) for the covered outpatient drug or biological, see section 1927(b)(3).

''(2) ANNUAL REPORT TO CONGRESS.—The Secretary shall submit to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Committee on Finance of the Senate an annual report on the operation of this section. Such report shall include information on the following:

''(A) Trends in average sales price under subsection (b).

''(B) Administrative costs associated with compliance with this section.

''(C) Total value of payments made under this section.

''(D) Comparison of the average manufacturer price as applied under section 1927 for a covered outpatient drug or biological with the manufacturer's average sales price for the drug or biological under this section.

''(f) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of manufacturer's average sales price under subsection (c).''.

(c) CONTINUATION OF PAYMENT METHODOLOGY FOR RADIOPHARMACEUTICALS.—Nothing in the amendments made by this section shall be construed as changing the payment methodology under part B of title XVIII of the Social Security Act for radiopharmaceuticals, including the use by carriers of invoice pricing methodology.

(d) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 1842(o) (42 U.S.C. 1395u(o)) is amended—

(A) in paragraph (1), by inserting '', subject to section 1847A and 1847B,'' before ''the amount payable for the drug or biological''; and

(B) by adding at the end of paragraph (2) the following: ''This paragraph shall not apply in the case of payment under section 1847A or 1847B.''.

(2) NO CHANGE IN COVERAGE BASIS.—Section 1861(s)(2)(A) (42 U.S.C. 1395x(s)(2)(A)) is amended by inserting ''(or would have been so included but for the application of section 1847A or 1847B)'' after ''included in the physicians' bills''.

(3) PAYMENT.—Section 1833(a)(1)(S) (42 U.S.C. 1395l(a)(1)(S)) is amended by inserting ''(or, if applicable, under section 1847A or 1847B)'' after ''1842(o)''.

(4) CONSOLIDATED REPORTING OF PRICING INFORMATION.—Section 1927 (42 U.S.C. 1396r–8) is amended—

(A) in subsection (a)(1), by inserting ''or under part B of title XVIII'' after ''section 1903(a)'';

(B) in subsection (b)(3)(A)—

(i) in clause (i), by striking ''and'' at the end;

(ii) in clause (ii), by striking the period and inserting ''; and''; and

(iii) by adding at the end the following new clause:

''(iii) for calendar quarters beginning on or after April 1, 2004, in conjunction with reporting required under clause (i) and by national drug code (NDC)—

''(I) the manufacturer's average sales price (as defined in section 1847B(c)) and the total number of units specified under section 1847B(b)(2)(A);

''(II) if required to make payment under section 1847B, the manufacturer's wholesale acquisition cost, as defined in subsection (c)(6) of such section; and

''(III) information on those sales that were made at a nominal price or otherwise described in section 1847B(c)(2)(B), which information is subject to audit by the Inspector General of the Department of Health and Human Services;

for a covered outpatient drug or biological for which payment is made under section 1847B.'';

(C) in subsection (b)(3)(B)—

(i) in the heading, by inserting ''AND MANUFACTURER'S AVERAGE SALES PRICE'' after ''PRICE''; and

(ii) by inserting ''and manufacturer's average sales prices (including wholesale acquisition cost) if required to make payment'' after ''manufacturer prices''; and

(D) in subsection (b)(3)(D)(i), by inserting ''and section 1847B'' after ''this section''.

(e) GAO STUDY.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study to assess the impact of the amendments made by this section on the delivery of services, including their impact on—

(A) beneficiary access to drugs and biologicals for which payment is made under part B of title XVIII of the Social Security Act; and

(B) the site of delivery of such services.

(2) REPORT.—Not later than 2 years after the year in which the amendment made by subsection (a)(1) first takes effect, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

(f) MEDPAC RECOMMENDATIONS ON BLOOD CLOTTING FACTORS.—The Medicare Payment Advisory Commission shall submit to Congress, in its annual report in 2004, specific recommendations regarding a payment amount (or amounts) for blood clotting factors and its administration under the medicare program.

(g) ESTABLISHMENT OF PHARMACEUTICAL MANAGEMENT FEE WHERE DRUGS PROVIDED THROUGH A CONTRACTOR.—Section 1848(a) (42 U.S.C. 1395w–4(a)) is amended by adding at the end the following new paragraph:

''(5) RECOGNITION OF PHARMACEUTICAL MANAGEMENT FEE IN CERTAIN CASES.—In establishing the fee schedule under this section, the Secretary shall provide for a separate payment with respect to physicians' services consisting of the unique administrative and management costs associated with covered drugs and biologicals which are furnished to physicians through a contractor under section 1847A (compared with such costs if such drugs and biologicals were acquired directly by such physicians).''.

(h) STUDY ON CODES FOR NON-ONCOLOGY CODES.—

(1) STUDY.—The Secretary shall conduct a study to determine the appropriateness of establishing and implementing separate codes for non-oncology infusions that are based on the level of complexity of the administration and resource consumption.

(2) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit a report to Congress on the study. To the extent the Secretary determines it to be appropriate, the Secretary may implement appropriate changes in the payment methodology for such codes.

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.—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 for cost control or recovery audits with private insurers, health care providers, health plans, or under the medicaid program under title XIX of the Social Security 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. ENHANCED DISPROPORTIONATE SHARE HOSPITAL (DSH) TREATMENT FOR RURAL HOSPITALS AND URBAN HOSPITALS WITH FEWER THAN 100 BEDS.

(a) DOUBLING THE CAP.—

(1) IN GENERAL.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended by adding at the end the following new clause:

''(xiv)(I) In the case of discharges in a fiscal year beginning on or after October 1, 2003, subject to subclause (II), there shall be substituted for the disproportionate share adjustment percentage otherwise determined under clause (iv) (other than subclause (I)) or under clause (viii), (x), (xi), (xii), or (xiii), the disproportionate share adjustment percentage determined under clause (vii) (relating to large, urban hospitals).

''(II) Under subclause (I), the disproportionate share adjustment percentage shall not exceed 10 percent for a hospital that is not classified as a rural referral center under subparagraph (C).''.

(2) CONFORMING AMENDMENTS.—Section 1886(d)(5)(F) (42 U.S.C. 1395ww(d)(5)(F)) is amended—

(A) in each of subclauses (II), (III), (IV), (V), and (VI) of clause (iv), by inserting ''subject to clause (xiv) and'' before ''for discharges occurring'';

(B) in clause (viii), by striking ''The formula'' and inserting ''Subject to clause (xiv), the formula''; and

(C) in each of clauses (x), (xi), (xii), and (xiii), by striking ''For purposes'' and inserting ''Subject to clause (xiv), for purposes''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect

to discharges occurring on or after October 1, 2003.

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.

''(IV) 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.

''(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.

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) MODIFICATION OF THE ISOLATION TEST FOR COST-BASED CAH AMBULANCE SERVICES.—

(1) IN GENERAL.—Section 1834(l)(8) (42 U.S.C. 1395m(l)), as added by section 205(a) of BIPA (114 Stat. 2763A–482), is amended by adding at the end the following: ''The limitation described in the matter following subparagraph (B) in the previous sentence shall not apply if the ambulance services are furnished by such a provider or supplier of ambulance services who is a first responder to

emergencies in accordance with local protocols (as determined by the Secretary).''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to ambulances services furnished on or after the first cost reporting period that begins after the date of the enactment of this Act.

(d) REINSTATEMENT OF PERIODIC INTERIM PAYMENT (PIP).—

(1) IN GENERAL.—Section 1815(e)(2) (42 U.S.C. 1395g(e)(2)) is amended—

(A) in the matter before subparagraph (A), by inserting '', in the cases described in subparagraphs (A) through (D)'' after ''1986''; and

(B) by striking ''and'' at the end of subparagraph (C);

(C) by adding ''and'' at the end of subparagraph (D); and

(D) by inserting after subparagraph (D) the following new subparagraph:

''(E) inpatient critical access hospital services;''.

(2) DEVELOPMENT OF ALTERNATIVE METHODS OF PERIODIC INTERIM PAYMENTS.—With respect to periodic interim payments to critical access hospitals for inpatient critical access hospital services under section 1815(e)(2)(E) of the Social Security Act, as added by paragraph (1), the Secretary shall develop alternative methods for such payments that are based on expenditures of the hospital.

(3) REINSTATEMENT OF PIP.—The amendments made by paragraph (1) shall apply to payments made on or after January 1, 2004.

(e) CONDITION FOR APPLICATION OF SPECIAL PHYSICIAN PAYMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1834(g)(2) (42 U.S.C. 1395m(g)(2)) is amended by adding after and below subparagraph (B) the following:

''The Secretary may not require, as a condition for applying subparagraph (B) with respect to a critical access hospital, that each physician providing professional services in the hospital must assign billing rights with respect to such services, except that such subparagraph shall not apply to those physicians who have not assigned such billing rights.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall be effective as if included in the enactment of section 403(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 (113 Stat. 1501A–371).

(f) FLEXIBILITY IN BED LIMITATION FOR HOSPITALS.—Section 1820 (42 U.S.C. 1395i–4) is amended—

(1) in subsection (c)(2)(B)(iii), by inserting ''subject to paragraph (3)'' after ''(iii) provides'';

(2) by adding at the end of subsection (c) the following new paragraph:

''(3) INCREASE IN MAXIMUM NUMBER OF BEDS FOR HOSPITALS WITH STRONG SEASONAL CENSUS FLUCTUATIONS.—

''(A) IN GENERAL.—Subject to subparagraph (C), in the case of a hospital that demonstrates that it meets the standards established under subparagraph (B) and has not made the election described in subsection (f)(2)(A), the bed limitations otherwise applicable under paragraph (2)(B)(iii) and subsection (f) shall be increased by 5 beds.

''(B) STANDARDS.—The Secretary shall specify standards for determining whether a critical access hospital has sufficiently strong seasonal variations in patient admissions to justify the increase in bed limitation provided under subparagraph (A).''; and

(3) in subsection (f)—

(A) by inserting ''(1)'' after ''(f)''; and

(B) by adding at the end the following new paragraph:

''(2)(A) A hospital may elect to treat the reference in paragraph (1) to '15 beds' as a reference to '25 beds', but only if no more than 10 beds in the hospital are at any time used for non-acute care services. A hospital that makes such an election is not eligible for the increase provided under subsection (c)(3)(A).

''(B) The limitations in numbers of beds under the first sentence of paragraph (1) are subject to adjustment under subsection (c)(3).''.

(4) EFFECTIVE DATE.—The amendments made by this subsection shall apply to designations made before, on, or after January 1, 2004.

(g) ADDITIONAL 5-YEAR PERIOD OF FUNDING FOR GRANT PROGRAM.—

(1) IN GENERAL.—Section 1820(g) (42 U.S.C. 1395i–4(g)) is amended by adding at the end the following new paragraph:

''(4) FUNDING.—

''(A) IN GENERAL.—Subject to subparagraph (B), payment for grants made under this subsection during fiscal years 2004 through 2008 shall be made from the Federal Hospital Insurance Trust Fund.

''(B) ANNUAL AGGREGATE LIMITATION.—In no case may the amount of payment provided for under subparagraph (A) for a fiscal year exceed $25,000,000.''.

(2) CONFORMING AMENDMENT.—Section 1820 (42 U.S.C. 1395i–4) is amended by striking subsection (j).

SEC. 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 shall adjust (subject to audit) 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) CLARIFICATION OF HOSPICE ROLE OF NURSE PRACTITIONERS.—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 a percent increase in the base rate of the fee schedule for a trip established under this subsection. In establishing such percent increase, the Secretary shall estimate the average cost per trip for the base rate in the lowest quartile as compared to the average cost for the base rate for such services that is in the highest quartile of all rural county populations.

''(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 quartile 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 5 percent.

(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of subsection (a).

SEC. 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)), as amended by section 101(b)(2), is amended—

(1) in subparagraph (F), by striking ''and'' after the semicolon at the end;

(2) in subparagraph (G), by striking the period at the end and inserting ''; and''; and

(3) by adding at the end the following new subparagraph:

''(H) any remuneration between a public or nonprofit private health center entity described under clause (i) or (ii) of section 1905(l)(2)(B) and any individual or entity providing goods, items, services, donations or loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other agreement, if such agreement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.''.

(b) RULEMAKING FOR EXCEPTION FOR HEALTH CENTER ENTITY ARRANGEMENTS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall establish, on an expedited basis, standards relating to the exception described in section 1128B(b)(3)(H) of the Social Security Act, as added by subsection (a), for health center entity arrangements to the antikickback penalties.

(B) FACTORS TO CONSIDER.—The Secretary shall consider the following factors, among others, in establishing standards relating to the exception for health center entity arrangements under subparagraph (A):

(i) Whether the arrangement between the health center entity and the other party results in savings of Federal grant funds or increased revenues to the health center entity.

(ii) Whether the arrangement between the health center entity and the other party restricts or limits a patient's freedom of choice.

(iii) Whether the arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

(2) INTERIM FINAL EFFECT.—No later than 180 days after the date of enactment of this Act, the Secretary shall publish a rule in the Federal Register consistent with the factors under paragraph (1)(B). Such rule shall be effective and final immediately on an interim basis, subject to such change and revision, after public notice and opportunity (for a period of not more than 60 days) for public comment, as is consistent with this subsection.

SEC. 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. RURAL HOSPICE DEMONSTRATION PROJECT.

(a) IN GENERAL.—The Secretary shall conduct a demonstration project for the delivery of hospice care to medicare beneficiaries in rural areas. Under the project medicare beneficiaries who are unable to receive hospice care in the home for lack of an appropriate caregiver are provided such care in a facility of 20 or fewer beds which offers, within its walls, the full range of services provided by hospice programs under section 1861(dd) of the Social Security Act (42 U.S.C. 1395x(dd)).

(b) SCOPE OF PROJECT.—The Secretary shall conduct the project under this section with respect to no more than 3 hospice programs over a period of not longer than 5 years each.

(c) COMPLIANCE WITH CONDITIONS.—Under the demonstration project—

(1) the hospice program shall comply with otherwise applicable requirements, except that it shall not be required to offer services outside of the home or to meet the requirements of section 1861(dd)(2)(A)(iii) of the Social Security Act; and

(2) payments for hospice care shall be made at the rates otherwise applicable to such care under title XVIII of such Act.

The Secretary may require the program to comply with such additional quality assurance standards for its provision of services in its facility as the Secretary deems appropriate.

(d) REPORT.—Upon completion of the project, the Secretary shall submit a report to Congress on the project and shall include in the report recommendations regarding extension of such project to hospice programs serving rural areas.

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

SEC. 501. REVISION OF ACUTE CARE HOSPITAL PAYMENT UPDATES.

Section 1886(b)(3)(B)(i) (42 U.S.C. 1395ww(b)(3)(B)(i)) is amended—

(1) by striking ''and'' at the end of subclause (XVIII);

(2) by striking subclause (XIX); and

(3) by inserting after subclause (XVIII) the following new subclauses:

''(XIX) for each of fiscal years 2004 through 2006, the market basket percentage increase minus 0.4 percentage points for hospitals in all areas; and

''(XX) for fiscal year 2007 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.''.

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 the lesser of 75 percent of the standardized amount (increased to reflect the difference between cost and charges) or 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. 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.—

(1) IN GENERAL.—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),''.

(2) NOT BUDGET NEUTRAL.—There shall be no reduction or other adjustment in payments under section 1886 of the Social Security Act because an additional payment is provided under subsection (d)(5)(K)(ii)(III) of such section.

(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 2004 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 discharges occurring on or after October 1, 2004.

SEC. 505. MEDPAC REPORT ON SPECIALTY HOSPITALS.

(a) MEDPAC STUDY.—The Medicare Payment Advisory Commission shall conduct a study of specialty hospitals compared with other similar general acute care hospitals under the medicare program. Such study shall examine—

(1) whether there are excessive self-referrals;

(2) quality of care furnished;

(3) the impact of specialty hospitals on such general acute care hospitals; and

(4) differences in the scope of services, medicaid utilization, and uncompensated care furnished.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a), and shall include any recommendations for legislation or administrative change as the Secretary determines appropriate.

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.

SEC. 513. CORRECTION OF TRUST FUND HOLDINGS.

(a) IN GENERAL.—Within 120 days after the effective date of this section, the Secretary of the Treasury shall take the actions described in subsection (b) with respect to the Federal Hospital Insurance Trust Fund (in this section referred to as the ''Trust Fund'') with the goal being that, after the actions are taken, the holdings of the Trust Fund will replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary, the obligations that would have been held by the trust fund if the clerical error had not occurred.

(b) OBLIGATIONS ISSUED AND REDEEMED.—The Secretary of the Treasury shall—

(1) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates as the obligations that—

(A) would have been issued to the Trust Fund if the clerical error had not occurred; or

(B) were issued to the Trust Fund and were redeemed by reason of the clerical error; and

(2) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error had not occurred.

(c) APPROPRIATION TO TRUST FUND.—Within 120 days after the effective date of this section, there is hereby appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, in consultation with the Secretary of Health and Human Services, to be equal to the interest income lost by the trust fund through the date of credit by reason of the clerical error.

(d) CLERICAL ERROR DEFINED.—For purposes of this section, the term ''clerical error'' means the failure to have transferred the correct amount from the general fund to the Trust Fund, which failure occurred on April 15, 2001.

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.

SEC. 604. INCLUSION OF PODIATRISTS AND DENTISTS UNDER PRIVATE CONTRACTING AUTHORITY.

Section 1802(b)(5)(B) (42 U.S.C. 1395a(b)(5)(B)) is amended by striking ''section 1861(r)(1)'' and inserting ''paragraphs (1), (2), and (3) of section 1861(r)''.

SEC. 605. ESTABLISHMENT OF FLOOR ON WORK GEOGRAPHIC ADJUSTMENT.

(a) MINIMUM INDEX.—Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)) is amended by adding at the end the following new subparagraph:

''(E) FLOOR AT 1.0 ON WORK GEOGRAPHIC INDEX.—

''(i) IN GENERAL.—Subject to clause (ii), after calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2006, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00.

''(ii) SECRETARIAL DISCRETION.—Clause (i) shall have no force or effect in law if the Secretary determines, taking into account the report of the Comptroller General under section 605(b)(2) of the Medicare Prescription Drug and Modernization Act of 2003, that there is no sound economic rationale for the implementation of that clause.''.

(b) GAO REPORT.—

(1) EVALUATION.—As part of the study on geographic differences in payments for physicians' services conducted under section 413, the Comptroller General of the United States shall evaluate the following:

(A) Whether there is a sound economic basis for the implementation of the adjustment of the work geographic index under section 1848(e)(1) of the Social Security Act under subsection (a) in those areas in which the adjustment applies.

(B) The effect of such adjustment on physician location and retention in areas affected by such adjustment, taking into account—

(i) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

(ii) the mobility of physicians, including specialists, over the last decade.

(C) The appropriateness of establishing a floor of 1.0 for the work geographic index.

(2) REPORT.—By not later than September 1, 2004, the Comptroller General shall submit to Congress and to the Secretary a report on the evaluation conducted under paragraph (1).

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) 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 payment 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 product to be functionally equivalent (or a similar standard) unless the Commissioner of Food and Drugs establishes a functional equivalence standard and certifies, under such standards, that the two products are functionally equivalent. If the Commissioner makes such a certification with respect to two or more products, the Secretary may, after complying with applicable rulemaking requirements, implement such standard with respect to such products under this subsection.''.

(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 be 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 be the greater of the amount determined under such fee schedule (without regard to this paragraph) or 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. PART B DEDUCTIBLE.

Section 1833(b) (42 U.S.C. 1395l(b)) is amended—

(1) by striking ''1991 and'' and inserting ''1991,''; and

(2) by striking ''and subsequent years'' and inserting ''and each subsequent year through 2003, and for a subsequent year after 2003 the amount of such deductible for the previous year increased by the annual percentage increase in the monthly actuarial rate under section 1839(a)(1) ending with such subsequent year (rounded to the nearest $1)''.

SEC. 629. 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. 630. 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.

SEC. 631. DEMONSTRATION PROJECT FOR COVERAGE OF CERTAIN PRESCRIPTION DRUGS AND BIOLOGICS.

(a) DEMONSTRATION PROJECT.—The Secretary shall conduct a demonstration project under part B of title XVIII of the Social Security Act under which payment is made for drugs or biologics that are prescribed as replacements for drugs and biologicals described in section 1861(s)(2)(A) or 1861(s)(2)(Q) of such Act (42 U.S.C. 1395x(s)(2)(A), 1395x(s)(2)(Q))), or both, for which payment is made under such part.

(b) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in 3 States selected by the Secretary.

(c) DURATION.—The Secretary shall conduct the demonstration project for the 2-year period beginning on the date that is 90 days after the date of the enactment of this Act, but in no case may the project extend beyond December 31, 2005.

(d) LIMITATION.—Under the demonstration project over the duration of the project, the Secretary may not provide—

(1) coverage for more than 10,000 patients; and

(2) more than $100,000,000 in funding.

(e) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the project. The report shall include an evaluation of patient access to care and patient outcomes under the project, as well as an analysis of the cost effectiveness of the project, including an evaluation of the costs savings (if any) to the medicare program attributable to reduced physicians' services and hospital outpatient departments services for administration of the biological.

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. ESTABLISHMENT OF REDUCED COPAYMENT FOR A HOME HEALTH SERVICE EPISODE OF CARE FOR CERTAIN BENEFICIARIES.

(a) PART A.—

(1) IN GENERAL.—Section 1813(a) (42 U.S.C. 1395e(a)) is amended by adding at the end the following new paragraph:

''(5)(A)(i) Subject to clause (ii), the amount payable for home health services furnished to the individual under this title for each episode of care beginning in a year (beginning with 2004) shall be reduced by a copayment equal to the copayment amount specified in subparagraph (B)(ii) for such year.

''(ii) The copayment under clause (i) shall not apply—

''(I) in the case of an individual who has been determined to be entitled to medical assistance under section 1902(a)(10)(A) or 1902(a)(10)(C) or to be a qualified medicare beneficiary (as defined in section 1905(p)(1)), a specified low-income medicare beneficiary described in section 1902(a)(10)(E)(iii), or a qualifying individual described in section 1902(a)(10)(E)(iv)(I); and

''(II) in the case of an episode of care which consists of 4 or fewer visits.

''(B)(i) The Secretary shall estimate, before the beginning of each year (beginning with 2004), the national average payment under this title per episode for home health services projected for the year involved.

''(ii) For each year the copayment amount under this clause is equal to 1.5 percent of the national average payment estimated for the year involved under clause (i). Any amount determined under the preceding sentence which is not a multiple of $5 shall be rounded to the nearest multiple of $5.

''(iii) There shall be no administrative or judicial review under section 1869, 1878, or otherwise of the estimation of average payment under clause (i).''.

(2) TIMELY IMPLEMENTATION.—Unless the Secretary of Health and Human Services otherwise provides on a timely basis, the copayment amount specified under section 1813(a)(5)(B)(ii) of the Social Security Act (as added by paragraph (1)) for 2004 shall be deemed to be $40.

(b) CONFORMING PROVISIONS.—

(1) Section 1833(a)(2)(A) (42 U.S.C. 1395l(a)(2)(A)) is amended by inserting ''less the copayment amount applicable under section 1813(a)(5)'' after ''1895''.

(2) Section 1866(a)(2)(A)(i) (42 U.S.C. 1395cc(a)(2)(A)(i)) is amended—

(A) by striking ''or coinsurance'' and inserting '', coinsurance, or copayment''; and

(B) by striking ''or (a)(4)'' and inserting ''(a)(4), or (a)(5)''.

SEC. 703. 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. 704. 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—

(1) the beneficiary has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) the beneficiary 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) the beneficiary requires skilled nursing services on a permanent basis and the skilled nursing is more than medication management;

(4) either (A) an attendant is needed during the day to monitor and treat the beneficiary's medical condition, or (B) the beneficiary needs daily skilled nursing on a permanent basis and the skilled nursing is more than medication management; and

(5) the beneficiary 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—Direct Graduate Medical Education

SEC. 711. EXTENSION OF UPDATE LIMITATION ON HIGH COST PROGRAMS.

Section 1886(h)(2)(D)(iv) (42 U.S.C. 1395ww(h)(2)(D)(iv)) is amended—

(1) in subclause (I)—

(A) by inserting ''AND 2004 THROUGH 2013'' after ''AND 2002''; and

(B) by inserting ''or during the period beginning with fiscal year 2004 and ending with fiscal year 2013'' after ''during fiscal year 2001 or fiscal year 2002''; and

(2) in subclause (II)—

(A) by striking ''fiscal year 2004, or fiscal year 2005,'' and

(B) by striking ''For a'' and inserting ''For the''.

Subtitle C—Chronic Care Improvement

SEC. 721. VOLUNTARY CHRONIC CARE IMPROVEMENT UNDER TRADITIONAL FEE-FOR-SERVICE.

Title XVIII, as amended by section 105(a), is amended by inserting after section 1807 the following new section:

''CHRONIC CARE IMPROVEMENT

''SEC. 1808. (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 or E 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 ADVANTAGE AND ENHANCED FEE-FOR-SERVICE PROGRAMS.

(a) UNDER MEDICARE ADVANTAGE PROGRAM.—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 Advantage organization with respect to each Medicare Advantage 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 Advantage plan of a Medicare Advantage 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 Advantage 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 Advantage 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) APPLICATION UNDER ENHANCED FEE-FOR-SERVICE PROGRAM.—Section 1860E–2(c)(3), as inserted by section 201(a), is amended by inserting '', including subsection (e) (relating to implementation of chronic care improvement programs)'' after ''The provisions of section 1852''.

(c) 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 1808 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 D—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) FACTORS AND EVIDENCE USED IN MAKING NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall develop guidance documents to carry out this paragraph in a manner similar to the development of guidance documents under section 701(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 371(h)).

''(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 9 months after the date of the request.

''(3) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—At the end of the 6-month period (or 9-month period for requests described in paragraph (2)(B)) that begins on the date a request for a national coverage determination is made, the Secretary shall—

''(A) make a draft of proposed decision on the request available to the public through the Medicare Internet site of the Department of Health and Human Services or other appropriate means;

''(B) provide a 30-day period for public comment on such draft;

''(C) make a final decision on the request within 60 days of the conclusion of the 30-day period referred to 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 a temporary or permanent code and implement the coding change.

''(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, 2004, and before January 1, 2009, 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. CLINICAL INVESTIGATION OF MEDICARE PANCREATIC ISLET CELL TRANSPLANTS.

The Secretary shall authorize payment under title XVIII of the Social Security Act for the routine costs for items and services for medicare beneficiaries received as part of a clinical investigation of pancreatic islet cell transplants conducted by the National Institutes of Health.

SEC. 736. DEMONSTRATION PROJECT FOR CONSUMER-DIRECTED CHRONIC OUTPATIENT SERVICES.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—Subject to the succeeding provisions of this section, the Secretary shall establish demonstration projects (in this section referred to as ''demonstration projects'') under which the Secretary shall evaluate methods that improve the quality of care provided to medicare beneficiaries with chronic conditions and that reduce expenditures that would otherwise be made under the medicare program on behalf of such individuals for such chronic conditions, such methods to include permitting those beneficiaries to direct their own health care needs and services.

(2) MEDICARE BENEFICIARIES WITH CHRONIC CONDITIONS DEFINED.—In this section, the term ''medicare beneficiaries with chronic conditions'' means an individual entitled to benefits under part A of title XVIII of the Social Security Act, and enrolled under part B of such title, but who is not enrolled under part C of such title who is diagnosed as having one or more chronic conditions (as defined by the Secretary), such as diabetes.

(b) DESIGN OF PROJECTS.—

(1) IN GENERAL.—In establishing the demonstration projects under this section, the Secretary shall evaluate practices employed by group health plans and practices under State plans for medical assistance under the medicaid program under title XIX of the Social Security Act that permit patients to self-direct the provision of personal care services.

(2) SCOPE OF SERVICES.—The Secretary shall determine the appropriate scope of personal care services that would apply under the demonstration projects.

(c) VOLUNTARY PARTICIPATION.—Participation of medicare beneficiaries in the demonstration projects shall be voluntary.

(d) DEMONSTRATION PROJECTS SITES.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall conduct no fewer than 3 demonstration projects established under this section. Of those demonstration projects, the Secretary shall conduct at least one in each of the following areas:

(1) An urban area.

(2) A rural area.

(3) An area that the Secretary determines has a medicare population with rate of incidence of diabetes that significantly exceeds the national average rate of all areas.

(e) EVALUATION AND REPORT.—

(1) EVALUATIONS.—The Secretary shall conduct evaluations of the clinical and cost effectiveness of the demonstration projects.

(2) REPORTS.—Not later than 2 years after the commencement of the demonstration projects, and biannually thereafter, the Secretary shall submit to Congress a report on the evaluation, and shall include in the report the following:

(A) An analysis of the patient outcomes and costs of furnishing care to the medicare beneficiaries participating in the projects as compared to such outcomes and costs to other beneficiaries for the same health conditions.

(B) Evaluation of patient satisfaction under the demonstration projects.

(C) Such recommendations regarding the extension, expansion, or termination of the projects as the Secretary determines appropriate.

TITLE VIII—MEDICARE BENEFITS ADMINISTRATION

SEC. 801. ESTABLISHMENT OF MEDICARE BENEFITS ADMINISTRATION.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by sections 105 and 721, is amended by inserting after 1808 the following new section:

''MEDICARE BENEFITS ADMINISTRATION

''SEC. 1809. (a) ESTABLISHMENT.—There is established within the Department of Health and Human Services an agency to be known as the Medicare Benefits Administration.

''(b) ADMINISTRATOR; DEPUTY ADMINISTRATOR; CHIEF ACTUARY.—

''(1) ADMINISTRATOR.—

''(A) IN GENERAL.—The Medicare Benefits Administration shall be headed by an administrator to be known as the 'Medicare Benefits Administrator' (in this section referred to as the 'Administrator') who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall be in direct line of authority to the Secretary.

''(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 4 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Administration, and shall have authority and control over all personnel and activities thereof.

''(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administration. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code. The Administrator shall provide for the issuance of new regulations to carry out parts C, D, and E.

''(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Administration as the Administrator considers necessary or appropriate, except as specified in this section.

''(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administration as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

''(2) DEPUTY ADMINISTRATOR.—

''(A) IN GENERAL.—There shall be a Deputy Administrator of the Medicare Benefits Administration who shall be appointed by the President, by and with the advice and consent of the Senate.

''(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 4 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be Acting Administrator of the Administration during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

''(3) CHIEF ACTUARY.—

''(A) IN GENERAL.—There is established in the Administration the position of Chief Actuary. The Chief Actuary shall be appointed by, and in direct line of authority to, the Administrator of such Administration. The Chief Actuary shall be appointed from among individuals who have demonstrated, by their education and experience, superior

expertise in the actuarial sciences. The Chief Actuary may be removed only for cause.

''(B) COMPENSATION.—The Chief Actuary shall be compensated at the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

''(C) DUTIES.—The Chief Actuary shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence.

''(4) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

''(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

''(1) DUTIES.—

''(A) GENERAL DUTIES.—The Administrator shall carry out parts C, D, and E, including—

''(i) negotiating, entering into, and enforcing, contracts with plans for the offering of Medicare Advantage plans under part C and EFFS plans under part E, including the offering of qualified prescription drug coverage under such plans; and

''(ii) negotiating, entering into, and enforcing, contracts with PDP sponsors for the offering of prescription drug plans under part D.

''(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C, part D, or part E, including demonstration projects carried out in part or in whole under such parts, the programs of all-inclusive care for the elderly (PACE program) under section 1894, the social health maintenance organization (SHMO) demonstration projects (referred to in section 4104(c) of the Balanced Budget Act of 1997), medicare cost contractors under section 1876(h), and through a Medicare Advantage project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved).

''(C) PRESCRIPTION DRUG CARD.—The Administrator shall carry out section 1807 (relating to the medicare prescription drug discount card endorsement program).

''(D) NONINTERFERENCE.—In carrying out its duties with respect to the provision of qualified prescription drug coverage to beneficiaries under this title, the Administrator may not—

''(i) require a particular formulary or institute a price structure for the reimbursement of covered outpatient drugs;

''(ii) interfere in any way with negotiations between PDP sponsors and Medicare Advantage organizations and EFFS organizations and drug manufacturers, wholesalers, or other suppliers of covered outpatient drugs; and

''(iii) otherwise interfere with the competitive nature of providing such coverage through such sponsors and organizations.

''(E) ANNUAL REPORTS.—Not later March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of parts C, D, and E during the previous fiscal year.

''(2) STAFF.—

''(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, without regard to chapter 31 of title 5, United States Code, other than sections 3102 through 3108, 3110 through 3113, 3136m and 3151, such officers and employees as are necessary to administer the activities to be carried out through the Medicare Benefits Administration. The Administrator shall employ staff with appropriate and necessary expertise in negotiating contracts in the private sector.

''(B) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

''(i) IN GENERAL.—The staff of the Medicare Benefits Administration shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 (other than section 5101) and chapter 53 (other than section 5301) of such title (relating to classification and schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(C) LIMITATION ON FULL-TIME EQUIVALENT STAFFING FOR CURRENT CMS FUNCTIONS BEING TRANSFERRED.—The Administrator may not employ under this paragraph a number of full-time equivalent employees, to carry out functions that were previously conducted by the Centers for Medicare & Medicaid Services and that are conducted by the Administrator by reason of this section, that exceeds the number of such full-time equivalent employees authorized to be employed by the Centers for Medicare & Medicaid Services to conduct such functions as of the date of the enactment of this Act.

''(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

''(A) IN GENERAL.—The Secretary, the Administrator, and the Administrator of the Centers for Medicare & Medicaid Services shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare & Medicaid Services to the Administrator as is appropriate to carry out the purposes of this section.

''(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator of the Medicare Benefits Administration such information and data in the possession of the Administrator of the Centers for Medicare & Medicaid Services as the Administrator of the Medicare Benefits Administration requires to carry out the duties described in paragraph (1).

''(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Centers for Medicare & Medicaid Services is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Centers for Medicare & Medicaid Services in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

''(d) OFFICE OF BENEFICIARY ASSISTANCE.—

''(1) ESTABLISHMENT.—The Secretary shall establish within the Medicare Benefits Administration an Office of Beneficiary Assistance to coordinate functions relating to outreach and education of medicare beneficiaries under this title, including the functions described in paragraph (2). The Office shall be separate operating division within the Administration.

''(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

''(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate, directly or through contract, to medicare beneficiaries, by mail, by posting on the Internet site of the Medicare Benefits Administration and through a toll-free telephone number, information with respect to the following:

''(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C, D, and E.

''(ii) Benefits, and limitations on payment under parts A and B, including information on medicare supplemental policies under section 1882.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, D, and medicare supplemental policies with benefits under Medicare Advantage plans under part C and EFFS plans under part E.

''(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the Medicare Advantage program under part C, the Voluntary Prescription Drug Benefit Program under part D, and the Enhanced Fee-for-Service program under part E.

''(e) MEDICARE POLICY ADVISORY BOARD.—

''(1) ESTABLISHMENT.—There is established within the Medicare Benefits Administration the Medicare Policy Advisory Board (in this section referred to the 'Board'). The Board shall advise, consult with, and make recommendations to the Administrator of the Medicare Benefits Administration with respect to the administration of parts C, D, and E, including the review of payment policies under such parts.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of parts C, D, and E the Board shall submit to Congress and to the Administrator of the Medicare Benefits Administration such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

''(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

''(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C, D, and E for services furnished to medicare beneficiaries.

''(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement to efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C, D, and E, and the program for enrollment under the title.

''(iii) IMPLEMENTATION OF RISK-ADJUSTMENT.—Evaluation of the implementation under section 1853(a)(3)(C) of the risk adjustment methodology to payment rates under that section to Medicare Advantage organizations offering Medicare Advantage plans (and the corresponding payment provisions under part E) that accounts for variations in per capita costs based on health status, geography, and other demographic factors.

''(iv) RURAL ACCESS.—Recommendations to improve competition and access to plans under parts C, D, and E in rural areas.

''(C) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

''(3) DUTY OF ADMINISTRATOR OF MEDICARE BENEFITS ADMINISTRATION.—With respect to any report submitted by the Board under

paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator of the Medicare Benefits Administration shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

''(4) MEMBERSHIP.—

''(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of seven members to be appointed as follows:

''(i) Three members shall be appointed by the President.

''(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairmen and the ranking minority members of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives.

''(iii) Two members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Senate Committee on Finance.

''(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

''(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

''(5) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(6) TERMS OF OFFICE.—

''(A) IN GENERAL.—The term of office of members of the Board shall be 3 years.

''(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

''(i) one shall be appointed for a term of 1 year;

''(ii) three shall be appointed for terms of 2 years; and

''(iii) three shall be appointed for terms of 3 years.

''(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

''(D) VACANCY.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

''(7) CHAIR.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

''(8) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than three times during each fiscal year.

''(9) DIRECTOR AND STAFF.—

''(A) APPOINTMENT OF DIRECTOR.—The Board shall have a Director who shall be appointed by the Chair.

''(B) IN GENERAL.—With the approval of the Board, the Director may appoint, without regard to chapter 31 of title 5, United States Code, such additional personnel as the Director considers appropriate.

''(C) FLEXIBILITY WITH RESPECT TO COMPENSATION.—

''(i) IN GENERAL.—The Director and staff of the Board shall, subject to clause (ii), be paid without regard to the provisions of chapter 51 and chapter 53 of such title (relating to classification and schedule pay rates).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(D) ASSISTANCE FROM THE ADMINISTRATOR OF THE MEDICARE BENEFITS ADMINISTRATION.—The Administrator of the Medicare Benefits Administration shall make available to the Board such information and other assistance as it may require to carry out its functions.

''(10) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Medicare Prescription Drug Account), such sums as are necessary to carry out this section.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendment made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) DUTIES WITH RESPECT TO ELIGIBILITY DETERMINATIONS AND ENROLLMENT.—The Administrator of the Medicare Benefits Administration shall carry out enrollment under title XVIII of the Social Security Act, make eligibility determinations under such title, and carry out parts C and E of such title for years beginning or after January 1, 2006.

(3) TRANSITION.—Before the date the Administrator of the Medicare Benefits Administration is appointed and assumes responsibilities under this section and section 1807 of the Social Security Act, the Secretary of Health and Human Services shall provide for the conduct of any responsibilities of such Administrator that are otherwise provided under law.

(c) MISCELLANEOUS ADMINISTRATIVE PROVISIONS.—

(1) ADMINISTRATOR AS MEMBER OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—Section 1817(b) and section 1841(b) (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking ''and the Secretary of Health and Human Services, all ex officio,'' and inserting ''the Secretary of Health and Human Services, and the Administrator of the Medicare Benefits Administration, all ex officio,''.

(2) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES; LEVEL FOR MEDICARE BENEFITS ADMINISTRATOR.—

(A) IN GENERAL.—Section 5314 of title 5, United States Code, by adding at the end the following:

''Administrator of the Centers for Medicare & Medicaid Services.

''Administrator of the Medicare Benefits Administration.''.

(B) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking ''Administrator of the Health Care Financing Administration.''.

(C) EFFECTIVE DATE.—The amendments made by this paragraph take effect on January 1, 2004.

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 2(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.

(e) PROCESS FOR REINSTATEMENT OF APPROVAL OF CERTAIN SNF TRAINING PROGRAMS.—

(1) IN GENERAL.—In the case of a termination of approval of a nurse aide training program described in paragraph (2) of a skilled nursing facility, the Secretary shall develop and implement a process for the reinstatement of approval of such program before the end of the mandatory 2 year disapproval period if the facility and program is certified by the Secretary, in coordination with the applicable State survey and certification agency and after public notice, as being in compliance with applicable requirements and as having remedied any deficiencies in the facility or program that resulted in noncompliance.

(2) TERMINATION OF APPROVAL DESCRIBED.—A termination of approval of a training program described in this paragraph is a mandatory 2-year disapproval provided for under section 1819(f)(2)(B)(iii) of the Social Security Act (42 U.S.C. 1395i–3(f)(2)(B)(iii)) if the only basis for the mandatory disapproval was the assessment of a civil money penalty of not less than $5,000.

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), a 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 first sentence of this subsection, if the National Committee on Vital and Health Statistics has not made a recommendation to the Secretary, within 1 year after 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, then the Secretary may adopt ICD–10–PCS and ICD–10–CM 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.

(d) MODIFICATION OF REQUIRMENT FOR MEDICAL SCREENING EXAMINATIONS FOR PATIENTS NOT REQUESTING EMERGENCY DEPARTMENT SERVICES.—

(1) IN GENERAL.—Section 1867(a) (42 U.S.C. 1395dd(a)) is amended—

(A) by designating all that follows ''(a) MEDICAL SCREENING REQUIREMENT.—'' as paragraph (1) with the heading ''IN GENERAL.—'';

(B) by aligning such paragraph with the paragraph added by paragraph (3); and

(C) by adding at the end the following new paragraph:

''(2) EXCEPTION FOR CERTAIN CASES.—The requirement for an appropriate medical screening examination under paragraph (1) shall not apply in the case of an individual who comes to the emergency department and neither the individual, nor another person on the individual's behalf, requests examination or treatment for an emergency medical condition (such as a request solely for preventive services, such as blood pressure screening or non-emergency laboratory and diagnostic tests).''.

(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 arrange to 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 used in computing the disproportionate patient percentage under such section for that hospital for the current cost reporting year. 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.

SEC. 954. TEMPORARY SUSPENSION OF OASIS REQUIREMENT FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS.

(a) IN GENERAL.—During the period described in subsection (b), the Secretary may not require, under section 4602(e) of the Balanced Budget Act of 1997 or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act (such information in this section referred to as ''non-medicare/medicaid OASIS information'').

(b) PERIOD OF SUSPENSION.—The period described in this subsection—

(1) begins on the date of the enactment of this Act; and

(2) ends on the last day of the 2nd month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare & Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c).

(c) REPORT.—

(1) STUDY.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies. Such study shall examine—

(A) whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, such agencies; and

(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection.

In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.

TITLE X—MEDICAID

SEC. 1001. MEDICAID DISPROPORTIONATE SHARE HOSPITAL (DSH) PAYMENTS.

Section 1923(f)(3) (42 U.S.C. 1396r–4(f)(3)) is amended—

(1) in subparagraph (A), by striking ''subparagraph (B)'' and inserting ''subparagraphs (B) and (C)''; and

(2) by adding at the end the following new subparagraphs:

''(C) SPECIAL, TEMPORARY INCREASE IN ALLOTMENTS ON A ONE-TIME, NON-CUMULATIVE BASIS.—The DSH allotment for any State—

''(i) for fiscal year 2004 is equal to 120 percent of the DSH allotment for the State for fiscal year 2003 under this paragraph, notwithstanding subparagraph (B); and

''(ii) for each succeeding fiscal year is equal to the DSH allotment for the State for fiscal year 2004 or, in the case of fiscal years beginning with the fiscal year specified in subparagraph (D) for that State, the percentage change in the consumer price index for all urban consumers (all items; U.S. city average), for the previous fiscal year.

''(D) FISCAL YEAR SPECIFIED.—For purposes of subparagraph (C)(ii), the fiscal year specified in this subparagraph for a State is the first fiscal year for which the Secretary estimates that the DSH allotment for that State will equal (or no longer exceed) the DSH allotment for that State under the law as in effect before the date of the enactment of this subparagraph.''.

SEC. 1002. 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)''.

(b) ANTI-DIVERSION PROTECTION.—Section 1927(c)(1)(C) (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.''.

TITLE XI—ACCESS TO AFFORDABLE PHARMACEUTICALS

Subtitle A—Access to Affordable Pharmaceuticals

SEC. 1101. 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)—

(A) 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

(B) by adding at the end the following subparagraph:

''(D)(i) An applicant may not amend or supplement an application to seek approval of a drug referring to a different listed drug from the listed drug identified in the application as submitted to the Secretary.

''(ii) With respect to the drug for which an application is submitted, nothing in this subsection prohibits an applicant from amending or supplementing the application to seek approval of a different strength.''; 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'';

(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).''; and

(ee) in the matter after and below subclause (IV) (as added by item (dd)), by striking ''Until the expiration'' and all that follows;

(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.—

''(I) IN GENERAL.—No action may be brought under section 2201 of title 28, United States Code, by an applicant under paragraph (2) for a declaratory judgment with respect to a patent which is the subject of the certification referred to in subparagraph (B)(iii) unless the forty-five day period referred to in such subparagraph has expired, and unless, if the notice provided under paragraph (2)(B) relates to noninfringement, the notice was accompanied by a document described in subclause (II). Any such action shall be brought in the judicial district where the defendant has its principal place of business or a regular and established place of business.

''(II) RIGHT OF CONFIDENTIAL ACCESS TO APPLICATION.—For purposes of subclause (I), the document described in this subclause is a document providing a right of confidential access to the application of the applicant under paragraph (2) for the purpose of determining whether an action referred to in subparagraph (B)(iii) should be brought. The document providing the right of confidential access shall contain such restrictions as to persons entitled to access, and on the use and disposition of any information accessed, as would apply had a protective order been entered for the purpose of protecting trade secrets and other confidential business information. Any person provided a right of confidential access shall review the application for the sole and limited purpose of evaluating possible infringement of the patent that is the subject of the certification under paragraph (2)(A)(vii)(IV) and for no other purpose, and may not disclose information of no relevance to any issue of patent infringement to any person other than a person provided a right of confidential access. Further, the application may be redacted by the applicant to remove any information of no relevance to any issue of patent infringement.

''(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)—

(A) 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

(B)(i) by redesignating paragraph (4) as paragraph (5); and

(ii) by inserting after paragraph (3) the following paragraph:

''(4)(A) An applicant may not amend or supplement an application referred to in paragraph (2) to seek approval of a drug that is a different drug than the drug identified in the application as submitted to the Secretary.

''(B) With respect to the drug for which such an application is submitted, nothing in this subsection or subsection (c)(3) prohibits an applicant from amending or supplementing the application to seek approval of a different strength.''; 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'';

(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

(VI) in the matter after and below clause (iv) (as added by subclause (V)), by striking ''Until the expiration'' and all that follows; 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.—

''(I) IN GENERAL.—No action may be brought under section 2201 of title 28, United States Code, by an applicant referred to in subsection (b)(2) for a declaratory judgment with respect to a patent which is the subject of the certification referred to in subparagraph (C) unless the forty-five day period referred to in such subparagraph has expired, and unless, if the notice the applicant provided under subsection (b)(3) relates to noninfringement, the notice was accompanied by a document described in subclause (II). Any such action shall be brought in the judicial district where the defendant has its principal place of business or a regular and established place of business.

''(II) RIGHT OF CONFIDENTIAL ACCESS TO APPLICATION.—For purposes of subclause (I), the document described in this subclause is a document providing a right of confidential access to the application of the applicant referred to in subsection (b)(2) for the purpose of determining whether an action referred to in subparagraph (C) should be brought. The document providing the right of confidential access shall contain such restrictions as to persons entitled to access, and on the use and disposition of any information accessed, as would apply had a protective order been entered for the purpose of protecting trade secrets and other confidential business information. Any person provided a right of confidential access shall review the application for the sole and limited purpose of evaluating possible infringement of the patent that is the subject of the certification under subsection (b)(2)(A)(iv) and for no other purpose, and may not disclose information of no relevance to any issue of patent infringement to any person other than a person provided a right of confidential access. Further, the application may be redacted by the applicant to remove any information of no relevance to any issue of patent infringement.

''(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) 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. 1102. 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 1101) 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.—As used in this subsection, 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.—As used in this subsection, 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. 1103. 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. 1104. 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)''.

Subtitle B—Federal Trade Commission Review

SEC. 1111. DEFINITIONS.

In this subtitle:

(1) ANDA.—The term ''ANDA'' means an abbreviated drug application, as defined under section 201(aa) of the Federal Food, Drug, and Cosmetic Act.

(2) BRAND NAME DRUG.—The term ''brand name drug'' means a drug for which an application is approved under section 505(c) of the Federal Food, Drug, and Cosmetic Act, including an application referred to in section 505(b)(2) of such Act.

(3) BRAND NAME DRUG COMPANY.—The term ''brand name drug company'' means the party that holds the approved application referred to in paragraph (2) for a brand name drug that is a listed drug in an ANDA, or a party that is the owner of a patent for which information is submitted for such drug under subsection (b) or (c) of section 505 of the Federal Food, Drug, and Cosmetic Act.

(4) COMMISSION.—The term ''Commission'' means the Federal Trade Commission.

(5) GENERIC DRUG.—The term ''generic drug'' means a drug for which an application under section 505(j) of the Federal Food, Drug, and Cosmetic Act is approved.

(6) GENERIC DRUG APPLICANT.—The term ''generic drug applicant'' means a person who has filed or received approval for an ANDA under section 505(j) of the Federal Food, Drug, and Cosmetic Act.

(7) LISTED DRUG.—The term ''listed drug'' means a brand name drug that is listed under section 505(j)(7) of the Federal Food, Drug, and Cosmetic Act.

SEC. 1112. NOTIFICATION OF AGREEMENTS.

(a) AGREEMENT WITH BRAND NAME DRUG COMPANY.—

(1) REQUIREMENT.—A generic drug applicant that has submitted an ANDA containing a certification under section 505(j)(2)(A)(vii)(IV) of the Federal Food, Drug, and Cosmetic Act and a brand name drug company that enter into an agreement described in paragraph (2) shall each file the agreement in accordance with subsection (c). The agreement shall be filed prior to the date of the first commercial marketing of the generic drug that is the subject of the ANDA.

(2) SUBJECT MATTER OF AGREEMENT.—An agreement described in this paragraph between a generic drug applicant and a brand name drug company is an agreement regarding—

(A) the manufacture, marketing or sale of the brand name drug that is the listed drug in the ANDA involved;

(B) the manufacture, marketing, or sale of the generic drug for which the ANDA was submitted; or

(C) the 180-day period referred to in section 505(j)(5)(B)(iv) of the Federal Food, Drug, and Cosmetic Act as it applies to such ANDA or to any other ANDA based on the same brand name drug.

(b) AGREEMENT WITH ANOTHER GENERIC DRUG APPLICANT.—

(1) REQUIREMENT.—A generic drug applicant that has submitted an ANDA containing a certification under section 505(j)(2)(A)(vii)(IV) of the Federal Food, Drug, and Cosmetic Act with respect to a listed drug and another generic drug applicant that has submitted an ANDA containing such a certification for the same listed drug shall each file the agreement in accordance with subsection (c). The agreement shall be filed prior to the date of the first commercial marketing of either of the generic drugs for which such ANDAs were submitted.

(2) SUBJECT MATTER OF AGREEMENT.—An agreement described in this paragraph between two generic drug applicants is an agreement regarding the 180-day period referred to in section 505(j)(5)(B)(iv) of the Federal Food, Drug, and Cosmetic Act as it applies to the ANDAs with which the agreement is concerned.

(c) FILING.—

(1) AGREEMENT.—The parties that are required in subsection (a) or (b) to file an agreement in accordance with this subsection shall file with the Commission the text of any such agreement, except that such parties are not required to file an agreement that solely concerns—

(A) purchase orders for raw material supplies;

(B) equipment and facility contracts;

(C) employment or consulting contracts; or

(D) packaging and labeling contracts.

(2) OTHER AGREEMENTS.—The parties that are required in subsection (a) or (b) to file an agreement in accordance with this subsection shall file with the Commission the text of any agreements between the parties that are not described in such subsections and are contingent upon, provide a contingent condition for, or are otherwise related to an agreement that is required in subsection (a) or (b) to be filed in accordance with this subsection.

(3) DESCRIPTION.—In the event that any agreement required in subsection (a) or (b) to be filed in accordance with this subsection has not been reduced to text, each of the parties involved shall file written descriptions of such agreement that are sufficient to disclose all the terms and conditions of the agreement.

SEC. 1113. FILING DEADLINES.

Any filing required under section 1112 shall be filed with the Commission not later than 10 business days after the date the agreements are executed.

SEC. 1114. DISCLOSURE EXEMPTION.

Any information or documentary material filed with the Commission pursuant to this subtitle shall be exempt from disclosure under section 552 of title 5, United States Code, and no such information or documentary material may be made public, except as may be relevant to any administrative or judicial action or proceeding. Nothing in this section is intended to prevent disclosure to either body of Congress or to any duly authorized committee or subcommittee of the Congress.

SEC. 1115. ENFORCEMENT.

(a) CIVIL PENALTY.—Any brand name drug company or generic drug applicant which fails to comply with any provision of this subtitle shall be liable for a civil penalty of not more than $11,000, for each day during which such entity is in violation of this subtitle. Such penalty may be recovered in a civil action brought by the United States, or brought by the Commission in accordance with the procedures established in section 16(a)(1) of the Federal Trade Commission Act (15 U.S.C. 56(a)).

(b) COMPLIANCE AND EQUITABLE RELIEF.—If any brand name drug company or generic drug applicant fails to comply with any provision of this subtitle, the United States district court may order compliance, and may grant such other equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Commission.

SEC. 1116. RULEMAKING.

The Commission, by rule in accordance with section 553 of title 5, United States Code, consistent with the purposes of this subtitle—

(1) may define the terms used in this subtitle;

(2) may exempt classes of persons or agreements from the requirements of this subtitle; and

(3) may prescribe such other rules as may be necessary and appropriate to carry out the purposes of this subtitle.

SEC. 1117. SAVINGS CLAUSE.

Any action taken by the Commission, or any failure of the Commission to take action, under this subtitle shall not at any time bar any proceeding or any action with respect to any agreement between a brand name drug company and a generic drug applicant, or any agreement between generic drug applicants, under any other provision of law, nor shall any filing under this subtitle constitute or create a presumption of any violation of any competition laws.

SEC. 1118. EFFECTIVE DATE.

This subtitle shall—

(1) take effect 30 days after the date of enactment of this Act; and

(2) shall apply to agreements described in section 1112 that are entered into 30 days after the date of enactment of this Act.

Subtitle C—Importation of Prescription Drugs

SEC. 1121. 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;

''(E) a drug that is inhaled during surgery; or

''(F) a drug which is a parenteral drug, the importation of which pursuant to subsection (b) is determined by the Secretary to pose a threat to the public health, in which case section 801(d)(1) shall continue to apply.

''(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 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 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 all 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);

''(3) require that any prescription drug from Canada imported by a domestic pharmacist or wholesaler under this section be contained in packaging which the Secretary has determined to be reasonably certain to be tamper-resistant and not capable of counterfeiting;

''(4) require that all prescription drugs from Canada imported by a domestic pharmacist or a wholesaler under this section contain a statement designed to inform the end-user of such drug that such drug has been imported from a foreign seller other than a manufacturer;

''(5) require that only prescription drugs which have not left the possession of the first Canadian recipient of such prescription drugs after receipt from the manufacturer of such prescription drugs be eligible for importation into the United States under this section;

''(6) require, if determined appropriate by the Secretary, that all prescription drugs imported from Canada under this section by domestic pharmacists and wholesalers enter the United States through ports of entry designated by the Secretary for purposes of this section;

''(7) contain any additional provisions determined by the Secretary to be appropriate to protect the public health; and

''(8) contain any additional provisions determined by the Secretary to be appropriate

to facilitate the importation of prescription drugs that do not jeopardize the public health.

''(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 and the price charged 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) 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) 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.

''(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 is not adulterated or misbranded; 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 under this section; 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 and the name of the United States agent for 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) 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.

''(j) WAIVER AUTHORITY FOR IMPORTATION BY INDIVIDUALS.—The Secretary may, for drugs being imported from a licensed Canadian pharmacy, 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. Such conditions shall include conditions that such drug or device be—

''(1) in the possession of an individual when the individual enters the United States;

''(2) imported by such individual from a licensed pharmacy for personal use by the individual, not for resale, in quantities that do not exceed a 90-day supply, which individual will use the drug or device (or for a family member of such individual);

''(3) accompanied by a copy of a valid prescription;

''(4) imported from Canada, from a seller registered with the Secretary;

''(5) a prescription drug approved by the Secretary under chapter V that is not adulterated or misbranded;

''(6) in the form of a final finished dosage that was manufactured in an establishment registered under section 510; and

''(7) imported under such other conditions as the Secretary determines to be necessary to ensure public safety.

''(k) 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 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).

''(l) 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.

''(m) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

''(n) CONDITIONS.—This section shall become effective only if the Secretary demonstrates to the Congress that the 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 prescription drugs 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)''.

The SPEAKER pro tempore. After 3 hours of debate on the bill, it shall be in order to consider the amendment printed in House Report 108–181, if offered by the gentleman from New York (Mr. RANGEL) or his designee, which shall be considered read, and shall be debatable for 1 hour, equally divided and controlled by the proponent and an opponent.

The gentleman from California (Mr. THOMAS), the gentleman from New York (Mr. RANGEL), the gentleman

from Louisiana (Mr. TAUZIN), and the gentleman from Michigan (Mr. DINGELL) each will control 45 minutes of debate on the bill.

The Chair recognizes the gentleman from California (Mr. THOMAS).

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume.

As we begin the 3 hours of debate on the primary bill and an additional hour on the substitute, I do want to indicate that this day, in my opinion, has been too long in coming.

I want to thank President Bush for his position during the campaign that Medicare needed to be modernized and we were overdue for putting prescription drugs in Medicare.

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I believe he has continued to be firm in his resolve that both the House, and the Senate now for the first time, pass legislation so that we can conference a common bill and send it to him for his signature.

I also want to thank the Speaker of the House. The gentleman from Illinois (Mr. HASTERT) was involved in these discussions prior to our becoming the majority and, of course, prior to his becoming Speaker. If you examine H.R. 1, you will find that the Speaker has been willing to be the lead author. I think it is entirely proper and appropriate that the Speaker of the House lead the House through the most fundamental and important change in Medicare since its inception.

I especially want to thank my colleague and friend and chairman of the Committee on Energy and Commerce, the gentleman from Louisiana (Mr. TAUZIN). In this institution, where jurisdictions are guarded with a pretty vicious willingness to have turf wars whenever necessary to hang on to your jurisdiction, the working relationship with the shared jurisdiction of the Committee on Energy and Commerce and the Committee on Ways and Means has been a very pleasant experience, and the working relationship between the staff, of which I will have more to say a little bit later, could not have been better.

And, frankly, the product we have before us, although the gentleman from Louisiana (Mr. TAUZIN) joined me in the initial sponsorship of legislation, we could not have gotten it through both committees and back together again in the Committee on Rules to present to you here today as H.R. 1 without complete and open and very comradely behavior between the chairman of the Committee on Energy and Commerce and this committee, and I thank him for that.

I especially thank the gentlewoman from Connecticut (Mrs. JOHNSON), who is the chairman of the Subcommittee on Health of the Committee on Ways and Means. The members of that committee have been very, very helpful in holding the hearings and continuing to shape this legislation. This bill, as it rightly should be, is the best piece of legislation that we have offered this House, notwithstanding the fact that twice previously we have passed Medicare modernization with prescription drugs.

And let me say that I do want to single out two members of the Committee on Ways and Means, the gentleman from Iowa (Mr. NUSSLE), who also happens to be the chairman of the Committee on the Budget, and the gentleman from North Dakota (Mr. POMEROY), who offered together a bipartisan amendment which was very significant in helping us redress the failure to provide those Americans especially in middle America but in principally rural areas with a fair and equitable Medicare program.

I want to thank, and I do not want to go through every staff member, but I do want to thank the chief of our Subcommittee on Health staff John McManus for the enormous number of hours he and the staff have put in. You cannot produce as complex and difficult a piece of legislation as you have in front of you without the dedicated staff. And I mean not just on the committees, but the Congressional Budget Office, and I will mention from Leg Counsel Ed Grossman, who is an institutional glue. He is the one who spends the hours to make sure that the language makes sense in the legislative language that we have before us. He is absolutely indispensable to the functioning of this institution, and I want to personally thank him once again for the hours of commitment that he has put in to produce this piece of legislation.

There are organizations and associations who have very strong feelings about the direction of Medicare and the changes that might be made, and I want to thank all of them for their openness and willingness to present comments upon which we reacted. Most recently, I think one of the more prominent organizations, formerly known as the American Association of Retired Persons, now AARP, and I am indebted to my colleague, the gentlewoman from California (Mrs. CAPPS), for circulating the letter from AARP, because I think it is very instructive. It provides us with an example of how these organizations point with pride and view with alarm some of the changes that are being made.

For example, the opening paragraph in the letter addressed to me says, and I quote, ''AARP is encouraged by the advancement in the House of legislation to add prescription drug coverage to Medicare. Relief from the high cost of drugs is long overdue. Our members and all older Americans and their families expect and need legislation this year. We appreciate your efforts and leadership toward this end.''

But they go on to say in the letter, in terms of a number of additional points, that they think certain areas need to be strengthened and perhaps some changes need to be made. For example, under low-income protections, they say, ''We are encouraged by the bill's inclusion of all Medicare beneficiaries, including dual eligibles.'' We spend $43 billion over the next decade picking up these low-income seniors. We believe they should be classified as seniors first in the Federal Medicare program and not low-income first, as they currently are today.

But they go on to say that they are concerned because eligibility is limited by a restrictive assets test. And we took that letter to heart and we have examined that provision, notwithstanding the fact that the original bill doubled the assets provision under the SSI, Social Security provisions for low-income eligibility. The bill had doubled it. We examined it, we determined that perhaps we should go that extra mile. Under the bill before you today we have tripled it. We have tripled the SSI standards in terms of low-income protections. These are the kinds of exchanges that improved this legislation as we move forward.

And let me say lastly that I am very pleased that the Senate, I believe, will pass legislation and join the House finally in conference to craft a piece of legislation that will become law. Mr. Speaker, I understand the rules of the House in terms of the very narrow line we must tread, and I am not allowed to mention a Senator, but just let me say that a senior Senator, who has been a leader in health care debate for a number of years, frankly needs to be commended, because without his courageous step forward I do not believe the Senate would have moved as quickly or as rapidly as they have to a conclusion on their legislation.

I have enjoyed my conversations that I have had with him over the years, obviously more frequently as I have moved into a position to help effect adding prescription drugs to Medicare. Although we have profound differences in terms of our view oftentimes of the role of the Federal Government and assistance, we have never ever left the focus of policy, and although we may differ, the differences have always been over policy.

Never, ever has he mentioned Jim Jones, Kool-aid, mass suicide. Never, ever in our discussions has he mentioned the Holocaust. Never, ever has he mentioned blacks or slavery. He has always carried on the discussion on the basis of substance and the differences that we have on substance and the fact that in this society, in this civil society, the debate ought to be over choices of a legislative nature rather than trying to create an atmosphere of fear. For that I am grateful for his friendship and the fact that we will meet in conference and, finally, seniors, who are the last bastion of paying the price of retail for drugs, that will no longer be the case. And for that, all of us will be grateful. Policy will have triumphed over politics.

Mr. Speaker, I reserve the balance of my time.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LAHOOD). Although it is permissible to refer to a Senator as the sponsor of legislation, other personal references are not permitted.

Mr. RANGEL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Rhode Island (Mr. KENNEDY).

(Mr. KENNEDY of Rhode Island) asked and was given permission to revise and extend his remarks.)

Mr. KENNEDY of Rhode Island. Mr. Speaker, I would just like to state for the record that the Senator from Massachusetts referred to is my father, and I rise in opposition to H.R. 1.

Mr. Speaker, I rise in opposition to the Republican prescription drug bill.

Our seniors know that Democrats have worked to provide them with universal, affordable, and reliable drug coverage.

And they know that THIS bill is just another Republican attempt to dismantle Medicare.

This bill won't help seniors . . . in fact, there is no guaranteed backstop to insure that there will be drug coverage in their area. Indeed, seniors may end up without ANY drug coverage . . . or forced into an HMO that they do not want to be in.

And the problems with the bill today will only increase in 2010, when premium support and competitive bidding kicks in.

Republicans divide this issue between helping our Nation's elderly now or helping our young in the future, but we can help both.

James, a Boy Scout from Lincoln, Rhode Island, wrote to me because he is worried about his two grandmothers who cannot afford their medications.

I hope he doesn't grow up only to realize that we passed a bill in Congress that actually made it worse for his loved ones.

We should not disappoint James, his family, or the forty million Medicare beneficiaries in this Nation.

Vote "no" on H.R. 1.

Mr. RANGEL. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I think this is one of those days that we will never forget as legislators. This is one of those days that I think as legislators we will never forget. And even though we have some people who have not studied the bill that are so anxious to believe that they are going to get prescription drug relief, I think at the end of the day that they might be able to see that this is the first step that has been specifically designed not to reform the Medicare system as we know it but to dissolve it.

There are some people who are honest enough, at least outside of this hallway, to admit that that is exactly what they would want to do, to dissolve the Medicare. Many of the people on the other side of the aisle, and perhaps a handful on our side, believe that health care should not be an entitlement, Social Security should not be an entitlement; that the free marketplace should be able to work its will; that government should not be involved in providing these type of services.

Ultimately, I do believe that when the bill is studied and they see that the transfer of the ability to determine how much prescription drugs will cost, which prescriptions would be filled, what is the recipient entitled to, when does the bill lock into place, and at the year 2010 what do they do with the voucher if we do not have Medicare, all of these things, I think, will be answered at some time, but I really hope that they are answered today.

We have many people that have worked hard on this bill; certainly the gentleman from Michigan (Mr. DINGELL) has been a champion for health care for decades; the gentleman from California (Mr. STARK), who will be handling the remainder of this bill, the gentleman from New Jersey (Mr. PALLONE), the gentleman from Ohio (Mr. BROWN), and so many others. But as I have said so many times publicly, at some point in time people will be asking, when they were moving to dissolve Medicare, where were you and what were you doing?

I think, as so many votes in the past, that people will remember this vote. And those of us who oppose this piece of legislation will be giving our colleagues an opportunity on voting for legislation that provides all of the coverage that the letter requested from AARP, and while parts of the letter was read, I think it is safe to say that the objections that were raised to the bill or the questions that they had hoped that would be changed, that that is handled in the substitute.

Mr. Speaker, I ask unanimous consent to allocate the remainder of my time to the gentleman from California (Mr. STARK), with the understanding that he be permitted to allocate the rest of the remaining time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from New York?

There was no objection.

Mr. THOMAS. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. FOLEY), a member of the Committee on Ways and Means.

Mr. FOLEY. Mr. Speaker, I thank the chairman for yielding me this time, and to both chairmen who have brought this bill to the floor, I congratulate them for this landmark legislation.

During the rule debate, it was a little depressing to me to hear so many people refer to the fact that our seniors would not be able to figure these programs out. These people we are talking about survived the Depression, they fought in World War II and Korea, they taught us how to read and write, they taught us how to ride our bikes and drive our cars. They are our parents. They are smart enough to figure this out.

I come from a district in Florida, the fifth largest population of Medicare recipients in the Nation, the fifth largest Medicare recipients in the Nation. When I go to town hall meetings, they do not ask for anything free. They want a break. They want a discount. They want an opportunity to shop. They want freedom in the marketplace. But they want security to know they will not go broke. This bill provides that.

The bill provides for a discount card that I helped author, along with Senator HAGEL, which provides immediate access to discount pharmaceutical prices. Real reforms in Medicare allowing generics, something I have heard about on this floor repeatedly from the other side of the aisle. We have to get generics to the market place sooner, faster, quicker, cheaper. That is in this bill.

This bill provides for increased rural funding for hospitals, which is an incredibly important thing for people in my community and rural communities like Glades, Okeechobee, Hendry, and Highlands County. These are Medicare reforms that will save billions of dollars.

□ 1915

Yes, this is an historic night, not one to be celebrating fear and animosity or negative pessimism about our seniors, but rejoicing in the fact that we are helping them provide for themselves and their families.

Yes, there is a phenomenal opportunity tonight to pass a bill that will help seniors in my community. And the instructions they gave me when I first ran for office and have continued to give me is do not make it free, do not make it cheap, do not make it for political purposes, make it so it works. This bill works, and I applaud the leadership for giving us a chance to make history tonight on the floor of the House.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, it is difficult to know where to begin to warn the seniors in this country about this sham of a bill and the beginning of the destruction of Medicare, as the Republicans have wanted to do for a number of years. There is no question that this is a major move toward privatizing Medicare. By the calculations that we have from the last feeble attempt to do this, of course Health and Human Services refuses to give us the most recent actuarial computations, but using the last ones, the Medicare premium for B in this drug benefit would rise to $142 a month if the premium could hold at $35.

By 2010, all Medicare will be privatized and immediately there will be a means test, the first time ever, an attempt to turn a government program into a welfare program, and the interesting thing is that every senior's income data will be turned over to any insurance company in the United States that requests it. So seniors, so much for their privacy. Every one of those people that calls on the phone to sell you some hokey insurance is going to have complete data on your income courtesy of the Republicans.

Mr. Speaker, the sad part even further is that the Republicans would like

to turn this over to private companies to operate it, and it is very interesting that one of the largest and best known private companies, Medco, a subsidiary of Merck was just indicted, or as they say, essentially indicted, by the U.S. Attorney in Philadelphia for a series of crimes committed on our Federal employees' health insurance benefits. This company that the Republicans would turn the management of this drug benefit over to was indicted for canceling, deleting and destroying patients mail order prescriptions to avoid penalties for late filing and mailing; short-changing patients on the number of pills paid for; making false statements to the insurance plan they were contracted with about compliance with mailing timelines; calling and inducing physicians to authorize switching to higher cost medications while representing that this would save money for the insurance company, which was untrue; fabricating records of calls by pharmacists to physicians, and the list goes on.

This is the type of company who supports the Republicans, and they in turn are paying back that favor by offering Medco and Merck and their ilk the opportunity to provide a so-called benefit to seniors. I say so-called benefit because the next cruel hoax in this bill is there is no benefit defined in the bill. Nowhere in the bill does it define a premium, nowhere in the bill does it define a copay, and nowhere in the bill does it define a benefit. Now, we can all do some math and the CBO actuaries tell us that the actuarial value of a suggested benefit might be $1,360. It is important to add that our actuarial benefit for our health employees' benefit plan is probably closer to $3,000, but there is nothing that states in this law that the U.S. Government shall create, provide, or require a benefit of any type. In other words, if the insurance companies cannot be induced or bribed into offering a benefit, there will not be any. This is a nothing bill. It does not provide a benefit.

Now, I guess perhaps Members may not want to just take my word for it, so I think it is important to note what many others might say about the bill.

Mr. Speaker, the Arizona Daily Star says that ''the Democratic bill is better in every respect,'' and that the House drug bill is ''awful'' and ''repulsive.''

The Chicago Tribune says the Medicare debate ''has more to do with campaign 2004 than providing a prescription drug benefit.''

The Long Island Newsday said that ''the proposals racing through the House are a mess. Unless they improve dramatically en route to passage, doing nothing would be better than enacting such flawed laws.''

The Evansville Courier & Press says the ''ridiculously complex Medicare reform now being considered by Congress may be one of the more irresponsible measures in the long history of cradle-to-grave legislation.''

The Akron Beacon Journal says that while the Medicare reform bills would address the lack of drug coverage in Medicare, beneficiaries might be ''no better off with the benefit than they are at present'' because ''on the key issues of affordability, the structure of premiums, deductibles and copayments, both versions follow an elaborate path to disappointment.'' The list goes on.

In North Carolina, the Raleigh News Observer says the bill's actual benefit does not begin to outweigh the drawbacks of its so-called reforms.

The Roanoke Times and World News says even if the drug bill passes, seniors still will have to fear the possibility they will face crushing drug bills.

In Kansas, the Windfield Courier says the doughnut hole ''hurts many seniors when they need the help the most.'' ''The majority Republicans are at risk of passing a Medicare bill that looks, walks and talks like a political campaign creature.''

Washington State, the Seattle Post-Intelligencer says what Congress finally sends to the White House will surely be a disappointment.

The Oregonian says it is difficult to see the congressional proposals for Medicare drug coverage as much more than a big letdown. They are thin in coverage and convoluted in delivery.

Mr. Speaker, I think we can sum this all up, people will say this is drug coverage for old folks. The truth is this bill is nothing but political coverage for the Republicans.

Mr. Speaker, I reserve the balance of my time.

Mr. THOMAS. Mr. Speaker, I yield myself 15 seconds.

Mr. Speaker, Members will find periodically during this 3-hour debate that we will take a very short segment of time to make sure that when an outlandish, outrageous, untrue statement has been made, we will correct the record immediately.

Mr. Speaker, I yield 1 minute to the gentlewoman from Connecticut (Mrs. JOHNSON), the chairman of the Subcommittee on Health for the Committee on Ways and Means.

Mrs. JOHNSON of Connecticut. Mr. Speaker, this bill does not allow the IRS to share your income information with insurance companies. The bill very clearly protects the confidentiality of your information, and there are criminal and civil penalties for violating those provisions. Violators can go to jail.

It is true that for 5 percent of the seniors, they will have a higher threshold for catastrophic coverage. I personally do not believe that someone with a $200,000 income living in a gated community should have exactly the same subsidy as someone struggling along on $25,000 or $30,000 of income. I think that is a strength of this bill. But if someone does not want the government to tell you what your catastrophic threshold is, you can opt out and just take the highest threshold. That is your right. But only 5 percent will fall above the threshold, and we think that is progressive. We think we need to target this benefit at those who need it the most, and that is what we do.

Mr. THOMAS. Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. CRANE), chairman of the Subcommittee on Trade, a long time member of the Committee on Ways and Means.

(Mr. CRANE asked and was given permission to revise and extend his remarks.)

Mr. CRANE. Mr. Speaker, I rise in support of H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003. As a member of the Committee on Ways and Means' Subcommittee on Health, I can say with confidence that this bill is a fair and balanced approach towards providing millions of America's seniors with prescription drug coverage.

Congress is long overdo in helping our seniors with the skyrocketing costs of their prescription medication. Seniors are struggling and we need to help them. But we cannot ignore that the current program without an expensive new drug benefit is not financially stable. The Medicare program is already struggling to provide a finite number of health services to nearly 41 million elderly and disabled. It is imperative that this House takes action before the retirement of the baby boom generation, which will add another 36 million beneficiaries to the Medicare roll. Simply adding a new drug benefit is not the answer.

I support H.R. 1 because it includes a number of reforms that will ensure the long-term fiscal integrity of Medicare through modernization. This legislation gives seniors the same range of private health insurance plans available to Members of Congress and other Federal employees. If seniors do not want to enroll in a private plan, they have the option of staying in traditional fee-for-service.

The time has come for Congress to work together to move past political rhetoric and provide prescription drug coverage for seniors. More importantly, it is time to institute reforms to ensure that future generations will have the security of knowing that Medicare will be there when they retire. I urge my colleagues on both sides of the aisle to support H.R. 1.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from California (Mr. MATSUI), a member of the Committee on Ways and Means.

Mr. MATSUI. Mr. Speaker, I thank the gentleman for yielding me this time.

I have to first of all say that I am extremely disappointed that my colleagues on the other side of the aisle have put this bill before us. It is a shame because if they would have thought through the matter better and instead of bringing up those tax cuts, particularly the dividend tax cut and

the capital gains tax cut, we could have gotten a bill on the floor that all Americans could be proud of, and every senior citizen in this country would not only be proud of, but would have an adequate benefit.

I think this bill is a sham and I think instead of covering senior citizens, what we are doing is giving my Republican colleagues cover, political cover that eventually the senior citizens will lift and begin to understand what this bill is really all about. I guarantee Members by the fall of this year, senior citizens in America will understand this bill and they will be very, very unhappy with a vote in favor of this legislation.

When we think about it for a minute, this bill does not do much at all. If a senior citizen has $5,000 worth of prescription drug coverage in any given year, the senior citizen will have to pay $4,000 immediately, $4,000 of the first $5,000 of coverage before they can even get $1 of Federal government benefit. They have to have $670 that they have to pay out in the form of monthly premiums, in the form of copayments.

□ 1930

And so this bill is not a good bill for senior citizens.

In addition to that, this bill will ultimately in the next 5 years begin the erosion of Medicare as we know it. Newt Gingrich had said when he became Speaker of the House a few years ago that he wanted to see Medicare wither on the vine. We had the gentleman from California (Mr. THOMAS) just the other day say on national television, ''Those who say that the bill would end Medicare as we know it, our answer is, 'We certainly hope so.'" Because what they really want to do is privatize Medicare, make it so that insurance companies could increase premiums to whatever they want to do and only insure the healthy senior citizen so that the chronically ill will ultimately wither on the vine.

This system that is being put forward today is one that will in fact do major damage to the Medicare system in America. Why did we have Medicare in 1964 in the first place? Because we knew senior citizens could not get coverage because seniors by their very nature are the ones that get ill and the ones that ultimately go into very, very difficult physical situations. And so ultimately what we are going to have is going back to 1964 with this legislation. That is their intent, because they want to see Medicare wither on the vine.

This bill is a bad bill and we need to vote ''no'' on it so the American public understands exactly what my colleagues on the other side of the aisle are attempting to do.

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume.

This is the first mention of the quote that I made, and it is not surprising that the quote is certainly truncated. Perhaps a journalism spot on The New York Times might be available to some of my colleagues given their ability to take reality and distort it. Here is my quote:

''Some of our friends on the other side of the aisle are saying that if this bill becomes law, it will be the end of Medicare as we know it. Our answer to that is, We certainly hope so. Why should seniors be the last group that pays retail prices for drugs?'' We have not heard that from the other side.

''Old-fashioned Medicare isn't very good. Why should the insurance for seniors be called MediGap? I think that indicates just how good the insurance is.'' We have not heard that from the other side.

But what I did say was, you will hear scare tactics. But seniors with extremely high drug costs when this becomes law will save more than 60 percent of their current costs if they spend $10,000 a year on prescription drugs today. That is real change. That is real progress, making Medicare a real day-to-day benefit. I would say to my colleagues, if you really think that current Medicare should not end, why in the world did you put up such a fit to have a substitute so that if we accept your bill, current Medicare as we know it will end as well? Half quotes are not going to get it done. Try the full quote, because if you do, you will vote ''yes'' on this bill.

Mr. Speaker, it is my pleasure to yield to the gentleman from Pennsylvania (Mr. GERLACH) to enter into a colloquy.

Mr. GERLACH. Mr. Speaker, I thank the gentleman from California for his dedication to adding a prescription drug benefit to Medicare. Members of the Pennsylvania delegation have some concerns as to whether State pharmaceutical assistance programs like PACE and PACENET in Pennsylvania will be able to fully coordinate their programs with Medicare drug plans to provide a seamless transition for beneficiaries and States that already have prescription drug plans.

Mr. THOMAS. I will tell the gentleman from Pennsylvania that we have a generous amount, and we believe it will be appropriate; but certainly as we get to conference, our intent is to provide a seamless transition for beneficiaries and States and that will be done.

Mr. GERLACH. I thank the gentleman.

Mr. THOMAS. Mr. Speaker, it is my pleasure to yield 2 minutes to the gentleman from Pennsylvania (Mr. ENGLISH), a member of the Committee on Ways and Means.

Mr. ENGLISH. Mr. Speaker, I rise in strong support of the bill before the House today. This bill is the most historic and significant addition to Medicare in the program's history. This Medicare bill offers enormous benefits for all of Pennsylvania's seniors while saving the Commonwealth hundreds of millions of dollars. The Medicare Prescription Drug and Modernization Act provides all seniors with a thorough, flexible, and voluntary prescription drug plan while at the same time augmenting Pennsylvania's PACE plan. Importantly, for the nearly 2 million seniors in Pennsylvania, this bill would allow PACE to wrap around the Federal benefit which would largely supplant and build on PACE's current benefits. And to ensure that Pennsylvania's seniors get maximum drug coverage, this Medicare bill would allow PACE to pay for beneficiaries' copays under Medicare while at the same time counting those contributions toward out-of-pocket expenditures to more rapidly trigger catastrophic coverage.

Our seniors have waited too long to receive the benefits that they deserve. This flexible, voluntary, and affordable plan would provide seniors with dependable benefits. This is a huge benefit for seniors in the roughly 10 States that have a significant State plan already in place.

Mr. Speaker, this bill also provides real help to America's rural health providers to allow them to deliver the highest quality care to seniors and meet the demanding fiscal challenges that they currently face. In many rural areas like my own district of western Pennsylvania, inequities in Medicare's wage reimbursements and payments for hospitals often drive workers, especially skilled nurses, to look for jobs in higher-paying metropolitan hospitals and contribute to staffing shortages in many local communities.

Several provisions in this bill mirror legislation I introduced earlier this year to help alleviate those high costs by increasing Medicare's salary reimbursements to our hospitals. These two provisions would pump $13.3 billion into the struggling rural health systems, and I am pleased to note that hospitals in my district alone would receive approximately $65 million as part of this fix. I ask for support for the bill.

Mr. STARK. Mr. Speaker, I am pleased to yield 3 minutes to the gentleman from Michigan (Mr. LEVIN).

(Mr. LEVIN asked and was given permission to revise and extend his remarks.)

Mr. LEVIN. Mr. Speaker, the Republican bill contains a ticking time bomb, a ticking time bomb of Medicare privatization set to go off in 2010. Under this bill, starting in 2010, seniors, in essence, would receive a voucher instead of Medicare's guaranteed benefits, instead of open access to doctors and hospitals and predictable costs.

Seniors who cannot afford to pay more than they do right now would have to leave Medicare and join HMOs. This so-called benefit for prescription drugs in the Republican bill serves as a decoy, but it is not a very good one.

The Republican drug plan is insurance without assurance. No assured premium, no assured deductible, no assured size of the gap between the basic coverage and stop-loss, no assured list of drugs, no assured list of pharmacies, no assured plan from one year to the

next. It could change from year to year.

From the very beginning, Republicans have wanted to use prescription drugs as leverage to end Medicare. The President said earlier to seniors, we will give you some prescription drug help depending on whether you leave Medicare and join an HMO. And now what this Republican bill is doing is using a very inferior drug insurance plan in 2006, not until then, to make everything except HMOs unaffordable for seniors in 2010. The chairman did say just a few days ago, ''Old-fashioned Medicare isn't very good,'' and I quote his quote. What Republicans call old-fashioned Medicare is the system of guaranteed benefits, set premiums and deductibles and access to doctors and hospitals that have served seniors so well since 1965. Republicans want to end all that, but current and future Medicare beneficiaries do not. And we Democrats intend to keep fighting for those good aspects of old-fashioned Medicare. Indeed, it has been very, very, very good.

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume. If it has been very, very good, why did the Democrats fight for a substitute which will change the structure significantly?

Mr. Speaker, I yield 1 minute to the gentlewoman from Connecticut (Mrs. JOHNSON) to point out once again an absolutely outrageous statement that cannot go unchallenged.

Mrs. JOHNSON of Connecticut. Mr. Speaker, scare tactics have no place in this debate. There are no vouchers in this bill. In 2010, a senior that wants to be in the Medicare program will be in the Medicare program exactly as they are now. They will be in that Medicare program and have that choice of the Medicare program in 2010, in 2011, in 2012, in 2013. They will never receive a voucher. That word is not in this legislation. It is used rhetorically to scare seniors. I want to assure the seniors listening that this bill represents the most dramatic expansion of benefits under Medicare since the program was founded, not only prescription drugs but additional preventive benefits and a whole system to support seniors with chronic illness.

Mr. STARK. Mr. Speaker, I am happy to yield 3 minutes to the gentleman from Maryland (Mr. CARDIN). The gentleman from Maryland understands that with proponents like THOMAS and JOHNSON, the seniors do not need any scaring from us.

Mr. CARDIN. Mr. Speaker, I oppose the passage of this bill. The passage will make it much more difficult for Congress to enact a meaningful prescription drug benefit for our Nation's seniors. Let me give you five reasons why.

Reason number one. There is no guaranteed benefit in this bill. Unlike seeing a doctor or going to a hospital, we cannot tell our seniors that their prescription drugs will be covered. It will be different in different parts of the country. Mr. Speaker, I tried to correct that by offering an amendment in the Committee on Ways and Means, and it was rejected by the Republicans. I tried to give this body an opportunity to vote on it, but the Committee on Rules would not make that amendment in order.

Reason number two. We are set on a course to privatize Medicare. Only private insurance can participate in the prescription drug coverage. Private insurance only has to offer a 1-year commitment. Mr. Speaker, my citizens of Maryland remember when we had Medicare+Choice; 100,000 Marylanders lost their coverage when all eight HMOs left Maryland. It is irresponsible to claim that private insurance companies are eager to return to a market that they have abandoned in the past.

Reason number three. This bill will jeopardize coverage for seniors who have good private retiree prescription drug coverage today. CBO has estimated that 30 percent of our seniors who currently have their own private coverage for prescription drugs through their prior employment will lose those benefits as a result of the enactment of this legislation.

Reason number four. We are missing an opportunity to bring down drug prices. The legislation specifically prohibits our government from using the purchasing power of 40 million beneficiaries to lower drug prices just like the Canadians do.

Reason number five. The benefits are inadequate. The Republicans project that this bill will provide for a $35 a month premium, $250 deductible, then some help up to $2,000, but then our seniors are on their own for the next $2,900. Our seniors are expected to pay a $35-a-month premium when they are not entitled to any benefit for a good part of the year. I think that is unrealistic.

My Republican friends say, well, you only have $400 billion. We offered alternatives within $400 billion that would provide real benefits. I offered a substitute that said, look, if you cannot afford all drugs, let us at least cover drugs for those illnesses such as high blood pressure and coronary artery disease and diabetes and severe depression. But, no, the Committee on Rules would not allow this body to decide whether that would be a better package and a guaranteed benefit package.

Mr. Speaker, I cannot support a bill that provides no guaranteed benefit, relies solely on the whim of private insurance companies, causes harm to seniors who currently have adequate prescription drug coverage, will not do enough to bring down the cost of prescription drugs, and provides inadequate benefits. Therefore, I will vote ''no'' on the Republican bill.

Mr. THOMAS. Mr. Speaker, I yield myself 1 minute.

You know, it just kind of makes you wonder what the Democrats did for 30 years when they were the majority, because, you know, when Republicans became the majority in 1995, there was literally no prevention and wellness in Medicare. We are the ones that are supposed to be destroying Medicare? We are the ones that added diabetes. We are the ones that added osteoporosis. We are the ones that added prostate and colorectal screening. We are the ones that added the mammography. In fact, in this bill that they continue to speak against, we provide for the first time every new beneficiary should have a physical.

□ 1945

I want to underscore that. Every new beneficiary should have a physical. In addition to that, we believe that cholesterol screening has now been advanced, and it should be provided as well.

I find it amazing that they go back to the same old scare statements.

Read the bill. It is an enhanced and an improved Medicare. What in the world were you doing for 30 years? The fact of the matter is you did not have a competent challenge.

What we have done is provide real change, and they are afraid those old frayed bumper stickers will not work anymore.

Mr. Speaker, I yield 3 minutes to the gentlewoman from Washington (Ms. DUNN), a very valued member of the Committee on Ways and Means.

Ms. DUNN. Mr. Speaker, I for one am very proud that the President in his State of the Union address directed the Congress to put together a program that will cost about $400 billion to provide prescription drugs for seniors because I think it is time to keep our promise to the people we represent and provide a comprehensive and voluntary prescription drug benefit for all seniors.

We have all heard stories of seniors paying too much for prescription drugs. This problem is even more acute among low-income seniors, especially for women who comprise half of Medicare beneficiaries with annual incomes below 150 percent of the poverty level. In this bill we help seniors on fixed incomes and those with high drug costs. A woman, for example, with an income of less than $14,400 today, which is 150 percent of poverty, will receive assistance from the Federal Government for prescription drugs. While all seniors will benefit, nearly 11 million or 34 percent of Medicare beneficiaries will qualify for additional assistance when this bill is fully implemented.

Improving Medicare is not only about providing a drug benefit, but it is also about giving seniors access to doctors, hospitals, Medicare HMOs, and other services they need. To ensure access to doctors, we address the low reimbursements that they are receiving. We also increase funding for rural hospitals so that seniors can get the health care service they need right in their community.

For Medicare HMOs, this bill requires Medicare to accurately account for

military retirees in the formula and that means higher Medicare+Choice reimbursements in areas with military facilities. Strengthening Medicare also means improving the quality of life for every senior. For this reason I am very happy that we were able to provide preventative services like cholesterol screening, initial physical exams and chronic care management to help those seniors with serious diseases.

Seniors will also have access to innovative treatments to deal with rheumatoid arthritis and other chronic diseases. This bill provides seniors immediate access to self-injectable biologics. Besides providing the choice of which drug works best for rheumatoid arthritis, these self-injectable treatments will allow seniors to receive treatments right in their homes instead of going to the hospital or to a physician's office and will take the burden off those hospitals, clinics and doctors.

This is a real prescription drug plan, Mr. Speaker. It is one that provides up to 25 percent in drug discounts for manufacturers. It covers seniors to participate in the drug program, and it protects those with very high drug costs. It strengthens Medicare's future without compromising the benefits seniors enjoy today. I ask my colleagues to support a real prescription drug by passing this legislation.

Mr. STARK. Mr. Speaker, I yield 3 minutes the gentleman from Washington (Mr. MCDERMOTT), a member of the Committee on Ways and Means, who understands that seniors are going to have to pay 4,000 bucks for the first $5,000 of drugs regardless.

Mr. MCDERMOTT. Mr. Speaker, well the rubber stamp Congress is ready tonight. The drug companies, after they contributed and got the President elected, gave him this bill, and they said this is what we want. The President brought it up here. We are rubber stamping it out of here. Can you believe that the Senate, excuse me, in another part of this building they are considering something like 400 amendments, but we cannot have one because when you are using a rubber stamp, you cannot have one single amendment in here. Nothing can be improved in this bill. Can you believe it? It is like the Ten Commandments. It is perfect. It came down from God or somewhere, or the White House.

This bill was put together by drug companies, 10 of them. They had $38 billion in profit last year. That is 50 percent of the profit of the Fortune 500. If the Members think they did not have an impact on this bill, why do they want to privatize? Why do they want to give no guaranteed benefit? Why do they want to have all openness in the world? And why do they put the one line in there that says that the Secretary cannot negotiate on behalf of 40 million people, soon to be 80 million people? They want it all broken up into little different pieces so they can divide and conquer. This little agency will get so much. But a little bit bigger one, we will give them a little bit higher benefit. They are going to divide and conquer the American people. This is a sham.

In Canada they get their price reduced very simply by saying let us make the Canadian price the average of the G–7. The United States is way up here and Canada is way down there. Why could we not pass a little amendment in here that said let us give the average of the G–7? I do not know. In my State everybody goes across the border to Canada or they mail across the border. They do it in Vermont. They do it in New Hampshire. They do it in Maine. They do it in New York State. Why? Because everybody knows the Canadians have got a better deal than we. But you say no, no, we cannot make one change. When we are sent in here with our rubber stamp to approve of everything George Bush does, we have to give him the bill exactly as he sent it over here.

The idea that you could come out here with a bill and say that we have a perfect piece of legislation, the seniors are like Abraham Lincoln. Do you remember, the founder of the Republican Party? He said, You can fool some people all of the time and all of the people some of the time, but you cannot fool all the people all of the time.

I know the President is going to raise $200 billion for ads in this campaign to say this, I got this from that rubber-stamped Congress and it is good for you, and he is going to give the tax cuts and the child never left behind, and he is going to give this stuff, and every one of those is phony. The child never left behind? He puts a budget out here $17 billion short to fund it, and the people are going to figure it out.

Counting on believing that the American people are stupid is not a good political way to go. Vote against this bill because the rubber stamp is wrong.

Mr. THOMAS. Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. SHAW), a valued member of the Committee on Ways and Means.

Mr. SHAW. Mr. Speaker, I thank the chairman for yielding me this time.

This is probably, I think without question, one of the most important sessions that this Congress has had regarding Medicare since its inception. We have heard a lot of argument about old fashioned Medicare and new Medicare and the changes, and the truth be known, both political parties understand that medical treatment has changed in the last 40 some years since Medicare first came on line. We know that. Drugs are more important to keep the seniors out of hospitals, to keep them mobile, to keep their quality of life moving. So this is a very important thing, and it is important that we put this in the Medicare law. And it is very important that we make it where the seniors can afford it.

Florida has the seven most heavily used Medicare congressional districts in the country. I have seen on more than one occasion, while standing in line waiting for a prescription to be filled, somebody going up. I have a very vivid memory of the last one I saw, this elderly lady coming up and finding out what her prescription drugs was going to cost and looking at this bottle and that bottle and then handing that bottle back. She was low income. This bill will take care of her. She will be taken care of under this bill, and she will not have to give that bottle back because she needs it. These are prescription medicines, these are what control her quality of life, and this is a good bill.

The Republican bill looks after the low-income people first, and it also takes care of those who are the heavy drug users because of the illnesses that they are suffering from. Obviously we can sweeten the pie by increasing the expenditures, but we heard tonight one of the Members from the other side was saying that we are letting it wither on the vine. We are putting $400 billion into Medicare. We are propping it up. We are putting some reforms in there, we are putting some cost containments in there that is going to make it a better deal. The price of drugs because of the Republican bill will come down, and the people that need it most, the heavy users and the low income, will be taken care of.

This is a very good bill. It is one that the Congress should definitely, definitely pass. H.R. 1, its time has come and it is time for this Congress to act. I compliment the chairman and all of those who did this very complex bill and put it together. It is a good bill and it is one this Congress should pass.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Wisconsin (Mr. KLECZKA), a member of the Committee on Ways and Means, who, unlike the authors of this bill, did not spend his entire life in the public trough but actually worked in private enterprise; so he understands what privatization is.

Mr. KLECZKA. Mr. Speaker, I worked for an insurance company before I was elected to the legislature.

So with that as an opening, Mr. Speaker, let me say to the body that in my view this is the beginning of the end of the Medicare program. For 38 years Medicare has provided seniors with quality health care, a defined benefit, and whether one lived in California, Alaska, Maine, or Florida, the premium was the same, they knew what the benefit was, and they knew what the services were, and it has worked.

So there are those in this House who say there has been a change in the way we deliver medicine today, and that is called drug therapy. Let us add that coverage to the Medicare program and we can use the purchasing power of the Federal Government to get the best deal on drugs for in excess of 40 million people. And there are those on the other side of the aisle who say no, we do not want to do that, and the reason is because that is going to cut into the

drug profits of their friends, the drug companies. But know full well, Mr. Speaker, we do it for the VA and it works and it works well.

So instead of doing a benefit connected to the Medicare program, what we are doing is we are going to send our seniors out to the private insurance market, we are going to tell them go shop for a drug-only policy. The policy that is being offered in this bill has one big problem, and that is once one spends $2,000 on drugs in any one year coverage stops until their expenditures total $4,900. Know full well during that period they are paying 100 percent of their drug cost. Their premiums go on. They are paying premiums and getting no benefit. There is something wrong with that system, and that is why this bill is very bad in that respect.

The other problem with the bill is we had this program for a couple years now called Medicare+Choice, and we are going to show those seniors that the private market who did not want them 35 years ago wants them now. They are holding their arms open. We want the seniors because we know they have a lot of drug costs and a lot of health care costs. So the Committee on Ways and Means and this Congress go along with this Medicare+Choice. What it is, is a private insurance company selling policies to seniors. Milwaukee, where I come from, has four of these companies and they were peddling these policies and offering the sun and the moon and all of a sudden bingo, three of them go belly up, the seniors have to scurry to get back into some type of Medicare program, and today we have one left. One left.

□ 2000

And the reimbursement for that one Medicare+Choice program is 110 percent of the Medicare rate. So clearly, we are not saving a heck of a lot of money with that Medicare choice plan.

Well, it is a failed experiment, Mr. Speaker. So what are we doing in this bill? We are changing the name. We are going to call it Medicare Advantage, and it is supposed to look and smell better; but, my friends, it is the same thing that has failed in the past. It will fail again.

Mr. Speaker, I urge a ''no'' vote on this legislation.

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, well, I guess, if all of the innovations are going to fail, what will be left is the current Medicare. I find it interesting that one of the reasons the gentleman from Wisconsin (Mr. KLECZKA), my friend, is going to vote against the bill is because there is no government ultimate negotiation of the price.

Let me tell my colleagues a story, and I believe before I give my colleagues the punch line, they will know the story. We have government negotiation of price. And as is typically the case, currently, in law, in the Medicaid program, it is called ''best price.'' That is where government determines how much the drug is going to cost. It is going to be the best price.

When we looked at ways to change Medicare, we looked at the ''best price'' concept. Guess what? We sat down with the Congressional Budget Office and we said, what would happen if we did not use best price? They sat down and calculated and they said, you know, if you actually had competition for the drugs, instead of putting in the government phony floor of ''best price,'' you could save $18 billion. Do my colleagues know why we do not have government negotiating the price? It would cost us tens of billions of dollars over a real negotiation on drugs. Yet, here we are, hearing the same old same old: I am going to vote ''no'' because we do not have government dictating the price. That is what has gotten us into the problem in the first place.

Mr. Speaker, it is my real pleasure to yield 3 minutes to the gentleman from Illinois (Mr. WELLER), a member of the Committee on Ways and Means.

(Mr. WELLER asked and was given permission to revise and extend his remarks.)

Mr. WELLER. Mr. Speaker, tonight we hear some partisan political rhetoric, particularly from the other side of the aisle, who began this process by announcing they were going to oppose the bill. It does not matter what is in it; they are going to oppose it.

So I think the important question that we really should ask is: What does this mean, this modernization of Medicare? What does it mean that we are modernizing Medicare for the 21st century? What does it mean that we are investing $400 billion in modernizing Medicare with prescription drugs?

When I think of prescription drug coverage, I think of the seniors who I have met over the 9 years I have had the privilege of serving in this body. They are men and women who I have talked with in their homes who sit there and they sit in that easy chair and right next to their chair, they have that tray, a tray full of pill bottles, and they talked and shared with me the choices they have had to make, whether or not they go to the drugstore, the grocery store that particular week because of the expenses they are facing because of rising prescription drug costs.

Well, those are the people that are the primary beneficiaries of this legislation. Because we have a plan before us that helps those who are truly needy, low-income, by ensuring they pay no premiums; and for others, they pay a pretty affordable premium. This plan would cost a senior about $35 a month, $1 a day. Think about that. A dollar a day for a senior participating in this plan. And if you qualify for Medicare today and you are going to be eligible tomorrow, you qualify and are able to take advantage of this new prescription drug plan. But for a dollar a day, it is projected you could save anywhere from 30 to 70 percent of your prescription drug costs.

Think about that. When you think of that elderly man or woman who you have had the opportunity to talk with in their home and sit there while they are seated in that chair, perhaps they are home-bound, they have that tray of pill bottles, and they are, frankly, very concerned because they cannot do much else, other than buy their drugs and hopefully get to the grocery store, they are going to really benefit from this plan. It is affordable. It is available for all seniors.

We also give seniors choices. It is affordable, a dollar a day, $35 a month; it provides real savings, 30 to 70 percent that is projected by nonpartisan analysts who look at this and say, what does it really mean, is the question they ask. To qualify for Medicare, you qualify for this program, and you are going to have choice. You do not have to pick the one-size-fits-all that some of my friends on the other side of the aisle want to have and say, seniors, you only get one choice, and we are going to tell you what it is.

Mr. Speaker, we are going to give seniors more than one choice so they can find a plan that best fits them. Think about that. That is what this really means. We are helping seniors who need help with their prescription drug costs. We are modernizing Medicare for the 21st century. We have a plan that is almost 50 years old that has not changed. We are going to modernize it. The most important choice that seniors face today is, of course, the availability and affordability of prescription drug costs.

Mr. Speaker, this is a commonsense plan. It deserves bipartisan support. I hope my friends on the other side of the aisle will do the right thing. I recognize that they set out today with a decision to oppose the bill, regardless of what is in it. Well, let us work together. Let us provide a bipartisan vote to provide prescription drug coverage that will help every senior in America.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume, because I do not intend to let unsubstantiated remarks go unchallenged either.

We do not oppose this bill because of what is in it, because there is nothing in it. There are no benefits in it. There is nothing in the bill except to spend money to get private insurance companies, if they decide to come.

Mr. Speaker, I yield 3 minutes to the gentleman from Georgia (Mr. LEWIS), who recognizes that.

Mr. LEWIS of Georgia. Mr. Speaker, here we are once again debating Medicare. Thirty-eight years ago, the Republicans did not like Medicare, and they do not like it now. In 1965, 88 percent of Republicans voted against Medicare. And here they are, once again, trying to privatize prescription drugs for seniors, just like they tried to privatize Medicare.

This is just another scheme by the Republicans to entice older voters. Not

last week, not last year, but just yesterday, the gentleman from California (Mr. THOMAS), the Republican chairman of the Committee on Ways and Means, made it crystal clear when he said, ''To those who say that the bill would end Medicare as we know it, our answer is: We hope so.'' He went on to say, ''Old-fashioned Medicare is not very good.'' Tell my mother. Tell your mother that old-fashioned Medicare is not good. Tell your grandmother, tell your grandfather that old-fashioned Medicare was not good. It was good in 1965. It was good yesterday. It was good then, and it is still good right now. We do not need to destroy Medicare. We need to save and strengthen Medicare.

Mr. Speaker, this bill is just another Republican scheme to deceive our seniors, to deceive our elderly. That is not right. That is not fair. I want my Republican colleagues to tell the American people the truth. We must tell our seniors that the Republican bill does not offer our seniors the basic right to affordable prescription drugs. We must and we will tell the American people that the Republicans want to privatize Medicare.

We must tell the American people the truth. This is no time to play partisan politics with the lives of our seniors.

The clock is running. Time is running out. My Republican colleagues, you still have time to do the right thing. Do not turn your back on our seniors, on the elderly. This is a matter of life and death.

I beg, I plead with my colleagues to vote against the Republican bill, not just for our parents, our grandparents, our children, but also for generations yet unborn. Old-fashioned Medicare was like a bridge over troubled waters. It was reliable. It was dependable then, and it is still dependable.

Ask the seniors, ask the old people who live on fixed incomes in our cities and rural areas. I say to my Republican colleagues, follow the dictates of your conscience. You have a moral obligation, a mission, and a mandate to uphold the legislation of 1965 when Lyndon Johnson signed the Medicare bill.

I urge my colleagues to vote against this unreliable bill.

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, I will tell my friend from Georgia, we do not intend to turn our backs on seniors. Indeed, we intend to reach out our hand. If someone wants to stay in yesterday's Medicare, they can tomorrow. We want to make sure of that, because in 1965 and yesterday, there were no drugs, there was no preventive care, there was no disease management, that by passage of this legislation, tomorrow there will be.

But Mr. Speaker, as we have carried on this debate about improving Medicare, and I know that to my friends on the other side of the aisle $400 billion does not look like much to them. I understand they are going to offer a substitute that proposes spending $1 trillion, rather than the $400 billion.

But at some point in this debate, we ought to realize that we are in the middle of the greatest intergenerational transfer of wealth in the history of the world. Because while we strive to provide a decent and appropriate health program for seniors, we all know someone else is going to be paying for it. And so we really ought to focus on what we are trying to do to make sure that the young people who are going to be carrying this bill understand that while we are providing additional benefits to seniors, we want to make sure that the program stays within the reasonable bounds of the $400 billion that we are proposing to add to Medicare.

Mr. Speaker, to insist on focusing on that, it is my real pleasure to yield 4 minutes to the gentleman from Louisiana (Mr. MCCRERY), the chairman of the Subcommittee on Select Revenue of the Committee on Ways and Means.

Mr. MCCRERY. Mr. Speaker, I rise in support of this legislation which reforms Medicare and adds prescription drugs to the program; but I arrived at this position of support haltingly, grudgingly, reluctantly. I will tell my colleagues why.

I was reluctant to support this bill because I believe the current Medicare program as it is structured is financially unsustainable. I believe it is only a matter of time before, as the financial experts tell us, Medicare, one of the two fastest growing programs in the Federal Government, consumes an ever-larger and larger share of our national income; an ever-larger and larger share of our Federal budget, with the potential to crowd out spending on other government priorities. And, as we all know, there are numerous, very important priorities of government. Health care is not the only one. I believe, Mr. Speaker, that as that occurred and as policymakers in Congress realized that Medicare was crowding out other spending, causing us to reduce our commitment to other priorities, we would do as most other countries that have similar programs have done: we would start to ration health care for our seniors. I do not want to do that.

So, Mr. Speaker, I was reluctant to add to the current program, which is going to go belly up or bust the budget, a new entitlement program, prescription drugs, which would exacerbate that situation, which would make it worse, which would get us to that point where we would have to start rationing health care faster. Yes, I was reluctant to do that.

But as I studied the bill and listened to those who put together the components of the bill, I realized that the reforms contained in the bill, particularly those beginning in the year 2010, which give us a chance to move Medicare into a form much like the FEHBP program, the premium support model that the Medicare Commission recommended several years ago, then I realized that this is maybe our last best chance to save Medicare in a way that we can afford it as a society, and deliver quality health care for our seniors.

□ 2015

So, Mr. Speaker, I am here after much thought and consideration and yes, reluctantly arriving here, but I am here because I do believe this is our best chance to save Medicare, to make it a truly viable program that will not bust the budget, and if we do not take advantage of this opportunity and I want to speak, Mr. Speaker, through you to the conservatives out there on both sides of the aisle about supporting this bill, do not blow this opportunity. If you are a conservative, if you are concerned about the cost of the Medicare program, do not miss this opportunity to give us the best chance to reform it in a way that can save costs over the long term, that can keep us from rationing health care, not only for our seniors, but I believe eventually for all of our society.

Mr. Speaker, I urge everyone to support this bill tonight and hope and pray that the reforms contained therein work.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, how short memories are. It was just an hour ago that we threw away $174 billion on useless medical savings accounts and over the last year or two we gave $800 billion in inheritance tax relief to an average of 10,000 people a year so we could punish a hundred million people a year by destroying their Medicare. They just do not remember. But the gentleman from Massachusetts, the distinguished member of the Committee on Ways and Means (Mr. NEAL) remembers.

Mr. Speaker, I yield 3 minutes to the gentleman from Massachusetts (Mr. NEAL).

Mr. NEAL of Massachusetts. Mr. Speaker, let me thank the gentleman from California (Mr. STARK) for yielding me time.

Only in this Chamber over the last few months could we have written $2 trillion out of our tax system irresponsibly over the next decade and then say that the cost of Medicare is unsustainable. Only in this Chamber could we have this debate from a political party who says, let us not take a truncated quotation. Let us not take a scare tactic. But you know what? You cannot truncate history.

When I came to this House 15 years ago, the Republican leader in the Senate, Bob Dole, had voted against the establishment of Medicare. The Republican leader in this House, Bob Michel, wonderful human being, had voted against the establishment of Medicare. And they say, do not use these quotes because they are not true. They are not for real.

Speaker Gingrich said, in time we would let Medicare wither on the vine. The third ranking Republican in the United States in the other body down the hallway, said recently, I believe the

standard benefit, the traditional Medicare program, has to be phased out. And they say, but trust us on Medicare. Do not be skeptical of our intentions. We have come to love Medicare.

There is not anybody on that side of the aisle that believes that tonight and there certainly is not anybody on this side of the aisle that believes that tonight as well. And then they argue, well, we have improved Medicare. Think of what we might have done without those tax cuts over the last 2 years.

A predictable, carefully defined benefit would have been in place for Medicare recipients. It is the closest thing, Medicare, that this Nation has ever had to universal health care. It is an extraordinary achievement for those who turn 65 years old, and they refer to it as old-fashioned Medicare and we are to trust them. But let us talk about Medicare+Choice where I live in Massachusetts, the private sector's answer to the problems of Medicare.

Well, they are all gone and the ones that are not gone have jacked premiums through the roof. They do not want to take care of the most vulnerable and whether we have a debate about government tonight and its role or not, that in the end is what government does. It takes care of those who are outside the mainstream of this economic life. Not the top 1 percent of the wage earners in this country, not those who benefit from the repeal of an estate tax. It is government that does that.

Medicare is a legacy and an amendment to the Social Security program, the greatest achievement domestically in this Nation's history. And that amendment in Medicare is a greatchild and a success of a determined Congress and an enlightened President, Lyndon Johnson. Tonight let us stand with history, stand with Roosevelt and stand with Lyndon Johnson on what Medicare has done to make us a much more equitable society. What a great achievement it is.

Reject the notion tonight of where they are going to take us, and that is down the road to privatization of Medicare.

Mr. STARK. Mr. Speaker, may I inquire of the time remaining?

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from California (Mr. THOMAS) has 7 minutes remaining. The gentleman from California (Mr. STARK) has 12 minutes remaining.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Texas (Mr. DOGGETT), a member of the Committee on Ways and Means.

Mr. DOGGETT. Mr. Speaker, since President Lyndon B. Johnson signed Medicare into law over massive Republican resistance, Republicans have never ceased in their determination to end Medicare. We all remember the partner of the gentleman from California (Mr. THOMAS), former House Speaker Newt Gingrich, who insisted that Medicare should be allowed ''to wither on the vine.'' He has been chattering again this month, that Medicare is an ''obsolete government monopoly.''

The gentleman from California (Mr. THOMAS) joined him yesterday by declaring, ''To those who say that [the bill] would end Medicare as we know it, our answer is: We certainly hope so.'' ''Old fashioned Medicare isn't very good,'' he added.

The gentleman may not like reporters, especially if they report, but really there is nothing new or inconsistent in this statement and many that he has made for years. He just referred a few moments ago to Medicare as ''yesterday's Medicare,'' denigrating and deriding it. ''Yesterday's Medicare,'' ''old fashioned Medicare'' has served millions of Americans pretty well.

The one problem we have with it is not the result of a defective Medicare. Rather the failure to deal with the outrageous, predatory pricing of prescription drugs has resulted from the sustained collusion of House Republicans and pharmaceutical manufacturers. We can do something meaningful about that, but this bill is not it.

What of this plan that seniors are finally offered tonight? It is basically a ''pay a lot and get a little'' plan. If you are a senior and you have been hoping and praying we would finally be able to overcome this Republican resistance and deal with prescription drugs, what do you get from this bill according to its own clear language? Well, this year you get nothing. Next year you get nothing. The year after that you get nothing. Oh, yes, you are entitled to a discount card. It is as valuable as one of those cards you pull out of a cereal box. With it and a dollar or two you can get a cup of coffee, but it does not guarantee you a cent of reduction in the cost of your medications.

Finally, in 2006 you get all their much ballyhooed help. If you have $4,900 in drug bills, and that is mighty easy to get at today's outrageous prices, you pay $3,500, and you get $1,400 paid for you, and that is only if you also pay an unknown premium, already estimated at least $35 per month. And such incomplete coverage at such a cost tells us what this initiative is really all about. This is a plan to eliminate Medicare and force seniors out into inadequate private insurance plans. This is not a prescription drug. This is a prescription for disaster.

I hope that our Republican colleagues continue holding up this poster about ''strengthening Medicare'' that they have been showing here because it looks like the type of solicitation scams that so many seniors receive weekly. Their poster shows seniors out frolicking on the beach because of all the benefits they will get, when in fact seniors will be denied the very protection they so desperately need on their prescription drugs. That is because those who are proposing this bill are the same folks, who tried to undermine Medicare from the time Democrats and Lyndon Johnson got it passed through Congress in 1965, and they have not relented until this very moment.

Mr. THOMAS. Mr. Speaker, I ask unanimous consent to place in the RECORD an exchange of letters between myself as chairman of the Committee on Ways and Means and the gentleman from Virginia (Mr. DAVIS), chairman of the Committee on Government Reform.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON WAYS AND MEANS,
Washington, DC, June 25, 2003.

Hon. TOM DAVIS,
Chairman, Committee on Government Reform, House of Representatives, Washington, DC.

DEAR CHAIRMAN DAVIS: Thank you for your letter regarding H.R. 2473, the ''Medicare Prescription Drug and Modernization Act of 2003.''

As you have noted, the Committee on Ways and Means has ordered favorably reported, as amended, H.R. 2473. The general text of this legislation will be incorporated into H.R. 1, the ''Medicare Prescription Drug and Modernization Act of 2003.'' I appreciate your agreement to expedite the passage of this legislation despite affecting programs within the jurisdiction of Committee on Government Reform. I acknowledge your decision to forego further action on the bill was based on the understanding that it will not prejudice the Committee on Government Reform with respect to the appointment of conferees or its jurisdictional prerogatives on this or similar legislation.

Finally, I will include in the Congressional Record a copy of our exchange of letters on this matter during floor consideration of H.R. 1. Thank you for your assistance and cooperation. We look forward to working with you in the future.

Best regards,

BILL THOMAS,
Chairman.

HOUSE OF REPRESENTATIVES,
COMMITTEE ON GOVERNMENT REFORM,
Washington, DC, June 25, 2003.

Hon. WILLIAM M. THOMAS,
Chairman, Committee on Ways and Means, House of Representatives, Washington, DC.

DEAR CHAIRMAN THOMAS: I am writing to confirm our mutual understanding with respect to the consideration of H.R. 2473, the Medicare Prescription Drug and Modernization Act of 2003, which was referred to the Committees on Ways and Means and Energy and Commerce. I am writing specifically regarding Sections 302 and 303, which waive provisions of the Federal Acquisition Regulation and exempts a newly established advisory committee from the Federal Advisory Committee Act (FACA). As you know, the Federal Acquisition Regulation and the Federal Advisory Committee Act are within the jurisdiction of the Committee on Government Reform.

I have concerns regarding the appropriateness of waiving FACA, as it would pertain to the Program Advisory and Oversight Commit proposed in section 302. I would welcome the opportunity to work with you and Chairman Tauzin to address the applicability of FACA to this proposed committee.

In the interests of moving this important legislation forward, I do not intend to ask for sequential referral of this bill. However, I do so only with the understanding that this procedural route should not be construed to

prejudice the Committee on Government Reform's jurisdictional interest and prerogatives on these provisions or any other similar legislation and will not be considered as precedent for consideration of matters of jurisdictional interest to my Committee in the future. Furthermore, should these provisions or similar provisions be considered in a conference with the Senate, I would expect Members of the Committee on Government Reform be appointed as outside conferees on those provisions.

Finally, I would ask that you include a copy of our exchange of letters on this matter in the Congressional Record during House debate of the bill. If you have questions regarding this matter, please do not hesitate to call me. I thank you for your consideration.

Sincerely,

TOM DAVIS,
Chairman.

I also include for the RECORD a quote:

Some of our friends on the other side of the aisle are saying that if this bill becomes law, it will be the end of Medicare as we know it. Our answer to that is, we certainly hope so. Why should seniors be the last group that pays retail prices for drugs? Old-fashioned Medicare is not very good . . . You're going to hear scare tactics . . . but seniors with extremely high drug costs, when this becomes law, will save more than 60 percent of current costs, that's real change, real progress, making Medicare a real day-to-day benefit.—Bill Thomas, Chairman, Committee on Ways and Means.

Mr. DOGGETT. Mr. Speaker, I ask unanimous consent to place in the RECORD the report from NBC news correspondent Norah O'Donnell entitled ''Prescription Drug Benefit Imminent'' from yesterday's MSNBC.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California?

There was no objection.

PRESCRIPTION DRUG BENEFIT IMMINENT

(By Norah O'Donnell)

After years of promising a prescription drug benefit for seniors, Congress is on the verge of a breakthrough. This week, the House and Senate are expected to pass bills that for the first time will allow seniors to sign up for a prescription drug plan in which the government helps pay their drug bills. The policy and political consequences are enormous.

Congress had agreed to spend $400 billion, which in effect means the biggest expansion of Medicare since its creation nearly four decades ago. Critics charge that the bill's passage is the largest expansion of a federal entitlement since Lyndon Johnson's Great Society, with huge costs to American taxpayers when the Baby Boomers enter the Medicare program.

Passions surrounding the Medicare reform bill are reaching a crescendo heading into votes in both the House and the Senate by the end of this week, perhaps as early as Thursday.

''To those who say that (the bill) would end Medicare as we know it, our answer is: We certainly hope so,'' declared Ways and Means Chairman Bill Thomas, R-Calif., Wednesday morning. ''Old-fashioned Medicare isn't very good,'' he added.

House Speaker Dennis Hastert, R-Ill., echoed the sense around Capitol Hill that this is indeed the year that it gets done. ''We are at the point now where politics and policy have to be married up,'' he said.

Health and Human Services Secretary Tommy Thompson appeared with Thomas and other GOP leaders Wednesday morning to release figures that purport to show what seniors would save on some popular drugs. For example, Thompson said that seniors are now paying $108.65 for 30 tablets of Lipitor. Under the system, he projects that the cost would come down to $86.92. Seniors would have to pay only 20% as co-pay ($17.38). That's a savings of $91.27, according to his figures.

But House Minority Leader Nancy Pelosi and other House Democrats fought back Wednesday, saying Thompson has forbidden Health and Human Services actuary Rick Foster from releasing his analysis of how much Part B premiums would go up under the House GOP plan. Part B is the existing program that insures seniors for medical services other than prescriptions.

They suspect the figures would show that the premium would rise substantially. A similar bill in 2000 would have resulted in a rise in Part B premiums of 47 percent. Pelosi and Rep. Pete Stark, D–Calif., say that Foster is being threatened with termination if he reveals the figures this time.

Once the measure passes, congressional Republicans and President George W. Bush will declare victory on an issue that Democrats have traditionally championed. ''This could be transformational in terms of the image of the Republican Party among seniors,'' Bill McInturff, a Republican pollster, said.

Seniors or older voters have historically favored Democrats when it comes to the issue of Medicare and prescription drugs. But a recent survey by the Kaiser Family Foundation found older voters now trust Republicans and Democrats equally.

Older Americans are the nation's most reliable voters. Two-thirds of them go to the polls. And with a large number of seniors living in big swing states that are expected to decide the presidential election in 2004, the issue could be pivotal.

As a quick example, George W. Bush lost the state of Pennsylvania to Al Gore by five points in the year 2000. He lost among older voters by a whopping 17 points. If the president improves his standing among older voters, he could close the margin of victory in such a state.

But the potential political windfall could be stymied once seniors get a closer look at the details of the plan. After conducting polls and focus groups, Republican strategists are warning fellow party members that seniors who've done the kitchen-table test are not happy.

In fact, according to an internal Republican memo by McInturff, obtained by NBC News, the pollster warns that, in focus groups, seniors ere very disappointed: ''The current drug coverage plan is not as generous as the private coverage two-thirds of seniors already enjoy. It's clear most seniors are first evaluating this plan in comparison to their current, private coverage, then deciding it's not as generous and certainly not a replacement for that coverage, so some are reacting unfavorably.''

McInturff is advising Republican lawmakers and the president that they can overcome deficiencies with the bill, stressing rhetorically that the plan provides seniors with additional choices in coverage.

GAPS IN COVERAGE

The nation's largest lobby for seniors, the American Association of Retired Persons, or AARP, has warned Congress that it is deeply concerned about huge benefit gaps in the plan. ''People are disappointed that there isn't more of a benefit here,'' said John Rother, policy director for the AARP. ''And sometimes they're mad, and sometimes they think, 'Well, at least it's a first step.' But everyone is disappointed.''

That's especially true for seniors like 77-year-old Pat Roussous of Madison, Conn. She suffers from arthritis, diabetes and high blood pressure. Her out-of-pocket drug costs are as much as $6,500 a year. ''It's only a start. And I'm not convinced it's going to go very far,'' she said.

Roussous is one of an estimated 10 million seniors who will fall into a benefit gap, because, under the Senate plan, the government will pay for half of drug costs up to $4,500. But, there's a huge gap for the next $1,300, where the beneficiary must pay for all of their drug costs.

Catastrophic coverage does not kick in until one's drug costs exceed $5,800. Then the government will pay 90 percent of drug cost over that amount.

''I think, the gap—where people are required to pay for the drug themselves—I can't imagine that working,'' said Roussous. ''Because those are the people who actually need to have the help.''

Still, the AARP will not use its political might to block the plan. ''This year, 'something' in prescription drugs is better than 'nothing,''' said Rother.

The bulk of the proposed assistance in the prescription drug plan will not be enacted until 2006. Until then, seniors will receive a discount card that will provide them with 10 to 15 percent off their drug costs. Low-income seniors will get an annual $600 credit.

Mr. THOMAS. Mr. Speaker, I yield myself 15 seconds.

I see the gentleman from Texas (Mr. DOGGETT) had two quotes connected with a description of myself, rather than the continuation of the real quote, and I can understand why he would fabricate the quote in that way. Because what I said was, why should seniors be the last group that pays retail prices for drugs? That really did not fit the intention of the gentleman's thrust, but that is simply the truth.

Mr. Speaker, I yield 2 minutes to the gentleman from Iowa (Mr. NUSSLE), the chairman of the Committee on Budget, but I proudly say also a member of Committee on Ways and Means.

Mr. NUSSLE. Mr. Speaker, I thank the gentleman for yielding me time and for his partnership and hard work on this bill.

The Democrats are living in 1965. Boy, we have heard a lot about that tonight. We have heard about Bob Dole and Lyndon Baines Johnson. Well, that is great but it is not 1965. Medicare is going bankrupt. Tax cuts did not cause that. Health care costs are out of control. The reimbursement system under Medicare is broken and it is not paying the bills. Hospitals are closing. Doctors are leaving rural areas or not taking Medicare patients at all. Cost shifting is running rampant onto the private pay side, and as a result, problems are running rampant within our health care system.

Benefits have not improved. We do not have drugs. We do not have prevention. We do not have disease management. We have a sick care system, and the Democrats have done nothing about it for the past 30 years since they did pass Medicare in 1965.

Doing nothing tonight is not an option, and that is why in the budget we put $400 billion to improve Medicare,

increasing Medicare by $400 billion, hardly withering on anybody's vine, because doing nothing is not an option. Tonight, H.R. 1 is the choice. It modernizes Medicare, saves it from bankruptcy, controls costs, modernizes benefits, fixes the Iowa and other rural reimbursement problems, keeps these hospitals open and viable so that they can pay the bills as a result of amendments that have been passed in both the Committee on Ways and Means and the Committee on Energy and Commerce.

Quality health care will be available in rural areas on into the future as a result of what we have done tonight. Inaction is not an option.

But there is one other choice. The Democrats will offer a $1 trillion Medicare drug benefit tonight; one that CBO says costs $1 trillion. Guess what? That not only busts the Republican budget, but it busts the Democratic budget and it busts both of our budgets combined. Do not bankrupt Medicare. Save it by passing H.R. 1.

Mr. STARK. Mr. Speaker, I yield 2¼ minutes to the gentlewoman from Ohio (Mrs. JONES), a member of the Committee on Ways and Means who understands that the Republican bill does not extend the life of the Medicare Trust Fund at all. In fact, it probably reduces it some.

Mrs. JONES of Ohio. Mr. Speaker, I will begin with a quote. ''Seniors face a confusing hodgepodge of co-payments and deductibles in Medicare. The system is irrational and difficult to navigate. Simplifying and modernizing cost sharing will make coverage easier to understand and will strengthen the Medicare program over the long term. I believe we can better design both Medicare and Medigap so that seniors and people with disabilities get the most of the health care dollars they spent.''

That is a quote from a Republican colleague. But let me report from Howard Brown, 77 years old, from Cleveland, Ohio. He complained about the complexity of the program that will involve choosing a plan, tracking out-of-pocket expenses, and knowing when the coverage kicks in, lapses and then resumes in severe cases, all according to a sliding scale of benefit.

Mr. BROWN said, ''I am too old to try to figure all this out. Make it simple. Make it plain so I can understand it.''

The people in the United States, the seniors who are on Medicare, they want a defined benefit giving them an entitlement and a guarantee. They want it to be affordable with reasonable premiums and deductibles. They want it to be designed to significantly reduce the price of their prescriptions, and they want a meaningful Medicare prescription drug bill that provides absolutely no gaps and no separate privatized ambulance.

□ 2030

But we have not heard any Republican get up tonight and define what the gap is. They have not explained to seniors across this country that there will be a gap in coverage, and it will not be Medicare improved for prescription drugs.

Truly, 35 years ago we did not think about prescriptions as being part of Medicare; but it is, in fact, a part of Medicare today, and our seniors do not want to wait till 2006 and then find out that after paying premiums all year that they do not get any coverage in this gap of coverage. Explain the gap Mr. and Mrs. Republican on the Republican side.

What about the new preventive? Every new beneficiary gets an opportunity, but what about the old folks? It is like Mrs. Ruby Bogus from Cleveland, Ohio, said. She was annoyed that the program would not begin until 2006, and do my colleagues know what she told her friends. Well, girls, I guess we will just have to live a little bit longer to get a prescription drug benefit.

Mr. THOMAS. Mr. Speaker, I yield myself 15 seconds.

If the gentlewoman would go to page 260, line 19, from the legislation before us now, I quote, ''Nothing in this part or the amendments made by this part shall be construed as changing the entitlement to defined benefits under part A and B of title XVIII of the Social Security Act.''

Mr. STARK. Mr. Speaker, if the Chairman could explain the gap, but obviously he cannot. So I am happy to yield 2 minutes to the gentleman from Texas (Mr. SANDLIN), a member of the Committee on Ways and Means.

Mr. SANDLIN. Mr. Speaker, it is the old bait and switch. The Republican leadership has used smoke and mirrors to trick seniors into thinking they are getting a Medicare prescription drug plan when in reality they are forcing them to seek medication from private insurance companies, not Medicare.

Mr. Speaker, this is not an entitlement Medicare plan for seniors. All this is is an entitlement to ask to be able to make an offer, to make a purchase from a reluctant, profit-seeking insurance company who may or may not accept that offer. Importantly, not a single insurance company in the United States of America has volunteered or agreed to take part in this program, not one, nada, zip, zilch. This plan is nothing more than a mere vapor.

What has history shown us about what happens when private insurance companies get involved in Medicare? Medicare+Choice, the great managed care experiment on our Nation's seniors, should have been named Medicare Minus Choice. After all, it has been a total disaster for seniors. Between 1998 and 2003 the number of Medicare+Choice plans dropped by more than half. In my home State of Texas, 313,000 Medicare+Choice seniors have been dropped by insurance companies just since 1999.

Question: Who sets the price of the drugs in the Republican insurance company plan? The Republican insurance company plan allows HMOs and pharmaceutical companies to determine how much to charge and what coverage to offer.

Mr. Speaker, I would like to take a vote, what do my colleagues think the insurance companies will choose, more coverage or less coverage? What will the pharmaceutical companies charge, more money or less money? The answer is clear.

The other day the President said, ''When the government determines which drugs are covered and which illnesses are treated, patients face delays and inflexible limits on coverage.'' And yet the Republican private insurance company bill wants to turn over these decisions to an insurance company who has financial interest in denying coverage. The more insurance companies deny, the more money they keep. Now, is that not special?

Mr. THOMAS. Mr. Speaker, I have one speaker to close.

Mr. STARK. Mr. Speaker, I am delighted to yield 1 minute to the gentleman from Georgia (Mr. SCOTT).

(Mr. SCOTT of Georgia asked and was given permission to revise and extend his remarks, and include extraneous material.)

Mr. SCOTT of Georgia. Mr. Speaker, let us get right to the chase of it. What the Republican plan is designed to do is end Medicare as we know it today. Make no mistake about it. I have the quote right here and it says, ''To those who say that the bill would end Medicare as we know it, our answer is: We certainly hope so.'' Bill Thomas, chairman of the Committee on Ways and Means, MSNBC News, on 6/25/2003.

It was stated, to back that up, the chairman of the Senate Republican conference said this, ''I believe the standard benefit, the traditional Medicare program, has to be phased out.''

That is what we are faced with today, and that is what the American people need to understand, and that is what the Democratic Party is doing in here today, to pull these covers off. We are talking about people who cannot afford it. Medicare was designed to help people, to help the least of us, to help those senior citizens who cannot afford the medicine. Government is there for something. They do not want it privatized.

Mr. Speaker, let me just say this from one of my constituents, and I want to read this note. He said: ''I am a 74-year-old retired senior on Medicare and this Medicare drug prescription plan is just a stone's throw away from privatization of Medicare. That should not be allowed to happen.'' Let us not let it happen.

SNELLVILLE, GA,
June 14, 2003.

Representative DAVID SCOTT,
Jonesboro, GA.

DEAR REPRESENTATIVE SCOTT: I'm a 74 year old retired senior that's on Medicare at home recovering from a massive heart attack and bladder infection so I am very concerned about what course of action Congress is presently taking on the Medicare Drug Prescription Plan.

When the news first came out that Congress was finally going to add prescription drugs to Medicare in order to provide financial relief for seniors that are paying way to much for their medication verses their meaner yearly income from Social Security and if they have one, their pension fund and any life savings they may have. At that time I heard that Congress would be working on such a plan Medicare beneficiaries would be given a choice if they needed and wanted their prescription drugs covered by Medicare. If they did all they had to do is sign up for it and pay whatever the cost of the plan covers. For the rest of us who are happy staying with Medicare and our present secondary insurance coverage that provides better prescription drug coverage at a lower cost would not have to participate in any Medicare prescription drug plan.

Seniors that don't have prescription drug coverage should be covered by this plan as a matter of choice, however; I feel it is unfair for Congress to make it a mandatory requirement for all seniors to pay for this plan which would override their own secondary insurance plan for their prescription drug plan. It just isn't fair. Why should we have to give up our plan and end up paying far more than what we are presently paying? I'm sure if all seniors were aware of what really is going on they would want to make it a matter of choice also.

Representative Scott please give us Medicare beneficiaries a choice to join or not to join the Medicare prescription drug coverage. Even though I'm not in your district I'm asking you to please support us many seniors by making sure this choice provision will get covered in the final bill that is sent to President Bush. If this choice does not become part of this Medicare Drug Prescription plan it is just a stone's throw away from the privatization of Medicare and that should not be allowed to happen. Please remember when you vote whatever the outcome is on this plan it will affect all Americans nation wide and in some way or other I'm sure it will have some sort of a bearing on the outcome of the 2004 elections.

May God Bless you and may God Bless America.

Sincerely yours,

RICHARD MCGRAW.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. WEXLER).

Mr. WEXLER. Mr. Speaker, I am privileged to represent the oldest district in this country, and I thought it was important to hear from some of those seniors who fought in World War II and Korea and who rebuilt this country after the depression.

Mr. and Mrs. Robert Moore of Lantana, Florida: ''Why do we worry about tax cuts for the rich while so many older folks have to choose between food and medicine?''

Speaking directly to the Republican plan, Mr. Arthur Taubman of Delray Beach, Florida: ''I prefer nothing instead of a botched up Republican plan.''

Mrs. Elaine Schwartz from Boynton Beach: ''It is very disappointing to me that I live in this wonderful country and senior citizens who have contributed for so many years supporting this country have been forgotten.''

Mrs. Schwartz has got it right, forgotten benefits. Drug benefits for seniors, forgotten; lower drug costs for seniors, forgotten by the Republican plan. American seniors by the Republican plan, forgotten.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. BELL).

Mr. BELL. Mr. Speaker, the gentleman from Texas (Mr. DELAY), the majority leader, has stated that the Democratic strategy on his Medicare bill is obstruction, obstruction, obstruction; but when the best that the GOP can do is create a plan that destroys Medicare, we should all rise in opposition.

I want to point out that the Republicans blocked every attempt at a Democratic substitute, sound proposals that would protect Medicare and provide comprehensive coverage for all seniors, regardless of the size of their bank accounts. The AARP, a trusted voice on this subject, says the Republican plan is not good public policy because it has too many coverage gaps.

Why do the Republicans oppose better plans without gaps for seniors? Well, the gentleman from Iowa says one of the plans is too expensive. It was not too expensive for them to pass the largest tax cut in American history, only to create the largest deficit this country has ever seen. It is just when it comes to providing our seniors with the most basic ability to protect their health the cost is too high.

It does seem to me to be a simple matter of priorities. So do we intend to obstruct the gentleman from Texas (Mr. DELAY) and the Republican's plan to destroy Medicare? Absolutely.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentlewoman from Texas (Ms. JACKSON-LEE).

(Ms. JACKSON-LEE of Texas asked and was given permission to revise and extend her remarks.)

Ms. JACKSON-LEE of Texas. Mr. Speaker, I did not want this historic debate to leave without my words in opposition to a plan that does nothing to serve the needs of seniors in America. The reason? Because I am proud that President Lyndon Baines Johnson in 1965 extended the lives of American senior citizens, but today we have a plan that will be shoved through on this floor that denies the preservation of Medicare, denies the real Medicare benefit. Lower prices are denied. Full coverage is denied. Choice of drugs is denied because when a sick senior citizen gets to a certain amount of their prescription drug benefit, then they drop through the doughnut hole; and if they survive, if they live through the gap between when we start paying for it, then they may be able to hit again when the amount of the prescriptions go up to $5,000.

The doughnut and privatization are two items in this particular legislation that I will stand against, and again, Medicare denied, real Medicare benefits denied, lower prices denied, full coverage denied, choice of drugs denied. This is a historic debate. Vote ''no'' and stand on the side of saving lives of America's senior citizens.

Mr. Speaker, when we look at the health care system for our seniors in the United States today, we see good news and bad news. The bad news is that drug costs are outrageously high. The good news is that Medicare is an effective and efficient program that is working well for our seniors, and that senior trust. I have never met a senior that disagree with these two facts: that drug costs are too high and need to be brought down, and that Medicare is a good program that needs to be protected.

So it is outrageous to me that the Prescription Drugs Bill that the Republicans are shoving through Congress today without opportunity for amendment or time for debate, is preserving the bad—the high cost of drugs—and is dismantling the good—Medicare.

We Democrats have been fighting for years for a Medicare prescription drug program that is (1) affordable; (2) available to all seniors and Medicare beneficiaries with disabilities; (3) offers meaningful benefits; and (4) is available in the Medicare program—the tried and true program that seniors trust.

And now it seems that we have the political momentum to make a good prescription drug benefit a reality. The President says he wants it. Both parties, both sides of Capitol—everyone has declared their commitment to getting affordable prescription drugs to our nation. So why is it that the only Medicare prescription drug ''plan'' the Republicans have to offer is a terrible bill with full of holes, and gifts to the HMOs, and protections for pharmaceuticals companies. Every time we get a chance to take a closer look at the Republican drug scheme, it becomes more obvious that it is just another piece of the Republican machine that is trying to dismantle Medicare and turn our federal commitment to our nation's seniors, over to HMOs and the private insurance industry.

The Republican plan would be run by HMOs, not Medicare. HMOs would design the new prescription drug plans, decide what to charge, and even decide which drugs seniors would get. Plus, HMOs would only have to promise to stay in the program for one year. That means that seniors might have to change plans, change doctors, change pharmacies, and even change the drugs they take every twelve months. Medicare expert Marilyn Moon told the Senate Finance Committee on Friday that ''There will be a lot of confused and angry consumers in line at their local pharmacies in the fall,'' if the Republican approach is not changed. She's right.

The Republican plan provides poor benefits, and has a giant gap in coverage. Under the House Republican plan, many seniors would be required to pay high premiums even when they don't receive benefits. Reportedly, under the House GOP plan, Medicare beneficiaries have a high $250 deductible. After they reach that deductible, they would then be required to pay a portion of their first $2,000 in drug costs—that is a fairly normal system. But, after a senior's costs hit $2000 for a year—that is when it becomes obvious just how bad this plan is. Once a senior's drug costs hit $2000, the Republican plan cuts them off. Even though they must continue to pay premiums, they get no assistance in paying their drug costs at all until their costs reach $5,100. Let me say that again. It seems so crazy, it is almost unbelievable. The sickest of our seniors, the ones on the most medications—once their

costs reach the $2000 mark—they fall into the Republican gap. They are left to pay the next $3000 out of their own pockets, while continuing to pay premiums. Almost half of seniors would be affected by this gap in coverage. They will be outraged, and our offices will be hearing about it. Already we are hearing that 4 out of 5 seniors, the people we are trying to help, are against this plan.

I have attended hundreds of health care briefings, and have read everything I can get my hands on, on the subject of improving Medicare and getting good health insurance to the American people. And I have never heard anyone say that a hallmark of a smart health insurance program is to have a giant gap in coverage for those who need help the most. Why would our Republican colleagues put in this ditch in the road to health for seniors? Because they wasted all of our nation's hard earned money, on massive tax breaks for the rich, and an unnecessary war.

So now they have placed an arbitrary budget cap on vital programs, pushed by President Bush, in order to compensate for the irresponsible Republican tax cut they jammed through this Congress and last Congress. The way they are dealing with the mess that they have made is by throwing bad policy after bad policy. To remain within their own arbitrary budget cap, they are pitching a bill that will provide a confusing, insubstantial benefit to the majority of seniors.

If the Republicans wanted to save money, they could have put in a provision that I and many Democrats have pushed for—and that is to allow the Secretary of the HHS to negotiate with the pharmaceutical to get fairer prices for the American people. I believe that the American pharmaceuticals industry is the best in the world. They make good products that benefit the world. But Americans are now paying double the cost for drugs than their counterparts in other rich nations such as German, Canada, Great Britain, or Japan. I am glad our companies are making money. But as we enact a prescription drug benefit under Medicare, access to drugs will rise—and drug company profits will rise as well. It is only fair that the Secretary should have the power to negotiate a good price for American consumers, to make sure we get the best returns possible on our federal investment.

Not only did the Republicans not put in a provision to allow such negotiations, they went out of their way to forbid the Secretary from trying to get better prices for Americans. Why? Because they value the profits of their corporate sponsors at Pharma, more than they do the well-being of our nation's seniors. American consumers are now subsidizing the drug-costs of the rest of the world. The Canadians, British, Germans, Japanese—the rich nations of the world—still pay half of what we pay for drugs. We need to bring leaders in the Pharmaceutical companies to the table. They want to sell their products to more Americans, and we want more Americans to have access to their products. Surely, the Secretary should be able work with the industry to negotiate a compromise that serves all Americans well.

Similarly, the Republican plan's design wastes billions in kickbacks for HMOs—instead of using that money to bring down the premiums and out-of-pocket costs that seniors and the disabled are forced to pay.

The Republican plan is to privatize Medicare starting in 2010. The whole reason that Medicare was developed in the first place, was that private industry would not rise to the challenge of taking care of our nation's seniors the way they deserve.

The Republican plan is a risky scheme only an HMO could love. The Bush Administration's Medicare Administrator has called traditional Medicare ''dumb'' and ''a disaster,'' highlighting Republicans' disdain for a program that Democrats have been fighting for since 1965. While Democrats have worked to modernize Medicare with prescription drugs, preventive care and other new benefits, Republicans are insisting on a riskier course even the Wall Street Journal calls a business and social ''experiment.''

The Republican plan destroys Employer Retiree coverage. The Congressional Budget Office has concluded that about one third of private employers will drop their retiree drug coverage under a proposal like the one being contemplated. In order to lower its cost, the House Republican plan stipulates that any dollar an employer pays for an employee's drug costs would not count towards the employee's $3,700 out-of-pocket catastrophic cap. This would therefore disadvantage seniors with employer retiree coverage because it would be almost impossible for them to ever reach the $3,700 catastrophic cap, over which Medicare would pay 100 percent of their drug costs. The practical effect of this is that employers will stop offering retiree coverage. That is a step in the wrong direction.

We can do better. The House Democrats' legislation, that I am a proud cosponsor of, is designed to help seniors and people with disabilities, not HMOs and the pharmaceuticals industry. Under the Democratic proposal, the new Medicare prescription drug program would be affordable for seniors and Americans with disabilities and available to all no matter where they lived. It offers a meaningful benefit with a guaranteed low premium; and would be available as a new ''Medicare Part D'' within the traditional Medicare program that seniors know and trust.

I am committed to getting seniors the prescription medications that their doctors deem they need. I want to work with our Colleagues on the other side of the aisle, and the Administration to make that happen. But unless I see a plan without a gap—with a consistent benefit—with some smart cost-controls—and some protections for Medicare, an excellent program for Americans, I cannot support this Republican drug scheme.

This bill is a sham. Our seniors have been looking forward to getting relief from the high cost of drugs. They will be waiting with anticipation until after the next elections, when this bill conveniently kicks in. When it does, they will be furious. Let's do better.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The Chair would remind the gentleman from California (Mr. STARK) that he has 30 seconds remaining.

Mr. STARK. Mr. Speaker, I yield myself the remaining time and will use it to sum up because that is about all the time it will take to explain what is in the Republican bill, which is nothing. It privatizes Medicare, and it promises a benefit as good as we Members of Congress get, and it does not get a third of the way there.

It is a hoax. It is phony. It is a fig leaf. It only gives coverage to the Republicans because there is nothing, absolutely nothing in this bill that requires anybody to provide a drug benefit to the seniors, and perhaps they will give the Republicans enough campaign money or promises and favors of other sorts to get them to change this in the future; but right now, sexual favors will not do it, nothing will do it. We are not giving the seniors anything but a hoax.

The SPEAKER pro tempore. All time for the gentleman from California (Mr. STARK) has expired.

The gentleman from California (Mr. THOMAS) has 4½ minutes remaining.

Mr. THOMAS. Mr. Speaker, I yield the remaining time to the gentlewoman from Connecticut (Mrs. JOHNSON), to close for our side, to continue to talk about the bill that for the first time in the history of Medicare provides low-income help, and she is the chairwoman of the Subcommittee on Health of the Committee on Ways and Means.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman for yielding me the time.

Today, is an historic day for America's seniors. Congress is about to fulfill the promise and the potential of Medicare, which has been one of our greatest success stories in our history; but when Medicare was created in 1965, prescription drugs were few and far between. Instead, painful and invasive surgeries were standard treatment; but now, with the health security of our seniors tied directly to medicines, medicines that extend life and restore hope, we must add prescription drugs to Medicare for all our seniors.

A Medicare program without a drug benefit is a false promise in the 21st century. I am proud to stand here on this House floor and bring prescription drugs to Medicare for all of our seniors and a benefit that is simple, generous, and fair.

It is simple because it pays 80 percent of the first $2,000 of drug costs; and it guarantees the peace of mind of our seniors, protecting them against catastrophic drug costs, covering all costs above $3,500.

It is generous because the average senior spends $1,200 on prescription drugs every year. Yet in this bill we cover 80 percent of the cost up to $2,000.

It is fair because it helps the low-income seniors more than any other group. It not only helps the very poor, below 150 percent of poverty, but for the first time, by allowing State subsidies to help seniors toward that threshold of catastrophic coverage, we help the next income group to have that security that seniors depend on in their retirement.

In addition, there is fairness at both ends of this bill. Should someone with a $200,000 income have the same level of catastrophic protection as a low-income senior? Of course not.

But modernizing Medicare cannot be just about prescription drugs, as important as prescription drugs are. It

must also be about addressing the most crippling threat to our seniors' well-being and their retirement. It must address chronic illness.

□ 2045

Current Medicare is an old-fashioned illness treatment program. This bill will provide seniors with chronic illnesses a chance to have truly progressive care, whose goal it is to prevent the progression of chronic illness. Our goal must be to be sure that if you have diabetes, you do not end up on dialysis.

Disease management is the new frontier in medicine. It will slow, interrupt or reverse disease. It requires more sophisticated technology. It requires greater patient involvement in their own care. But it results in higher quality health care and much improved quality of life and lower costs for hospital care, emergency room care, and doctors' visits.

Mr. Speaker, this bill will bring the cutting edge of medical science and modern technology to the service of our seniors and disabled veterans. With over half of our seniors suffering from five or more chronic illnesses and using 80 percent of Medicare's resources, we must bring chronic disease management to the service of our seniors. And no bill to this point has ever done that. So I am proud to say that this bill brings both prescription drugs and preventive health care programs to Medicare and will provide unprecedented vitality to our Medicare program.

In conclusion, let me remind us all that this bill will revitalize our Medicare Choice plans and provide that reliable high-quality care year after year after year that seniors depend on, a more holistic integrated care than fee-for-service can provide. So I ask my colleagues tonight to support wholeheartedly and enthusiastically H.R. 1. It is historic. It brings prescription drugs into Medicare and it prepares Medicare to provide 21st century medicine to our seniors in the years to come.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). All time allocated to the Committee on Ways and Means has expired. The gentleman from Louisiana (Mr. TAUZIN) is recognized for 45 minutes.

Mr. TAUZIN. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, when the chairman of the Committee on Ways and Means, the gentleman from California (Mr. THOMAS), opened this debate tonight in presenting H.R. 1 to the floor, he acknowledged the extraordinary cooperation and the spirit by which our two committees, the venerable Committee on Ways and Means and the venerable Committee on Energy and Commerce, of the House have worked together on this bill again this Congress, with the kind of harmony and dedication to accomplishing a good purpose for this country that is seldom seen between committees that often fight and juggle for jurisdiction. I want to commend him for that statement and acknowledge my personal gratitude for him and the entire membership of the Committee on Ways and Means and their great staff for the spirit in which they worked with the Committee on Energy and Commerce to accomplish this historic moment for our country.

I also want to thank the gentlewoman from Connecticut (Mrs. JOHNSON) of the Committee on Ways and Means for the extraordinary work she has personally given to this effort and the way in which she has worked with members of the Committee on Energy and Commerce, so many long hours, to accomplish this bill.

It is important also that I highlight, while not acknowledging all the staff who contributed so many hours, the head of our health care staff of the Committee on Energy and Commerce, Mr. Pat Morrisey, who has done Herculean work once again on behalf of this effort. And I want to acknowledge and thank, again, Mr. Ed Grossman, who is a legend in the Legislative Counsel's office, in terms of his contribution to this entire body and the work we do in preparing legislation for the floor.

When we began this effort 2½ years ago to create once again an opportunity for this House to pass a prescription drug benefit for Medicare and, at the same time, to modernize a system that is in deep trouble, we announced that the entire effort in health care would be dedicated to a theme of patients first; the idea that everything we did should be designed to make sure that patients in America continue to have the best health care delivery system in our country and, importantly in this area, that seniors get something they desperately need; and that is that every senior get access to prescription drug coverage and that the Medicare system itself, which has long been absent of that important product in the arsenal of products that keep our seniors healthy and long living in our country, that prescription drugs be added to this system, this important new element of health care in our country that has long been missing from the program.

At the same time, we recognize that the worst thing that can happen to any citizen is to be forced to go to a single store, whether it is a government-run store or a private-run store. We know when there is only one store in town, generally you get bad products and bad services and often bad attitudes. No matter what store it is, no matter who runs it, when more than one store is available, when we have choice, whether it is choice between a government store or a privately-run store, all of a sudden prices become better, products become better, attitudes become better, and service becomes better.

We know that Medicare is described by so many members of the Committee on Ways and Means as being in deep trouble. We know it is on a path toward insolvency. And Medicare, a system by which so many citizens have depended on for years for their health care, is absent this vital asset of prescription drug coverage. So we began our efforts to make sure we could add that coverage to the bill. We have been doing this over several Congresses now, and every year we battle over what is the right number to fund this program and how best to fund it.

I want to point out that we owe a great debt of gratitude to the chairman of the Committee on the Budget, the gentleman from Iowa (Mr. NUSSLE), for including this year $400 billion for us to fund this effort. In last year's budget, we dealt with considerably less. In fact, in the Democratic budget that was prepared for the year 2002, our friends on the other side allocated only $330 billion to their effort to fund prescription drugs. This year, our Committee on the Budget provided us with $70 billion more than even the Democrats did when they prepared their budget for the year 2002. And I want to thank the Committee on the Budget and Chairman NUSSLE for that great effort.

With that amount of money available, we have been able to construct this year, as the gentleman from California (Mr. THOMAS) and his team have so adequately described, a much better bill, a bill richer in benefits, more secure in the texture of its structure, to make sure that seniors would, in fact, have more choices. Those like my mother, who want to stay in Medicare, cannot only stay in Medicare but enjoy a prescription drug benefit now; and those who might enter their senior years knowing about choice, liking choice, preferring choice, having the availability of different plans offered in the private sector that they could choose their prescription drug benefit from.

That is the kind of world we hope to create when we pass this bill tonight, a bill that historically modernizes the Medicare system and, at the same time, brings some more stores to town and makes sure that every store, the government store and the private stores, all have the products that seniors need so desperately, and that is prescription drugs.

In this bill this year, we do a number of other things. We address the concerns of many of our health care providers in terms of their lack of proper reimbursement from the government, and we add reimbursements to hospitals and physicians and caregivers across America. We have an excellent, and I thank the Committee on Ways and Means again for their work on this, we have an excellent rural package that will provide $27.2 billion of assistance to rural health care givers and hospitals to beef up care in America where care is desperately short and, unfortunately, hospitals are closing and doctors are leaving their practices.

Indeed, because this bill adds to the mix of choices that seniors will have in the future, there are predictions from CBO that Medicare will get back on its

feet, will not necessarily have to go insolvent. It will have a chance to be one of the options that seniors wish to choose for a long time in the future.

These benefits are going to benefit all Americans. I know there is some talk about how the plan has coverage and then there is a donut hole and there is coverage again for catastrophic coverage. The discounts provided to seniors in this bill will be available at all stages of prescription drug coverage, at all stages of prescription drug use and purchase throughout the bill. Seniors will see lower drug expenses in this bill. CBO estimates, in many cases, by as much as 50 to 70 percent. All seniors will benefit.

And for the seniors who live below 135 percent of poverty, and there are thousands and millions of those seniors living across America, this bill provides a 100 percent subsidy, 100 percent coverage for the drugs they are going to need under this prescription drug plan. And that is a pretty good effort and that is a pretty good reform of our system.

Indeed, we are also going to do some interesting things. We are concerned about the high prices of drugs. And like the Senate, we include reforms in the Hatch-Waxman laws that will speed the approval of generic drugs into the marketplace. And we reformed that awful, that awful wholesale price system that the government currently uses with phony wholesale prices that force seniors to pay 20 percent of phony prices whenever they suffer cancer and have to endure cancer therapies and urinary tract therapies and respiratory therapies. In short, we are going to lower the cost of drugs to America across the board, and we are going to increase the availability of drug coverage for every senior in this country and build new options for seniors to choose from. That is a pretty good package.

I want to again congratulate all who worked on it and all in the two committees who contributed so much to it. In the House Committee on Energy and Commerce we had 65 amendments, I think 29 recorded votes, over 22½ hours of debate again this year. Are we ready for this vote tonight? You bet we are. Are seniors ready for the debate to end? You bet they are. Are seniors ready for us to really do it this year? You know it. Are seniors ready for this House, the Senate, and the President to come together and actually sign a law that gives them these benefits, instead of constantly just debating the issue? You know that is true.

This is a historic moment, and this is our time to get it done.

Mr. Speaker, I reserve the balance of my time.

The SPEAKER pro tempore. The gentleman from Michigan (Mr. DINGELL) is recognized for 45 minutes.

Mr. DINGELL. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, three things: One, this is a bad bill. Two, it is not the Senate bill. And, three, it destroys Medicare as we now know it.

And if you do not believe it, take the words of my good friend, the chairman of the Committee on Ways and Means, who says, ''To those who say this bill would end Medicare as we know it. Our answer is, we certainly hope so. Old-fashioned Medicare isn't very good.''

Well, it is a safety net that has preserved and protected the health and the well-being of Americans for 38 years. It has been a fabulous system for the protection of the health and the welfare of the people.

This thought echoes the words of Speaker Gingrich, who wanted Medicare to wither on the vine.

Well, it is a fraud upon the American people. It provides very little for most people who are looking for the benefit of receiving prescription pharmaceuticals. What it does is it subsidizes the insurance companies. It does not control prices. It does not stimulate competition. It affords to the senior citizens a situation where they wait 2 years. And after they wait 2 years, what do they get? An enormous donut hole into which they fall after they have spent $2,000, during which period, for a period of about $2,900, they get no additional help from their government, but during which time they have to pay more money, more money, to not draw any benefits.

And it should be noted there is no requirement whatsoever, none in this legislation, that requires the insurance companies, who will begin getting subsidized enormously in just 2 years after the enactment, to do a single thing to provide for prescription pharmaceuticals for the benefit of their subscribers. Indeed, most insurance companies have said they do not want to participate in the pharmaceutical-only care benefit that would be offered by this legislation. So they have set up this wonderful situation where there will be enormous boundless subsidies to try to induce somebody to come in and set up HMOs which will serve the people in the area or provide prescription pharmaceuticals to them.

The Democrats have a simple, easy-to-understand piece of legislation, one which builds upon the practices which we have used in Medicare with such great success and so efficiently for so long to see to it that the people get the benefit on the payments of a modest sum and a modest deductible and then they get their benefits. No donut hole during which they do not gain benefits.

And I would note that, by an interesting circumstance, many people under this wonderful Republican bill will pay a lot more than they will get out of this legislation. It is a piece of legislation which can best and most kindly be defined as a fraud upon a group of people who have high hopes that their Congress is going to take care of them.

□ 2100

Well, this Congress is going to take care of them; it is going to give them a deceitful piece of legislation which benefits them very little, if at all.

Mr. Speaker, less than 2 weeks ago, the House Republicans divorced themselves from the Senate bipartisan legislation and unveiled their lengthy and complicated proposal to make sweeping changes in Medicare. After taking months to develop more than 300 pages of fine print in secret consultation with selected corporate allies, they rammed the bill through committees last week and are ramming it through the House today under a rule developed in the wee hours this morning. No hearings, no significant opportunity for public comment, no concessions—just the way the House Republican leadership wants things.

But the Republican leadership is playing with fire. Not content merely to privatize a watered-down drug benefit, this bill, H.R. 1 privatizes the entire program in 7 years. As Chairman THOMAS said yesterday, ''[t]o those who say that [the bill] would end Medicare as we know it, our answer is: We certainly hope so. * * * Old fashioned Medicare isn't very good.'' And a Republican Senate leader was quoted last month as saying that ''I believe the standard benefit, the traditional Medicare program, has to be phased out,'' echoing Speaker Gingrich's 1995 prediction that traditional Medicare would ''wither on the vine.'' The list goes on. Former Majority Leader Dick Armey said, also in 1995, that Medicare was ''a program I would have no part of in a free world.'' Most recently, the Bush administration official in charge of Medicare, Tom Scully, 2 months ago called Medicare an ''unbelievable disaster'' and a ''dumb system.'' And, of course, I was here in 1965 to witness the overwhelming majority of Republicans vote for the motion to recommit the legislation that created Medicare.

How will seniors react when told they will be forced to pay more to see their family doctor, or accept whatever doctors and benefits a private plan chooses to give them? How will seniors react when traditional fee-for-service Medicare is no longer a trusted safety net? How will seniors react when given a voucher and told to fend for themselves in the insurance marketplace—the same marketplace that failed them before Medicare? They should, and will, be outraged.

Seniors will also be angry when they learn that the Republican drug benefit helps insurance companies more than them. Democrats propose a true benefit provided under Medicare, with set premiums and benefits. Republicans propose payments to insurers to offer uncertain benefits, with uncertain premiums. The only certainty in the Republican plan is a huge coverage gap, when seniors will continue to pay premiums after substantial out-of-pocket expenses, and yet receive no benefit. And drug costs will continue to rise, because the Republicans prevent bargaining by Medicare to make prescription drugs more affordable to seniors.

Other nasty surprises will hurt seniors as well. Cuts in payments to hospital, when many are closing down. Inadequate payments to doctors, when seniors' access already is jeopardized. Increasing seniors' costs by $8.3 billion for their Part B coverage. These are short-sighted acts of extraordinary callousness.

I urge my colleagues to reject this dangerous Republican plan. Our senior citizens deserve better than to be guinea pigs for risky ideological experimentation.

Mr. Speaker, I reserve the balance of my time.

Mr. TAUZIN. Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. BILIRAKIS), the chairman of the Subcommittee on Health.

Mr. BILIRAKIS. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, I rise in support of H.R. 1, and I urge my colleagues to lend their support to this very important bill. We have before us a historic opportunity to provide our constituents with a meaningful prescription drug benefit that our Nation can afford. While the bill before us certainly is not perfect, it targets the $400 billion available under our budget resolution towards areas where it can do the most good.

Our bill provides a great deal of assistance to our lower-income seniors for whom we waive a deductible and coinsurance requirements. These seniors, those with incomes below 150 percent of the poverty level, which in 2002 was $13,290 for an individual and $17,910 for a married couple, will only be responsible for a small copayment per prescription.

In addition, the bill targets the prescription drug benefit towards where the need is greatest. Beneficiaries are only responsible for 20 percent of their drug costs between a $250 deductible and a $2,000 initial coverage limit. When we consider that the 2003 median drug costs for Medicare beneficiaries are estimated to be $1,390, it is clear that our bill provides a very good, upfront benefit.

Finally, the bill ensures that seniors will have the peace of mind of knowing that their annual drug costs will be capped at no more than $3,500 out of pocket. While that number does rise for some wealthier seniors, I would note that 95 percent of seniors will qualify for the $3,500 figure. Our bill makes other improvements to the Medicare program, and includes some Medicare payment modifications to ensure that beneficiaries will still have access to high-quality health care.

I would like to close by noting my great disappointment with my colleagues on the other side of the aisle, who for 30 years when they controlled this House did not do a thing for Medicare. I had to sit through a 3-day markup where my intentions and those of my colleagues were constantly questioned. Republicans were often accused of not being willing to commit adequate resources to a Medicare prescription drug benefit. I find that odd since in 2001, 2 years ago, the Democratic substitute to the budget resolution included only $330 billion for a new drug benefit. Republicans added $70 billion to that number only 2 years later, and still our colleagues accuse us of underfunding that benefit.

Mr. Speaker, all this tells me is that most Democrats only care about engaging in a reckless bidding war with Republicans and not about developing a reasonable, affordable benefit. H.R. 1 is a good bill, and its passage today will move us one step closer to a law which will provide real help to tens of millions of Medicare beneficiaries.

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the gentleman from Ohio (Mr. BROWN), the ranking member of the Subcommittee on Health.

Mr. BROWN of Ohio. Mr. Speaker, for years Republicans have tried to frighten seniors by telling them that Medicare was going broke. The media in this country scolded the Republicans for their Mediscare tactics. Well tonight, Republicans have graduated from using Mediscare tactics to a new level, and that is scam.

Mediscam number one: my Republican colleagues tout H.R. 1 as the largest expansion of Medicare since the program's inception calling their plan generous. But under H.R. 1, seniors will be required to pay $4,000 out of pocket to receive $5,000 in benefits. That is not generous; that is not even insurance.

Mediscam number two: my Republican colleagues say we should pass H.R. 1 because seniors deserve better coverage options like those available to Members of Congress, yet this bill's drug coverage is less generous than the least generous coverage available to Members of Congress. That is not treating seniors like Members of Congress; that is treating seniors for suckers.

Mediscam number three: my Republican colleagues say H.R. 1 gives seniors coverage they can trust. It is an expansion of the old, failed Medicare+Choice program which has dropped coverage for 2 million seniors outright. H.R. 1 is not coverage you can trust; H.R. 1 is coverage that cashes the check, then leaves seniors hanging.

Mediscam number four: my Republican colleagues say H.R. 1 will enhance the security of America's retirees, but the nonpartisan Congressional Budget Office says about one-third of employers will drop their retiree benefits if H.R. 1 becomes law. In other words, H.R. 1 will force seniors out of the drug coverage they now have. It will force seniors out of the drug coverage they now have.

Mediscam number five: my Republican colleagues say H.R. 1 will bring prices down through the magic of competition. How could that be? The drug industry wrote this legislation; the insurance industry wrote this legislation. They do not want lower prices, they want higher prices, and that is why my Republican colleagues took out any ability for the Secretary of Health and Human Services to lower drug prices. In fact, the drug companies gave $85 million to my Republican friends for their reelection in 2002 and tens of millions of dollars to President Bush.

Mediscam number six: my Republican colleagues say forcing seniors into private health insurance will reduce health care costs because private plans are more efficient. My Republican friends know that private insurance plans actually operate less efficiently than Medicare with administrative costs five times higher than Medicare.

Mr. Speaker, it is irresponsible to spend tax dollars bribing HMOs. It is irresponsible to provoke employers into dropping retiree health coverage. Vote ''no'' on H.R. 1.

Mr. TAUZIN. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, the Mediscam bill that the gentleman just described is patterned after H.R. 1495, authored by the gentleman from California (Mr. STARK), the gentleman from Michigan (Mr. DINGELL), the gentleman from California (Mr. WAXMAN), and the gentleman from Ohio (Mr. BROWN) just a few sessions ago in the 106th Congress.

It provided a $220 deductible, 20 percent cost share up to $1,700, a doughnut hole with a $3,000 catastrophic coverage, and no defined premiums. Does that sound familiar? The bill we wrote today is patterned after a bill written by my friends on the other side of the aisle back then, and they complain today that it is Mediscam.

Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. STEARNS), the chairman of the Subcommittee on Commerce, Trade and Consumer Protection.

(Mr. STEARNS asked and was given permission to revise and extend his remarks.)

Mr. STEARNS. Mr. Speaker, we have heard from the Democrats that this is a plan that will not work and is a fraud. We had 2 days of hearing, and I never heard a plan from the gentleman from Michigan (Mr. DINGELL) or the gentleman from Ohio (Mr. BROWN). We had 64 amendments.

PARLIAMENTARY INQUIRY

Mr. BROWN of Ohio. Mr. Speaker, parliamentary inquiry.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). Will the gentleman yield for a parliamentary inquiry?

Mr. STEARNS. Mr. Speaker, I do not yield.

The SPEAKER pro tempore. The gentleman from Florida (Mr. STEARNS) controls the time.

Mr. STEARNS. Mr. Speaker, what we have here is a plan that the Republicans have been on their knees trying to come up with to try and solve this problem. It is voluntary. It brings choice, everything that the Federal employees health benefit plan has, the same program that all these folks have.

Joshua Hammond wrote a book called ''The 7 Cultural Forces,'' which defines who we are as Americans; and one of those cultural forces is we are ready, fire, aim. That is, sometimes we do not get it perfect. We do the best we can, and that has been our history for 230 years. Is this bill perfect? No. In fact, the people on this side will argue back and forth, but all of us know this bill is not perfect. However, we have carefully balanced the needs and resources from home health to physical therapy.

This bill contains the long-overdue addition of a prescription drug benefit. Our seniors and disabled beneficiaries have waited many years, particularly true in Florida; and I am pleased to be part of the solution and part of that markup that we did for 2 days.

Now the folks on this side of the aisle say they have a bill. Their bill is for $1 trillion. Ours meets the budget demands of $400 billion. If we could spend all we want in the world, that would be the Democrat's plan.

But at long last Medicare beneficiaries will have available the same options that the President of the United States has, the Senate and the House and the staff here in Congress, a choice to choose the plan that best meets their needs.

Mr. Speaker, I am very happy that part of this plan that we have here has a demonstration project in consumer directed care for chronic conditions such as folks with diabetes. It is analogous to the successful consumer-directed care demonstration and evaluation projects, known as cash and counseling in Florida, Arkansas and New Jersey. It is consumer-directed, and in fact this type of plan is part of the American Postal Workers Union. It has a consumer-directed option. So what we have with Medicaid, we are going to have with Medicare. I am glad that is part of the solution we have.

So I would conclude by saying to my colleagues who are wondering what to do on this side of the aisle, come along with us. It is a start. It is not perfect. We can move it to the Senate, have a conference on it, and improve it. In fact, the gentleman from Louisiana (Mr. TAUZIN) in the markup amended the bill with a GAO study of the impact of this new cost regime. It is my hope that this will provide an objective, balanced approach and give us a proper understanding of how much this whole thing is going to cost. I commend the chairman every step of the way trying to be balanced, listening to the Democrats' amendments, many of which were accepted, many we defeated.

Mr. Speaker, thank you for bringing this package of Medicare additions, updates and reforms here to the Floor today. There is much here to applaud. We have carefully balanced needs and resources varying from home health to the physical therapy cap. Most significantly, this bill contains the long-overdue addition of a prescription drug benefit to Medicare. Our seniors and disabled beneficiaries have waited for this for many years now, and I am pleased to be part of the solution. At long last, Medicare's beneficiaries will have available to them the same options that we, and the Senators, and all of our staff and employees have: a choice of selections from which to choose the plan that best meets their needs.

Leading off with ''choice,'' I am pleased that my provision for a voluntary, small-scale, controlled demonstration project in consumer-directed care for Medicare beneficiaries with chronic conditions, my particular interest is diabetes, is included in H.R. 1 as Section 736.

This would be an analog to the successful Consumer-Directed Care Demonstration and Evaluation Projects, known nationally as ''Cash and Counseling,'' in Medicaid in Florida, Arkansas, and New Jersey. the Energy and Commerce Committee held a hearing June 5 on Consumer-Directed Care, and every single Member praised that demonstration's progress, but many cautioned not to overreach expanding its application. I agree. To that end, at markup I agreed to language from my friend, the ranking Member of the Committee, the gentleman of Michigan, Mr. DINGELL, tightening some boundaries for the demonstration project. The Consumer-Directed Care demo is working, let's expand the elements of Consumer-Directed Care that have been successful in a voluntary, incremental fashion and see how the demonstration in Medicare might be evaluated down the road.

Section 736 will direct the Secretary to design a demonstration project allowing for participating Medicare beneficiaries to cash out the value of certain services. They then, with the assistance of a designated ''counselor'' of their choosing, and government-provided fiscal intermediary, would have some flexibility in making decisions directing care for their condition.

Furthermore, Consumer-Directed Care type models are now offered in major health plans in the private sector: in 2003, the American Postal Workers Union (APWU–AFL–CIO) are the very first Federal employee group with a Consumer-Directed Care plan available to them. Do our Medicare beneficiaries deserve any less choice?

At the June 5 hearing, the National Director of Cash and Counseling, Dr. Kevin Mahoney, outlined that there are generally three characteristics of a condition that make it a good fit for the consumer-directed care model. Disabilities fit these three, and I believe diabetes does, too: (1) It is chronic, and one of the most self-managed diseases; (2) it follows a relatively predictable course of treatment; and (3) there is room for choice, in tailoring a treatment plan to the individual.

I remind my colleagues that under the Medicaid demonstration, satisfaction has been in the high 90 percentage, no adverse health outcomes have occurred (in some measures it has improved), and fraud has been virtually zero.

From that, I must turn to other provisions of the bill. I do not stand here without some reservations. For example, the reform of reimbursement for oncologists. No one, no Member, no oncologist, and no patient wishes for the accounting mismatch of Average Wholesale Price (AWP), to perpetuate, and we should never let dialogue about AWP degrade into accusations about gaming the system. It is true that H.R. 1 eliminates the current overpayment on Medicare-covered drugs, while concurrently increasing the practice expense reimbursement to appropriate levels that reflect their costs. But my understanding is that this is still a net decrease for the practice. I ask that the negotiations continue in good faith. In Energy and Commerce, Chairman TAUZIN amended the bill with a GAO study of the impact of this new cost regime, and it is my hope that this will provide an objective, accepted arbiter on true proper costs of administering total community-based cancer care.

Further, I harbor concerns that this bill not become a runaway money train. We have budgeted $400 billion over 10 years: is that a ceiling, or a floor? It is a logical modernization to add prescription drug coverage to the Medicare program; none of us would choose a health plan in FEHBP (Federal Employee Health Benefits Program) that lacked drug coverage. And, through economies of scale, both the traditional fee-for-service program and the participating private sector plans will have the purchasing power to contain costs. However, there always runs the risk of this exploding beyond our control. We have a responsibility for the fiscal health of this nation, and it is essential that proper cost containment be addressed in conference, as I understand the Speaker has assured.

Mr. TAUZIN. Mr. Speaker, I yield myself 15 seconds.

Mr. Speaker, just to correct the record, the Democrats did offer a substitute plan in our committee which was defeated, and I think it is pretty close to the substitute plan we will see later tonight.

Mr. Speaker, I yield 10 seconds to the gentleman from Florida (Mr. STEARNS).

Mr. STEARNS. Mr. Speaker, if the Democrats' plan is for $1 trillion and our is for $400 billion, we cannot say they offered a plan that met the budget requirements. I would like to ask the Democrats tonight: Do you have a plan that is under $400 billion like the Republicans?

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. DEUTSCH).

Mr. DEUTSCH. Mr. Speaker, the House bill in front of us, as the ranking Democrat of our full committee has ably quoted the chairman of the Committee on Ways and Means in his own words, ''To those who say the bill would end Medicare as we know it, the answer is we certainly hope so.''

This bill is a nonstarter. The Republicans in the Senate oppose it. It will not happen. It destroys Medicare. I am going to take my 2 minutes and even talk about that.

Mr. Speaker, I am going to talk about the disingenuous nature of the proposal that the Republicans are fostering at this point as a final product. And I say disingenuous because both this bill and that proposal does absolutely nothing about cost containment. How can they have a prescription drug bill that does nothing on cost containment? It is totally disingenuous.

For real seniors, and I would encourage all of my colleagues to talk to seniors because one of the things that is going on in America today is we do not know the number. We just had the FDA in our committee again several times. We do not know the number of how many seniors are availing themselves of purchases through Canada by the Internet, but it is easily 10 million seniors. We have 10 million seniors who are purchasing drugs in Canada where the benefits of purchasing drugs in Canada far exceed any proposal the Republicans have made. Just because people are old, just because they are sick does not mean they are stupid. They are going to continue to purchase them. So this bill for most seniors, for probably over 95 percent of the seniors in America, does absolutely nothing.

□ 2115

What it does is even worse, though. In a Congress, in a country, in a society that is facing the largest budget deficits in the history of the world, we take $400 billion out of working Americans, give it to seniors, but effectively take that $400 billion and flush it down the toilet and we get absolutely nothing from my Republican colleagues' proposal.

Mr. TAUZIN. Mr. Speaker, I first want to take 15 seconds, if I may, to point out that the bill before us does now contain the drug reimportation provisions similar to the Senate provisions and adds language directing the FDA to conduct rulemaking to make sure that there is safe packaging, to make sure when we do get drugs under any such program, that they are safe and effective.

Mr. Speaker, I yield 4 minutes to the gentleman from Pennsylvania (Mr. GREENWOOD), distinguished chairman of the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, our grand inquisitor.

(Mr. GREENWOOD asked and was given permission to revise and extend his remarks.)

Mr. GREENWOOD. I thank the gentleman for yielding me this time.

Mr. Speaker, my parents, my mother and father, are 81 years of age, alive and well, and I would like to dedicate all the work that I have put into this bill to them and I know it will benefit them immensely. My father used to say when I was a young lad, ''Jim, there are three kinds of people in this world. There are shirkers, there are workers and there are jerkers. The shirkers are the people who just don't do anything. They don't contribute. They don't help. The workers are the people who roll up their sleeves and get the job done. The jerkers are the ones that all the time the workers are working they keep tugging at them, pulling at them, jerking them around trying to interfere with the work.''

I would submit that the Democratic Party, in all due respect, between 1965 and 1994, when they lost control of the House, were shirkers when it came to the issue of a prescription drug benefit, for they did nothing. They did not provide a big plan, a little plan, a medium-sized plan, they did not provide a plan with a doughnut, without a doughnut. They did not provide a plan of any kind. They did nothing. We have been the worker party. We have passed a prescription drug bill in this House year after year since we have had control. That is hard to do. That is hard to do because mature legislators have to figure out how to strike a balance.

We have people in this House who do not want to vote for this bill. They do not want to vote for this bill because they think it is too liberal. They think it is a big new entitlement program that will bankrupt the country. They are against it because it is too liberal. There are a whole lot of people in this House who cannot vote for this and will not vote for it because it is too conservative; it does not spend enough money; it is not big government enough; it uses private sector factors, influences to curb prices. If you want to get 218 votes for a bill to provide a prescription drug benefit to the elderly and the disabled in this country, you have to work very hard with very complex issues and strike a political balance down the center through the eye of the needle to get the job done, and that is what this bill before the House of Representatives stands for. That is what it results from.

Now we have got the jerkers. We are trying to get this carefully balanced, incredibly complicated piece of work that our staff on both sides of the aisle have labored over for years to get done, want to try to move it through the House today, get it over to Senate, we have got some bipartisan support here, we have got some bipartisan support in the Senate, and we are going to get it done. And at the end of the day when the little old ladies and the little old men in my district and your districts who have been writing us letters and saying, with tears rolling down their cheeks, I have got a prescription for cholesterol drugs, I have got a prescription for antidepressants, I have got a prescription for my arthritis, I have got a prescription for this and for that and I can't afford them, what am I going to do. We have all been getting those letters for years and years. And when this year is over and when we stand with the President of the United States and he signs these bills, we will say to the little old men and the little old ladies and the disabled people of all ages in our district, we got the job done, when nobody else could or nobody else would. Whether the shirkers did not do their job or the jerkers tried to get in the way, the workers will get the job done and this will be an historic year for the Medicare program of this United States.

I am proud of everyone on either side of the aisle who actually rolled up their sleeves and contributed to the product.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. I thank the distinguished ranking member of the committee for yielding me this time.

Mr. Speaker, for those that are listening in this evening, besides the vote that some Members of Congress have had to take on going to war, I consider this the most important vote in the House of Representatives. Tonight we debate a bill where there is only one thing that the two parties agree on, and that is that our seniors deserve prescription drug coverage.

For 38 years, there has been a gold standard for those that are 65 years and older and it was named Medicare. How dare my colleagues on this side of the aisle say that the Democrats have not done a damn thing. I regret those words in the RECORD. We love Medicare. We put it on the books, and we have defended it ever since then. And we want a policy in Medicare that is ennobling and recognizes what senior citizens are.

The advertisers are very busy, but beware. Beware of the advertising. Read the bill. If your insurance salesman comes to you, the first thing you say is, how much is this going to cost a month? Read the bill. There is no premium cost in the bill. It says choice. Yes, there will be choice of insurance companies but not choices of doctors.

By 2010, every senior citizen that is listening in, you will be forced, you will be mandated to go into a private insurance program. That is what our friends have written.

Mr. TAUZIN. Mr. Speaker, I am pleased to yield 2 minutes to the distinguished gentleman from the great State of Nebraska (Mr. OSBORNE).

Mr. OSBORNE. Mr. Speaker, rural health care is struggling. The hospitals are closing and many doctors are leaving. If you are in a small community and the doctor leaves or the hospital closes, the whole community begins to unravel. H.R. 1 addresses the troubles that we see currently in rural health care. Number one, it lowers the labor share of the wage index for rural hospitals. This allows them to be more competitive with urban areas in terms of salary scale.

Number two, H.R. 1 increases Medicare reimbursement for rural doctors. Sixty percent of the patient load in my district and many other rural districts are Medicare patients. Doctors simply cannot afford to treat Medicare patient loads of this size because on many Medicare patients they lose money. As a result, they cut back Medicare patients or sometimes leave the area.

Thirdly, H.R. 1 provides a full and permanent equalization of Medicare payments to rural hospitals. An appendectomy is not cheaper in a small hospital than in a large urban hospital. In some cases it is actually more expensive. Also, H.R. 1 provides additional home health care payments and provides provision for rural ambulance.

Mr. Speaker, the reason I want to come to the floor tonight is simply to thank the gentleman from Louisiana for all that he has done for rural health care. This is probably, as far as I am concerned, the most important part of the bill. I would also like to say I represent a rural area. Many retirees in my area live on fixed incomes. Most of these people are making 15, $20,000 a year. Most of them are spending 30, 40, 50 percent of their income on prescription drugs. And so the number one concern that I see in rural America is the prescription drug bill. This bill offers considerable help to these people.

Again, I would like to thank the gentleman from Louisiana, the gentleman from California (Mr. THOMAS) and also the gentleman from Iowa (Mr. NUSSLE). I urge the passage of H.R. 1.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New York (Mr. ENGEL).

Mr. ENGEL. I thank my friend for yielding me this time.

Mr. Speaker, I rise in strong opposition to this bill. This bill is a cruel hoax perpetrated on America's seniors. This bill is not about helping seniors. It is all about privatizing Medicare. This is not the Senate bill. This bill is a wolf in sheep's clothing. It purports to help seniors. All it does is create a goal that many people on the other side of the aisle have wanted for years, the privatization of Medicare. This bill drains the lifeblood out of the Medicare program and breaks the promise we made to seniors 38 years ago when Medicare was created.

I wish this Congress could have come together for an historic moment that would finally provide seniors with the type of prescription drug coverage they need and deserve. Unfortunately, we are doing a disservice to our seniors by shortchanging them with a woefully inadequate drug benefit. Why is it inadequate? Let us face it, there is not enough money in this bill because my friends on the other side of the aisle have bankrupted this government with huge tax cuts, huge tax cuts to benefit the rich, huge tax cuts which make it impossible to help entitlement programs like Medicare. When the leaders over there said they wanted Medicare to wither on the vine, they were speaking the truth and that is what is happening today. With the enactment of this bill, Medicare is withering on the vine.

When I came to Congress 15 years ago, my goal was to provide meaningful prescription drug benefits. My bill and others, 1045, would keep the promise of Medicare, which was created to prevent seniors from having their life savings ravaged by health care costs. Today we are considering no such thing. The legislation before us is not a promise kept to seniors, it is a promise kept to HMOs and insurance companies. This is not the Senate bill. The Senate bill was a starting point to improve upon. This bill bankrupts Medicare, privatizes it by the year 2010. American seniors will not have Medicare as they know it by 2010. Again, when you have tax cuts for the rich and you do it to help your rich friends and you want to strangle social programs and entitlement programs, you do not have an adequate bill.

This bill should be rejected.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Maryland (Mr. WYNN).

Mr. WYNN. Mr. Speaker, I thank the gentleman for yielding me this time. I rise in strong opposition to the Republican plan. This Medicare reform plan is woefully inadequate. Everyone agrees that a real prescription drug plan would cost between $600 and $800 billion. This plan only provides $400 billion. Why? My Republican colleagues will say, well, this is because that's all we can afford. The truth of the matter is that is all we can afford because of their big tax cuts. But keep in mind, you did not get a big tax cut. The wealthy got a big tax cut. Mr. and Mrs. Average American got cuts in service, cuts in benefits and cuts in quality. What we have here this evening is an attempt by the Republicans to do prescription drug coverage on the cheap.

There are three problems with this. First, in their plan, there are no guaranteed drug benefits. The private insurers determine what drugs are going to be available to you, not your needs. So that if your drugs are not covered, then you have to pay the full price. This is no prescription drug benefit. Second, there are no fixed premiums. You hear the Republicans tell you, well, it's going to be $35 a month. Wait a minute. $35 a month is nowhere in their bill. These premiums could rise to as much as $85 a month. You will drive seniors into bankruptcy with that.

The third problem with this plan is the hole in the doughnut, the gap. Under the Republican plan, this plan they are talking about tonight, after the first $2,000 of prescription drug costs, you have to pay the rest up to $5,000. That is a gap of $3,000. Again, that would drive seniors into bankruptcy. The neediest, sickest seniors do not get the benefits when they need it, the consequence of doing prescription drug coverage on the cheap. Forty-eight percent of Medicare beneficiaries will fall into this gap. This is not a true prescription drug plan.

Second, this bill contains something called Medicare reform. That is another name for privatizing and destroying Medicare as we know it. Plans will have to compete. Medicare will compete against private plans and our seniors will be forced out of a plan that they have come to trust. This plan will not work, will not provide the benefits as a safety net for our seniors. I urge its rejection.

Mr. TAUZIN. Mr. Speaker, I yield myself 10 seconds to ask a question. If this plan funded at $400 billion is prescription drugs on the cheap, what do you call the $330 billion that was allotted by the Democratic budget for the year 2002?

□ 2130

Mr. Speaker, I yield 3 minutes to the gentleman from North Carolina (Mr. BURR), the distinguished vice chairman of the Committee on Energy and Commerce.

(Mr. BURR asked and was given permission to revise and extend his remarks.)

Mr. BURR. Mr. Speaker, I am here tonight to thank the chairman of the Committee on Energy and Commerce and the gentleman from Michigan (Mr. DINGELL), ranking member, our colleagues on the House Committee on Ways and Means, the leadership of the House for having the foresight to move forward with legislation to recognize that there is a problem in America, a problem that we have ignored for a decade, the need to add a prescription drug plan. I did not come here to argue with anybody. I came here because I believe we can do better. I believe we can do better than the bill we have proposed. I believe we can do better than the substitute that is offered.

America understands why we have not solved this because all they need to do is listen to us. We talk about each other's bills in a way that we point out things that we think are bad. We forget that we are talking about a population that has nothing. I wish we could have started with something smaller, but something that was targeted to people who are faced with the decision every day of do I buy drugs or do I buy food? But we have been convinced by this town that our only action has to be something comprehensive, something that includes everybody, something that includes those who have a minimal income and those who have an income of $1 million a year. We have not excluded anybody. We will not exclude them over here and we will not exclude them over here, because there are associations and groups that represent seniors, and they have never met those seniors, but we have.

Mr. Speaker, we owe our constituents more than to sit on this floor and tear up each other's legislation. We have to be for something. To get up here and debate that we are against this and we are against that and it is bad, it is inadequate is only a suggestion that we are not good enough to serve here, that they ought to look for replacements. I would challenge all of us.

I do not know what the outcome of tonight would be. I will vote no on both proposals that come up. I do not suggest on either side of the aisle that Members do that. That is what I am going to do. I have come to the conclusion, but never forget if we want a real solution to this, a real solution that affects real people, then we have got to put our heads together and work together and remember who it is that we are trying to provide for in this bill. I reluctantly say that I will vote against this.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Texas (Mr. GREEN).

(Mr. GREEN of Texas asked and was given permission to revise and extend his remarks.)

Mr. GREEN of Texas. Mr. Speaker, following the gentleman from North Carolina, my good friend, it is frustrating because I feel the same thing, that we were given a plan and even though we spent 3 days and a long night debating it in committee we did not really get to legislate because we really had a plan given to us and it was either take it or leave it. But this is the most important issue that we will consider this year not only for our seniors but for everyone. I know a lot of my colleagues feel that we should support any legislation because it is a step in the right direction or maybe it is like the Senate bill.

This is not the Senate bill. The Senate has a better idea. It is not as good as I would like, but it is better than what we have on the floor today.

This legislation would require Medicare to move to a competitive program by 2010. A lot of different terms are used to describe the model in this bill, whether it is called defined contribution, voucher, premium support, or something else, but it abolishes Medicare as we know it. The bottom line is it is privatization of Medicare. It will take the responsibility of providing meaningful, affordable, quality health insurance away from the government, like 1965, and shift the burden onto the shoulders of our seniors. The legislation relies entirely on private insurance plans to provide drug benefits for seniors. No government fall-back plan, no safety nets for seniors living in areas where drug plans do not offer coverage. It places blind faith in private drug plans that they will sign people up. That is the ultimate in faith-based policy making. There is a huge gap in this coverage that will disproportionately hurt individuals who need drug coverage. Those with the highest drug costs, they will fall into this doughnut hole. Once one has a little over $3,000 a year up to a little over $5,000, they fall in this hole.

I talked to a senior this evening who has a little over $300 a month in prescription drug cost. They will still pay their $35 plus a month, but they will not get one dime of benefits because they will be in this doughnut hole.

The ultimate anti-competitive part is that this bill prohibits the Secretary from negotiating lower drug costs. The VA does it, Medicare does it, private insurance does it, but we are prohibiting in this bill the Secretary of Health and Human Services to reduce costs for our seniors. That is why it is outrageous.

The substitute, on the other hand, is the kind of benefit that seniors support. It is affordable, comprehensive, and will actually help drive down the costs of prescription drugs.

Yes, it's more expensive than the base bill, but you cannot provide a prescription drug benefit on the cheap.

Finally, there's one issue that I'd like to raise about a provision that would limit the ability of physicians to refer patients to specialty hospitals in which they have a financial interest.

There is language in the Senate bill which could hurt some innovative practices that are occurring in specialty hospitals.

Patients need access to a broad range of facilities, and should be able to choose a hospital that has expertise in their specific health needs.

I know that some have suggested limiting the percentage profit that physicians can enjoy under these arrangements, or to limit the percentage of physician ownership and I hope that both sides can sit down and reach a solution to this problem.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from Missouri (Ms. MCCARTHY).

(Ms. MCCARTHY of Missouri asked and was given permission to revise and extend her remarks.)

Ms. MCCARTHY of Missouri. Mr. Speaker, the Republican Medicare bill fails to provide seniors with meaningful prescription drug coverage and is an attempt to end Medicare as we know it. With their plan seniors will have no assurance from 1 year to the next on what plan will be available to them, what drugs will cost them nor what doctors will serve them. Under their plan many seniors will have to pay a premium without receiving any assistance with their drug costs.

Seniors deserve affordable prescription drugs without gaps in coverage. Our seniors should not be forced to pay more to keep their choice of doctors. Not only would the plan before us limit or charge extra for choice, it would force seniors to go to a primary care physician before seeing a specialist.

The Republicans have produced a plan that fails to make prescription drugs more affordable and, disturbingly, ends the Medicare system that has been an irreplaceable safety net to millions of people for the past four decades. Instead they are creating a plan that costs seniors a lot and gives them very little.

Mr. Speaker, I urge my colleagues to oppose H.R. 1, the so-called Medicare Prescription Drug and Modernization Act of 2003, and to support the Democratic motion to recommit which will preserve Medicare and provide our seniors with the affordable prescription drugs they need.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. FERGUSON), one of our newer members on the Committee on Energy and Commerce.

Mr. FERGUSON. Mr. Speaker, I thank the chairman and ranking member and members of the committee who have worked so hard on this bill.

I rise in strong support of H.R. 1. It includes an amendment that I offered in the Committee on Energy and Commerce which will assist our most vulnerable seniors by allowing State drug spending to count towards a senior's catastrophic limit. Especially in States like New Jersey, this provision is going to dramatically reduce seniors' out-of-pocket spending while saving our States $5 billion.

About a year ago I stood in the well of this House when we debated the drug bill last year and I told the Members about my mom who has been battling cancer and who is only alive today by the grace of God and because she has had access to great medical care and the prescription drugs which have quite literally saved her life. I am proud that my State of New Jersey is home to thousands of researchers and scientists and companies which have spent their entire lives and billions of dollars on research to find the cures of tomorrow. This very day, today, they are working on finding the cures to cancers and diabetes and AIDS and Alzheimer's.

What are we here to do tonight? We are here to make these great products more affordable and more available to more people.

As much as I love my mom, her situation is not unique. She is like millions of other Americans who depends on prescription drugs for their quality of life. Our responsibility today is to pass this generous and responsible bill, to make the miracle cures of tomorrow available to people like my mom. Just as importantly, though, we have to do so in a way which values and encourages the incredible research and innovation which will create the cures of tomorrow because I do not only love my mom, but my wife and I love and treasure our three young children and it is they who will benefit as well because the lives of our children and our children's children will be better and stronger and more fulfilling because of the new cures that will be found and the fact that they will be affordable because of this plan. That is our charge. That is our responsibility. Let us pass this plan tonight.

Mr. DINGELL. Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from Maryland (Mr. HOYER), the very able and respected minority whip.

Mr. HOYER. Mr. Speaker, I thank the gentleman for yielding me this time.

Mr. Speaker, if truth in advertising applies to legislation, we would have a duty to warn America's seniors, beware, the Republicans' prescription drug bill could be hazardous to your health. This bill is nothing less than an historic betrayal of America's seniors. The GOP pretends that it is merely extending Medicare, but in fact the bill is the most dangerous attempt yet to dismantle the most popular health care program in history.

The Republicans fought the adoption of Medicare in 1965. Their majority leader said that Medicare should not exist in a free society. Yesterday the chairman of the Committee on Ways and Means, the architect of this bill, said on television, and the Members can read it here, ''To those who say that [the bill] would end Medicare as we know it, our answer is we certainly hope so.''

This bill would drive seniors out of Medicare and into the arms of private insurers. There is no guaranteed monthly premium. There is no defined benefit for seniors. There is no guaranteed access to drugs seniors must have. The only guarantee in this bill is that it would leave a huge gap in coverage. Seniors would pay a $250 deductible, $420 a year in premiums, and all costs between $2,000 and $5,100 in drug expenses. That is $3,100 left to seniors to pay. This bill even prohibits the government from negotiating lower drug prices for seniors.

In contrast, the Democratic substitute offered by the gentleman from

Michigan (Mr. DINGELL) and the gentleman from New York (Mr. RANGEL) would provide a prescription drug benefit that guarantees affordable, universal and voluntary Medicare coverage for prescription drugs. There are no gaps in coverage. Seniors would pay $25 a month, $100 deductible, and then 20 percent coinsurance. Their out-of-pocket expenses would be limited to $2,000 a year. That is 1,100 under the gap that exists in the Republican bill.

The Republican plan also does not give the Secretary of Health and Human Services the authority to negotiate prices. Our bill does. I would ask the Members to vote for this substitute which guarantees prescription drug coverage for seniors.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I am always happy to accommodate the gentleman from Louisiana (Mr. TAUZIN), my dear friend, even when he is pushing an outrageous piece of legislation under an appallingly constrictive rule.

Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from Massachusetts (Mr. MARKEY), and I ask the chairman from the Committee on Energy and Commerce to listen closely.

Mr. MARKEY. Watch out, Grandma. Watch out, Grandpa. The GOP is selling snake oil off the back of a wagon, and, boy, do they have a prescription for you.

Mr. Speaker, every senior citizen gets a bottle with three bitter pills. Bitter pill number one is a lethal dose of privatization poison. The Republicans are diverting Medicare funds into private drug plans with no maximum premiums, no guaranteed coverage, and a cynical drive to destroy the Medicare program.

Bitter pill number two is a dose of crushing costs. Incredibly the Republican bill injects $400 billion into Medicare but spends it in such a tangled, convoluted, copay-riddled, incomprehensible, doughnut-hole-hollowed maze of bureaucracy and lacks any effective effort to keep prescription drug prices from continuing to soar, that Grandma is actually going to spend more under this proposal than if we had just left well enough alone.

□ 2145

Bitter pill number three is a privacy piracy pill in the form of income tax forms. The Republicans require senior citizens to hand over to corporations sensitive personal information from income tax returns and the most intimate details of their medical care as a condition of qualifying for any catastrophic coverage. This information will then be turned against seniors in marketing schemes intended to cherry-pick the most desirable recruits into private plans, further weakening the foundation of Medicare for the seniors who need it most.

This is a black day for Medicare. Mr. Speaker, GOP used to stand for Grand Old Party. Now it stands for Forget Old People.

Mr. TAUZIN. Mr. Speaker, now that we have heard from the doctor of showmanship, we are going to hear from a real OB-GYN doctor.

Mr. Speaker, I yield 2½ minutes to the gentleman from Georgia (Mr. GINGREY).

(Mr. GINGREY asked and was given permission to revise and extend his remarks.)

Mr. GINGREY. Mr. Speaker, I thank the gentleman from Louisiana for yielding me this time.

Mr. Speaker, as a physician Member of this body, I rise in strong support of H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003.

I do not take lightly voting for a Federal program that expends $400 billion of the taxpayers' money. Being responsible with that money is a burden that I take very seriously. As appropriators of the people's revenue, we must assure that each dollar is spent wisely. That is a high hurdle, but I believe the Medicare Modernization Act clears that hurdle.

This act is an investment that brings Medicare into the 21st century. We will save money as we expand the focus of Medicare spending to include preventive care. Seniors who take the right drugs at the right time are more likely to stay healthy; and they are less likely to need expensive, prolonged hospitalizations, painful and complicated surgical procedures and, sometimes, yes, extended nursing home stays. For that reason, I do not think that this program will really cost $400 billion over 10 years. It will only cost that much if it does not work.

My experience as a physician for more than 28 years teaches that a prescription drug program for preventive care will pay dividends and increase health and a better quality of life. It is true what they say: an ounce of prevention is worth a pound of cure. And it is a lot less expensive.

This Congress has a great opportunity to expand the coverage for seniors, particularly our needy seniors, while, at the same time, strengthening the system so that it will be around to serve the baby boom generation as it moves into retirement. We will serve tomorrow's seniors as we are serving today's.

Some of our friends on the other side of the aisle insisted today that this bill could be the death of Medicare. They were even grandstanding around with black arm bands. That is interesting, Mr. Speaker, because their Democratic alternative would cost nearly $1 trillion, threatening to slam the entire Medicare system onto the rocks of financial insolvency long before 2030.

The plan that we will vote on tonight provides a good, strong benefit for our seniors; but just as important, it provides a sustainable benefit that will be there for future generations of seniors.

I encourage my colleagues on both sides of the aisle to bring Medicare into the 21st century. Vote for the Medicare Prescription Drug and Modernization Act tonight and deliver on your promise to our beloved seniors.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Ohio (Mr. STRICKLAND).

Mr. STRICKLAND. Mr. Speaker, I would just like to point out to my friend, the gentleman who just spoke, my understanding is that he voted recently to give $800 billion to about 200,000 people. Surely to God we can do a little better than that for our 40 million senior citizens.

Make no mistake about it. This bill will provide no stable, affordable prescription drug benefit for our seniors, but I will tell my colleagues what it will do. It will ultimately destroy Medicare's social insurance structure, a structure that has provided successful services to our seniors since 1965.

Let me give a clear example of how this bill will fail. The Republicans claim that premiums offered by the private plans will be about $35 a month. But there is no provision in this bill that will guarantee a $35 monthly premium or even a range of premiums near $35. Despite what we have heard, despite what we have heard, understand this: there is nothing in this bill to keep the private plans from charging any premium they choose to charge.

Now, in fact, Nevada is the only place this model has been tried; and in Nevada, the premiums were $85 a month. Furthermore, premiums will be different from State to State, from county to county, even from ZIP code to ZIP code.

Finally, private plans will be able to increase their premiums each year without any regulation, leaving seniors subject to the possibility of wildly fluctuating premiums.

Now, I offered a simple amendment in the Committee on Energy and Commerce last week that would have corrected this problem and guaranteed seniors a $35 monthly premium, regardless of which drug plan they chose to enroll in or where they lived. Every single Republican voted against that amendment. Last night, I asked the Committee on Rules. On a party line vote, they denied me the right to offer this amendment.

Republicans continue to say their bill will cost $35 a month. It is not true. They ought to stop saying it.

Mr. TAUZIN. Mr. Speaker, what is absolutely true is that 529,000 citizens of Ohio are given free coverage under this bill because they live under 135 percent of poverty.

Mr. Speaker, I yield 3 minutes to the gentleman from Rockwall, Texas (Mr. HALL), a Democrat and my dear friend.

(Mr. HALL asked and was given permission to revise and extend his remarks.)

Mr. HALL. Mr. Speaker, I rise in support of this bill because I am for a bill. I want to see a bill passed. I want a bill that can pass this House. I want a bill that can get to the conference committee. I want a bill that we can consider along with the Senate bill and get

the best of both bills for the best people of this country.

Almost 40 years ago when I was in the Texas senate, Members of this Congress came to Texas, came to the Texas house and the senate, touting two great programs that they were going to introduce and pass. They named them Medicare and Medicaid. And they said by 1990, Medicare could cost $9 billion a year. And as I remember, they said Medicaid could cost almost $1 billion a year. They told us that we really needed to monitor the program closely or the costs could double.

Well, my colleagues know what has happened to the cost, what has happened to Medicaid and Medicare. There is an awful lot to do, and we need to be doing it.

There is no doubt that Medicare has helped millions of seniors escape dire poverty and live fuller lives. There is also no doubt that medical costs have far outstripped inflation due to a number of factors, including expansion of benefits, increased use, and coverage of the disabled population. Our seniors are staring into their pocketbooks to find the money they need for their care. We desperately need to do something to save a great program for people in their golden years.

Mr. Speaker, Medicare needs to be modernized to include a meaningful provision for drug coverage. In my lifetime, we have seen how prescription drugs have greatly improved and extended the lives of Americans. We have also seen how the cost of those life-providing drugs can trouble families every day. Unfortunately, Congress has almost been timid in seeking parity between the prices drug companies have charged domestic dispensers compared to the nondomestic dispensers just across our borders.

While American drug companies need added alliance for research and development, and I am willing to give them that, for 10 key drugs for seniors, Americans pay an average of 150 percent more for the drugs than Canadians. This is unacceptable. I do not like price controls. The marketplace provides the competition necessary to deliver the best price for the people in need. We have to lower the cost of prescription drugs, and my hope is that we can all work together, including drug companies, to come up with new, better, and more creative ways to achieve affordable prescription drugs.

As we look at introducing new competition among providers for services, we should consider provisions that respect the choices available to current Medicare beneficiaries. These seniors and the disabled have paid for and have come to expect a traditional Medicare system and the safety net that it provides them, and they should be able to retain their current plans if they continue to be pleased with them. The Senate improved upon this provision, and I hope that is included in the final bill.

The Senate and the House bills have good provisions to achieve our goal. Like many people, I am not completely satisfied with this bill, but I am very hopeful that we can pass a bill.

I am particularly pleased that we are introducing long-overdue Medicare reforms that will bring health care into the 21st century; namely—regulatory reforms and provider reimbursement issues. We are all aware that providers nationwide, including our rural providers, have been diminishing in the face of increasing costs and decreasing reimbursement. We simply must confront this issue because without access, the rest of the program is meaningless.

Like many people,I am not completely satisfied with this bill, but I am also not satisfied to see this program collapse. We are closer than we have ever been to making some meaningful reforms and providing a prescription drug benefit to seniors. I am hopeful that we will improve this bill in the conference committee as we seek to find a bipartisan solution to our common problem. This is just a first step in an ongoing process of reform to ensure that our seniors get the care that they deserve. Congress, through its oversight and yearly appropriations process, will continue to monitor the program—making necessary changes and improvements to guarantee healthy years for our Medicare population.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from California (Mrs. CAPPS).

Mrs. CAPPS. Mr. Speaker, I thank my distinguished ranking member for yielding me this time.

Mr. Speaker, the Medicare bill before us is not a good bill. The coverage it provides is unreliable and insufficient. After a senior has used $2,000 in medications, they get no more help until they have spent another $2,900 out of pocket without help and while continuing to pay premiums. And that is only if a private plan chooses to come into their area. This bill turns Medicare into a voucher, handing it over to the insurance companies and forcing seniors to pay more. It reneges on a promise that we have made to America's seniors by ending Medicare as they know it.

In addition, the bill before us cuts cancer care by hundreds of millions of dollars, jeopardizing access to cancer care for seniors who face this dreaded diagnosis. If this bill passes, many cancer centers will close. Others will curtail their services, admit fewer patients, and lay off oncology nurses and critical support staff. This bill is supposed to make it easier for patients to get health care, but it will actually make it harder for cancer patients to get the care they need.

It is true that Medicare beneficiaries are paying too much for their oncology medications. We all agree we must fix this. But Medicare also pays way too little for essential oncology services, and so the overpayment for oncology drugs has been used to pay for treatments oncologists provide to cancer patients. We must fix both parts of this problem, but this bill still cuts hundreds of millions of dollars from cancer care. And it still risks the lives of cancer patients.

We will all go home after passing a Medicare bill, and we will face our constituents. I, for one, do not want to tell the cancer patients in my district that Congress has decided to curtail their treatment and endanger their care.

We can do better. We must. I urge my colleagues to vote against this bill.

Mr. TAUZIN. Mr. Speaker, I yield myself 10 seconds. I want to point out our bill provides 430 million new dollars to oncologists in America, twice that provided to any other specialist for nonpractice expenses, twice as much as any other specialist.

Mr. Speaker, I am pleased to yield 3 minutes to the distinguished gentleman from Texas (Mr. BARTON), the chairman of the Subcommittee on Energy of the Committee on Energy and Commerce.

(Mr. BARTON of Texas asked and was given permission to revise and extend his remarks.)

Mr. BARTON of Texas. Mr. Speaker, first, I want to commend my chairman, the gentleman from Louisiana (Mr. TAUZIN), for his work in this noble effort, and I want to thank him for allowing the reform group that I have been a part of in his committee the opportunity to present an alternative and to try to make that a part of the package. I really appreciate that.

I would say to my friends on the Democratic side of the aisle, as they have talked about privatizing Medicare, that the first thing that we need to do is preserve Medicare. I would point out that if we do nothing to the existing Medicare program, the projections are that within the next 5 to 10 years, there will be no Medicare, because doctors and hospitals will opt out of the system because they are not able to be reimbursed adequately for the services they are providing.

So the first thing that we need to do is to preserve the current Medicare system, and the bill before us does that with such things as competitive bidding for durable medical equipment and other reforms.

The second thing I would like to point out is that we understand that seniors need a prescription drug benefit.

□ 2200

And my reform group was able to get into this bill a transition program that if this bill becomes law within 90 days of enactment, 17 million seniors in this country will begin to get a prescription drug benefit immediately. They will get a prescription drug card, and if they are low income those drug cards will have $800 of benefits on them; and if they are moderate income, they will have $500; and if they are upper income, they will have $100. Their families and employers can add money to those cards, up to $5,000, and within 90 days of enactment there will be a prescription drug benefit. Not 3 years from now, not 4 years from now but within 90 days. And that drug benefit will not require a deductible, and it will not require any paperwork. It will not have any doughnuts.

It will require a modest co-pay, but then you get your prescription drugs plus any discounts that the prescription drug benefit card allows you. And I think that is important that we as a country say to our senior citizens, not that we want to get old people but that we want to give our parents and our grandparents a break. We want to give them a benefit and we want to do it sooner rather than later.

I think the most important thing about this bill is that there is an acknowledgment and a guarantee that there will be a benefit, there will be a prescription drug benefit.

Now, we can debate and we will debate whether it is adequate or it needs to be more generous or whether it needs to be more universal or whether it needs to be more targeted to the people that need it the most, but the important step is we are giving the benefit, we are adding the benefit and we are doing it now. And our transition program will kick in within 90 days of enactment, no later than September of 2004. So I will vote for this bill and hope we can perfect it as we go through the process.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Pennsylvania (Mr. DOYLE).

Mr. DOYLE. Mr. Speaker, I represent Allegheny County, Pennsylvania, the second oldest county in the country. And this is indeed a sad day for seniors in Allegheny County because instead of providing our seniors with an affordable prescription drug plan under Medicare, instead, tonight we will give seniors a Medicare+Choice style drug plan.

Now, we all remember in Pennsylvania what Medicare+Choice is. That is the HMOs trying to provide Medicare, the same companies that left hundreds of thousands of Pennsylvanians high and dry, not only in my State but all across this country, when they pulled out of their plans.

This plan is nothing more than a huge subsidy to drug companies and will eventually lead to the privatization of Medicare. Do not just take our work for it. The AARP, which represents more senior citizens than any other organization in this country, says, The provisions that would establish a premium support structure beginning in 2010 could destabilize the traditional Medicare program and lead to much higher costs for beneficiaries. Rather than expand choice, this provision could limit choice by leading to a substantially higher cost for beneficiaries who want to stay in the traditional Medicare program. Those who choose not to enroll in private plans should not be put at a financial disadvantage.

The other part of this plan that I just find unbelievable right here in title VIII, section 801 is we prohibit the administrator of the program from negotiating better prices from the drug companies on behalf of taxpayers. We are going to spend $400 billion of taxpayers' money, and we always hear from our friends, let us run government like a business. Well, what business does not negotiate for more favorable prices? But not this plan.

Our government is prohibited from negotiating lower prices on behalf of senior citizens. I watch seniors in Pittsburg get on buses every month and drive to Canada to buy their drugs, because they cannot afford them in this country, for half the price of what they have to pay for in the United States. And now when we finally have an opportunity to take the buying power of all these senior citizens and negotiate more favorable prices from the drug companies, this bill specifically prohibits us from doing that.

Mr. Speaker, this is a bad bill. We should vote it down.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the gentleman from Georgia (Mr. BURNS).

Mr. BURNS. Mr. Speaker, I appreciate the chairman for yielding me time.

Mr. Speaker, we have a bill before us tonight that will improve and it will preserve Medicare. This bill will continue to provide seniors with fundamental health care they so desperately need but provide something more. It provides something that my constituents want and need in affordable prescription drug plan for all Americans and seniors.

Mr. Speaker, I am a co-sponsor of H.R. 1 for one simple reason: Because seniors in my home State of Georgia must have an improved Medicare system. They must have prescription drug coverage. They do not want excuses. They want action. They want it now. The time for stale ideas and old systems and gimmickry are over.

H.R. 1 is legislation we can support because it preserves a system our seniors know and love, while it addresses the issues of increased coverage and solvency of a program for baby boom generations. Make no mistake, we are far from finished in our efforts to fix our Nation's health care challenges, but this is the first step into a new world of advanced health care. Through H.R. 1, seniors in Georgia can decide the coverage plan that best fits their needs. Seniors in Georgia will be able to decide which prescription drug plan through Medicare is the best option. For those who have no coverage and pay exorbitant prices for their drugs out of their own pocket, these benefits are real. We are providing them with real savings and real choices.

Mr. Speaker, it is time for Congress to step up to the plate and ensure Medicare's future for all Americans.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Maine (Mr. ALLEN).

Mr. ALLEN. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, the Republican prescription drug bill transforms Medicare into Maybe care. Depending on where you live, maybe you get your traditional Medicare and maybe you do not. Depending on what plan you have, maybe you keep your doctor or maybe you do not. Depending on what year it is, maybe you keep a good package of benefits or maybe you pay very high prices for a low, low package of benefits.

And the Republicans are here tonight saying choices, choices, choices. We are giving America's seniors choice. Well, what kind of choice are they giving America's seniors? Well, not a choice of doctors and not a choice of hospitals. What they are saying is we are going to give you a choice of insurance plans. Well, no one in my State of Maine has ever come up to me and said, You know what I really want is not a choice of doctors or hospitals, I want to see different brochures, different insurance brochures. Please have some insurance agents call me and talk about their different plans.

What is happening in Maine, in the private sector with this wonderful competition for the employed market is every year 20 percent increases, 30 percent increases, higher payments, lower benefits. That is competition and choice and what the Republicans are saying is that is what America's seniors need. It is unbelievable. Every senior I talk to says we want lower prices. Please give us lower prices. We are buying from Canada. We are taking buses to Canada, and this bill prevents the administrator from negotiating lower prices for America's seniors.

This bill is never likely to work in my opinion, but if it did, you ought to follow the money. Who gains from this bill? The insurance companies will make millions, hundreds of millions of dollars. The pharmaceutical industry will be able to keep charging the highest prices in the world. America's seniors lose. You follow the money to the insurance companies and the pharmaceutical industry and you can tell who wins under this bill.

This bill is a nightmare for America's seniors. Reject this bill and support the Democratic substitute.

Mr. TAUZIN. Mr. Speaker, how much time remains on each side?

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Louisiana (Mr. TAUZIN) has 8 minutes remaining. The gentleman from Michigan (Mr. DINGELL) has 14½ minutes remaining.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Louisiana (Mr. JOHN).

(Mr. JOHN asked and was given permission to revise and extend his remarks.)

Mr. JOHN. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, I strongly support a drug benefit in Medicare. And in some aspects, the Democrats have won because it has not been that long ago, just a few short years, that the Republicans wanted to take a privatized outside-of-Medicare, a drug benefit. But

now all of the debate is about it being a part of Medicare. So in that aspect, I think that we have won as Democrats. But I do believe that what they have done with this bill is continue to try to privatize Medicare and the benefits that are in it.

An entire generation of baby boomers are upon us, Mr. Speaker, and in just a few years away we are going to have to deal with this. Unfortunately, this bill falls short of what our seniors deserve as it has holes in it that the Republicans refuse to plug.

Perhaps the $174 billion bill that we passed just previous to this debate could have been used for the doughnut to be plugged. Efforts to fix this problem were denied us through the amendment process in this body on this debate. I offered amendments to try to bring some certainty with 2 years for our seniors to try to provide our rural ambulance services, our rural home health care and our rural doctors a fair reimbursement. In particular, I believe this bill falls short in addressing the needs of rural seniors and rural Americans. In fact, our previous experience should tell us that it has not worked. It is not profitable to offer plans to seniors in rural areas. In southwest Louisiana we have no Medicare+Choice plans.

I urge Members to vote against this, and I urge the other side to work, as the Senate did, in a bipartisan fashion to fashion a bill that our seniors can use.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Florida (Mr. DAVIS).

Mr. DAVIS of Florida. Mr. Speaker, one of the things that Democrats and Republicans ought to be able to agree upon tonight is that we owe our seniors truthfulness. We should be very clear and honest with them and ourselves as to exactly what is happening. Our failure to do so is a cardinal sin because it is ultimately to disrespect our seniors.

This bill offered by the House Republicans is based on a remarkable fixation with private insurance companies. Private insurance companies throughout the country in Washington have said once again they do not want the money that is being offered under this bill to write these private insurance plans.

The distinguished chairman of the committee's response to that is we will subsidize 99 percent of this cost as necessary to get private insurance companies to sell this benefit. How often in Washington, D.C. do you hear somebody turn down that type of money the government is offering them? Something is wrong with this plan.

I salute the Republicans on the committee who acknowledge they were concerned about whether private insurance companies would offer this benefit to seniors. Some of them are going to vote against the bill tonight based on that concern. A number of Democrats have said to those Republicans and others, we will work with you on a bill that fits within our budget constraints but let us have a traditional Medicare benefit that provides drug coverage.

What does this bill do? It does not set any maximum premium. It does not set any maximum deductible. It has a doughnut that almost 50 percent of seniors will experience after they have spent $2,000 on drug costs. During that time period they will be forced to pay a premium for basically nothing.

I would like to bring a chart up here to also show you just how complicated this plan will be that is being foisted on seniors. This represents a relatively detailed description of what this bill attempts to do.

Would somebody on the majority please explain to me how this bill works and how any senior at home, Democrat, Republican or Independent, is expected to understand how to use this drug benefit?

Mr. Speaker, I ask unanimous consent for 2 additional hours to explain the chart.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

Mr. TAUZIN. Mr. Speaker, I object.

The SPEAKER pro tempore. Objection is heard.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the gentleman from Kentucky (Mr. WHITFIELD), a distinguished member of the Committee on Energy and Commerce.

Mr. WHITFIELD. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, tonight is the culmination of 4 or 5 years of debate of a prescription drug benefit for our senior citizens here in America. I hear a lot of the criticism and I have heard it all day today about private insurance companies being involved in this program that we are submitting tonight. Yet, I would remind those on the other side of the aisle that private insurance companies are involved in Medicare as it exists today and has been for some time because it is the private companies that are responsible for the reimbursement of our health care.

□ 2215

So private companies are already very much involved in our Medicare system today.

I would also say, what benefit are seniors going to get from this program? First of all, if they are 135 percent of the poverty level and below, and I can tell my colleagues, in my district that is about 60 percent of them, they are not going to have to pay anything. The government's going to pay their premium for them. The only thing that they will have to pay is a $2 small copay for a generic drug and a $5 copay for a name-brand drug. What is wrong with a program that provides free medicines for seniors who today cannot get them?

I would also say that in addition to that tremendous benefit, and we provide catastrophic coverage for them as well, but in addition to that tremendous benefit, we have a rural health package in this bill that is going to help rural America, rural health providers. It is going to provide $27 billion over 10 years for our rural areas, and the disproportionate share payment for our rural hospitals, children's hospitals around the country, urban hospitals that treat our citizens on Medicaid, our hospitals over the next 10 years are going to get $3.8 billion for those who treat the neediest in our society.

This is a program that we should all be supporting, and certainly we should not support the Democratic substitute.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from California (Ms. SOLIS).

(Ms. SOLIS asked and was given permission to revise and extend her remarks.)

Ms. SOLIS. Mr. Speaker, I thank our ranking member for yielding me the time.

I rise tonight in opposition to this bill. We have heard a lot tonight about how this bill is going to help our seniors from the other side of the aisle. Well, I want to talk about the seniors that I represent in my hometown in the San Gabriel Valley in East Los Angeles, California.

In my congressional district, I represent nearly 6,000, 6,000 seniors in poverty, making less than $11,000 a year. For them the cost of prescription drugs is so overwhelming that they often have to forgo between paying their medicine or having a meal or paying a phone bill. That is what it means to seniors in my district.

This is a choice that no senior citizen should have to make. Yet the Republican bill does nothing to reduce the cost of prescription drugs. It does not allow us to use the purchasing power of Medicare beneficiaries to negotiate lower drug prices. How ironic, just like we do for the Veterans Administration.

So what do we tell Grandma, living alone on a fixed income who cannot afford her medicine? Sorry, but Medicare has a new drug benefit, but it is not for you? Sorry, but Medicare is raising part B deductibles by eight times as much as our Social Security cost-of-living increase?

Only the Democratic alternative that we will debate later on tonight will do what I think my senior citizens want to hear, and it will provide them with the guaranteed, affordable, easy-to-use drug benefit that is part of Medicare.

Let us be clear tonight. For our seniors, for our grandmothers, our uncles, our fathers and our mothers, there is only one thing to talk about tonight and it is about medicine. This should not be about privatization or insurance companies or anything else. Let us give our senior citizens the help they need to pay for that medicine.

Let us oppose this proposal being put forward tonight by the Republicans and support the Democratic prescription drug bill.

Mr. TAUZIN. Mr. Speaker, how much time remains on each side?

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Louisiana (Mr. TAUZIN) has 6 minutes remaining. The gentleman from Michigan (Mr. DINGELL) has 8½ minutes remaining.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Arkansas (Mr. BERRY).

Mr. BERRY. Mr. Speaker, I thank the distinguished gentleman from Michigan for yielding me the time, and I appreciate his leadership on this and all other matters before this House.

Mr. Speaker, one thing we understand is the Republicans are in the majority. They are in charge. You can do whatever you want to do. You have got the Senate. You have got the White House. Now, you may talk more trash than a $3 radio, but you are in charge.

The difference in these two plans is very simple. The Democrats would offer you the best plan, the best price, and we will pay 80 percent and let the patient, the Medicare beneficiary, pay 20 percent. The Republicans only, on the other hand, will allow the pharmaceutical companies, by law, statutorily, to continue to rob our senior citizens, charge them the highest price and let them pay 80 percent; and they will pay 20 percent of the bill, if you are lucky enough to live long enough.

They come to the floor repeatedly this evening and talk about this bill is not perfect. Boy, you have got that right. I will agree with you on that one.

They say it is historic, and they are right. Never before in the history of this Republic has there been such an outrageous attempt to provide the ability to insurance companies, as if they needed any help, to rob and deceive and cheat our senior citizens. Never before have they been presented with an opportunity, the pharmaceutical companies, to cheat and continue to rob our senior citizens.

It is indeed historic by their own admission. The chairman of the Committee on Ways and Means says we want to end Medicare as you know it. I suggest you all get you a buckeye. It will bring you good luck and keep rheumatism away. That is all you are going to get through this Medicare program.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Texas (Mr. BURGESS).

(Mr. BURGESS asked and was given permission to revise and extend his remarks.)

Mr. BURGESS. Mr. Speaker, I thank the chairman for yielding me the time, and certainly I want to acknowledge the great leadership of our chairman and the gentleman from Texas (Mr. BARTON), as well, who proposed the prescription drug card.

I rise tonight to support H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003.

Mr. Speaker, this debate is about taking care of America. This debate is about making a guarantee to senior citizens that they will have access to quality medical care which includes prescription drugs. This debate is about ensuring the future of Medicare. This debate is about delivering better outcomes at lower cost.

H.R. 1 is a strong solution to these serious problems. Providing prescription drugs for America's seniors is the right thing to do. I cannot picture what medicine would look like today if pharmaceuticals were not an available treatment option. Physicians and other providers would have no option but to resort to seriously invasive treatments when confronted with acute medical conditions.

There is no doubt that Americans have benefited from the development of new and innovative medicines. New drugs can improve and extend lives. New drugs exist that can dramatically reduce cholesterol, fight cancer, alleviate debilitating arthritis.

An entirely new class of medicines, collectively known as selective estrogen receptor modulators, are available for reducing breast cancer mortality rates, and one day may see an expanded role in preventing this disease.

Unfortunately, Medicare has been deeply rooted in the medicine of 1965, not the medicine of today; and this has negatively impacted the health of our senior citizens.

Tonight, the House of Representatives will take a bold step to improve the lives of senior citizens. Not only will seniors have greater access to prescription drugs, but built-in reforms will hold down the cost of these medications.

In a report released today by Secretary Tommy Thompson, seniors will save substantially through upfront drug discounts under the House plan. The Medicare actuary estimates seniors will see an immediate savings of 25 percent off their current prescription drug costs.

On the other side of the aisle, those who were wearing the arm bands earlier today, where were those arm bands in 1998 and 1999? Where were those arm bands when that administration refused to even open the book and look at the Medicare commission, bipartisan commission?

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Michigan (Ms. KILPATRICK).

(Ms. KILPATRICK asked and was given permission to revise and extend her remarks.)

Ms. KILPATRICK. Mr. Speaker, I thank the ranking member for yielding me the time in this most difficult discussion, but what a sham we have today for our seniors of America who built this country. Not only do you not have a prescription drug benefit, but this one you will not get till 2006, if you get it at all. It will privatize Medicare by the year 2010.

What most people want in America, including seniors, is to contain the high costs of prescription drugs. This bill prohibits the Secretary of Health and Human Services from negotiating lower prices for prescription drugs. That in itself is enough to say vote ''no'' on this bill. What a sham for the seniors who built this country.

This plan will destroy the retirement benefits that companies in my district like General Motors, like Daimler Chrysler already are giving to their retirees. This plan is a disincentive for them to keep giving that. Vote ''no'' on this plan. It is unfortunate I do not have any more time. Vote ''no.''

Mr. Speaker, I rise today to express my disappointment and opposition to H.R. 1. We, in Congress, over the last few years, have repeatedly pledged to provide seniors with the prescription drug coverage they so desperately need—and deserve. My Republican colleagues have touted this day as a ''historical day.'' Unfortunately, for Democrats, who support a meaningful, universal, and comprehensive drug plan under Medicare, this day is not a ''historical day'' in the positive sense but a day when we failed on our promise to come through for our seniors. What this bill does do is afford the Republicans the ability to say to seniors, ''We came through on our pledge.'' Unfortunately, their rhetoric does not match up to the emptiness that will be felt in our seniors' pocketbooks. Nor does it match up in providing seniors with real choice and a meaningful, comprehensive prescription drug program.

The GOP Prescription Drug Plan is a flawed plan, period. It would put the power in the hands of private insurers—those same insurers who have abandoned seniors in providing essential health care services in the past. Why our Republican colleagues want to give even more power to HMOs and private insurers is a question I cannot answer. However, the consequences of such actions will be felt by the most vulnerable in our society.

The majority of seniors across our nation live on fixed monthly incomes. With so many seniors today living longer, this also means that they need to save as much money as they can to ensure their survival over the years. They cannot afford to pay exorbitant costs for their drugs. Moreover, seniors need security. What they do not need is to be forced into private managed care plans that are able to opt-out of coverage for seniors at their free will. Seniors deserve better—they deserve a universal, comprehensive, affordable, and meaningful drug plan under Medicare.

The House Republican prescription drug bill is even worse than the one considered by Congress last year and goes much further in privatizing Medicare. Seniors would need to use private insurance companies for drug coverage and these private insurance companies and managed care plans would design the new prescription drug plans. These insurance plans would also need to commit to the program for only one year. What does this mean? It means that seniors can be dropped from their plan year-to-year. They would have to change their plan, their doctor, and the drugs they take every 12 months. This puts seniors at the mercy of private insurance companies, rather than giving them an option that provides

them with the security and stability they need. Seniors do not want to be forced into an HMO. In fact, 72 percent of seniors polled say they do not want to be forced into getting coverage through an HMO. We need to listen to those we are trying to serve.

The GOP plan also receives an ''F'' on the affordability scale. Under their plan, seniors would be required to pay high premiums even if they are not receiving coverage. The Republican plan would deny assistance to those seniors with drug costs between $2,000 and $4,900. Nearly half of Medicare beneficiaries would fall into this ''coverage gap'' every year; however, they would still be expected to pay the monthly premium. Seniors would be asked to continue paying for a service they are not receiving—a service that does not honor seniors with meaningful support in the first place.

Another glitch in the Republican bill is its inability to deal with the underlying problem—the rising costs of prescription drugs. Seniors want help in curbing the increasing costs of prescription drugs. In fact, seniors prefer cost control measures by a vote of two to one. While seniors want help in purchasing their medicines, they also want solutions in curbing the rising costs. The Republican bill does not do this. It neglects to include an important provision supported by Democrats to provide the Secretary of Health and Human Services with the authority to negotiate for lower prices like the Veterans' Administration has done. Including cost-control provisions is the right and responsible thing to do; however, our Republican friends do not see the benefit of this. How unfortunate.

The Democratic Substitute, which I proudly support, is the coverage that will fulfill our pledge to seniors. It provides them with real assistance within Medicare and includes provisions to curb the high cost of prescription drugs. Seniors do not need to worry about paying more in the future if they decide to stay in the traditional Medicare program. They do need to worry about this with the Republican bill, since the ''competitive bidding'' provision would force seniors to pay more for their prescription drugs than they do now. Seniors want a plan that is straight up, no-nonsense, and significant. That is what Democrats have provided in the substitute measure.

I want to do right by the seniors in my district and for seniors all across the nation who are struggling to pay for the prescription drugs they need to live fulfilling and healthy lives. H.R. 1 was constructed with the interests of pharmaceutical companies and private insurance companies at heart. The voice of seniors was nothing but a faint echo in the rooms where this bill was constructed and their best interests have been left in the dust. For these reasons, I vote against passage of H.R. 1. We need to safeguard our nation's seniors, not private insurance companies.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from New Jersey (Mr. PASCRELL).

(Mr. PASCRELL asked and was given permission to revise and extend his remarks.)

Mr. PASCRELL. Mr. Speaker, I really suggest that the other side go to see the movie, it is an old movie, ''Thelma and Louise.'' Thelma turns to Louise and says, ''Do not settle, Louise.''

You have settled. You blew it. In fact, the seniors already are angry. The plan does not even go into effect until 2006. Why are they angry? They are angry because this is a question of values. Just when you need it most, the plan ends.

The second reason why they are angry is you are going to force them into HMOs. Look what happened in New Jersey on Medicare+Choice. Now you are going to call it Medicare plus advantage. Bill Safire would have a picnic on this.

This is a joke and a sham, and you know it. Look at that record that you have provided, that we provided, all of us in the State of New Jersey, where they lost 100,000 people. What we are going to do, as the gentleman from Pennsylvania said just a few moments ago, is subsidize insurance plans. That is what we are going to do.

The third reason why they are ticked off is that there is no control over prices. Boy, are they angry. You blew it.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from California (Ms. WATERS).

Ms. WATERS. Mr. Speaker, last night we debated the Homeland Security appropriations bill. The Republicans made excuses about not spending enough money to truly secure our homeland. Tonight, the Republicans are crying broke and claiming we do not have enough money to fund credible prescription drug coverage for our seniors.

This bill 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 giveaway 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 and the pharmaceutical industry and the insurance industry that give huge campaign contributions to the Republicans.

Mr. Speaker, the Republicans have given huge tax cuts to the wealthy, promised the Iraqis a universal health care plan. They are spending millions attempting to buy the loyalty of warlords in Afghanistan, and the President just gave Musharraf $3 billion.

Seniors, call your Republican Members and ask them why they do not take care of the seniors of this country.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the gentleman from Arkansas (Mr. ROSS).

Mr. ROSS. Mr. Speaker, I thank the gentleman from Michigan (Mr. DINGELL), the ranking member, for yielding me the time.

As the owner of a small-town family pharmacy, I got sick and tired of seeing seniors who could not afford their medicine or could not afford to take it properly. That is why back in 2000 I decided to run for the United States House of Representatives.

□ 2230

But tonight, what we are debating is nothing more than a false promise for our seniors. Seniors need an accountant to figure out this plan.

I put a calculator to it, and here is what the Republican national leadership plan offers our seniors. Seniors will pay the first $2,520 of the first $3,500 worth of medicine they need every year. Now, let us contrast that a moment to a health care plan provided for Members of Congress, those who wrote this plan. Guess what they pay? Seven hundred dollars of the first $3,500 worth of medicine.

They want to provide seniors with little help while continuing to take care of Members of Congress. It is simply wrong. This is not a seniors bill, this is a bill written by the big drug manufacturers for one reason only. To privatize Medicare. To privatize Medicare so that Medicare cannot command discounts.

Mr. DINGELL. Mr. Speaker, I would inform the gentleman from Louisiana at this time that I have one speaker remaining.

Mr. TAUZIN. Mr. Speaker, who has the right to close?

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Louisiana has the right to close.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time and the right to close.

Mr. DINGELL. Mr. Speaker, I yield the balance of my time to the distinguished gentlewoman from California (Ms. PELOSI), the minority leader, to close.

Ms. PELOSI. Mr. Speaker, I thank the distinguished gentleman from Michigan for yielding me this time and for his tremendous leadership. He has been fighting this fight for America's seniors for access to quality health care for all Americans and an affordable prescription drug benefit for America's seniors. We are all in your debt.

Mr. Speaker, today is a sad day for America's seniors. Another sad day, late at night in the Chamber of the House of Representatives, where the budget priorities of our country should be debated to their fullest extent, but where the limitation on time is placed so that the American people can never really get the full story. This prescription drug benefit bill discussion is an historic occasion for our country because it does indeed, it does indeed give us the opportunity to expand Medicare to provide a guaranteed affordable defined benefit for our seniors. The Senate has taken up the bill for the past 2 weeks. They have considered 30 amendments to the bill. Thirty amendments. The House is considering the bill this evening with no opportunity for amendment.

I do want to commend the gentleman from Michigan (Mr. DINGELL) and the

gentleman from New York (Mr. RANGEL), the ranking member on the Committee on Ways and Means, for the proposal that they will be putting forth tonight, which is a real prescription drug benefit for seniors. I commend the gentleman from California (Mr. DOOLEY) for his limited opportunity but great product that he put forth on the previous question on the rule earlier. Another excellent proposal. And I commend the Blue Dogs, the gentleman from California (Mr. THOMPSON) and the gentleman from Arkansas (Mr. BERRY), for their hard work on our motion to recommit, which we hope will be allowed on the floor tonight.

Any one of these would be far superior to the proposal that is being put forth by the Republicans today. Why it is so sad is because we are supposed to honor our parents. Our senior citizens built our country. They raised our families, the backbone of America. They fought our wars. Some of them are part of the greatest generation. Some of them lived through the New Deal, many of them the Fair Deal, and tonight they are getting a raw deal. What makes it so sad is that we had the opportunity to do it right, and one of those opportunities we will hear about next, the Dingell-Rangel/Rangel-Dingell Democratic proposal, of which we are very proud.

Nearly 40 years ago, when Medicare came into existence, it came at a time when many, many seniors had no access to health care, and now almost every senior in America has access to quality health care. At the time, there was no prescription drug benefit included in the package. That was unfortunate. Today, it is imperative that we have a prescription drug benefit in the package. The advances to science have been so miraculous. Seniors today, if they have a prescription drug benefit, would be able to self-administer drugs, which would not only be an adjunct to physician or hospital care but be a supplement for it. It would be a substitute for it.

So think of what it means to the quality of life for our seniors in order for them to have that independence and to be able to know that it is guaranteed, defined, and dependable. Think of what it means to the taxpayer in the reduction of cost in medical services to seniors because they can have access to prescription drug benefits. That is what makes this such a tragedy. It makes it such a tragedy.

So tonight, instead of honoring our parents and our seniors, we are foisting a hoax upon them, at least the Republicans are. And a cruel hoax it is indeed. In doing so, the Republicans insult the intelligence, they insult the intelligence of America's seniors. Many of you are blessed to still have your parents with you, and some of us are even bordering on being seniors ourselves, but any of you who have your parents or dear relatives who are older know that they are into stats. They know their statistics. They know their blood count, they know their blood pressure, they know their bank account balance, they know the cost of everything, many of them, because many of them are on fixed incomes and the slightest change has an impact on their economic security.

So I want those seniors who are so sensitive to changes in cost to take a look at this chart, which was in the New York Times this morning, and it says, ''Under House GOP Bill Seniors' Out-of-pocket Drug Costs Remain Staggering.'' Remain staggering. The average cost that seniors will pay in drug costs in 2006 is reported to be $3,155. So let us take the $3,000 line for the Republican hoax on seniors. If the beneficiary's annual drug costs are $3,000, seniors out there, if you are paying about $3,000, under the House bill your deductible will be $250. Your premium will be $420. The share of initial coverage is $350. Gap in coverage, here is where you fall into the gap, $1,000.

So of that $3,000 worth of drug cost, you, America's seniors, will be paying $2,020 out-of-pocket. Where is the benefit? And this is the best case scenario. These prices that you see here are suggestions to the HMOs. The prices could be much more, and your out-of-pocket cost could be much more.

I do not know how many of you think the hole is the most delicious part of the donut, but seniors, when they fall into this donut hole where they get no coverage, they still pay the premium. They are paying a premium for something that is not there. It is not there. And of course, if they pay $4,500 in drug costs, they are paying $3,520 out-of-pocket. A cruel hoax on America's seniors. And they call that modernization. I call it humiliation. I call that insulting the intelligence of America's seniors.

It was interesting, in this same article today one senior who was quoted on the subject said, ''Do you think anybody in Washington, D.C. has any idea what people on a limited income have to do to live?'' Clearly, the Republicans do not. They are just too busy giving the biggest tax breaks to the highest-end people in our country. They are just too busy giving those tax breaks that they cannot write a decent prescription drug benefit for seniors.

In fact, I might add seniors and children. Where, oh where did the child tax credit go in all of this, as we adjourn tomorrow? Tax cuts instead of child tax credits. Tax cuts instead of prescription drug benefits. At the beginning of life; toward the end of life. It is a cruel hoax.

And so, my colleagues, no matter what the Republicans tell you about their bill, the euphemism that it is a modernization of Medicare is really a laugh. It is an elimination of Medicare. Because no matter what they tell you, the facts are these: The Republicans do not provide a guaranteed defined benefit for seniors. The Republican bill does not reduce the high cost of prescription drugs.

Indeed, the hardest to explain to anyone is that the bill prohibits the Secretary of Health and Human Services from negotiating for best prices. I repeat: Not only does the bill not bring down the cost of drugs, it prohibits the Secretary of HHS from negotiating for the best prices. Every business in America, indeed the VA, does that. Volume gives you leverage; gives you opportunity. Except in this bill it is prohibited.

And at this point I want to say that the proposal put forth by the gentleman from Michigan (Mr. DINGELL) and the gentleman from New York (Mr. RANGEL), the cost of it would be cut in half, cut in half, if the Secretary had the authority, which our bill calls for, and indeed took that responsibility to negotiate for best prices.

What the bill does also, instead of modernizing Medicare, is to unravel not only Medicare, and I hope seniors are listening, not only the prescription drug benefit, but part A and part B along with the prescription drug benefit, forcing seniors to compete and pay more to stay in Medicare, the Medicare they know and trust. I repeat: When this bill, in 2010, comes to fruition, seniors will have to pay more to stay in Medicare for part A, part B, and prescription drug benefits.

And this is really a sad one in their bill. The employer piece. The employer piece. There are many businesses in America who honor their responsibility to their retirees. The CBO, the Congressional Budget Office, estimates that under the Republican bill one-third of all retirees who get their benefits from their employers will lose their coverage. Millions of seniors will be worse off.

So that is why I say this is really a tragedy. It is a missed opportunity. It could be so good. It could be bipartisan. It could be what seniors expect and deserve. Democrats have a better idea. The Rangel-Dingell/Dingell-Rangel proposal, the two distinguished gentlemen who have spent a lifetime in public policy promoting access to quality health care, whose credentials are impeccable in this regard, they support Medicare. They have promoted a bill that is worthy of the seniors whom we respect. It is a guaranteed defined benefit under Medicare. It does give the authority to the Secretary to negotiate for best prices. It protects seniors' options in terms of their employers giving them benefits; not making millions of seniors be worse off.

America's seniors deserve a benefit that is affordable, with reasonable premiums and deductibles. America's seniors deserve a benefit that is available to all seniors and disabled Americans, including Americans in rural areas.

N O T I C E

Incomplete record of House proceedings.

Today's House proceedings will be continued in the next issue of the Record.