House of Representatives

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MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003—Continued

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

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

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

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

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

Members might further ask how would the contracts be awarded under this privatization of Medicare, and the answer in a fairy tale world would be shared risk capitation of performance. But the truth is this is not a fairy tale. It happens to be the truth. That was the Democratic proposal on Medicare prescription drugs, but tonight Democrats have come to the floor one after the other and criticized this plan because it contained many of those same features. Different, however, in some respects because this plan provides better coverage for seniors on the bottom. In fact, while some of my friends came to the floor and called this a sad day and said how sorry they were for the citizens of California, this bill we proposed would put 14 million California senior citizens in plans that would cost them no premiums, no deductibles, free entry for drugs in California for 14 million senior citizens, half a million in Indiana, half a million in Ohio, half a million in Pennsylvania, almost a million in Texas, and so on and so forth, free drug coverage under this plan, and yet the fantasy plan offered by the Clinton administration just a few years ago containing many of the same elements is somehow forgotten. It is somehow put away in a closet. It is somehow not to be remembered, and this plan is to be attacked. When we test credibility of arguments on the floor of the House, test them against the reality of the plan offered by the Democrats and the reality of the plan offered today.

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

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

There is nobody in this House that loves their mother more than I love my mother. I challenge Members on that. She is a three-time cancer survivor, she is 86 years old, and she won first place at the Senior Olympics this year in shotput, and if you give her trouble, I will sic her on you.

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

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

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

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

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

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

What should we be doing?

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

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

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

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

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

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

Mr. UDALL of New Mexico. Mr. Speaker, for far too long, as I traveled around the state of New Mexico, seniors have told me their heartaches and their problems doing government paperwork.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The proposed House bill would fail to offer meaningful prescription drug coverage to the millions of low-income women with incomes below the 135 percent poverty level who do not have employer-based health care. Also, the House bill would raise the amount of co-payments that our country’s poorest women Medicare beneficiaries are forced to pay.
Unlike the House bill, the Senate proposal, while not perfect, would be far more helpful to elderly women who range from 74 to 160 percent of the poverty level. Under the House bill, the out-of-pocket costs paid by elderly women will still make it difficult for them to get their much-needed prescription medicines. The Senate bill is targeted on helping women seniors who are in greatest need of assistance will receive up to 40 percent fewer prescriptions than those seniors who are able to afford private insurance. Our elderly women, who are among our most vulnerable citizens, deserve far better treatment than this. It is critical that as Members of Congress, we help women and all seniors by expanding Medicare to offer a prescription drug benefit that is universal, affordable, dependable, and voluntary. We can do no less than to offer elderly women access to adequate healthcare that they can afford and easily access.

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

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

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

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

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

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

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

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

Once retired, women earn less than men because:

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

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

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

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

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

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

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

Finally, H.R. 1 is flawed because it offers seniors an inadequate prescription drug benefit. I support a voluntary prescription drug benefit paid for by Medicare. I am committed to providing a comprehensive benefit that is universal, affordable, dependable, and voluntary.

In contrast to the “mystry” provision which allows seniors to “pick” their HMOs, the Senate approach to providing a prescription drug benefit is simple: the sickest and the poorest beneficiaries are in greatest need of assistance. Providing a guaranteed benefit for all seniors, no matter where they live, how ill they are, or what kind of illness they have. This bill proposes to turn the prescription drug benefit over to HMOs and the private insurance industry. That means that drugs would be available at lower prices if they are not guaranteed—the insurance industry would be able to charge whatever they want for the premium. In addition, it would be the insurance companies that get to decide what drugs will be covered, and what drugs will not be covered. What this means for seniors is that there will not be a consistent, reliable program for all seniors is that there will not be a consistent, reliable program for all seniors across the country. Seniors in my district might pay higher premiums and get less coverage than their counterparts in other areas of the country. Or, they may get better coverage for lower premiums. We just don’t know because it will be left up to the private insurance companies and the HMOs.

This bill also raises out-of-pocket costs for those who need the protection that Medicare had traditionally provided: the sickest and the poorest beneficiaries. In addition to the “mystery” provision which allows seniors to “pick” their HMOs, the Senate approach to providing a prescription drug benefit is simple: the sickest and the poorest beneficiaries are in greatest need of assistance. Providing a guaranteed benefit for all seniors, no matter where they live, how ill they are, or what kind of illness they have. This bill proposes to turn the prescription drug benefit over to HMOs and the private insurance industry. That means that drugs would be available at lower prices if they are not guaranteed—the insurance industry would be able to charge whatever they want for the premium. In addition, it would be the insurance companies that get to decide what drugs will be covered, and what drugs will not be covered. What this means for seniors is that there will not be a consistent, reliable program for all seniors is that there will not be a consistent, reliable program for all seniors across the country. Seniors in my district might pay higher premiums and get less coverage than their counterparts in other areas of the country. Or, they may get better coverage for lower premiums. We just don’t know because it will be left up to the private insurance companies and the HMOs.

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Dear Sir, I am writing my Senators and Representatives to plead our case regarding Medicare proposals that could endanger patient access to chemotherapy. I am a lung cancer survivor, age 72, and my husband, age 76, is now undergoing chemo, for liver cancer. Chemo drugs are required for my husband’s quality of life now and MRI’s have shown the tumor have diminished in size, so “it’s working!”

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

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

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

Deception claims to the contrary, the bill, which calls for private drug-only plans, would not make drugs affordable. It has no mechanism for keeping prices down, no negotiation for acceptable terms, no guarantee of defined and stable costs. Seniors would be at the mercy of private plans. They would lose their choice of doctors. They would be at risk for access to the same benefits as seniors in metropolitan areas.

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

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

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

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

It’s because just last week, the Republican leadership decided that they would rather eliminate estate taxes for millionaire than help seniors afford prescription drugs. They in-

sisted on spending a total of $820 billion to help 8,000 millionaires. For almost the same cost, we could give millions of seniors a real prescription drug benefit. Millionaires or millions of seniors? The Republicans give new meaning to the phrase “better off dead.” If you’re rich and dead, Republicans don’t want you to lose a dime. But if you’re alive and can’t afford the high cost of prescription drugs—well, good luck. You might want to be dead. I dare my Republican colleagues to tell their mothers what they’re doing to Medicare.

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

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

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

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

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

The Republican plan is difficult to explain, but let me try: it begins with uncertain private health insurance premiums; then, seniors must buy a private drug-only policy; if insurance companies refuse to offer a plan, even when the companies are bribed with an almost no-risk contract. This bill would benefit insurance companies, not extend a benefit to our seniors. This bill would guarantee that 23 million seniors will have unequal coverage of medications!

It’s because just last week, the Republican leadership decided that they would rather endanger prescription drug benefits, with Medicare paying 80 percent; and a limit of $2,000 in out-of-pocket costs per beneficiary per year. Health care is essential in greater Minnesota. The hospitals in many small communities throughout northern and northeastern Minnesota are the major employer in town, and the health care they offer is critical for economic development and tourism. The Range/Dingell bill offers a substantial improvement in payments to the hospitals and doctors in rural Minnesota who provide those critical health care services.

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

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

The Democratic bill would provide an additional billion for all rural ambulance providers by increasing payments for ambulance services. The increases we propose would ensure the financial solvency of St. Mary’s Life Flight, enabling it to continue assisting, for example, people who are injured while vaca-

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

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

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

The $400 billion allocated for the Medicare drug benefit is not being spent widely under this legislation. High-income Medicare beneficiaries like Warren Buffett are subsidized 73 percent by the Federal government for their drug-only insurance plans. Low-income seniors who are not dually eligible have no cost-sharing assistance for their drug spending between $2,000 and $30,000. The majority is commanded to negotiate with insurance companies who will game the system to receive a 99.99-percent subsidy when 73 percent would have been fine. Mr. Speaker, that’s not a negotiation—the insurance company will hold all of the cards. No money is being spent on a fallback plan. Seniors in rural areas of North Carolina will not have drug coverage if insurance companies refuse to offer a plan, even when the companies are bribed with an almost no-risk contract. This bill would benefit insurance companies, not extend a benefit to our Nation’s seniors.

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

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

Where do my colleagues think the extra money is coming from? When CBO realizes that their estimated insurance penetration rate was off by 10 percent that money will come out of future physician, hospital, nursing home, and home health care reimbursement rates. If only 85 percent of seniors sign up for drug coverage and plans’ subsidies skyrocket, that money will come out of Food and Drug Administration modernization efforts, National Institutes of Health research, and bioterrorism preparedness. Congress is working with a limited pot of money, and Congress must account for those accounts based on the seniors’ needs. Senior’s Congressional Budget Office to write former employers could put money into the accounts and receive a tax deduction. And insurance companies would offer catastrophic coverage that is subsidized by the federal government for low-income seniors. Unfortunately, that plan is not on the floor today.

Mr. Speaker, I wanted to be able to come to the floor today and vote for a good Medicare prescription drug benefit because of the drastic and thoughtless cuts in Medicare reimbursements. Since 1997, Congress has done nothing substantive in Medicare except try to fix the damage done under the BBA. I cannot support this legislation that builds on and magnifies those 6-year-old mistakes. I regret that I cannot and will not vote for this legislation.

Mr. UDALL of Colorado. Mr. Speaker, I want to support a Medicare prescription drug bill, but I can’t support the one we are considering today. Without an inflationary update, the bill will force seniors into HMOs, and will endanger drug benefits that many seniors get through their retirement plans. In fact, instead of drafting a Medicare drug benefit bill, the Republican Majority has used this opportunity to try to end Medicare as we know it.

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

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

Second, the House bill does not include an important “fallback” provision that requires that traditional Medicare would step in as a backup if private insurers show no interest in selling drug plans in a particular area. Currently, private plans don’t exist in many parts of the country, including many smaller cities, rural and mountain areas in Colorado. I’ve heard from many seniors in my district who have been quoted extremely high prices, like $6,000 and are now having trouble finding a doctor. In addition, 88 percent of all Medicare beneficiaries are enrolled in traditional Medicare. So, without this “fallback” safety net provision, seniors would have no coverage in regions where insurers say it’s unprofitable to provide it, especially rural areas.

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

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

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

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

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

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

Second, this bill guarantees coverage under Medicare.

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

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

Fourth, this bill has no gaps in coverage. Under the Democratic plan, when a senior has spent $2,000 on drugs, the government picks up the remaining costs. A senior who has spent $2,000 under the Republican plan, they’re dropped. They get zero coverage until they’ve spent $4,900. The Republican bill does not simply have one big problem. It has several huge problems.

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

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

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

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

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

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

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

Second, there is no provision in the House bill on how to provide a benefit to seniors in areas where two insurance products are not available or are too expensive. It is simply not realistic, nor fair, for seniors in one region to have products available and seniors in another region to not have choice because two plans have not been forthcoming.

Furthermore, I am adamantly opposed to the proposal for a so-called ‘value card’ to be managed by the private sector. This is a piece that is simply not realistic, nor fair, for seniors in one region to have products available and seniors in another region to not have choice because two plans have not been forthcoming.

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

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

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

The government should encourage employers, families and others to help seniors with the purchase of expensive prescription drugs.

It is time that we admit that no proposal that comes to the House floor that meets the budget requirements will fully address all the prescription drug requirements of seniors. Every plan will have a so-called donut hole. There should be no “so-called donut hole.” The government’s assistance to beneficiaries should be a defined contribution. This type of benefit would be manageable and known.

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

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

Any entity qualified by the Centers for Medicare and Medicaid Services could offer a drug value card to seniors. Card issuers would negotiate with pharmaceutical manufacturers for discounts on drug utilizing the same mechanisms that are available in the private sector to drive down costs and improve health care services.

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

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

Protection from catastrophic drug expenses would also be offered at $10,000 through the

private sector, with federal subsidies on the premium for those with low incomes.

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

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

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

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

Mr. PAUL. Mr. Speaker, while there is little debate about the need to update and modernize the Medicare system to allow seniors to use Medicare funds for prescription drugs, there is much debate about the proper means to achieve this end. However, much of that debate is phony, since neither H.R. 1 nor the alternative allows seniors the ability to control their own health care. Both plans give a large bureaucracy the power to determine which prescription drugs seniors receive.

Under both plans, federal spending and control over health care will rise dramatically. The only difference is that the alternative puts seniors under the total control of the federal bureaucracy, while H.R. 1 shares this power with “private” health maintenance organizations and insurance companies. No wonder supporters of nationalized health care are celebrating the greatest expansion of federal control over health care since the Great Society.

I am pleased that the drafters of H.R. 1 incorporate regulatory relief legislation, which I have supported in the past, into the bill. This will help relieve some of the tremendous regulatory burden imposed on health care providers by the Federal Government. I am also pleased that H.R. 1 contains several good provisions addressing the congressionally-created crisis in rural health and attempts to ensure that physicians are fairly reimbursed by the Medicare system.

However, Mr. Speaker, at the heart of this legislation is a fatally flawed plan that will fail to provide seniors access to pharmaceuticals of their choice. H.R. 1 provides seniors a choice between staying in traditionally Medicare or joining an HMO or a Preferred Provider Organization (PPO). No matter which the senior selects, choices about which pharmaceuticals are available to seniors will be made by a private sector bureaucracy. Furthermore, the bureaucrats will have poor to determine the aggregate prices charged to the plans. Being forced to choose between types of bureaucrats is not choice.

Thus, in order to get any help with their prescription drug costs, seniors have to relinquish their ability to choose the type of prescriptions that meet their own individual needs! The inevitable result of this process will be rationing,
as Medicare and/or HMO bureaucracies attempt to control costs by reducing the reimbursements paid to pharmacists to below-market levels (thus causing pharmacists to refuse to participate in Medicare), and restricting the type of pharmacies seniors may use in the name of cost effectiveness. Bureaucrats may even go so far as to forbid seniors from using their own money to purchase Medicare-covered pharmaceuticals. I remind my colleagues that today the federal government prohibits seniors from using their own money to obtain cost-effective pharmaceuticals that differ from those “approved” of by the Medicare bureaucracy!

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

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

Setting up a system where by many of those currently receiving private coverage are hired into the government program exacerbates the problems with this bill: it harnesses the bankruptcy of the Medicare program and the federal government. According to Medicare Trustee, and professor of economics at Texas A&M University, Tom Saving, the costs of this bill could eventually amount to nearly 40 percent of the public debt of $3.8 trillion! Of course, estimates such as this often widely underestimate the costs of government programs. For example, in 1965, the government estimate that the Medicare Part B hospitalization program would cost $9 billion in 1990, but Medicare Part B costs $66 billion in 1990!

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

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

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

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

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

The alternative suffers from the same flaws, and will have the same (if not worse) negative consequences. It is simply assumed that Congress can spend to two-thirds of the current public-held debt of $3.8 trillion! Of course, estimates such as this are granted monopoly over pharmaceutical products and sunset provisions in the Medicare Medical Savings Accounts (MSA) program. Medicare MSAs allow seniors to use Medicare dollars to cover the costs of prescription drugs in a manner that increases seniors’ control over their own health care.

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

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

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

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

Finally, Mr. Speaker, I would like to comment on the procedure under which this bill was brought before the House. Last week, the committees with jurisdiction passed two separate, but similar Medicare prescription drug bills. In the middle of last night, the two bills were merged to produce H.R. 1. The bills reported out of Committee were each less than 400 pages, yet the bill we are voting on today is 892 pages. In the middle of the night, the bill mysteriously doubled in size! Once again, members are asked to vote on a significant piece of legislation with far reaching effects on the American people without having had the chance beforehand, study, or even see major portions of the bill.

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

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

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

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

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

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

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

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

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

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

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

My medication is $135.00 per month. Fortunately, I am not on any medications. If we both were not working part-time, I guess I would have to make a choice between food and medication—does one eat to survive or take the medication for a "long and happy life?"

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

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

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

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

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

The biggest problem with the leadership bill is the fact that the plans must offer Medicare in 2010. This is a radical provision that will be the demise of the traditional Medicare program on which our seniors have depended for nearly 40 years. In 2010, seniors will be given a lump sum to purchase health insurance, including traditional Medicare. There is concern that the healthy seniors will leave traditional Medicare and the premiums will increase dramatically, up to 47 percent. In addition, under the leadership bill, each local area will have a different premium for fee-for-service Medicare. For example, in Wisconsin, seniors might have to pay more to enroll in fee-for-service Medicare than seniors in Florida. This is a drastic departure from Medicare’s fundamental principle that seniors across the country pay the same premium for the fee-for-service benefit. Therefore, we do not provide a real solution to the problem of prescription drug coverage for our seniors. The Republican plan falls woefully short.

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

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

In addition, both of these alternatives provide substantial improvements to Medicare payments for rural providers. Both pieces of legislation include equalizing the dispar- proportionate share hospital payments for rural hos- pitals, an increased in the bad debt limit for critical access hospitals, and a geographic adjust- ment for rural physicians. None of these provi- sions are included in the leadership’s bill.

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

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

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

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

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

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

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

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

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

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

In addition to the excellent work and leader- ship of Chairman THOMAS and Chairman Jor-Jack, I want to thank my co-he- roes—John McManus and Deb Williams—who have worked so tirelessly on these provisions.

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

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

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

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

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

It forces seniors into risky HMO plans and new private fee-for-service plans that will not cover all seniors’ costs!
A plan that offers coverage to all seniors—even Hispanics! It’s time to take seniors off the bus to Tijuana!

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

We all know that drug prices are spiraling out of control. Maine seniors are forced to take bus trips to Canada to buy affordable prescription drugs. Our seniors have to go all the way to Mexico to get the life-saving medicine they need. This is not safe and it is not fair. I am angered when I think about all of the people that the Republicans are leaving behind in the health and well-being of our seniors. Seniors deserve to be protected in a safe and fair healthcare plan. In my district, San Bernardino, California, seniors are boarding buses to Tijuana so they can afford to buy prescription drugs. Our seniors have to go all the way to Mexico to get the life-saving drug they need.

Do you have a grandparent or parents who can’t afford to buy prescription drugs?

I think about the senior who makes $8,000 a year. He is lucky enough to have assets and owns a car. According to Republicans, that is wealthy! They will give tax breaks to millionaires, but under their plan, a man who makes $8,000 a year and is lucky enough to own a car, is too wealthy to get medicines that will ease his pain and save his life!

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

When I think about this plan, I think about all of the seniors who can’t afford life saving prescription drugs. I think about the senior who has glaucoma and prostate cancer and makes only $8,000 a year.

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

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

When I think about this plan, I think about the senior who might make $10,000 a year. This senior will pay one-fifth of his or her income to cover the Republican coverage gap.

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

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

Under the Republican plan they may start in Tijuana. But after a couple of years, Medicare will only be a voucher program and where will seniors be?

In an HMO plan and still in Tijuana buying medicine.

My constituents deserve better than the Republican plan!

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

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

A plan that actually works for America’s seniors!

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

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

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

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

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

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

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

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

A plan that has offered coverage for all seniors— even Hispanics! It’s time to take seniors off the bus to Tijuana!

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

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

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

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

Mr. Speaker, I believe the Democrats are right. Mr. Bush would provide $400 billion to provide America’s seniors with a truly comprehensive, voluntary prescription drug plan.

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

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

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

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

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

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

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

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

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

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

Mr. Speaker, let me close by repeating this: $400 billion is only half as good as $800 billion . . . . but it is $400 billion better than nothing.

We can’t get near that plan if we reject this proposal today. In the spirit of advancing the process, I will support this bill. I reserve the right, however, to vote against a bill that emerges from Congress that does not address the significant flaws in the legislation before us tonight.

But I reject this Republican Medicare bill. There are still serious questions about how its various provisions would be administered. It’s time to stop blaming. It’s time to stop financing a bipartisan basis to develop a final bill that represents consensus.

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

Mr. Speaker, I believe the Democrats are right.

As Rep. Charles B. Rangel, Ranking Democrat on the Committee on Ways and Means, stated, "To get prescription drug coverage, seniors would have to go to an HMO by another name. Then, all the choices would belong to the private insurance provider—which drugs are covered, which pharmacies you can choose, who your doctor is, etc."

Mr. Speaker, this bill is an empty pillbox—it is a paltry solution to the problem of providing adequate prescription drug coverage to our seniors; rather, it is creating an inadequate system—based on a provider concept that does not currently exist and will not likely work in practice.

A better alternative to H.R. 2473 is The Medicare RX Drug Benefit an Discount Act (H.R. 1199) offered by my friend CHARLIE RANGEL of New York. This prescription drug plan would guarantee that every Medicare beneficiary, no matter what they live, could have a prescription drug benefit while increasing the cost for persons who need the benefit will not be able to afford its costs.

Furthermore, the use of health maintenance organizations (HMOs) and other private organizations to obtain prescription drugs would deter many seniors from getting the benefit. As Rep. Charles B. Rangel, Ranking Democrat on the Committee on Ways and Means stated, "To get prescription drug coverage, seniors would have to go to an HMO by another name. Then, all the choices would belong to the private insurance provider—which drugs are covered, which pharmacies you can choose, who your doctor is, etc."

Mr. Speaker, this bill is an empty pillbox—it is a paltry solution to the problem of providing adequate prescription drug coverage to our seniors; rather, it is creating an inadequate system—based on a provider concept that does not currently exist and will not likely work in practice.

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

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

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

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

Unlike the proposal put forth by the Bush Administration and endorsed and worsened by the House GOP Leadership, H.R. 1199 would not require seniors to join an HMO or similar private plan in order to get a prescription drug benefit. In fact, Medicare beneficiaries would be guaranteed a prescription drug benefit rather than offered a marginal voluntary plan under H.R. 2473. This plan would ensure that we keep our social compact with our seniors. The Republican plan fails to do that.
Since its inception 1965, Medicare has provided important protection for millions of aged and disabled persons. H.R. 2473 would be a detriment to improving and securing this system. I lend my voice in opposition and urge my colleagues to vote against H.R. 4273 and to support H.R. 11.

Mr. WATERS. Mr. Speaker, I rise to oppose this Medicare privatization plan, which is masquerading as a prescription drug bill. This bill would force seniors who want prescription drug coverage to get it from private insurance. It provides no guarantee that insurance plans will be available, and when they are, premiums and benefits will vary wildly. The bill also provides no coverage when a senior’s prescription drug costs are between $2,000 and $4,900 per year. This huge coverage gap affects 47 percent of Medicare beneficiaries.

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

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

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

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

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

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

And, I am sure we all wish lifesaving drugs were more affordable for our families, friends, and neighbors. The prescription drug industry’s politically responsible plan that will remain solvent in years to come, is easily accessible, and increasingly beneficial to seniors of all regions and means, was a daunting one.

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

Beginning October 1, Medicare reimbursements to rural areas would finally mirror those for large urban ones. Having lamented for a
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number of years over the inequity of this provi-
sion within the Medicare reimbursement sys-
tem, I am particularly pleased that this is being
addressed in the bill.

A drug benefit for seniors and a rejuvena-
tion of the Medicare system are essential to
seniors and their caregivers. The delivery of
Medicare, as we know it today, has been under
continual strain. The program was first con-
ceived, and the pro-
gram ought to be modernized to reflect the in-
creases in medical technology and the utiliza-
tion of a wide range of care options.

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

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

Mr. KNOLLENBERG. Mr. Speaker, today
we have an opportunity to provide our seniors
with a new prescription drug benefit and im-
proved access to health care. It is a long over-
due step in updating and improving Medicare.
Today’s vote will provide choice and care to
those who need it most. Our 6.5 million low-
income seniors will receive a fully covered
premium and a cost sharing benefit when their
drug benefit switches from Medicaid to Medi-
care, paying no more than $2 per generic pre-
scription and no more than $5 for name brand
drugs. This will also save states about $6.6
billion a year in Medicaid costs.

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

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

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

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

Instead of following the Senate’s lead and
working toward a compromise that will im-
prove Medicare, a wildly popular and success-
ful program, the House Republican leadership
has chosen instead of add provisions to this
legislation that.attacks the foundation of the
Medicare program. The bill does not include a
federal fallback if private plans choose not to
offer a benefit. The experience that my con-
stituents have had with Medicare+Choice show
that private health care plans are at best an
unstable partner for Medicare, and financial
analysts have consistently publicly questioned
whether “drug only” plans will ever be offered.

For these reasons, it is absolutely vital that
Medicare provide a viable and guaranteed fall-
back for Medicare beneficiaries.

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

The Senate has drafted legislation that has
broad support among Senators across the ide-
ological spectrum. This legislation has won the
support of both President Bush and Senator TED KENNEDY. Together with Repre-
sentative THOMPSON and the Blue Dog Caucus, I am supporting legislation that
uses the framework of the Senate compromise and improves on it, making it a
much stronger bill. The Thompson substitute is an important building in
employer contributions to they will count toward the out-

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

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

This bill allows private insurance companies
to decide premiums, prescription drug cov-

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

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

In addition, the brunt of the bill is about pro-
viding voluntary prescription drug coverage to
Medicare eligible individuals. There is a con-
servative critique that it is too expensive, and
an affordable health care. The Democratic substitute does just that—it lowers
drug prices, guarantees coverage and enables
seniors to get their medicines at the pharmacy of
their choice. The Rangel/Dingell substitute addresses
my concerns more effectively and I
will strongly support it.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

And it does nothing to contain costs. It prohibits the Secretary of Health and Human Services from even engaging in negotiations with the drug companies on behalf of the enrollees.

As a result, many seniors will pay more than they do now and their premiums will rise as the cost of drugs rises.

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

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

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

Mr. Speaker, we must provide a meaningful drug plan with guaranteed, defined benefits—without any gaps and without doughnut holes. We should stop letting costs of the Medicare sys-t-e-m, where seniors will not be forced to shop around for a plan only to be unceremoniously dropped soon thereafter. Giving them a plan that seniors have come to rely on and feel safe with is what we should be doing. That is real economic security. Medicare—the same plan my 89 year-old mother relies on today.

This debate is as important and historic as any I have been a part of in this body. If we allow this bill to become law, we are essentially creating a two-tiered Medicare to contract my friend from Michigan, Mr. Dingell, fought to pass 38 years ago. And by doing so, we would be saying that guaranteed health care for our seniors is no longer an obligation or responsibility of this government. I do not come to Congress to preside over the dismantling of Medicare. That contract must be honored. I urge my colleagues to support a plan that does that.

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

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

If you believe the Republican bill solves the prescription drug crisis facing our seniors . . .

or responsibility of this government.

Mr. Speaker, we must provide a meaningful prescription drug plan that does that.

It goes something like this:

I've got some ocean front property in Arizona from my front porch you can see the sea.

I've got some ocean front property in Arizona and if you buy that I'll throw the Golden Gate in free.

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

I say to my Republican colleagues, it is time to stop this heinous scam on seniors! It is time to show the greatest generation in our country that Republicans want to listen to them.

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

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

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

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

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

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

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

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

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

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

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

The SPEAKER pro tempore. Mr. Speaker, I'll recognize the gentleman from Louisiana, Mr. RANGEL.

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

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

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

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

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

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

(c) BIPA; Secretary.—In this Act:

(1) BIPA.—The term "BIPA" means the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as enacted into law by section 111 of Public Law 106-55.

(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.

Sec. 101. Voluntary Medicare outpatient prescription drug benefit program.

Part D—Voluntary Medicare Prescription Drug Benefit for the Aged and Disabled.

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

TITLE II—MEDICAID
Sec. 201. Medicare-choice improvements.
Sec. 202. Making permanent change in Medicare+Choice reporting deadlines and annual, coordinated election period.
Sec. 203. Specialized Medicare+Choice plans for special needs beneficiaries.
Sec. 204. Medicare MSAs.
Sec. 205. Extension of reasonable cost contract.
Sec. 206. Extension of municipal health services demonstration project.

TITLE III—COMBATTING WASTE, FRAUD, AND ABUSE
Sec. 301. Medicare secondary payer (MSP) provisions.
Sec. 302. Competitive acquisition of certain items and services.
Sec. 303. Reform of payment for drugs and biologicals under the medicare program.
Sec. 304. Demonstration project for use of recovery audit contractors.

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

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

Subtitle B—Other Provisions
Sec. 511. Payment for covered skilled nursing facility services.
Sec. 512. Coverage of hospice consultation services.

TITLE VII—PROVISIONS RELATING TO PARTS A AND B
Subtitle A—Physicians' Services
Sec. 601. Revision of updates for physicians' services.
Sec. 602. Studies on access to physicians' services.
Sec. 603. MedPAC report on payment for physicians' services.

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

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

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

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

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

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

TITLE IX—REGULATORY REDUCTION AND CONTRACTING REFORM
Subtitle A—Regulatory Reform
Sec. 901. Construction; definition of supplements.
Sec. 902. Issuance of regulations.
Sec. 903. Compliance with changes in regulations and policies.
Sec. 904. Reports and data relating to regulatory reform.

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

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

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

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

Sec. 933. Revisions to Medicare appeals process.

Sec. 934. Prepayment review.

Sec. 935. Recovery of overpayments.

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

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

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

Sec. 945. Emergency medical treatment and stabilization.

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

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

Sec. 949. Conforming authority to waive a program exclusion.

Sec. 950. Treatment of certain dental claims.

Sec. 951. Furnishing hospitals with information related to compute drug formula.

Sec. 952. Revisions to reassessment provisions.

Sec. 953. Other provisions.

Sec. 1001. Importation of prescription drugs.

Sec. 1101. Short title.

Sec. 1103. 30-month stay-of-effectiveness period.

Sec. 1108. EMTALA improvements.

Sec. 1109. Emergency medical treatment and active labor act (EMTALA) technical advisory group.

Sec. 1110. Authorization of use of arrangements to provide core hospice services in certain circumstances.

Sec. 1112. Application of OSHA bloodborne pathogens standard to certain hospitals.

Sec. 1118. BIPA-related technical amendments and corrections.

Sec. 1119. Conforming authority to waive a program exclusion.

Sec. 1120. Treatment of certain dental claims.

Sec. 1121. Furnishing hospitals with information related to computerized drug formula.

Sec. 1122. Revisions to reassessment provisions.

Sec. 1123. Other provisions.

TITLE I—MEDICARE PRESCRIPTION MEDICINE BENEFIT

SEC. 101. VOLUNTARY MEDICARE OUTPATIENT PRESCRIPTION MEDICINE PROGRAM.

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

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

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

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

"MEDICARE OUTPATIENT PRESCRIPTION MEDICINE BENEFIT"

"SEC. 1859. Subject to the succeeding provisions of this part, the voluntary prescription medicine benefit program under this part provides the following:

"(1) Premium.—The monthly premium is $25.

"(2) Deductible.—The annual deductible is $100.

"(3) Coinsurance.—The coinsurance is 20 percent.

"(4) Out-of-pocket limit.—The annual limit on out-of-pocket spending on covered medicines is $2,000.

"(5) Negotiating fair prices with pharmaceutical manufacturers"

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

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

"(c) Authority to contract with entities to administer benefits under this part to eligible beneficiaries in the region or on a national basis.

"(1) Authority for contracts.—

"(II) Awards contracts to such contractors to administer benefits under this part to eligible beneficiaries in the region or on a national basis.

"(II) Procedure.—The Secretary shall establish procedures under which the Secretary—

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

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

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

"(3) Competitive procedures.—Competitive procedures (as defined in section 45S of the Office of Personnel Management Policy Act (42 U.S.C. 403(s))) shall be used to enter into contracts under this part.

"(4) Terms and conditions.—Such contracts shall have such terms and conditions as the Secretary shall specify and shall be for such terms (at least 2 years, but not to exceed 5 years) as the Secretary shall specify consistent with this part.

"(5) Use of pharmacy contractors in price negotiations.—Such contracts shall require the contractor involved to negotiate contracts with manufacturers that provide for maximum prices for covered outpatient prescription medicines that are lower than the maximum prices negotiated under section 1859A(a), applicable. The price reductions shall be passed on to eligible beneficiaries and the Secretary shall hold the contractor accountable for meeting performance requirements with respect to price reductions and limiting price increases.

"(6) Area for contracts.—

"(A) Regional basis.—

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

"(II) Partial regional basis.—

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

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

"(B) Determination.—

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

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

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

"(II) No administrative or judicial review.—The determination of administrative areas under this paragraph shall not be subject to administrative or judicial review.

"(7) Submission of bids.—

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

"(ii) Bid that covers multiple areas.—The Secretary shall permit an entity to submit a single bid for multiple areas if the bid is applicable to all such areas.

"(B) Required information.—The bids described in subparagraph (A)—

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

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

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

"(iv) a detailed description of the performance requirements for which the administrative fee of the entity will be subject to review pursuant to section 1859E(a)(1)(A) and, if so, the amount of such reduction and how such reduction is tied to performance requirements described in subsection (c)(4)(A)(ii);

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

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

"(I) selecting preferred prescription medicines;

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

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

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

"(ix) such other information that the Secretary determines is necessary in order to carry out the requirements of this part.
The procedures under clause (vi) shall include the use of a pharmaceutical and therapeutics committee of the members of which include practicing pharmacists.

The pharmacy contractor shall, consistent with the requirements of this part and the goals of providing quality pharmacy care and of containing costs, award a contract to a pharmacy contractor that submitteds bid that meet the minimum standards established under this part and by the Secretary to award a contract, the Secretary shall consider the comparative merits of each bid, as determined on the basis of relevant factors, with respect to—

(i) how well the contractor meets such minimum standards;

(ii) the amount the contractor will charge the Secretary for administering the benefits under the contract;

(iii) the length of time the pharmacy contractor establishing under subsection (c)(2) and performance requirements for which the administrative file of the entity will be subject to risk pursuant to subsection (c)(4)(A)(ii);

(iv) the proposed negotiated prices of covered outpatient medicines and annual increases such prices;

(v) factors relating to benefits, quality and performance, beneficiary cost-sharing, and consumer satisfaction;

(vi) past performance and prior experience of the contractor in administering a prescription medicine benefit program;

(vii) effectiveness of the contractor in containing costs and improving pharmacy law maintenance;

(viii) other factors as the Secretary deems necessary to evaluate the merits of each bid.

(C) EXCEPTION TO CONFLICT OF INTEREST RULES.—In awarding contracts with pharmacy contractors under this part, the Secretary shall not be subject to the restrictions on Federal contracts generally applicable to Federal acquisitions (subject to such safeguards as the Secretary may find necessary to impose) in circumstances where the Secretary finds that such waiver—

(i) is not inconsistent with the—

(I) purposes of the programs under this part;

(II) best interests of beneficiaries enrolled under this part; and

(iii) permits a sufficient level of competition for such contracts, promotes efficiency of benefits administration, or otherwise serves the objectives of the programs under this part.

(i) I N GENERAL.—The pharmacy contractor shall—

(A) provide assurance that covered outpatient prescription medicines are accessible and convenient to eligible beneficiaries enrolled under the programs; and

(B) arrange for the availability of covered prescription medicines under this part.

(i) MAINTENANCE.—The pharmacy contractor shall ensure that covered outpatient prescription medicines are accessible and convenient to eligible beneficiaries enrolled under the programs. The pharmacy contractor shall arrange for the availability of covered prescription medicines under this part.

(ii) STANDARDS.—In establishing standards under clause (i), the Secretary shall—

(A) require that the pharmacy contractor maintain standards and programs for the administration of benefits under the contract consistent with the requirements of subsection (d)(3)(C) (relating to adherence to negotiated prices) and the goals of providing quality pharmacy care and of containing costs;

(B) require that the pharmacy contractor maintain standards and programs for the administration of benefits under the contract consistent with the requirements of subsection (d)(3)(C) (relating to adherence to negotiated prices) and the goals of providing quality pharmacy care and of containing costs;

(C) require that the pharmacy contractor maintain standards and programs for the administration of benefits under the contract consistent with the requirements of subsection (d)(3)(C) (relating to adherence to negotiated prices) and the goals of providing quality pharmacy care and of containing costs;

(ii) DEPARTMENT OF STATE.—The pharmacy contractor shall maintain standards and programs for the administration of benefits under the contract consistent with the requirements of subsection (d)(3)(C) (relating to adherence to negotiated prices) and the goals of providing quality pharmacy care and of containing costs.

(iii) QUIESCE.—The pharmacy contractor shall—

(A) maintain their prescription medicine cost data (including data on discounts) available for review and audit by the Secretary;

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

(iii) QUIESCE.—The pharmacy contractor shall—

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(iii) QUIESCE.—The pharmacy contractor shall—

(A) maintain their prescription medicine cost data (including data on discounts) available for review and audit by the Secretary;
section 1851(h) (relating to marketing material and application forms) with respect to this part in the same manner as such requirements apply under part C, except that the procedures established for making payments to each pharmacy contractor with a contract under this part for the administration of the benefits under such contracts shall provide for the following:

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

**(ii) Risk Requirement.—**An adjustment of a percentage (determined under subparagraph (B)) of the administrative fee payable to a pharmacy contractor for such benefits (based on a pharmacy contractor's performance in administering the benefits under such contracts), in addition to the provisions of this paragraph, the procedures established under this subsection shall include the following:

- The contractor shall meet all applicable Federal requirements and State and local licensing requirements.
- The contractor shall assure that the contractor, in administering the benefits under such contracts, pursues performance requirements established by the Secretary.

**(III) Quality Service.—**The contractor shall provide for the following:

- The contractor shall provide for quality clinical care, as measured by such factors as providing notification to such beneficiaries and to providers in order to prevent adverse outcomes and reduce serious complication errors and specific clinical suggestions to improve health and patient and pre-scriber education as appropriate.

**(II) Quality Clinical Care.—**The contractor shall provide for the following:

- The contractor shall provide for quality clinical care, as measured by such factors as providing notification to such beneficiaries and to providers in order to prevent adverse outcomes and reduce serious complication errors and specific clinical suggestions to improve health and patient and pre-scriber education as appropriate.

**(III) Quality Clinical Care.—**The contractor shall provide for the following:

- The contractor shall provide for quality clinical care, as measured by such factors as providing notification to such beneficiaries and to providers in order to prevent adverse outcomes and reduce serious complication errors and specific clinical suggestions to improve health and patient and pre-scriber education as appropriate.

**(IV) Quality Clinical Care.—**The contractor shall provide for the following:

- The contractor shall provide for quality clinical care, as measured by such factors as providing notification to such beneficiaries and to providers in order to prevent adverse outcomes and reduce serious complication errors and specific clinical suggestions to improve health and patient and pre-scriber education as appropriate.

**(V) Quality Clinical Care.—**The contractor shall provide for the following:

- The contractor shall provide for quality clinical care, as measured by such factors as providing notification to such beneficiaries and to providers in order to prevent adverse outcomes and reduce serious complication errors and specific clinical suggestions to improve health and patient and pre-scriber education as appropriate.

**(VI) Quality Clinical Care.—**The contractor shall provide for the following:

- The contractor shall provide for quality clinical care, as measured by such factors as providing notification to such beneficiaries and to providers in order to prevent adverse outcomes and reduce serious complication errors and specific clinical suggestions to improve health and patient and pre-scriber education as appropriate.
of generic medicines and other medicines.

(b) PART C—In the case of an individual who is enrolled under this part and is enrolled in a Medicare+Choice plan under part C, the individual shall be provided the benefits under this part through such plan and not through payment under this part.

(c) LATE ENROLLMENT PENALTIES; PAYMENT OF PREMIUM.—(1) IN GENERAL.—In the case of a late enrollment described in subsection (b)(4), subject to the succeeding provisions of this paragraph, the Secretary shall establish procedures for increasing the amount of the monthly premium under this part applicable to such enrollee by an amount that the Secretary determines is actuarially sound for each such period.

(2) TERMS USED.—For purposes of this paragraph (2), the term 'countable cost-sharing' means—

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

(ii) cost-sharing under subsections (c)(3)(B) and (c)(3)(C)(i).

(3) COVERED OUTPATIENT PRESCRIPTION MEDICINE BENEFITS.—Entitlement to have payment made on the individual's behalf for covered outpatient prescription medicines.

(4) LIMITATION ON COST-SHARING FOR PART B OUTPATIENT PRESCRIPTION MEDICINES.—Once an enrollee has incurred aggregate countable cost-sharing (as defined in subparagraph (B)) equal to the stop-loss limit specified in subsection (c)(4) for an individual, the Secretary shall reduce the elimination of cost-sharing otherwise applicable under part B for additional expenses incurred in the year for outpatient prescription medicines or biologics for which payment is made under part B.

(5) BOUNTABLE COST-SHARING DEFINED.—For purposes of this paragraph, the term 'bountable cost-sharing' means—

(i) the amount which is payable under part B, and

(ii) the amount which is payable under part B for which payment is made under part B.
countable cost-sharing (as defined in subparagraph (2) and (3); and
(C) any product when furnished as part of, or as incident to, a diagnostic service or any other item or service for which payment may be made under this title; or
(D) any product that is covered under part B of this title.
(c) PAYMENT OF BENEFITS.—
(I) COVERED OUTPATIENT PRESCRIPTION MEDICINES.—There shall be paid from the Federal Medicare Prescription Medicine Trust Fund, in the case of each enrollee who incurs a deductible, a reasonable dispensing fee.
(II) PREFERRED MEDICINES.—The coinsurance under this paragraph in the case of each enrollee who incurs a deductible, amount equal to the stops-loss limit under paragraph (3) for the year involved.
(III) APPEALS RIGHTS RELATING TO COVERAGE OF NONPREFERRED MEDICINES.—
(A) PROCEDURES REGARDING THE DETERMINATION OF MEDICATIONS THAT ARE MEDICALLY NECESSARY.—Each pharmacy contractor shall have in place procedures on a case-by-case basis to treat a nonpreferred medicine as a preferred medicine under this part if the medicine is determined to be necessary based on the determinations of the Covered Outpatient Prescription Drug Trust Fund to the Federal Supplemental Medical Insurance Trust Fund, supplemented with requirements established by the Secretary (or the pharmacy contractor). Any increase under such paragraph (or this subparagraph) for a year after 2006 for prescription medicine benefits under this part shall be equal to the monthly premium rate for a year after 2006 for prescription medicine benefits under this part is the average per capita aggregate expenditures for the previous year increased by such percentage.
(IV) PERMITTING APPLICATION UNDER PART B OF NEGOTIATED PRICES.—
(A) IN GENERAL.—With respect to expenses incurred in a year after 2006, the deductible under paragraph (2) is equal to the deductible determined under subparagraph (A) of section 1859G(d)(2)(B) for the previous year increased by such percentage increase in per capita program expenditures made by the Secretary. In general, the deductible determined under subparagraph (A) of section 1859G(d)(2)(B) for the previous year increased by such percentage increase in per capita program expenditures made by the Secretary shall be equal to the stop-loss limit determined under paragraph (3) for the previous year increased by such percentage increase.
(B) ESTIMATION OF INCREASE IN PER CAPITA PROGRAM EXPENDITURES.—The Secretary shall adjust such percentage increase in per capita program expenditures made by the Federal Medicare Prescription Medicine Trust Fund for the year involved as compared to the previous year. The Secretary shall also compute (beginning with 2003) the actuarial percentage increase in such aggregate expenditures in order to provide for reconciliation of deductibles, stop-loss limits, and premiums under the second sentence of section 1859G(d)(2).
(2) AMOUNT OF PREMIUMS.—
(A) MONTHLY PREMIUM RATE IN 2006.—The monthly premium rate for a year after 2006 for prescription medicine benefits under this part is the amount specified in section 1859A.
(B) INFLATION ADJUSTMENT FOR SUBSEQUENT YEARS.—The monthly premium rate for a year after 2006 for prescription medicine benefits under this part is equal to the monthly premium rate for the previous year under this subsection increased by the percentage increase in per capita program expenditures made in the previous year. Any increase under this subparagraph that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

ADMINISTRATION; QUALITY ASSURANCE—
"Sec. 1859E. (a) RULES RELATING TO PROVISION OF BENEFITS.—
"(1) PROVISION OF BENEFITS.—
"(A) IN GENERAL.—In providing benefits under this part, the Secretary (directly or through the contracts with pharmacy contractors) shall ensure that the provisions of this part include the following methods to reduce medication errors and ensure appropriate use of medications and the payment of pharmacy contractors, as approved by the Secretary, to make exceptions to subsection (c)(3)(C) (relating to cost-sharing for non-preferred medicines) to encourage the utilization of appropriate preferred medicines, as the case may be.
"(B) AMOUNT OF COINSURANCE.—
"(I) the deductible under paragraph (2) is equal to the deductible determined under subparagraph (A) of section 1859G(d)(2)(B) for the previous year increased by such percentage increase in per capita program expenditures made by the Secretary. In general, the deductible determined under subparagraph (A) of section 1859G(d)(2)(B) for the previous year increased by such percentage increase in per capita program expenditures made by the Secretary shall be equal to the stop-loss limit determined under paragraph (3) for the previous year increased by such percentage increase.
(B) ESTIMATION OF INCREASE IN PER CAPITA PROGRAM EXPENDITURES.—The Secretary shall adjust such percentage increase in per capita program expenditures made by the Federal Medicare Prescription Medicine Trust Fund for the year involved as compared to the previous year. The Secretary shall also compute (beginning with 2003) the actuarial percentage increase in such aggregate expenditures in order to provide for reconciliation of deductibles, stop-loss limits, and premiums under the second sentence of section 1859G(d)(2).
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(B) ESTIMATION OF INCREASE IN PER CAPITA PROGRAM EXPENDITURES.—The Secretary shall adjust such percentage increase in per capita program expenditures made by the Federal Medicare Prescription Medicine Trust Fund for the year involved as compared to the previous year. The Secretary shall also compute (beginning with 2003) the actuarial percentage increase in such aggregate expenditures in order to provide for reconciliation of deductibles, stop-loss limits, and premiums under the second sentence of section 1859G(d)(2).
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"(B) CONSTRUCTION.—Nothing in this sub-
section shall be construed to prevent the Secre-
tary (directly or through the contracts with
pharmacy contractors) from using incen-
tives to encourage enrollees to select gen-
eric or other cost-effective medicines, so long as—
(i) such incentives are designed not to re-
sult in an increase in the aggregate expend-
itures under the Federal Medicare Prescrip-
tion Medicine Trust Fund; and
(ii) a beneficiary's coinsurance shall be no greater than 20 percent in the case of a pre-
ferred medicine (including a nonpreferred medicine treated as a preferred medicine under §1859d(b)).

"(2) CONSTRUCTION.—Nothing in this part
shall preclude the Secretary or a pharmacy
contractor from—
(A) requiring prescribing providers, phar-
macists, and enrollees to volunteer medical and cost benefits of preferred medicines;
(B) requesting prescribing providers to con-
sider a preferred medicine prior to dis-
pensing of a nonpreferred medicine, as long as such request does not unduly delay the provision of the medicine;
(C) establishing a program to encourage en-
rrolees under this part to select cost-effect-
ev medicine or less costly means of receiv-
ing the medicine;
(D) using price negotiations to achieve re-
duced prices on covered outpatient prescrip-
tion medicines, including new medicines, for which there are few thera-
peutically or medically equivalent medicines of a particular clinical importance to individuals en-
rrolled under this part; and
(E) utilizing information on medicine prices of OECD countries and of other payors
in the United States in the negotiation of prices under this part.

"(b) PAYMENT FRAUD AND ABUSE SAFEGUARDS.—The Secretary shall—
"(1) REQUIREMENTS WITH RESPECT TO PRE-
FERRED MEDICINES.—Negotiations of con-
tracts with manufacturers with respect to coverage for less costly medicines under this part shall be conducted in a man-
er so that—
(A) there is at least a contract for a medi-
icine in each therapeutic class (as defined by the Secretary in consultation with
such Medicare Prescription Medicine Advis-
ory Committee);
(B) at least 1 medicine available in a therapeutic class, there are contrac-
tes for at least 2 medicines within such class unless determined clinically inap-
propriate in accordance with standards established by the Secretary; and
(C) if there are more than 2 medicines available in a therapeutic class, there is a con-
tract for each medicine and a contract for a generic medicine substitute if available unless determined clinically inappropriate in accordance with standards established by the Secretary.

"(2) ESTABLISHMENT OF THERAPEUTIC
CLASS.—The Secretary, in consultation with the
Medicare Prescription Medicine Advisory
Committee (established under section 1884), shall establish for purposes of this part therapeutic classes and assign to such classes covered outpatient prescription medi-
cines.

"(3) DISCLOSURE CONCERNING
PREFERRED MEDICINES.—The Secretary shall provide, through pharmacy contractors or otherwise, a
"(a) disclosure to current and prospective enrollees and to participating providers and
pharmacies in each service area a list of the
preferred medicines and differences in appli-
cable cost-sharing between such medicines and nonpreferred medicines; and
(b) any contract with providers and phar-
macy enrolllees and to participating providers and phar-
macies in each service area of changes to any such list of preferred medicines and dif-
fences in their cost-sharing.

"(4) NO REVIEW.—The Secretary's establish-
ment of therapeutic classes and the assign-
ment of medicines to such classes and the
issuance of final regulations establishing such therapeutic classes and the inex-
brecidence of breakthrough medicines are not subject to ad-
ministrative or judicial review.

"(c) CONFIDENTIALITY.—The Secretary shall
ensure that the identification of individu-
ally identifiable health information relat-
ing to the provision of benefits under this part is protected in accordance with
standards for the privacy of such information pro-
mulgated by the Secretary under the Health
Insurance Portability and Accountability Act of 1996, or any subsequent comprehensive and more protective set of confidentiality standards enacted into law or promulgated by the Secretary. Nothing in this subsection shall be construed as preventing the coordi-
nation of data with a State prescription
program under this part.

"(d) FRAUD AND ABUSE SAFEGUARDS.—The Secretary, with the assis-
tance of the Inspector General, is authorized and directed to issue regulations establishing appropriate safeguards to prevent fraud and abuse under this part. Such safeguards, at a minimum, should include compliance programs, certifi-
cation data, audits, and recordkeeping prac-
tices. In developing such regulations, the
Secretary shall consult with the Attorney General and other law enforcement and regula-
tory agencies.

"FEDERAL MEDICARE PRESCRIPTION MEDICINE
TRUST FUND.

"SEC. 1859F. (a) ESTABLISHMENT.—There is hereby created on the books of the Treasury of the United States a trust fund to be known as the 'Federal Medicare Prescription Medicine Trust Fund' (in this section referred to as the 'Trust Fund'). The Trust Fund shall consist of such gifts and bequests as may be provided in section 1888 of this title and such amounts as may be depos-
ited in, or appropriated to, such fund as pro-
vided in this part.

"(b) APPLICATION OF SMI TRUST FUND PRO-
VISIONS.—The provisions of subsections (b) through (i) of section 1858 shall apply to this part and the Trust Fund as if the same were applicable to, as they apply to part B and the Federal Sup-
plementary Medical Insurance Trust Fund, respectively.

"(c) COMPENSATION FOR EMPLOYERS COVERING RETIREE MEDICINE COSTS.

"SEC. 1859G. (a) IN GENERAL.—In the case
of an individual who is eligible to be enrolled under this part and is a participant or bene-
ficiary in a group health plan that provides outpatient prescription medicine cov-
verage to retirees the actuarial value of
such coverage shall be equal to the actuarial value of the
extent to which the coverage offered under such group health plan meets the requirements of this Act and other reasonable, necessary, and related requirements that are administered under this section, as deter-
mined by the Secretary.

"(b) ANNUAL ASSURANCES AND NOTICE
BEFORE TERMINATION.—The sponsor of the plan shall—
(A) annually attest, and provide such as-
surances as the Secretary may require, that the coverage offered under the group health plan meets the requirements of this section and will continue to meet such requirements for the duration of the sponsor's participa-
tion in the program under this section; and
(B) in the event a sponsor fails to provide notice to the Secretary and covered enrollees—
(i) at least 120 days before terminating its plan, and
(ii) immediately upon determining that the
actuarial value of the prescription medi-
cine benefit under the plan falls below the
actuarial value required under subsection (a).

"(3) FEDERAL MEDICARE PRESCRIPTION MEDICINE
ADVISORY COMMITTEE.

"SEC. 1859H. (a) ESTABLISHMENT OF COM-
MITTEE.—There is established in the Depart-
ment of Health and Human Services a Federal
Medicare Prescription Medicine Advisory
Committee (in this section referred to as the 'Committee').

"(b) FUNCTION OF COMMITTEE.—The Com-
mittee shall advise the Secretary on policies
related to—
(A) the development of guidelines for the
implementation and administration of the
prescription drug benefit program under this part; and
(B) the development of..."
(A) standards required of pharmacy contractors under section 1899(d)(5) for determining if a medicine is as effective for an enrollee or has a significant adverse effect on an enrollee compared to a generic; (B) standards for—
(i) defining therapeutic classes;
(ii) adding new therapeutic classes;
(iii) authorizing prepayment of out- patient prescription medicines; and
(iv) identifying breakthrough medicines;
(C) procedures to evaluate the bids submitted by pharmacy contractors under this part;
(D) procedures for negotiations, and standards for entering into contracts, with manufacturers or other appropriate experts; and
(E) procedures to ensure that pharmacy contractors with a contract under this part are in compliance with the requirements under this part.

For purposes of this part, a medicine is a "breakthrough medicine" if the Secretary, in consultation with the Committee, determines that it is a new product that will make a significant and major improvement by reducing physical or mental illness, reducing mortality or morbidity, as required by section 1862(n)(4); and no other product is available to beneficiaries that achieves similar results for the same condition. The Committee may consider cost-effectiveness when establishing standards for defining therapeutic classes and assigning drugs to such classes under subparagraph (B).

(2) MEMBERSHIP.—
(A) IN GENERAL.—The members of the Committee shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education, experience, and attainments, exceptionally qualified to perform the duties of members of the Committee.
(B) SPECIFIC MEMBERS.—Of the members appointed under paragraph (1)—
(i) 5 shall be chosen to represent practicing physicians, 2 of whom shall be gerontologists; 
(ii) 2 shall be chosen to represent practicing nurse practitioners; 
(iii) 4 shall be chosen to represent pharmacists; 
(iv) 1 shall be chosen to represent the Centers for Medicare & Medicaid Services; 
(v) 4 shall be chosen to represent actuaries, health economists, researchers, and other appropriate experts; 
(vi) 1 shall be chosen to represent emerging medicine technologies; 
(vii) 1 shall be chosen to represent the Food and Drug Administration; and
(viii) 1 shall be chosen to represent individuals enrolled under this part.

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

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

(f) COMMITTEE PERSONNEL MATTERS.—
(U) THE CIRCULAR.—(D) procedures for defining therapeutic classes and assigning drugs to such classes covered under subparagraph (B); procedures for negotiating, and standards for entering into contracts, with manufacturers or other appropriate experts; and procedures to ensure that pharmacy contractors with a contract under this part are in compliance with the requirements under this part.

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(U) THE CIRCULAR.—(D) procedures for defining therapeutic classes and assigning drugs to such classes covered under subparagraph (B); procedures for negotiating, and standards for entering into contracts, with manufacturers or other appropriate experts; and procedures to ensure that pharmacy contractors with a contract under this part are in compliance with the requirements under this part.
"(3) Risk Adjustment.—The Secretary shall establish a methodology for the adjustment of the payment amount under this subsection in a manner that takes into account the relative costs of providing outpatient prescription medicines by Medicare-Choice enrollees. Such methodology shall be designed in a manner so that the total payments under part D of title XVIII are not changed as a result of the application of such methodology."

(b) Application of Adjusted Community Rate (ACR).—Section 1854 (42 U.S.C. 1395w–24) is amended by adding at the end the following:

"(1) Section 1854 (42 U.S.C. 1395w–21) is amended—

(A) in subsection (a)(1)(A), by striking "parts A and B" and inserting "parts A, B, and D"; and

(B) in subsection (i) by inserting "and, if applicable, part D" after "parts A and B.""

(2) Section 1852 (42 U.S.C. 1395w–22(a)(1)(A)) is amended by inserting "(and under part D to individuals also enrolled under such part)" after "parts A and B.""

(3) Section 1852 (42 U.S.C. 1395w–22(d)(1)) is amended—

(A) by striking "and" at the end of subparagraph (D); and

(B) by striking the period at the end of subparagraph (E) and inserting "and"; and

(C) by adding at the end the following:

"(F) the plan for part D benefits guarantees or assures equal opportunity for enrollees to the extent that it would be required to be covered under part D.

In carrying out subparagraph (F), a Medicare-Choice organization shall have the same authority to enter into contracts with respect to coverage of preferred medicines as the Secretary has under part D, but subject to an independent contractor appeal or other appeal process that would be applicable to determinations by such a pharmacy contractor to the extent that such determinations involve the use of prescription medicines for an enrollee to the extent that it would be required to be covered under part D.

In carrying out paragraph (F), a Medicare-Choice organization has the same authority to enter into contracts with respect to coverage of preferred medicines as the Secretary has under part D, but subject to an independent contractor appeal or other appeal process that would be applicable to determinations by such a pharmacy contractor to the extent that such determinations involve the use of prescription medicines for an enrollee to the extent that it would be required to be covered under part D.

"(5) Limitation on Cost-Sharing.—In no event may a Medicare-Choice organization include a requirement that an enrollee pay cost-sharing in excess of the cost-sharing otherwise permitted under part D."

SEC. 103. MEDIGAP REVISIONS.

(a) Required Coverage of Covered Outpatient Prescription Medicines.—Section 1812(p)(2)(B) (42 U.S.C. 1395h(a)(2)(B)) is amended by inserting before "and" at the end of the following clause: "including a requirement that an enrollee pay cost-sharing in excess of the cost-sharing otherwise permitted under part D.

"(2) Effective Date.—The amendment made by subsection (a) shall take effect on January 1, 2006.

(b) Cost-Sharing.—Section 1812(p)(3) (42 U.S.C. 1395h(a)(3)) is amended—

(1) in subparagraph (A), by striking "and" at the end of clause (i), and

(2) by adding "and" at the end of clause (ii);

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

"(iii) premiums under section 1859D(d);"

"(4) in subparagraph (B), by inserting "and section 1859D(c)(10) and section 1859D(c)(13)(C)(i)" after "1813; and"

"(5) in subparagraphs (C), (D), and (E), by striking "section 1858(b)(2) and section 1858(b)(2)."

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

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

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

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

"(v) for making medical assistance available for Medicare cost-sharing described in section 1905(p)(3)(A)(iii) and Medicare cost-sharing described in section 1905(p)(3)(B) for low-income Medicare beneficiaries (as defined in section 1905(d)(1)(B)); for the extent to which it relates to benefits provided under part D of title XVIII, and the assistance for Medicare beneficiaries who are enrolled under part D of title XVIII and are described in section 1905(p)(1)(B) or would be so described but for the fact that their income exceeds 100 percent of the official poverty line (referred to in such section) for a family of the size involved;"

"(ii) subject to section 1905(p)(4), for individuals (other than qualified Medicare beneficiaries) that are enrolled under part D of title XVIII and would be described in section 1905(p)(3)(B) but for the fact that their income exceeds 100 percent of the official poverty line (referred to in such section) for a family of the size involved;"

"(vii) for making medical assistance available for Medicare cost-sharing described in section 1905(p)(3)(B) for low-income Medicare beneficiaries (as defined in section 1905(d)(1)(B)); for the extent to which it relates to benefits provided under part D of title XVIII, and the assistance for Medicare beneficiaries who are enrolled under part D of title XVIII and are described in section 1905(p)(1)(B) or would be so described but for the fact that their income exceeds 100 percent of the official poverty line (referred to in such section) for a family of the size involved;"

"(ii) subject to section 1905(p)(4), for individuals (other than qualified Medicare beneficiaries) that are enrolled under part D of title XVIII and would be described in section 1905(p)(3)(B) but for the fact that their income exceeds 100 percent of the official poverty line (referred to in such section) for a family of the size involved;"

"(ii) subject to section 1905(p)(4), for individuals (other than qualified Medicare beneficiaries) that are enrolled under part D of title XVIII and would be described in section 1905(p)(3)(B) but for the fact that their income exceeds 100 percent of the official poverty line (referred to in such section) for a family of the size involved;"

"(ii) subject to section 1905(p)(4), for individuals (other than qualified Medicare beneficiaries) that are enrolled under part D of title XVIII and would be described in section 1905(p)(3)(B) but for the fact that their income exceeds 100 percent of the official poverty line (referred to in such section) for a family of the size involved;"

"(ii) subject to section 1905(p)(4), for individuals (other than qualified Medicare beneficiaries) that are enrolled under part D of title XVIII and would be described in section 1905(p)(3)(B) but for the fact that their income exceeds 100 percent of the official poverty line (referred to in such section) for a family of the size involved;"

"(ii) subject to section 1905(p)(4), for individuals (other than qualified Medicare beneficiaries) that are enrolled under part D of title XVIII and would be described in section 1905(p)(3)(B) but for the fact that their income exceeds 100 percent of the official poverty line (referred to in such section) for a family of the size involved;"

"(ii) subject to section 1905(p)(4), for individuals (other than qualified Medicare beneficiaries) that are enrolled under part D of title XVIII and would be described in section 1905(p)(3)(B) but for the fact that their income exceeds 100 percent of the official poverty line (referred to in such section) for a family of the size involved;"
SEC. 108. EXPANSION OF MEMBERSHIP.

(a) Expansion of Membership.—For purposes of paragraph (1), in section 1855(e) (42 U.S.C. 1395w–23(e)) is amended—

(1) by striking paragraph (3)(A) (42 U.S.C. 1395w–23(e)(3)(A)) after "Subject to subsection (g)".

(2) by striking paragraph (4) (42 U.S.C. 1395w–23(e)(4)) after "(4) The Committee on Budget for the previous year" and inserting before the period at the end the following: "The Commission shall consist of such number of members as the Secretary may specify.".

(b) Expansion of Duties.—Section 1855(b)(2) (42 U.S.C. 1395w–23(b)(2)) is amended by adding at the end the following:

"(2) Protection of the interests of program participants in a State pharmaceutical assistance program, and to ensure quality in the appropriate dispensing and utilization of such medicines and to ensure quality in the management of costs and utilization of prescription drugs.

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

"(4) Principles of medicare reimbursement for services provided under part A and B.

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

"(6) The methodologies used to establish a single point of contact for enrollment in a State pharmaceutical assistance program and the development of a State Pharmaceutical Assistance Transition Commission to carry out its responsibilities under this section.

"(7) The relationship of pharmacy acquisition costs to the prices so negotiated and paid.

"(8) The methodologies used to establish a single point of contact for enrollment in a State pharmaceutical assistance program and the development of a State Pharmaceutical Assistance Transition Commission to carry out its responsibilities under this section.

"(9) The impact of the program on the promotion of the development of breakthrough medicines.

"(ii) Protection of the financial and flexibility of States; and

"(iii) The relationship of pharmacy acquisition costs to the prices so negotiated and paid.

"(iv) The methodologies used to establish a single point of contact for enrollment in a State pharmaceutical assistance program and the development of a State Pharmaceutical Assistance Transition Commission to carry out its responsibilities under this section.

"(v) The impact of the program on the promotion of the development of breakthrough medicines.".

SEC. 109. STATE PHARMACEUTICAL ASSISTANCE TRANSITION COMMISSION.

(a) Establishment.

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.

(b) Definitions.—For purposes of this section:

(1) STATE PHARMACEUTICAL ASSISTANCE PROGRAM DEFINED.—The term "State pharmaceutical assistance program" means a program (other than the medicaid program) that is 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.

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

"(A) The methodologies used for the management of costs and utilization of prescription medicines.

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

"(1) 2006, is equal to $25,000,000; and

"(2) a Medicare+Choice under this part for the previous year; and

"(3) a Medicare+Choice under this part for the previous year; and

"(4) a Medicare+Choice under this part for the previous year; and

"(5) a Medicare+Choice under this part for the previous year; and

"(6) a Medicare+Choice under this part for the previous year; and

"(7) a Medicare+Choice under this part for the previous year; and

"(8) a Medicare+Choice under this part for the previous year; and

"(9) a Medicare+Choice under this part for the previous year; and

"(10) a Medicare+Choice under this part for the previous year; and

"(11) a Medicare+Choice under this part for the previous year; and

(ii) Protection of the financial and flexibility of States; and

(iii) The relationship of pharmacy acquisition costs to the prices so negotiated and paid.

(iv) The methodologies used to establish a single point of contact for enrollment in a State pharmaceutical assistance program and the development of a State Pharmaceutical Assistance Transition Commission to carry out its responsibilities under this section.

(v) The impact of the program on the promotion of the development of breakthrough medicines.

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

"(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 program participation.

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

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

"(4) Principles of medicare reimbursement for services provided under part A and B.

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

"(6) The methodologies used to establish a single point of contact for enrollment in a State pharmaceutical assistance program and the development of a State Pharmaceutical Assistance Transition Commission to carry out its responsibilities under this section.

"(7) The relationship of pharmacy acquisition costs to the prices so negotiated and paid.

"(8) The methodologies used to establish a single point of contact for enrollment in a State pharmaceutical assistance program and the development of a State Pharmaceutical Assistance Transition Commission to carry out its responsibilities under this section.

"(9) The impact of the program on the promotion of the development of breakthrough medicines.

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

"(H) TERMINATION.—The Commission shall terminate 30 days after the date of submission of the report under subsection (d).
SEC. 202. MAKING PERMANENT CHANGE IN MEDICARE-CHOICE CHOICE PLANS. 

(a) CHANGE IN REPORTING DEADLINE.—Section 1854(a)(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 program, the Secretary shall adjust for the costs of military facility medical services of the Department of Defense or the Department of Veterans Affairs in determining 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.”

(b) METHOD OF DETERMINING RATES.—Section 1853(c)(3) (42 U.S.C. 1395w-23(c)(3)) is amended—

(1) in paragraph (A), by striking “of payment for 1997 determined under section 1857” and inserting “of payment for 1997 determined under section 1857, 1859 . . .”;

(2) by striking paragraph (B) and inserting the following new paragraph:

“(B) DELAY IN ANNUAL, COORDINATED ELECTION PERIOD.—Section 1851(a)(3)(B) (42 U.S.C. 1395w-23(a)(3)(B)) is amended—


(2) by striking “and each subsequent year” and inserting “and each subsequent year”; and

(3) by inserting “and after 2004” after “2005”.

(c) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—Section 1853(b)(3) (42 U.S.C. 1395w-23(b)(3)) is amended—

(1) by striking “after 2005” and inserting “and after 2005”;

(2) by striking “and 2005” and inserting “and each subsequent year”;

(3) by striking “and 2005” and inserting “and each subsequent year”;

(4) by striking “and 2005” and inserting “and each subsequent year”; and

(5) by striking “and 2005” and inserting “and each subsequent year”.

SEC. 203. SPECIALIZED MEDICARE-CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.

(a) TREATMENT AS COORDINATED CARE PLANS.—Section 1851(a)(2)(A) (42 U.S.C. 1395w-21(a)(2)(A)) is amended by striking at the end the following new sentence: “Specialized Medicare-Cchoice Plans for special needs beneficiaries means a Medicare-Cchoice plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).”

(b) SPECIALIZED MEDICARE-CHOICE PLAN FOR SPECIAL NEEDS BENEFICIARIES DESIGNATED.—Section 1856(h)(2) (42 U.S.C. 1395w-26(h)(2)) is amended by adding at the end the following new paragraph:

“(4) SPECIALIZED MEDICARE-CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—

“(A) IN GENERAL.—The term ‘specialized Medicare-Cchoice Plan for special needs beneficiaries’ means a Medicare-Cchoice plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

“(B) SPECIAL NEEDS BENEFICIARY.—The term ‘special needs beneficiary’ means an individual who—

“(i) is institutionalized as defined by the Secretary;

“(ii) is entitled to medical assistance under a State plan under title XVIII; or

“(iii) meets such requirements as the Secretary may determine would benefit from enrollment in a specialized Medicare-Cchoice Plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.”

(c) RESTRICTION ON ENROLLMENT PERMITTED.—Section 1859 (42 U.S.C. 1395w-29) is amended by adding at the end the following new subsection:

“(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE-CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare-Cchoice Plan for special needs beneficiaries, the Medicare Administrator shall restrict the enrollment of individuals under the plan to individuals who are within one or more classes of special needs beneficiaries.”

SEC. 204. MEDICARE MSAS.

SEC. 205. EXTENSION OF REASONABLE COST CONTRACTS.

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

“(C) the accuracy of risk adjustment methods;”

SEC. 206. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 9215(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1395b–1 note), as previously amended, is amended by striking “December 31, 2009” and inserting “December 31, 2009” and all that follows and inserting “December 31, 2009, but only with respect to individuals who reside in the city in which the project is operated and so long as the total number of individuals participating in the project does not exceed the number of such individuals participating as of January 1, 1996.”

TITLE III—COMBATTING WASTE, FRAUD, AND ABUSE

SEC. 201. 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 1921(h)(2) (42 U.S.C. 1395y(b)(2)) is amended—

(A) in subparagraph (A)(ii), by striking “promptly” and inserting “promptly (as determined in accordance with the Secretaries’ regulations)”;

(B) in subparagraph (B)—

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

(ii) by inserting before the first clause “(I)”;

(iii) by redesignating the first paragraph “(II)”;

(iv) by inserting new paragraphs (II), (III), as so redesignated, the following new clause:

“(II) AUTHORITY TO MAKE CONDITIONAL PAYMENT.—The Secretary may make payment to the provider of services or patient with respect to an item or service if a primary plan described in subparagraph (A)(i) has not made or cannot
reasonably be expected to make payment with respect to such item or service promptly (as determined in accordance with regulations). Any such payment by the Secretary shall be considered as payment under 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 1994 (Public Law 98-369).

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

(1) in subparagraph (A), in the matter following clause (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 makes such payment for items or services under 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 to make 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 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 with respect to items or services, the United States may bring an action against any or all entities that are or were required or responsible (directly, as an insurer or self-insurer, as a third-party administrator, as an employer that sponsors or contributes to a primary plan,自负 insurance, or otherwise) in whole or in part.

(c) CLERICAL AMENDMENTS.—Section 1834(a) (42 U.S.C. 1395w-3) is amended to read as follows:

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 PROGRAM.—  

"(A) IN GENERAL.—The Secretary shall establish and implement programs under which competitive acquisition areas are established throughout the United States 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 begin—  

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

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

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

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

"(2) Waiver of Certain Provisions.—In carrying out the programs, the Secretary shall strive to ensure that the Federal Acquisition Regulation as are necessary for the efficient implementation of this section, including that the Secretary and the entities involved shall provide for appropriate review and advice to the Secretary concerning) the quality standards specified under subparagraph (B)(ii) among items and services in a manner corresponding to paragraphs (3) through (5) of section 1834(a).  

"(3) CONTENTS OF CONTRACT.—  

"(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(a) which require minimal self-adjustment by the patient do not require expertise in trimming, bending, molding, assembling, or customizing to fit to the patient.  

"(D) EXCEPTION AUTHORITY.—In carrying out the programs under this section, the Secretary may exempt—  

"(1) 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  

"(2) 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 OR 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 under which competitive acquisition areas are established throughout the United States 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.  

"(5) PHYSICIAN AUTHORIZATION.—The Secretary shall determine 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 Secretary shall determine 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 competitive acquisition areas for the furnishing of competitively priced 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 for the furnishing of competitively priced items and services 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 determined by the Program Advisory and Oversight Committee (established under subsection (c)).  

"(ii) The entity satisfies all provisions relating to competition conducted in the area and other requirements specified by the Secretary concerning) the quality standards specified under subparagraph (B)(ii) among items and services in a manner corresponding to paragraphs (3) through (5) of section 1834(a).

"(3) Development of Quality Standards for Each Product.—  

"(1) IN GENERAL.—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 in the Federal Register.

"(ii) Consultation with Program Advisory and Oversight Committee.—The Secretary shall consult with the Program Advisory and Oversight Committee established under subsection (c) to review (and advise the Secretary concerning) the quality standards referred to in clause (i).  

"(3) CONTENTS OF CONTRACT.—  

"(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) shall not be less than the quality standards that would otherwise apply if this section did not apply and shall include consumer services standards.  

"(4) LIMIT ON NUMBER OF CONTRACTORS.—  

"(A) IN GENERAL.—The Secretary shall 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.  

"(B) LIMITATION ON NUMBER OF CONTRACTORS.—In the case of any such continuation, 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 entities for such services in the geographic area covered under the contract on a timely basis.
"(B) MULTIPLE WINNERS.—The Secretary shall award contracts to multiple entities submitting bids in each area for an item or service.

(2) PAYMENT.—Payment under this part for competitively priced items and services described in subsection (a)(2) shall be based on the bids submitted and accepted under this section and on quality of 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 drugs and products, including products that may provide a therapeutic advantage to beneficiaries, before determining the appropriate payment amounts for such items 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 of quality of services with respect to the products that are subject to bidding.

(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 have 15 members as the Secretary may designate.

(3) DUTIES.—

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

(i) The Secretary may contract with an appropriate entity on a competitive basis to provide for the technical assistance described in this subparagraph.

(ii) The Committee shall provide advice and technical assistance to the Secretary with respect to the following functions:

(a) The Committee shall perform such additional functions as the Secretary may designate.

(b) The Committee shall provide advice and technical assistance to the Secretary with respect to the following functions:

(c) The Committee shall provide advice and technical assistance to the Secretary with respect to the following functions:

(d) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual report on the programs under this section. Each such report shall contain information on savings, reduction in beneficiary cost-sharing and quality of such items and services, and beneficiary satisfaction.

(e) DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

(1) 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 clinical laboratory screening tests); and

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

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

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

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

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

(c) CONFORMING CHANGES.—

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

(3) by striking ''(1)(E)(i)'' and inserting ''(1)(E)(i) , and (H)(i)'';

(4) in paragraph (10)(B), by inserting ''in'' immediately after the reference to the same HCPCS code shall be the payment basis as otherwise provided in this section for such orthotics furnished in such 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 basis 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 such section—

(A) in paragraph (1)(B), by striking 'The payment amount recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under such section shall be the payment basis determined under such competitive acquisition program in a competitive acquisition area under section 1847(a)'';

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

(C) in paragraph (2)(A)(i), by striking ''The payment amount recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under such section shall be the payment basis determined under such competitive acquisition program in a competitive acquisition area under section 1847(a)'';

(D) in paragraph (2)(B), by striking ''This subsection'' and inserting ''Subject to subparagraph (E)(i) of this subsection'';

(E) APPLICATION OF COMPETITIVE ACQUISITION; ELIMINATION OF INHERENT REASONABLENESS AUTHORITY.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended to read as follows:

(A) for which payment is otherwise made under such 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 basis 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 such section—

(A) in paragraph (1)(B), by striking 'The payment amount recognized under subparagraph (B)(ii) for an area that is not a competitive acquisition area under such section shall be the payment basis determined under such competitive acquisition program in a competitive acquisition area under section 1847(a)'';

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

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

(E) APPLICATION OF NDC CODES.—If the Secretary determines that there is insufficient data available with respect to the actual, current acquisition price for the drug or biological, the Secretary may substitute for the quarters involved an appropriate payment for the drug or biological for such average acquisition price.

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

(2) DEFINITION OF AVERAGE ACQUISITION PRICE.—

(I) IN GENERAL.—For purposes of this section, the term 'average acquisition price' means, with respect to a drug or biological and with respect to each dosage form and strength of the drug or biological product (without regard to any special packaging, labeling, or identifiers on the dosage form or...
product or package), the average of all final sales prices charged by the manufacturer of the drug or biological product in the United States, excluding sales exempt from inclusion in the computation of best price under section 1927(c)(1)(C) (other than under clause (ii)(III) of such section) and excluding sales subject to a rebate under section 1927, as reported to the Secretary under section 1927(b)(3)(C) shall apply with respect to the drug or biological involved under this part.

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

(i) The sum of all final sales prices charged by the manufacturer under this subsection, computed on a per unit basis, less the applicable price reductions, price rebates, and other discounts

(ii) Prompt pay discounts and cash discounts

(iii) Charge-backs

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

(v) Free goods and services.

(vi) Rebates

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

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

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

(i) The sum of all final prices charged by the manufacturer under this subsection, by

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

(D) DISTRIBUTION OF REPORTS.—The Secretary shall promptly distribute applicable payments made under this part to manufacturers, wholesalers, and retailers and to such other persons as may be appropriate to verify the accuracy of the information reported.

(E) PENALTIES.—The Secretary may make subsequent adjustments to the information required under subparagraph (A) to reflect differences in the costs of dispensing and other adjustments in net price realized (taking into account rebates and other amounts affecting net price), regardless of the period for which such a rebate or other adjustment in net price might have been earned.

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

(G) DISPENSING FEE.—If payment for a drug or biological product is received from a pharmacist approved to dispense drugs or biologicals under this part, the Secretary shall pay an adequate amount to cover any applicable dispensing fees, and the information shall include updated information on the net price charged by the manufacturer attesting to the accuracy of the information reported. Such information shall in effect for the net price realized (taking into account rebates other amounts affecting net price), regardless of the period for which such a rebate or other adjustment in net price might have been earned.

(H) PAYMENT REQUIRED ON AN ASSIGNMENT-BASED RELATIONSHIP.—

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

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

(2) EFFECTIVE DATE.—Subject to subsection (i)(2), the amendment made by paragraph (1) shall apply to drugs and biologicals furnished on or after January 1, 2005.

(b) MEDICARE PAYMENT FOR DRUG ADMINISTRATION SERVICES.—

(1) IN GENERAL.—The Secretary shall revise the payment practice relative value units for drug administration services for years beginning with the year 2005 in accordance with this section.

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

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

(B) FORM OF REPORTING.—Information required to be reported under subparagraph (A)(i) shall be reported in a form and manner specified by the Secretary. The information required to be reported shall include the identification of the generic name of the drug (or biological product) named in the description of the service, the natural drug code (NDC) and the HCPCS code assigned to the drug or biological, the dosage form, strength, volume, and route of administration, and the date on which the payment was made for a quarter shall be submitted not later than 30 days after the end of the quarter. The information shall be accompanied by a written certification by the manufacturer attesting to the accuracy of the information reported. Such information shall in effect for each such quarter of the period involved that are included in subparagraph (A)(i) of such section and excluding sales prices charged by the manufacturer for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for drug administration services under section 1848 of the Social Security Act (42 U.S.C. 1395w-4).

(c) PAYMENTS FOR CHEMOTHERAPY SUPPORT SERVICES.—

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

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

(E) PENALTIES.—The Secretary may make subsequent adjustments to the information required under subparagraph (A) to reflect differences in the costs of dispensing and other adjustments in net price realized (taking into account rebates and other amounts affecting net price), regardless of the period for which such a rebate or other adjustment in net price might have been earned.

(F) FORM OF REPORTING.—Information required to be reported under subparagraph (A)(i) shall be reported in a form and manner specified by the Secretary. The information required to be reported shall include the identification of the generic name of the drug (or biological product) named in the description of the service, the natural drug code (NDC) and the HCPCS code assigned to the drug or biological, the dosage form, strength, volume, and route of administration, and the date on which the payment was made for a quarter shall be submitted not later than 30 days after the end of the quarter. The information shall be accompanied by a written certification by the manufacturer attesting to the accuracy of the information reported. Such information shall in effect for each such quarter of the period involved that are included in subparagraph (A)(i) of such section and excluding sales prices charged by the manufacturer for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for drug administration services under section 1848 of the Social Security Act (42 U.S.C. 1395w-4).

(U) UPDATE.—For years after 2005, the relative values determined under paragraph (4) term "chemotherapy support services" are services furnished by the staff of physicians to patients undergoing treatment for cancer that were not included in the computation of clinical staff costs under subsection (b) of this section. Such services include social worker services, nutrition counseling, psychosocial services, and similar services.

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

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

(W) CONVERSION TO RELATIVE VALUE UNITS.—The Secretary shall convert the total practice expenses determined under paragraph (3) to practice relative value units for chemotherapy support services by dividing clinical staff costs by the conversion factor that will be in effect for the physician fee schedule for 2005. The relative value units as so determined shall be used in determining the fee schedule amounts paid for chemotherapy support services under such section 1848.
(d) Cancer Therapy Management Services.—Beginning in 2003, the Secretary shall recognize and pay a payment amount for the service of cancer therapy management to account for the greater pre-service and post-service time associated with visits and consultations conducted by physicians treating cancer patients compared to typical visits and consultations. The payment amount shall vary by the level and type of the related visit or consultation.

(e) Other Services Without Physician Work Relative Value Units.—Beginning in 2003, the Secretary shall develop a revised methodology for determining the payment amounts for services that are paid under the fee schedule established by section 1848 of the Social Security Act (42 U.S.C. 1395w-4) and that do not have physician work relative value units, including radiation oncology services. Such methodology shall result in payment amounts that fully cover the costs of furnishing such services. Until such time as the methodology for such services is revised and implemented, all such services shall be protected from further payment cuts due to factors such as shifts in utilization or removal of specialty services that are paid under the fee schedule established by such section 1848 and that do not have physician work relative value units.

(f) Report.—Not later than April 1, 2004, the Secretary shall submit to Congress a report on the payment amounts that may vary by the level and type of care furnished to cancer patients in the various settings of care. Such methodology shall result in payment amounts that fully cover the costs of furnishing such services. Until such time as the methodology for such services is revised and implemented, all such services shall be protected from further payment cuts due to factors such as shifts in utilization or removal of specialty services that are paid under the fee schedule established by such section 1848 and that do not have physician work relative value units.

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

(2) Baseline Study.—The first phase of the study shall include the following objectives: (A) The extent to which the current Medicare payment system, prior to implementation of the amendments made by this section, facilitates appropriate access to care for cancer patients in the various treatment settings.

(B) The identification of the comprehensive range of services and counseling, and recommendations on the cost-effectiveness of furnishing such services. Until such time as the methodology for such services is revised and implemented, all such services shall be protected from further payment cuts due to factors such as shifts in utilization or removal of specialty services that are paid under the fee schedule established by such section 1848 and that do not have physician work relative value units.

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

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

(E) The development of a framework for assessing how the amendments made by this Act affect the provision of care to Medicare patients with cancer.

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

(G) Study Required by Paragraph (2) to Be Submitted to Congress.—(A) The study required by paragraph (2) shall be submitted to the Congress and the Secretary of Health and Human Services no later than January 31, 2004.

(B) The study required by paragraph (3) shall be submitted to the Congress and the Secretary of Health and Human Services no later than December 31, 2003.

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

(3) Delay in Effective Date.—The amendment made by subsection (a)(1) shall not apply to blood clotting factors furnished before the first day of the first calendar year that begins at least 6 months after the date the report required by paragraph (1) has been submitted to Congress.

Title IV—Rural Health Care Improvements

Section 401. Fairness in the Medicare Disproportionate Share Hospital (DSH) Adjustment for Rural Hospitals

(4) Equalizing DSH Payment Amounts.—(a) In general.—Section 1886(d)(5)(F)(vii) (42 U.S.C. 1395ww(d)(5)(F)(vii)) is amended—

(1) in subclause (I) by inserting ''and before October 1, 2004,''; and

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

(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 fee-for-service payments for durable medical equipment, other than home health services, or

(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 section 1874A of such Act (42 U.S.C. 1395u), or a Medicare Administrative Contractor under section 1874A of such Act.

(2) Preference for Entities with Demonstrated Capacity and Experience.—(A) In general.—The Secretary shall give preference to those risk entities that the Secretary determines have demonstrated capacity and experience in a recovery audit contract under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated capacity and experience in a recovery audit contract under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated capacity and experience in a recovery audit contract under this section, the Secretary shall give preference to those risk entities that the Secretary determines have demonstrated capacity and experience in a recovery audit contract under this section.

(B) The Secretary may not enter into a recovery audit contract under this section with an entity only if the entity has failed to undergo a determination made under title XVIII 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.

(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 considered 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.
CONFIRMING AMENDMENTS.—

(1) CONFORMING 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’’ and inserting ‘‘IN DIVERSE AREAS’’;

(B) in the matter preceding clause (i), by striking ‘‘IN’’ and inserting ‘‘FOR’’; and

(C) in clause (i), by striking ‘‘the reasonable costs’’ and inserting ‘‘the reasonable costs’’.

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

(A) in the matter preceding subparagraph (A), by striking ‘‘before fiscal year 1997’’; and

(B) in subparagraph (A), by striking ‘‘for fiscal years before fiscal year 1997’’ and inserting ‘‘for fiscal years before fiscal year 1997’’.

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 1833(t)(13) (42 U.S.C. 1395l(t)(13)) to reflect the most current data available, the Secretary shall establish a frequency for revising such weights, including the labor share, in such market basket to reflect the most current data available more frequently than once every 5 years.

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

SEC. 405. IMPROVEMENTS TO CRITICAL ACCESS HOSPITAL PROGRAM.

(a) Increase in Payment Amounts.—

(1) In General.—Sections 1814(l), 1834(g)(1), and 1861(mm)(4) (42 U.S.C. 1395f(l); 1395f(m)); and 42 U.S.C. 1395t(a)(3) are each amended by inserting ‘‘equal to 102 percent of’’ before ‘‘the reasonable costs’’.

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

(c) Coverage of Costs for Certain Emergency Room On-Call Providers.—Section 1814(g)(5) (42 U.S.C. 1395f(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) to provide emergency services’’ and inserting ‘‘emergency room physicians who are on-call (as defined by the Secretary) to provide emergency services’’; and

(C) by striking ‘‘physicians’’ services and inserting ‘‘services covered under this title’’. DA

Note.—The amendment made by paragraph (a) shall apply with respect to costs incurred for services provided on or after January 1, 2004.
(1) IN GENERAL.—Section 1820(c)(2)(B)(iii) of title 42, United States Code (42 U.S.C. 1395l(t)(7)(D)(i)) is amended to read as follows:

"(iii) provides not more than a total of 25 additional physician and services positions for services furnished on or after January 1, 2004, and for any reference period that does not exceed, as determined on an annual, average basis, 96 hours per patient;".

(2) CONFORMING AMENDMENT.—Section 1820(f) of title 42, United States Code (42 U.S.C. 1395m(g)(2)) is amended by striking "and the number of beds used at any time for acute care inpatient services does not exceed 15 beds".

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on or after October 1, 2004.

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

(a) ELIMINATION.—

(1) IN GENERAL.—Section 1835(f)(2)(B) of title 42, United States Code (42 U.S.C. 1395w(h)(4)) is amended—

"(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to amounts paid on or after July 1, 2003.".

(b) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall apply to amounts paid on or after January 1, 2005.

(5) REINSTATED OF PERIODIC INTERIM PAYMENT (PIP).—

(a) IN GENERAL.—Section 1815(e)(2) of title 42, United States Code (42 U.S.C. 1395i–4(e)(2)) is amended—

"(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to amounts paid on or after January 1, 1997.".

(b) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to amounts paid on or after January 1, 2004.

(c) CONFORMING AMENDMENT.—Section 1820(f) of title 42, United States Code (42 U.S.C. 1395m(g)(2)) is amended by adding at the end the following new paragraph:

"(D) Subject to subparagraph (A), paragraph (C), and subparagraph (G), the Secretary may adjust the reference resident level for a hospital, the 3 most recent consecutive cost reporting periods of the hospital for which cost reports have been submitted (or, if not submitted) on or before September 30, 2002.".

(7) RECONSTRUCTION OF REDISTRIBUTION PROGRAM.—

(a) IN GENERAL.—Section 1886(h)(4) of title 42, United States Code (42 U.S.C. 1395ww(h)(4)) is amended—

"(1) 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 clause (iii)(ii), effective for cost reporting periods beginning on or after January 1, 2004, the otherwise applicable resident limit shall be reduced by 75 percent of the difference between such limit and the reference resident level specified in clause (iii) (or clause (iv) if applicable).

"(ii) REDUCTION 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 submitted (or, if not submitted) on or before September 30, 2002.

"(iii) REFERENCE RESIDENT LEVEL.—Subject to subparagraph (iv), the reference resident level specified in this subsection for a hospital is the highest resident level for the hospital during any of the reference periods (as defined in clause (iii)(i)) that is less than the otherwise applicable resident limit for the hospital for the cost reporting period that includes July 1, 2003.

"(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 with a hospital in a hospital's affiliated group (as defined by the Secretary under section (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.

"(vi) REDISTRIBUTION.—Subject to subparagraph (F), the Secretary may adjust the reference resident level for a hospital to the reference resident level for the hospital for the cost reporting periods that include July 1, 2003.

"(vii) CONSIDERATIONS IN REDISTRIBUTION.—The Secretary shall take into account the need for such an increase by specialty and location where necessary.

"(viii) LIMITATION.—No increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2005.

(2) CONSIDERATIONS IN REDISTRIBUTION.—

(a) IN GENERAL.—If a hospital's resident level for a hospital as provided in clause (i) is provided under subclause (I), 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)(3)(I)(ii) of the Social Security Act (as added by subsection (a)).

(3) 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)(3)(I)(ii) of the Social Security Act (as added by subsection (a)).
(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 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 payments for OPD services furnished on or 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(f) of the Social Security Act (42 U.S.C. 1395f(f)), costs incurred by rural providers of services by ambulatory payment classification groups exceeding those costs incurred by urban providers of services by ambulatory payment classification groups (APCss) exceed those costs incurred by urban providers of services in urban areas. The study shall be conducted on and after January 1, 2004.

(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(f) to reflect those higher costs by January 1, 2005.

SEC. 408. EXCLUSION OF CERTAIN RURAL HEALTH CENTER AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES FROM THE PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.—Services described in this clause are—
(1) rural health clinic services (as defined in paragraph (2) of section 1861(aa)); and
(2) 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 SERVICES TO SERVE HOSPICE PATIENTS.—
(a) IN GENERAL.—Section 1861(dd)(3)(B) (42 U.S.C. 1395w–23(b)(3)) is amended—
(1) in clause (i)(i), by striking "(ii)" and inserting "(ii)";
and
(iii) 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—
(1) rural health clinic services (as defined in paragraph (2) of section 1861(aa));
and
(2) 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. 410. IMPROVEMENT IN PAYMENTS TO RURAL 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 the period of not more than 180 days after the date of enactment of this Act, the Secretary shall increase the payment amount otherwise made under section 1902 of such Act (42 U.S.C. 1395f(f)) for such services by 30 percent.

(b) WAIVER OF DUAL ELIGIBILITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1886 of the Social Security Act (42 U.S.C. 1395f(f)) applicable to home health services furnished during a period to offset the increase in payments resulting from the application of this subparagraph.

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 the period of not more than 180 days after the date of enactment of this Act, the Secretary shall increase the payment amount otherwise made under section 1902 of such Act (42 U.S.C. 1395f(f)) for such services by 30 percent.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to cost re-
P(III) The arrangement between the health center entity and the other party protects a health care professional's independent medical judgment regarding medically appropriate treatment.

The Secretary may also include other standards and criteria that are consistent with the intent of Congress in enacting the exception established under this section.

(b) E FFECTIVE DATE.—The amendment enacted under paragraph (1) of this section shall be effective and final immediately on an interim basis, subject to such change and revision, after public notice and opportunity (for a pe-

SEC. 412. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDER-SERVED POPULATIONS.—
(a) IN GENERAL.—Section 1128(b)(3)(D) (42 U.S.C. 1320a–7(b)(3)) is amended—
(1) in subparagraph (A), by striking "and" after the semicolon at the end; and
(2) by inserting at the end of such subparagraph:
"(ii) Any remuneration between a public or nonprofit private health center entity described under subsection (a) or (b) of section 1801 of the Social Security Act (42 U.S.C. 1395f(f)) 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 such health care entity or a network of such health care entities to 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, by regulations, any exceptions to the requirements set forth in section 1128(b)(3)(D) 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 such exceptions relating to the exception for health center entity arrangements under subparagraph (A):
(i) Whether the arrangement between the health center entity and the other party 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.

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, as it is scheduled to be in effect on the date of the enactment of this Act, and the Social Security Act (42 U.S.C. 1395ww–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 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).

SEC. 414. TREATMENT OF MISCELLANEOUS COST REPORTING PERIODS FOR SOLE COMMUNITY HOSPITALS.—
(a) IN GENERAL.—Section 1128(b)(3)(I) (42 U.S.C. 1320a–7(b)(3)(I)) is amended by adding at the end the following new clause:
"(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.

(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 407 of Balanced Budget Act of 1997 (Public Law 105–135) is amended beyond:—
(1) in subsection (a)(4), by striking "4-year" and inserting "5-year"; and
(2) in subsection (d)(3), by striking "$30,000,000" and inserting "$50,000,000".
SEC. 416. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED HOSPITAL WAGE INDEX.

(a) In general.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)) is amended—

(1) Wage levels.—The Secretary and inserting "WAGE LEVELS.—"

"(i) In general.—Except as provided in clause (ii), the Secretary;" and

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

"(iii) 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 the number of Medicare beneficiaries determined under subparagraph (B)."

(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 provisions of this subsection (and the amendments made by this subsection) 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.".

(c) Adding Bonus Payment for Certain Physician Scarcity Areas.—

(1) In general.—Section 1833 (42 U.S.C. 1395l) is amended by adding at the end the following new subsection:

"(u) INCENTIVE PAYMENTS FOR PHYSICIAN SCARCITY.—

(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 payable for such services under this part, there shall also be paid an amount equal to 5 percent of the payment amount for the service under this part.

(2) 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, 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.—Under rules of individuals who are residing in the county and are entitled to benefits under part A or enrolled under this part, or both.

(3) 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. 1395l(m)) is amended—

(A) by inserting "(1)" after "(m)"; and

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

"(2) Effective date.—The amendments made by subsection (a) shall apply to physicians' services furnished or after January 1, 2004.

SEC. 418. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

Section 1886(d) (42 U.S.C. 1395ww(d)) is amended by adding at the end the following new paragraph:

"(12) Payment adjustment for low-volume hospitals.—

(A) Payment adjustment.—

(i) In general.—Notwithstanding any other provision of this section, for each cost reporting period beginning on or after January 1, 2004, the Secretary shall provide for an additional payment to each low-volume hospital that has been defined under paragraph (1) for the year involved for discharges occurring during that cost reporting period which is equal to the applicable percentage increase (determined under clause (ii) of the amount paid to such hospital under this section for such discharges.

(ii) Applicable percentage increase.—

The Secretary shall determine a percentage increase applicable under this paragraph that ensures that—

"(I) no percentage increase in payments under this paragraph exceeds 25 percent of the payment amount for such low-volume hospital under this section for such discharges occurring during such cost reporting period (as determined under this paragraph) otherwise made to a low-volume hospital under this section for each discharge; and

"(II) low-volume hospitals that have the lowest number of discharges during a cost reporting period receive the highest percentage increases in payments due to the application of this paragraph.

"(B) The percentage increase in payments to any low-volume hospital under this subsection for the year involved is less than the percentage increase in payments under this paragraph for such hospital under this section for the year involved.".
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(1) PAYMENT BASED ON REASONABLE COSTS.—The amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

(2) SECONDARY COST-SHARING.—Withholding section 432, no coinsurance, deductible, copayment, or other cost-sharing otherwise applicable under such part B shall apply with respect to such test.

SEC. 420. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC ADJUSTMENTS OF PAYMENTS FOR PHYSICIANS’ SERVICES.

Section 1848(e)(3) (42 U.S.C. 1395ww(e)(3)) is amended—

(i) in subparagraph (A), by striking “subparagraphs (B) and (C)” and inserting “subparagraphs (B), (C), and (D)”

(ii) 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 ‘work floor index’ means—

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


(F) FLOOR FOR PRACTICE EXPENSE AND MALPRACTICE GEOGRAPHIC INDICES.—For purposes of payment for services furnished on or after January 1, 2004, after calculating the practice expense and malpractice indices in clauses (i) and (ii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.

SEC. 421. AMBULANCE PAYMENT RATES.

(a) PAYMENT RATES.—Section 1884(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended to read as follows:

(3) Payment rates in subsequent years for all ambulance services.—In the case of any ambulance service furnished under this part in 2004 or any subsequent year, the Secretary shall assign an eligible new technology to the fee schedule for such service at amounts equal to the payment rate under the fee schedule for such service furnished during the previous year times the percent-age increase in the Consumer Price Index for all urban consumers (United States city average) for the 12-month period ending with the last day of the previous year.

(b) Adjustment in rural rates.—For years beginning with 2004, the Secretary, after taking into consideration the recession and the report submitted under section 221(b)(3) the Medicare, Medicaid, and SCHIP Benefits Improvements and Protection Act of 2000, shall adjust the fee schedule payment rates that would otherwise apply under this subsection for ambulance services provided in low density rural areas based on the increased cost (if any) of providing such services in such areas.

(c) FLOOR FOR INPATIENT HOSPITAL SERVICES.

Title V—Provisions Relating to Part B

Subtitle A—Inpatient Hospital Services

Sec. 501. Adjustment for Indirect Costs of Medical Education (IME).

Section 1886(d)(5)(B)(ii) (42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended by striking “on or after October 1, 2002,” and inserting “during fiscal year 2003; and

(b) by striking the period at the end and inserting “the Secretary shall—

(1) by striking “and” at the end of subclause (VI);

(2) in subclause (VII)—

(A) by striking “or on or after October 1, 2002,” and inserting “during fiscal year 2003; and

(B) by striking the period at the end and inserting “the Secretary shall—

(3) by inserting after subclause (VII) the following new subclauses:

(VIII) during each of fiscal years 2004 and 2005, ‘c’ is equal to 1.35.

(IX) on or after October 1, 2005, ‘c’ is equal to 1.35.

Sec. 502. Recognition of New Medical Technology Under Inpatient Hospital PPS.

(a) Improving Timeliness of Data Collection.—Section 1886(d)(5)(K)(ii) (42 U.S.C. 1395ww(d)(5)(K)(ii)) is amended by adding at the end the following new clause:

(iii) Under the mechanism established by this paragraph, the Secretary shall provide for further clarification of the criteria for determining whether items and services are medically necessary and appropriate under section 1922(a)(1)."

(b) Process for Public Input.—Section 1886(d)(5)(K)(iv) (42 U.S.C. 1395ww(d)(5)(K)(iv)), 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)"

(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 the service or technology not described in the second sentence of clause (vii) represents an advance in medical technology that substantially improves the diagnosis or treatment of beneficiaries.

(II) 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.

(III) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement.

(IV) The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, and other interested parties may present comments, recommendations, and data to the clinical staff of the Medicare program 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)), as 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 technology. Within such groups the Secretary shall assign an eligible new technology into
a diagnosis-related group where the average costs of care most closely approximate the costs of care of using the new technology. In such case, the new technology would no longer cost more than 75 percent of the standard deviation for the diagnosis-related group involved under clause (ii)(I). No add-on payment under this subparagraph in such case with respect to such new technology and this clause shall not affect the application of paragraph (4)(C)(iii)."

(b) DEPARTMENT OF  MEDICARE  AND  MEDICAID  SERVICES  TRANSMISSION.—The definition of "Physician consultation on or after January 1, 2004." is amended by adding at the end of the following:

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For purposes of this paragraph, "physician consultation on or after January 1, 2004." means:

(A) In general.—The consultation is furnished by a physician to a hospital in connection with the diagnosis of a patient and the care of such patient who is in a hospital inpatient service as defined in section 1861(r) of the Social Security Act, as amended by this Act, or after such date as the Secretary may designate, and such consultation is furnished after January 1, 2004.

(B) Exception.—For purposes of this paragraph, "physician consultation on or after January 1, 2004." does not include any consultation.
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(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) In this subsection, 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 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 management and symptom control;
(B) counseling the individual with respect to end-of-life issues and care options; and
(C) advising the individual regarding advance care planning.
(b) PAYMENT.—Section 1814(a)(42 U.S.C. 1395l(a)(42)) 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 previsit, postvisit, or other support services for patients with 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 striking the semicolon before the period at the end the following: ‘‘(and services described in section 1821(a)(5))’’. (d) IMPLEMENTATION.—The amendments made by this section shall apply to services provided by a hospice program on or after January 1, 2004.
TITLE VI—PROVISIONS RELATING TO PART B
Subtitle A—Physicians’ Services
SEC. 601. REVISION OF UPDATES FOR PHYSICIANS’ SERVICES.
(a) UPDATE FOR 2004 AND 2005.—
(1) IN GENERAL.—Section 1848(d) (42 U.S.C. 1395w–4(f)(2)(D)) is amended—
(A) in paragraph (1)—
(i) in subparagraph (A), by inserting ‘‘and severe for’’ before ‘‘or’’;
(ii) in subparagraph (B), by striking ‘‘or 100 percent’’, and inserting ‘‘or 100 percent’’;
(iii) in subparagraph (C), by striking ‘‘or 100 percent’’, and inserting ‘‘or 100 percent’’; and
(iv) in subparagraph (D), by striking ‘‘or 100 percent’’, and inserting ‘‘or 100 percent’’; and
(B) in paragraph (2), by striking ‘‘as defined in section 1833(b) (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(1)(2)(C) (42 U.S.C. 1395w–4(f)(2)(C)) is amended—
(A) by striking ‘‘average annual’’ and inserting ‘‘average annual’’; 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 gross domestic product growth rate for years beginning with 2003.
SEC. 602. STUDIES ON ACCESS TO PHYSICIANS’ SERVICES.
(a) GAO STUDY.—The Secretary shall conduct a study on access of beneficiaries to physicians’ services under the medicare program.
(1) STUDY.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1). The report shall include the following:
(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 of:
(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.
(3) The report shall include the following:
(a) A study of the extent to which the Centers for Medicare & Medicaid Services takes into account the impact of law and regulations on the sustainable growth rate.
Subtitle II—Preventive Services
SEC. 611. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION.
(a) COVERAGE.—Section 1861(s)(3) (42 U.S.C. 1395w–1(s)(3)) 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’’.
(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395w) 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. 1395f–1(b)) is amended—
(A) by striking ‘‘(or 100 percent’’ and inserting ‘‘(or 100 percent’’;
(B) in clause (O), by inserting ‘‘(or 100 percent’’ before ‘‘of the case of an initial preventive physical examination, as defined in section 1861(ww)’’;
(2) COINSURANCE.—Section 1833(a)(1) (42 U.S.C. 1395f(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) GAO STUDY OF PHYSICIANS’ SERVICES.—
Section 1848(1)(2)(D) (42 U.S.C. 1395w–4(f)(1)(D)) is amended by inserting ‘‘(or 2WW)” after ‘‘(or 2WW)”.
(e) OTHER CONFORMING AMENDMENTS.—
Section 1832(a) (42 U.S.C. 1395y(a)) is amended—
(1) in paragraph (1)—
(A) by striking ‘‘and’’ at the end of subparagraph (H); and
(B) by striking the semicolon at the end of subparagraph (I) and inserting ‘‘; and’’; and
(2) by adding at the end the following new subparagraph:
‘‘(J) in the case of an initial preventive physical examination, which is performed...”
SEC. 612. COVERAGE OF CHOLESTEROL AND BLOOD LIPID SCREENING.

(a) COVERAGE.—Section 1833(t)(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;

(3) by adding at the end the following new sub-

"(X) cholesterol and other blood lipid screening tests (as defined in subsection (XX));"

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395l), 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 and, the purpose of early detection of abnormal cholesterol and other lipid levels.

"(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency and type of cholesterol and other blood lipid screening tests, except that such frequency may not be more than once every 2 years.

(c) FREQUENCY.—Section 1862(a)(1) (42 U.S.C. 1395a(a)(1)), as amended by section 613(e), is amended—

(1) by striking "and" at the end of sub-

paragraph (I);

(2) by striking the semicolon at the end of

paragraph (J) and inserting ";''; and''; and

(3) by adding at the end the following new sub-

paragraph:

"(K) in the case of a cholesterol and other blood lipid screening test (as defined in section 1833(t)(2)), which is performed more frequently than is covered under section 1861(xx)(x));''.

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests fur-

nished on or after January 1, 2005.

SEC. 613. WAIVER OF DEDUCIBLE FOR COLORECTAL CANCER SCREENING TESTS.

(a) IN GENERAL.—The first sentence of section 1833(b) (42 U.S.C. 1395l(b)), as amended by section 613(c)(1), is amended—

(1) by striking "and" before "(7)''; and

(2) by inserting before the period at the end the following:—

"(i) such test is performed more frequently than once every 2 years;'';

(b) CONFORMING AMENDMENTS.—Paragraphs (2)(C)(ii) and (3)(C)(ii) of section 1833(d) (42 U.S.C. 1395m(d)) are each amended—

(1) by striking "DEDUCTIBLE AND" and the heading;

(2) in clause (I), by striking "deductible or" each place it appears.

(c) EFFECTIVE DATE.—The amendment made by this section shall apply to items and services furnished on or after January 1, 2004.

SEC. 614. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPP FEE SCHEDULE.—Section 1833(t)(1)(B)(iv) (42 U.S.C. 1395l(t)(1)(B)(iv)) is amended by inserting be-

fore the period at the end the following:—

"and does not include screening mammography (as defined in section 1861(j)) and unilateral and bilateral diagnostic mammography''.

(b) ADJUSTMENT TO TECHNICAL COMPONENT.—For diagnostic mammography performed on or after January 1, 2004, for which payment is made under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w-4), the Secretary, based on the most recent cost data available, shall provide for an appropriate adjustment in the payment amount for the technical component of the diagnostic mammography.

(c) EFFECTIVE DATE.—The amendment made by this subsection shall apply to mamm-

ography 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)(1) (42 U.S.C. 1395l(t)) is amended—

(A) by redesignating paragraph (12) as paragraph (13); 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—

(ii) exceed 95 percent of the average whole-

sale price for the drug; or

(iii) be less than the average price for the drug.

"(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 section 1927(k));''.

"(ii) EXCEPTION.—Such term does not in-

clude—

"(I) a drug for which payment was made under subparagraph (g) of section 1847A as calculated and applied by the Secretary for purposes of this paragraph.

(c) AMOUNT PAYABLE.—Section 1833(t)(2) (42 U.S.C. 1395l(t)(2)) is amended—

(1) by striking ''and'' before ''(7)''; and

(2) by striking the semicolon at the end of

paragraph (D) and inserting ";''.

(d) EFFECTIVE DATE.—The amendments made by this subsection shall apply to tests fur-

nished on or after January 1, 2004.
which the acquisition costs is less than $50

(3) GAO REPORT.—The Comptroller General of the United States shall conduct a study to determine the payment methods under section 1833(t)(13)(B) of the Social Security Act, as added by paragraph (1), for drugs 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 drugs.

(c) APPLICATION OF FUNCTIONAL EQUIVALENCE TEST.—

(1) IN GENERAL.—Section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by adding at the end the following new subparagraph:

"(F) For 2010 and each succeeding year, the blended rate shall be based 20 percent on the fee schedule under paragraph (1), 60 percent on the regional fee schedule, and 20 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule."

"(G) For 2010 and each succeeding year, the blended rate shall be based 20 percent on the fee schedule under paragraph (1), 60 percent on the regional fee schedule, and 20 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule."

"(H) The National Kidney Foundation."

"(I) The National Institute of Diabetes and other similar standards, and the Secretary of Health and Human Services.

"(J) Economists.

"(K) Researchers."

"(L) BURSTING COMPOUNDS FOR PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate for pediatric facilities."

"(M) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES FURNISHED IN 2004.—Notwithstanding any other provision of law, the rate to be paid for services furnished under section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)) shall be increased by 1.6 percent."

"(N) ONE-YEAR MORATORIUM ON THERAPY CAPS: PROVISIONS RELATING TO REPORTS.—

(a) YEARLY MORATORIUM ON THERAPY CAPS.—Section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by adding "and inserting "(D), and (E)"; and inserting "Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2003, and until"

"(o) 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 for pediatric facilities."

"(p) BURSTING COMPOUNDS FOR PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate for pediatric facilities."

"(q) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES FURNISHED IN 2004.—Notwithstanding any other provision of law, the rate to be paid for services furnished under section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)) shall be increased by 1.6 percent."

"(r) ONE-YEAR MORATORIUM ON THERAPY CAPS: PROVISIONS RELATING TO REPORTS.—

(a) YEARLY MORATORIUM ON THERAPY CAPS.—Section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by adding "and inserting "(D), and (E)"; and inserting "Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2003, and until"

"(o) 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 for pediatric facilities."

"(p) BURSTING COMPOUNDS FOR PEDIATRIC FACILITIES.—Subparagraphs (A) and (B) shall not apply, as of October 1, 2002, to pediatric facilities that do not have an exception rate for pediatric facilities."

"(q) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES FURNISHED IN 2004.—Notwithstanding any other provision of law, the rate to be paid for services furnished under section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)) shall be increased by 1.6 percent."

"(r) ONE-YEAR MORATORIUM ON THERAPY CAPS: PROVISIONS RELATING TO REPORTS.—

(a) YEARLY MORATORIUM ON THERAPY CAPS.—Section 1881(b)(7) (42 U.S.C. 1395rr(b)(7)) is amended by adding "and inserting "(D), and (E)"; and inserting "Subject to section 422(a)(2) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2003, and until"
under section 221(d) of the Medicare, Medicaid, and SCHIP Balanced Budget Reconciliation Act of 1999 (relating to utilization patterns for outpatient therapy).

(c) IDENTIFICATION OF CONDITIONS AND DISORDERS 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 1873(d) of the Social Security Act (42 U.S.C. 1395t(g)(4)).

(2) REPORTS TO CONGRESS.—

(A) PRELIMINARY REPORT.—Not later than July 1, 2003, 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.

(2) CONFORMING AMENDMENTS.—(a) in paragraph (1), by striking "no more

(2) in paragraph (2), by adding "and" at the end of sub

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

...
(i) History of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds.

(ii) 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 shall not be more often than twice within the 12-month period following the date of the most recent diabetes screening test for each individual.

(c) FREQUENCY.—Section 186a(1)(42 U.S.C. 1395f(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”;

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

“(L) in the case of a diabetes screening tests or test (as defined in section 1861(yy)(2)), which is performed more frequently than is covered under section 1861(yy)(3)).”;

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after the date that is 90 days after the date of enactment of this Act.

TITLE VII—PROVISIONS RELATING TO PARTS A AND B

Subtitle A—Chronic Care Improvement

SEC. 701. UPDATE IN HOME HEALTH SERVICES.

(a) CHANGE TO CALENDAR YEAR UPDATE.—

(1) IN GENERAL.—Section 1895(b) (42 U.S.C. 1395fff) is amended—

(A) in paragraph (3)(B)(i)—

(i) by striking “each fiscal year beginning with fiscal year 2002 and for fiscal year 2003 and for each subsequent year beginning with fiscal year 2004;”;

(ii) by inserting “or year” after “fiscal year”;

(B) in paragraph (3)(B)(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;

(ii) by inserting “or year” after “fiscal years”;

(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 fiscal years 2002 and 2003, and for each subsequent year beginning with fiscal year 2004, shall be such amount (or amounts) for the previous calendar quarter.

(b) CHANGES IN UPDATES FOR 2004, 2005, AND 2006—


(A) in paragraph (1)—

(i) by striking “and” at the end of subclause (I);

(ii) by redesignating subclause (II) as subclause (I); and

(iii) in subclause (I), as so redesignated, by striking “and” and inserting “or”;

(iv) by striking after subclause (I) the following new subclause:

“(1) each of 2004, 2005, and 2006 the home health prospective payment system margins for home health agencies under the home health prospective payment system established pursuant to title XVIII 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 (HHRRGs)) among such agencies. The study shall use the partial or full-case or cost reports filed by home health agencies.

(b) REPORT.—Not later than 2 years after the date of enactment of this Act, the Commission shall submit to Congress a report on the study under subsection (a).

SEC. 702. 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 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 homebound for purposes of receiving home health services under the Medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a Medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if the beneficiary—

(1) has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) requires the individual to receive assistance from another individual with at least 3 of the 5 activities of daily living for the rest of the individual’s life;

(3) requires 1 or more home health services to achieve a functional condition that gives the individual the ability to leave home; and

(4) requires technological assistance or the assistance of another person to leave the home.

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that may participate in the project may not exceed 15,000.

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to beneficiaries to determine the quality of care, patient outcomes, and additional costs, if any, to the Medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this section, the Secretary shall submit to Congress a report on the project using the data collected under subsection (e) and shall include—

(1) an examination of whether the provision of home health services to Medicare beneficiaries under the project—

(A) adversely affects the provision of home health services under the Medicare program;

(B) directly causes an unreasonable increase in expenditures under the Medicare program for the provision of such services that is directly attributable to such clarification;

(C) 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 Medicare beneficiaries from 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 the following provisions 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 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 XIX 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.

SEC. 703. 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. 1395h).

SEC. 704. DEFINITIONS.—In this section—

(1) term.—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) activity of daily living.—The term “activities of daily living” means eating, toileting, transferring, bathing, and dressing.

(4) Secretary.—The term “Secretary” means the Secretary of Health and Human Services.

Subtitle B—Chronic Care Improvement

SEC. 705. VOLUNTARY CARE IMPROVEMENT UNDER TRADITIONAL FEE-FOR-SERVICE.

Title XVIII is amended by inserting after section 1826 the following new section:

“CHRONIC CARE IMPROVEMENT

“SEC. 1870. (a) IN GENERAL.—

(1) IN GENERAL.—The Secretary shall establish a process for providing chronic care improvement programs in each CCIA region for Medicare beneficiaries who are not enrolled under part C and who have certain chronic conditions, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), stroke, prostate and colon cancer, hypertension, or other disease as determined by the Secretary to be 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 term ‘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.

(E) CONSTRUCTION.—Nothing in this section shall be construed as expanding the amount, duration, or scope of benefits under this title.

(F) 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 establish a chronic care improvement organization, health insurer, provider organization, a group of physicians, or any other legal entity that the Secretary determines appropriate.

(4) MEDICARE MEDICATIONS.—In establishing and carrying out individual plans under a program, a contractor shall, directly or through subcontractors—

(i) guide beneficiaries 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.

(5) INFORMATION.—The Secretary may require the contractor to provide that programs that are accredited by evidence-based practice guidelines or other criteria as determined by the Secretary.

(6) CONTRACT TERMS.—In entering into a contract with an entity under this section, the Secretary shall establish payment rates that assure that medicare program outlays plus administrative expenses (that would not otherwise be incurred) shall the funding under this section exceed the expenditures that would have been incurred under this title for a comparable population in the absence of any action under this section for the 3-year contract period.

(7) 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.

(8) PERFORMANCE STANDARDS.—Payment to contractors under this section shall be based on the meeting of clinical and financial performance standards set by the Secretary.

(9) CONTRACT 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

(1) financial outcomes.

II. 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 in the following:

(1) the scope of implementation (in terms of both regions and chronic conditions);

(2) program design;

(3) improvements in health outcomes and financial efficiencies that result from such implementation;

(4) CLINICAL TRIALS.—The Secretary shall conduct randomized clinical trials, that compare program participants with medicare beneficiaries who are offered, but decline, to participate in such program, in order to assess the potential of programs to—

(i) reduce costs under this title; and

(ii) 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 Medicare+Choice plans exceed $100,000,000 over a period of 3 years.

II. CHRONIC CARE IMPROVEMENT UNDER MEDICARE+CHOICE PLANS.

(a) IN GENERAL.—Section 1395w–22 (42 U.S.C. 1395w–22) is amended—

(1) by amending subsection (e) to read as follows:

(e) IMPLEMENTATION OF CHRONIC CARE IMPROVEMENT PROGRAMS FOR BENEFICIARIES WITH MULTIPLE OR SUFFICIENTLY SEVERE CHRONIC CONDITIONS.—

(1) IN GENERAL.—Each Medicare+Choice organization with respect to each Medicare+Choice plan it offers shall have in effect, enrollees in sufficient numbers identified as” having one or more chronic conditions, a chronic care improvement program that is designed to manage the needs of such enrollees and that meets the requirements of this subsection.

(2) ENROLLEE WITH MULTIPLE OR SUFFICIENTLY SEVERE CHRONIC CONDITIONS.—For purposes of this subsection the term ‘enrollee with one or more chronic conditions’ means, with respect to enrollee in a Medicare+Choice plan of a Medicare+Choice organization, an enrollee in the plan who has one or more chronic conditions, such as congestive heart failure, diabetes mellitus, end-stage renal disease, stroke, cancer, hypertension, or other disease as identified by the organization as appropriate for chronic care improvement.

(g) CHRONIC CARE PLANS.

(A) IN GENERAL.—Each Medicare+Choice plan under subsection (e) of section 1395w–22 shall be designed, goal-oriented, chronic care improvement plan.

(B) IDENTIFICATION OF ENROLLEES.—Each such plan shall have a method for identifying and enrolling enrollees with multiple or sufficiently severe chronic conditions, and shall identify enrollees identified under subparagraph (B) 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.

(3) 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 enrollee in a Medicare+Choice plan of a Medicare+Choice organization, an enrollee in the plan who has one or more chronic conditions, such as congestive heart failure, diabetes mellitus, end-stage renal disease, stroke, cancer, hypertension, or other disease as identified by the organization as appropriate for chronic care improvement.

(C) IDENTIFICATION OF ENROLLEES.—Each such plan shall have a method for identifying and enrolling enrollees with multiple or sufficiently severe chronic conditions, and 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)
(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 consulta-

tion with experts in the field of chronic care, consumers, and family caregivers, working to inte-

grate care delivery and create more seamless transitions across settings and over time.

(b) REPORT.—The report under this sub-

section 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) EXAMINATION.—shall conduct an evalua-
tion that includes a description of the status of the implementation of chronic care im-
provement programs under section 1807 of the Social Security Act, the quality of health care services provided to individuals in such program, the health status of the participants of such program, and the cost savings attributed to implementation of such program.

(b) REPORT.—Not later than 2 years after the date of implementation of such chronic care improvement programs under the elements of the plan; the Commission shall submit a report on such evalu-

aion.

Subtitle C—Other Provisions

SEC. 731. MODIFICATIONS TO MEDICARE PAY-
MENT ADVISORY COMMISSION (MEDPAC).

(a) EXAMINATION OF BUDGET CON-
SEQUENCES.—Section 1805(b)(4) U.S.C. 1395b-
6(b) is amended by adding at the end the fol-
lowing new paragraph:

(4) ACCREDITATION.—The Secretary may provide that chronic care improvement pro-
grams that are accredited by qualified orga-

nizations under the criteria as determined by the Secretary; and

(ii) Coordination of health care services, including all their co-morbidities, 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, and health self-assessment.

(iii) develop a clinical information data-
base to track and monitor each participant ac-
cross settings and to evaluate outcomes.

(3) ADDITIONAL REQUIREMENTS.—The Sec-

retary may establish additional require-
ments for chronic care improvement pro-
grams under this section.

(4) ACCREDITATION.—The Secretary may pro-
vide that chronic care improvement pro-
grams that are accredited by qualified orga-

nizations under the criteria as determined by the Secretary; and

(b) ACCREDITATION.—The Secretary may pro-
vide such standards and requirements for chronic care improvement programs that the Secretary may specify.

(5) DETERMINATION/report.—Each Medicare+Choice organization with respect to its chronic care improvement program under this subsection shall monitor and re-

port to the Secretary on the quality of care and efficacy of such program as the Secretary may require; and

(b) EFFECTIVE DATE.—The amendments made by this section shall be conducted in not more than 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 Acad-

emy of Sciences to conduct a study of the barriers to effective integrated care improve-
ment for medicare beneficiaries with mul-
tiple or severe chronic conditions across set-
tings and over time and to submit a report under subsection (b).

(b) SPECIFIC ITEMS.—The study shall ex-
amine the statutory and regulatory barriers to coordinating care across settings for medi-

care beneficiaries in transition from one set-
ting to another (such as between hospital, nursing home, hospice, and home). The study shall specifically identify the following:

(1) A comparison of the cost and quality data across settings.

(2) Policies that impede the establishment of a comprehensive clinical information systems to track health status, utilization, cost, and quality data across settings.

2. Report on the demonstration project.

(b) PAYMENT.—

(2) Such recommendations regarding the

amounts expended from the Trust Funds as a re-

sult of the demonstration project con-
ducted under this section shall be submitted to the Secretary and Congress not later than June 1, 2004.

(c) DURATION.—The Secretary shall con-
duct the demonstration project for a period of 3 years.

(d) VOLUNTARY PARTICIPATION.—Participa-
tion of medicare beneficiaries in this dem-
stration 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 partici-

ate in the demonstration project, the Sec-

retary shall give preference to those agencies that are currently licensed or cer-
tified through common ownership and control to furnish medical adult day care ser-

vices.

(g) WAIVER AUTHORITY.—The Secretary may wa

(1) An analysis of the patient outcomes and
(costs) of furnishing care to the medicare beneficiaries.

(2) Recommendations regarding the

amount of additional payments made under
section 1805 of the Social Security Act (42 U.S.C. 1396ff) to reflect any increase in
amounts expended from the Trust Funds as a re-

sult of the demonstration project con-
ducted under this section.

SUBTITLE C—OTHER PROVISIONS

SEC. 731. MODIFICATIONS TO MEDICARE PAY-
MENT ADVISORY COMMISSION (MEDPAC).

(a) EXAMINATION OF BUDGET CON-
SEQUENCES.—Section 1805(b)(2)(B)(i) (42 U.S.C. 1395b-6(b)) is amended by in-

serting "the efficient provision of care" after "ex-
penditures for;"

(2) APPLICATION OF DISCLOSURE REQUIRE-
MENTS.—

(I) DETERMINATION/report.—The Med-

icare Payment Advisory Commission shall conduct a study and submit a report to Con-
gress by not later than June 1, 2004, on the cost and quality (of care) of medicare beneficiaries with multi-
tiple or severe chronic conditions across set-
tings and over time to integrate care delivery and create more seamless transitions across settings and over time.

SEC. 732. DEMONSTRATION PROJECT FOR MED-
ICARE ADULT DAY CARE SERVICES.

(a) ESTABLISHMENT.—Subject to the suc-
ceeding provisions of this section, the Sec-

retary of Health and Human Services shall estab-
lish 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 beneficiar-

y, permit a home health agency, directly or under arrangements with a med-

ical adult day care facility, to provide med-

ical adult day care services as a substitute for an episode of home health services that would otherwise be provided in the bene-

ficiary's home.

(b) PAYMENT.—

(1) IN GENERAL.—The amount of payment for an episode of care for home health ser-

vices, 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 Se-

curity Act (42 U.S.C. 1395k).

(2) BUDGET NEUTRALITY FOR DEMON-
STRATION PROJECT.—Notwithstanding any other provi-
sion of law, the Secretary shall provide an appropri-
ate reduction in the aggregate amount of additional payments made under section 1895 of the Social Security Act (42 U.S.C. 1396ff) to reflect any increase in amounts expended from the Trust Funds as a re-

sult of the demonstration project con-
ducted under this section.

(c) DEMONSTRATION PROJECT SITES.—The project established under this section shall be conducted in not more than 5 States se-
lected by the Secretary that license or cer-
tify providers of services that furnish med-

ical adult day care services.

(d) DURATION.—The Secretary shall con-
duct the demonstration project for a period of 3 years.

(e) VOLUNTARY PARTICIPATION.—Participa-
tion of medicare beneficiaries in this dem-

stration 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 partici-

ate in the demonstration project, the Sec-

retary shall give preference to those agencies that are currently licensed or cer-
tified through common ownership and control to furnish medical adult day care ser-

vices.

(g) WAIVER AUTHORITY.—The Secretary may waive such requirements of title XVIII of the Social Security Act as may be nec-

essary for the purposes of carrying out the demonstration project, other than waiving the requirement that an individual be home-
based in order to be eligible for benefits for home health services.

(h) EVALUATION AND REPORT.—The Sec-
retary shall conduct a study and evaluate the clinical and cost effectiveness of the dem-

onstration project. Not later 30 months after the commencement of the project, the Sec-

retary shall submit a report on the evaluation, and shall include in the report the fol-

owing:

(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 under the same home health services.

(2) Such recommendations regarding the

extension, expansion, or termination of the
project as the Secretary determines appropriate.

(i) Definitions.—In this section:

(A) Home Health Agency.—The term "home health agency" means the term as defined in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(B) 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; and

(B) a program of supervised activities furnished in a group setting in the facility that—

(i) meet such criteria as the Secretary determines appropriate; and

(ii) is designed to promote physical and mental health of the individuals; and

(C) such other services as the Secretary may specify.

(4) Medicare Beneficiary.—The term "medicare beneficiary" means an individual entitled to benefits under part A, or enrolled for-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 (I) covered hospital.

(b) Medicare Coverage of Routine Costs Associated With Certain Clinical Trials.—

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

(A) by inserting "consistent with subsection (k) of this section, the terms 'national coverage determination' and 'local coverage determination' have the meaning given such terms in paragraph (1)(B) and (2)(B), respectively, of section 1886(f)(5)."; and

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

(II) Effective Date.—The amendments made by paragraph (I) shall apply to national and local coverage determinations as of January 1, 2004.

(1) A Medicare+Choice plan under part C.

(II) A plan offered by an eligible organization under section 1877.

(III) A program of all-inclusive care for the elderly (PACE) under section 402(b)(114 Stat. 2763A–550), as enacted into law by section 1(a)(6) of Public Law 106–554, is reenacted.

(IV) A social health maintenance organization (SHMO) demonstration project established under section 402(b)(11) of the Omnibus Budget Reconciliation Act of 1990 (Public Law 100–203).

(b) Conforming Amendment.—Section 542 of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–550), as enacted into law by section 1(a)(6) of Public Law 106–554, is repealed.

(c) Effective Dates.—The amendments made by this section shall take effect as if included in the enactment of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (114 Stat. 2763A–463), as enacted into law by section 1(a)(6) of Public Law 106–554.
SEC. 735. MEDICARE PANCREATIC ISLET CELL TRANSPLANT DEMONSTRATION PROJECT.

(a) Establishment.—In order to test the appropriateness of pancreatic islet cell transplantation, not later than 120 days after the date of the enactment of this Act, the Secretary shall establish a demonstration project which the Secretary, provides for payment under the medicare program under title XVIII of the Social Security Act for pancreatic islet cell transplantation and related items and services in the case of medicare beneficiaries who have type I (juvenile) diabetes and have end stage renal disease.

(b) Authorization.—The authority of the Secretary to conduct the demonstration project under this section shall terminate 5 years after the date of the establishment of the project.

(c) Evaluation and Report.—The Secretary shall conduct an evaluation of the outcomes of the demonstration project. Not later than 120 days after the date of the termination of the demonstration project under subsection (b), the Secretary shall submit to Congress a report on the project, including recommendations for such legislative and administrative action as the Secretary deems appropriate.

(d) Payment Methodology.—The Secretary shall establish an appropriate payment methodology for the provision of items and services under the demonstration project that includes a payment methodology that bundles, to the maximum extent feasible, payment for all such items and services.

(e) Waiver Authority.—The Secretary may waive compliance with the requirements of title XVIII of the Social Security Act to the extent and for such period as the Secretary determines is necessary to conduct the demonstration project.

TITLE VIII—MEDICAID

SEC. 801. CONTINUATION OF MEDICAID DSH ALLOTMENT ADJUSTMENTS UNDER BIPA 2000.

(a) In General.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396a–4(f))—

(1) in paragraph (2)—

(A) in the heading, by striking "THROUGH 2002" and inserting "THROUGH 2003";

(B) by striking "ending with fiscal year 2002" and inserting "ending with fiscal year 2003"; and

(C) in the table in such paragraph, by striking the columns labeled "FY 02" and "FY 03";

(2) in paragraph (3)(A), by striking paragraph (2) and in inserting paragraph (4); and

(3) as added by section 701(a)(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000 (as enacted into law by section 4(a)(6) of Public Law 106-554)—

(A) by striking "FOR FISCAL YEARS 2001 AND 2002" in the heading;

(B) in subparagraph (A), by striking "Without respect to paragraph (2), the" and inserting "The";

(C) in subparagraph (C)—

(i) by striking "NO APPLICATION" and in inserting "same";

(ii) by striking "without regard to" and in inserting "taking into account";

(D) in subparagraph (D) of section 701(a)(1) of the Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, as amended by adding after paragraph (3) a new subsection as follows:

(4) if the Secretary publishes a final regulation that includes a provision that is not a substantive change, unless the Secretary determines that—

(i) the proposal is necessary to meet such circumstances. If the Secretary intends to vary such provisions to the publication of a final regulation, the Secretary shall cause to have published in the Federal Register notice of the different timeline established with respect to such regulation. Such notice shall include a brief explanation of the justification for such variation.

(f) Payment Methodology.—The Secretary shall establish an appropriate payment methodology for the provision of items and services under the demonstration project that includes a payment methodology that bundles, to the maximum extent feasible, payment for all such items and services.

(g) Waiver Authority.—The Secretary may waive compliance with the requirements of title XVIII of the Social Security Act to the extent and for such period as the Secretary determines is necessary to conduct the demonstration project.
(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) **Regulatory Reform 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:

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(II) 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.
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(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a Medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the Medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contractor as of the date of expiration, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every five years.

(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among Medicare administrative contractors consistent with the provisions of this paragraph. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide public notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred, a description of the provisions and subparagraphs affected by such transfer, and contact information for the contractors involved).

(D) INCENTIVES FOR QUALITY.—The Secretary shall provide incentives to Medicare administrative contractors to provide quality service and to promote efficiency.

(E) PERFORMANCE 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 liabilities, knowledge of services covered, and other matters as the Secretary finds pertinent.

(2) CONSULTATION.—In developing contract performance requirements, the Secretary shall develop performance requirements applicable to functions described in subsection (a)(4).

(B) CONSULTATION.—In developing such requirements, the Secretary may consult with the Medicare administrative contractors, organizations representing individuals entitled to benefits under part A or enrolled under part B, and other appropriate organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements.

(C) CONTRACTS.—All contract 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 about the Medicare administrative contractor as the Secretary may find necessary in performing his functions under this title; and

(B) to maintain such records and afford such access to the records of such contractor as the Secretary may find 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 shall contain a provision obligating the contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or any other person required before the execution of the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

(6) TERMINATION.—The Secretary shall, in terminating a contract under this section, either—

(A) provide that the contractor shall pay the Secretary, in an amount sufficient to cover the expenses incurred by the contractor under the contract, less the amounts otherwise allowable, reasonable, or allocable, or

(B) extinguish such contract in whole or in part.

(7) CONFIDENTIALITY.—A contractor or other person described in subparagraph (A) shall maintain the confidentiality of information collected, used, or disclosed by the Secretary to administer this title, except that such information shall be disclosed—

(A) to the extent authorized by this title; or

(B) to any judicial or administrative proceeding (relating to the claims administration process) who is made a party to such proceeding, unless the Secretary determines, after reasonable notice and opportunity for hearing, that disclosure of such information is otherwise allowable, reasonable, or allocable.

(8) COMPLAINTS.—A complaint alleging a violation of the provisions of this section shall be referred to the Secretary for investigation and action.

(F) 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 Regulation.

(G) CONSTRUCTION OF PARTS.—Nothing in this title shall be construed to modify, amend, or affect any other part of this Act, other than this title, and nothing in this title shall be construed to modify, amend, or affect any other part of this Act, other than this title.

(H) ASSUMPION OF RISKS.—The Secretary shall not be liable for any claim arising from or relating directly to the performance of the functions described in subsection (a)(4) to the extent that the contractor assumes the risks associated with such performance, except that the Secretary shall be liable for any claim arising from or relating directly to the performance of the functions described in subsection (a)(4) if the contractor fails to assume or distribute such risks.

(I) MAINTENANCE OF EVIDENCE.—A Medicare administrative contractor shall maintain such books, records, and other evidence as the Secretary may require to assure the correctness and completeness of payments by the contractor under this section.

(2) CONTRACT REQUIREMENTS.—To the extent practical, the Secretary shall establish a uniform provision in contracts entered into under this section that requires the Medicare administrative contractor (or a person who is made a party to any proceeding described in such subparagraph as a certifying officer) to defend (including indemnifying the Secretary to be criminal in nature, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to any such proceeding before the Secretary finds that such costs arose directly from such conduct, the contractor shall reimburse the Secretary for costs of indemnification.

(3) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (B)(i)), 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 is 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 Regulation.

(F) CONSTRUCTION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1872(b)(1) 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 benefits), and section 1842(b)(2)(B) of such Act (relating to timely review of determinations) and section 1874A with respect to the administration of such 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 payment by such officer under this section if it was based upon an authorization that meets the applicable requirements for such internal controls established by the Comptroller General of a certifying officer designated as provided in paragraph (3) of this subsection.

(G) 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 officer under this section if it was based upon an authorization that meets the applicable requirements for such internal controls established by the Comptroller General of a certifying officer designated as provided in paragraph (3) of this subsection.

(B) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of section 3729 through 3731 of title 31, United States Code (commonly known as the 'False Claims Act').

(C) 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 contractor 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 necessary, enter into a settlement with such 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 or administrative proceeding to be fraudulent, fraudulent, or grossly negligent. If indemnification is provided by the Secretary with respect to any such proceeding before the Secretary finds 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 (B)(i)), and costs (including reasonable legal expenses).
(B) by striking "such agency or organization" and inserting "such medicare administrator" each place it appears.
(7) Subsection (l) is repealed.
(c) CONFORMING AMENDMENTS TO SECTION 1874(a)(1) RELATING TO CONTRACTS.—Section 1874(a)(1) (42 U.S.C. 1395uu(a)(1)) 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 "contractors and" and inserting "medicare administrative contractors and";
(iii) in subparagraph (D), by striking "and shall contain" and inserting "shall contain and";
(iv) in subparagraph (E), by striking "the Secretaries" and inserting ""the contractors"; and
(v) in subparagraph (H), by striking ""the contractor"" each place it appears.
(4) Subsection (c) is amended—
(A) by striking paragraph (1);
(B) in paragraph (2)(A), by striking "contractor having a contract under section 1874A of such Act", and inserting "medicare administrative contractor having a contract under section 1874A of such Act", and all references to the Secretary under such section (a) and inserting "medicare administrative contractor having a contract under section 1874A of such Act", and all references to the Secretary under such section (a) and inserting "medicare administrative contractor having a contract under section 1874A of such Act";
(C) in paragraph (3)(B)—
(i) by striking "carrier" and inserting "medicare administrative contractor";
(ii) by striking "carrier" and inserting "medicare administrative contractor" each place it appears;
(iii) by striking "carrier" and inserting ""the contractor"" each place it appears; and
(D) in paragraphs (5)(A) and (5)(B)(iii), by striking "licensing agreements (L), by striking "and shall contain" and inserting "shall contain and";
(E) in paragraph (6), by striking "carrier" and inserting "medicare administrative contractor"
(F) in paragraph (7), by striking "the carrier" and inserting "the secretaries" each place it appears.
(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 Secretaries"; and
(ii) by striking "Each such carrier" and inserting ""The Secretaries"; and
(B) in paragraph (3)(A) (relating to determining and making payments) shall be necessary to implement such amendments.
(R) 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 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.

(1) REQUIREMENTS FOR INFORMATION SECURITY.—
(A) GENERAL.—Section 1874A, as added by section 911(a)(1), is amended by adding at the end the following new subsection:
(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to in such provisions.
(C) CONSTRUCTION FOR FUTURE CONTRACTS.—Such amendments shall not apply to contracts in effect on or after October 1, 2010.
(D) WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—During the period beginning on the date of enactment of this Act and before the date specified under subsection (l), the Secretary may enter into new agreements under section 1816 of title XVIII of the Social Security Act (42 U.S.C. 1395f-16), without regard to any of the provider nomination provisions of such section.
(R) 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. 1395f-16, 1395p) to contracts under section 1874A, as added by subsection (a)(1).
(3) AUTHORIZING CONTINUATION OF MIP FUNCTIONALITIES.—The provisions contained in the exception in section 1893(c)(2) of the Social Security Act (42 U.S.C. 1395ccc-2(c)(2)), notwithstanding the amendments made by this section, and any reference in such provi-
"(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). In addition to such evaluations under this title and an assessment of compliance with the requirements of this subsection and related information security policies and guidelines, including policies and procedures as may be prescribed by the Director of the Office of Management and Budget and applicable implementing guidance 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 function referred to in paragraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1856 or 1842, the first independent evaluation conducted pursuant to subparagraph (A) shall be completed prior to commencing such functions.

(ii) Ongoing Evaluation.—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 to paragraph (A) shall be completed within 1 year after the date the contractor commences functions referred to in clause (i) under this section.

(C) REPORT OF EVALUATION.—

(i) TO THE DEPARTMENT OF HEALTH AND HUMAN SERVICES.—The results of independent evaluations under subparagraph (A) shall be submitted promptly to the Inspector General of the Department of Health and Human Services and to the Secretary.

(ii) TO CONGRESS.—The Inspector General of the Department of Health and Human Services shall be submitted 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 354(c) of title 44, United States Code.

(b) APPLICATION OF REQUIREMENTS TO FISCAL INTERMEDIARIES AND CARRIERS.—

(1) IN GENERAL.—(A) Coordination of Education and Outreach Activities.—The provisions of section 1874A(f) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary and each carrier under section 1816 of such 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.

(C) Provider Education and Technical Assistance.—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 ON USE OF METHODOLOGY IN ASSESSING CONTRACTOR PERFORMANCE.—

(a) IN GENERAL.—Section 1874A, as added by section 911(a)(1) and as amended by section 912(a)(2), is amended by adding at the end the following new subsection:

"(f) Incentives to improve contractor performance.—

(1) IN GENERAL.—Section 1874A, as added by section 911(a)(1) and as amended by section 912(a)(2), is amended by adding at the end the following new subsection:

"(i) Incentives to improve contractor performance in provider education and outreach.—The Secretary shall use specific claims payment error rates or similar methodologies to determine if Medicare administrative contractors are taking steps to improve the accuracy, consistency, and timeliness of information provided or made available as required by this title.

"(ii) Incentives to improve contractor performance in identifying and addressing claims processing errors.—The Secretary shall use specific claims payment error rates or similar methodologies to determine if Medicare administrative contractors are taking steps to improve the accuracy, consistency, and timeliness of information provided or made available as required by this title.

"(iii) Incentives to improve contractor performance in provider education and outreach.—The Secretary shall use specific claims payment error rates or similar methodologies to determine if Medicare administrative contractors are taking steps to improve the accuracy, consistency, and timeliness of information provided or made available as required by this title.

"(iv) Incentives to improve contractor performance in identifying and addressing claims processing errors.—The Secretary shall use specific claims payment error rates or similar methodologies to determine if Medicare administrative contractors are taking steps to improve the accuracy, consistency, and timeliness of information provided or made available as required by this title.

"(v) Incentives to improve contractor performance in provider education and outreach.—The Secretary shall use specific claims payment error rates or similar methodologies to determine if Medicare administrative contractors are taking steps to improve the accuracy, consistency, and timeliness of information provided or made available as required by this title.

"(vi) Incentives to improve contractor performance in identifying and addressing claims processing errors.—The Secretary shall use specific claims payment error rates or similar methodologies to determine if Medicare administrative contractors are taking steps to improve the accuracy, consistency, and timeliness of information provided or made available as required by this title.

"(vii) Incentives to improve contractor performance in provider education and outreach.—The Secretary shall use specific claims payment error rates or similar methodologies to determine if Medicare administrative contractors are taking steps to improve the accuracy, consistency, and timeliness of information provided or made available as required by this title.

"(viii) Incentives to improve contractor performance in identifying and addressing claims processing errors.—The Secretary shall use specific claims payment error rates or similar methodologies to determine if Medicare administrative contractors are taking steps to improve the accuracy, consistency, and timeliness of information provided or made available as required by this title.

"(ix) Incentives to improve contractor performance in provider education and outreach.—The Secretary shall use specific claims payment error rates or similar methodologies to determine if Medicare administrative contractors are taking steps to improve the accuracy, consistency, and timeliness of information provided or made available as required by this title.

"(x) Incentives to improve contractor performance in identifying and addressing claims processing errors.—The Secretary shall use specific claims payment error rates or similar methodologies to determine if Medicare administrative contractors are taking steps to improve the accuracy, consistency, and timeliness of information provided or made available as required by this title.

"(y) Incentives to improve contractor performance in provider education and outreach.—The Secretary shall use specific claims payment error rates or similar methodologies to determine if Medicare administrative contractors are taking steps to improve the accuracy, consistency, and timeliness of information provided or made available as required by this title.

"(z) Incentives to improve contractor performance in identifying and addressing claims processing errors.—The Secretary shall use specific claims payment error rates or similar methodologies to determine if Medicare administrative contractors are taking steps to improve the accuracy, consistency, and timeliness of information provided or made available as required by this title.

"(b) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS OF SERVICES AND SUPPLIERS.—The Secretary shall use specific claims payment error rates or similar methodologies to determine if Medicare administrative contractors are taking steps to improve the accuracy, consistency, and timeliness of information provided or made available as required by this title.

"(c) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—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.

"(d) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

(4) REPORT ON USE OF METHODOLOGY IN ASSESSING CONTRACTOR PERFORMANCE.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report that describes the Secretary's methodology for assessing the accuracy, consistency, and timeliness of the information provided or made available as required by this title.

(B) DEVELOPMENT OF STANDARDS.—

(1) IN GENERAL.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided or made available as required by this title.

(2) EFFECTIVE DATE.—The Secretary shall, in consultation with organizations representing providers of services and suppliers, and individuals entitled to benefits under part A or enrolled under part B, establish standards relating to the accuracy, consistency, and timeliness of the information provided or made available as required by this title.

(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 provided or made available as required by this title.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect October 1, 2004.
Supplementary Medical Insurance Trust Fund] $25,000,000 for each of fiscal years 2005 and 2006 and such sums as may be necessary for succeeding fiscal years.

(2) The funds made available under paragraph (1) shall be used to increase the conduct of a Medicare contractor 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.—

(a) 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)).

(b) 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.

(c) Effective Date.—The amendment made by paragraph (1) shall take effect on October 1, 2005.

(d) Requirement to Maintain Internet Sites.—

(1) In General.—Section 1899, as added by subsection (a), as amended by subsection (d) is further amended by adding at the end of the following new subsection:

(d) Internet Sites; FAQs.—The Secretary shall enter into contracts with Medicare contractors 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 XIX insofar as it relates to such programs).''

(2) Effective Date.—The amendment made by paragraph (1) shall take effect on October 1, 2005.

(f) Additional Provider Education Provisions.—

(a) 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 subsection:

(e) Encouragement of Participation in Education Program Activities.—A Medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

(f) Construction.—Nothing in this section or section 1899(g) shall be construed as providing for disclosure by a Medicare contractor, or each Medicare contractor, 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 under section 1816 and a carrier with a contract under section 1849;

(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services or supplier that has no authority under this title or title XIX 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.

(g) Omnibus Budget Reconciliation Act of 1990.—The amendment made by paragraph (1) shall be used to increase the conduct of the demonstration program under section 1842.

Title II—Small Provider Technical Assistance Demonstration Program

SEC. 922. SMALL PROVIDER TECHNICAL ASSISTANCE DEMONSTRATION PROGRAM.

(a) Establishment.—The Secretary shall establish a demonstration program (in this section referred to as the "demonstration program") under this subsection that is designed to provide technical assistance to small providers of services or suppliers (as defined in paragraph (1)) 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).

(b) Requirements.—The technical assistance described in this paragraph is—

(A) evaluation and recommendations regarding billing systems, and

(B) information and assistance regarding policies and procedures under the Medicare program, including coding and reimbursement.

(c) 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.

(d) 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 1899(g)(1)(B) of the Social Security Act, as inserted by section 5(f)(1)(B) of P.L. 104-193) 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 investments of the entity's work by the Inspector General of Department of Health and Human Services or the Comptroller General of the United States.

(e) 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.

(f) Avoidance of Recovery Actions for Problems Identified as Corrected.—The Secretary shall avoid recovery actions for fraud and notwithstanding any other provision of law, any errors found in a compliance review for a small provider of services or suppliers that participated 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 preceding paragraph 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.

(g) GAO Evaluation.—Not later than 2 years after the date on which 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.

(h) 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 demonstration program) to be equal to 25 percent of the cost of the technical assistance.

(i) 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 1886(a)(2)(U.S.C. 181 et seq.) is amended—

(1) by adding at the end of the heading the following: "d; Medicare Provider Ombudsman;''

(2) by inserting "Practicing Physicians Advisory Council ("P.P.A.C.");" before "(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 title X (including provisions of title XI and those 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 provided 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;

(2) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

(A) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations to suspend or discontinue actions where there is widespread confusion in program administration),
“(B) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and supplies.

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

(b) Medicare Beneficiary Ombudsman.—

(1) Medicare Beneficiary Ombudsman. Title XVIII, as previously amended, is amended by inserting after section 1899 the following new section:

"MEDICARE BENEFICIARY OMBUDSMAN

SEC. 1899. (a) IN GENERAL.—The Secretary shall appoint within the Department of Health and Human Services a Medicare Beneficiary Ombudsman who shall have expertise and experience in the fields of health care and education of (and assistance to) individuals entitled to benefits under this title.

(b) Duties.—The Medicare Beneficiary Ombudsman shall:

(1) receive complaints, grievances, and requests for information submitted by individuals entitled to benefits under part A or enrolled under part B, or both, with respect to any Medicare program; and

(2) provide assistance with respect to complaints, grievances, and requests referred to in paragraph (1), including:

(A) assistance in collecting relevant information for such individuals, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, Medicare+Choice organization, or the Secretary;

(B) assistance to such individuals with any problems arising from disenrollment from a Medicare+Choice plan under part C; and

(C) assistance to such individuals in presenting information under section 1862–2(b)(4)(D) and (D) of the Social Security Act, or enrolled under part B of such title, or both, through the toll-free number 1-800-MEDICARE, including an assessment of whether the information provided is sufficient to inform such individuals.

In conducting the study, the Comptroller General shall examine the education and training of the individuals providing information through a toll-free number 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 in notices to beneficiaries that are included in the Medicare+Choice program that are issued after the date of the enactment of this Act, to 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.

SEC. 926. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN HOSPITAL DISCHARGE PLANS.

(a) Availability of Data.—The Secretary shall provide for a study to determine whether the information provided is sufficient to inform such individuals.

(b) By inserting before the period at the end the following:

"(B) the cost-effectiveness of providing beneficiary assistance through out-stationing Medicare specialists at local offices of the Social Security Administration.

SEC. 927. 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 a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (related provisions in title XI of such Act) are transferred from the respective Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(b) Transfer of 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 a 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, to the extent that the administrative law judgments transferred under paragraph (1) from the Centers for Medicare & Medicaid Services and its contractors are subject to supervision by, another other officer of the Secretary, but shall not report to, be subject to supervision by, another other officer 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 appropriate Act, the Secretary shall have authority to hire administrative law judges to hear such cases with respect to transfers of authority to the Department with prior experience in handling medicare and medicaid appeals and in a manner consistent with prior experience in handling medicare appeals and in a manner consistent with

(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 603 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–528), 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(f)(2) (42 U.S.C. 1395ff(f)(2)) as amended by BIPA, is amended—

(1) in paragraph (1)(A), by inserting "subject to paragraph (2) " before "for judicial review of directly appealable decisions";

(2) in paragraph (1)(F)—

(A) by striking clause (i);

(B) by striking "PROCEEDING" and all that follows through "DETERMINATION" and inserting "DETERMINATIONS AND RECONSIDERATIONS";

and

(c) by redesignating clauses (i) and (ii) as clauses (i) and (ii) and by moving the indentation of such clauses (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 of the Secretary, and that has been notified that the application for benefits has been denied, and (i) both, who has filed an appeal under paragraph (1) (D) 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 once only with respect to the 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 matter in controversy and that there is no material issue of fact in dispute and 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 from the receipt of 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 regulations relevant to the matter in controversy and that there is no material issue of fact in dispute and 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 the 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 a motion brought jointly by more than one applicant, the judicial district in which the greatest number of applicants are located) or in the district court for the District of Columbia.

(iv) INTEREST ON AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is subject to an administrative law judge 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 by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or the purpose of reimbur syndrome due providers of services or suppliers under this Act.

(D) REVIEW PANELS.—For purposes of this subparagraph, a 'review panel' consisting of 3 members (who shall be administrative law judges, members of the Departmental Appeals Board, or qualified individuals described in subparagraph (A)) shall be established by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or the purpose of reimbursement due providers of services or suppliers under this Act.

(e) AUTOMATION OF 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 not 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 or suppliers described in subparagraph (A) 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)(B). 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.

(F) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

SEC. 933. 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—

(i) section 1819(b)(2) of such Act (42 U.S.C. 1395d–3(h)(2)(B) which is applied on an immediate basis, has been imposed. Under such a process such proceedings shall be provided in cases of termination.

(2) 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 (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums as may be necessary for fiscal years 2005 and each subsequent fiscal year as may be necessary.

The purposes for which such amounts are available include increasing the number of administrative law judges (and their staffs) and the appellate level staff at the Departmental Appeals Board of the Department of Health and Human Services and educating such judges and staffs on long-term care issues.

SEC. 934. REVOCATION OF MEDICAID AND MEDICARE AGREEMENT DETERMINATIONS.—

(1) REQUIREMENT FOR DETERMINATION.—

(A) IN GENERAL.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1), as added by BIPA and as amended by section 302(a) of the Social Security Act Amendments of 2000 (Pub. L. 106–117), is amended—

(i) by striking "(II)";

(ii) in clause (i)(II), within 60 days of the date of the determination described in such subparagraph; or

(iii) clause (iii)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

(B) By striking clause (ii) and clause (iii) and 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 precludes the introduction of the evidence at or before that reconsideration.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 1998.

(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, the notice shall include—

“(A) the specific reasons for the determination, including the clinical or scientific evidence used in making the determination;

“(B) the procedures for obtaining additional information concerning the determination; and

“(C) notification of the right of the individual entitled to benefits under part A or enrolled under part B, or both, and shall include—

“(i) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

“(ii) the procedures for obtaining additional information concerning the decision; and

“(iii) notification of the right of 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)(B) (42 U.S.C. 1395ff(c)(3)(B)) 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 FOR 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.—(1) 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; and

“(iii) does not have a material familial, financial, or professional relationship with such a party.

(II) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in this paragraph 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 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 adding 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;”;

“(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—

“(i) shall meet the qualifications in paragraph (4) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of services as a reviewer (allopathic or osteopathic), each reviewing professional shall be a physician (allopathic or osteopathic).

(2) INDEPENDENCE.—

“(A) IN GENERAL.—Subject to paragraph (4), a reviewing professional 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;

“(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 any decision rendered by the contractor or by any reviewing professional.

(4) LICENSURE AND EXPERTISE.—Each reviewing professional—

“(A) shall be a physician (allopathic or osteopathic) who is appropriately credentialed or licensed in one or more States to deliver health care services 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 for services or goods under part B, or both, any of the following:

(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, or employee of the Centers for Medicare and Medicaid Services, or of such contractor.

(B) The individual (or authorized representative) involved in the case.

(C) The entity which provided the services or goods in the case.

(D) An individual or entity that is related to the individual or entity involved in the case.

(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 regulation to have a sufficient interest in the case involved.

(3) REDUCING MINIMUM NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1893(c)(4) (42 U.S.C. 1395f(c)(4)) is amended by striking ‘‘12 qualified independent contractors under this subsection’’ and inserting ‘‘with a sufficient number of qualified independent contractors (but fewer than 4 such contractors) to conduct re-

frames applicable under this subsection’’.

(42 U.S.C. 1395h) and a carrier under section 912(b), 921(b)(1), and 921(c)(1), is further amended by striking ‘‘with a sufficient number of qualified independent contractors under this subsection’’ and inserting ‘‘with a sufficient number of qualified independent contractors under this subsection’’.

(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 1897A(a)(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.

(a) IN GENERAL.—Section 1893 (42 U.S.C. 1395f) is amended by striking subparagraphs (A) and (B) and inserting ‘‘(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, or employee of the Centers for Medicare and Medicaid Services, or of such contractor.

(B) The individual (or authorized representative) involved in the case.

(C) The entity which provided the services or goods in the case.

(D) An individual or entity that is related to the individual or entity involved in the case.

(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 regulation to have a sufficient interest in the case involved.’’

(h) CONDUCT OF PREPAYMENT REVIEW.—

(1) IN GENERAL.—The carriers and fiscal intermediaries conducting random prepayment reviews shall develop and conduct random prepayment reviews of claims as if determined to be appropriate by the Secretary.

(2) LIMITATION ON RECOUPMENT.—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.

(3) RELATION TO NO FAULT PROVISION.—Nothing in this subsection 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 1899(c)(1), the Secretary may not take any action to recover any overpayment from such provider until the decision on the reconsideration has been rendered.

(B) COLLECTION WITH INTEREST.—Insofar as the determination on such appeal is adverse to the provider, any interest on the overpayment shall accrue on and after the date of the original notice of overpayment. Insofar as such determination is adverse to 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.

(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 defined by the Secretary by regulation);

(4) PROVISION OF SUPPORTING DOCUMENTATION.—In the case of a provider of services or supplier with respect to which amounts were overpaid, the Secretary may request the periodic production of records or supporting documentation for a
(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.—If a provider of services or supplier, after giving 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 account such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

(i) shall provide notice of such determination to the provider of services or supplier, including an explanation of the reason for such determination; and

(ii) in order to resolve the overpayment, may offer the provider of services or supplier—

(I) the opportunity for a statistically valid random sample; or

(II) a consent settlement.

The opportunity provided under clause (i)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

(D) Consent settlement defined.—For purposes of this paragraph, the term ‘‘consent settlement’’ means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to settle a projected overpayment based on less than a full and valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

(6) Notice of overutilization 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 as overutilized particular billing codes or procedures that may be overutilized by that class of providers of services or suppliers under the programs under this title (as defined in title XI insofar as they relate to such programs).

(7) Payment audits.—

(A) Written notice for post-payment audits.—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) Notification 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; and

(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);

(C) Exception.—Subparagraphs (A) and (B) shall not apply if the provision of notice to the contractor pending лица in 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)(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.

(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 establish the procedures for 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 establish a standard methodology for selecting claims for abnormal billing patterns under section 1893a(f)(8) of the Social Security Act, as added by subsection (a).

(c) Claim submissions.—

(1) In general.—Section 1893(d)(10)(D)(i) (42 U.S.C. 1395ww(d)(10)(D)(vi)) is amended by adding after subclause (ii) the following: ‘‘(1) an application for a change in enrollment (or resubmit) an application for a change described in section 1866(d)(10)(C)(i)(I) of the Social Security Act for fiscal year 2004 if the provider establishes to the satisfaction of the Secretary that the use of corrected or supplementary data under

(2) Effective date.—The amendment made by paragraph (1) shall apply to fiscal years beginning after June 26, 2003.
the amendment made by paragraph (1) would materially affect the approval of such an application.

(b) Application of Budget Neutrality.—If one or more of the hospital’s applications are approved as a result of paragraph (1) and subparagraph (A) for fiscal year 2004, the Secretary shall make a proportional adjustment in the amounts determined under section 1866(d)(3) of the Social Security Act (42 U.S.C. 1395ww(d)(3)) for fiscal year 2004 to assure that approval of such application does not result in an aggregate payment for fiscal year 2004 to assure that approval of such application does not result in an aggregate payment for fiscal year 2004 to assure that approval of such application does not result in an aggregate payment for fiscal year 2004 to assure that approval of such application does not result in an aggregate payment.

(2), under the process established under this section and that shall be applied by such contractor, any reference in section 1869(g) of such Act (as added by such amendment) 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 SRG.—For purposes of applying section 1841(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 program for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (5)) has been provided and in instances in which a beneficiary indicates on such a notice that the beneficiary does not intend to seek to have the item or service that is the subject of the notice furnished.

(2) Outreach and Education.—The Secretary shall establish a program of outreach and education for beneficiaries and providers of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the Medicare program.

(3) GAO Report on Use of Advanced Beneficiary Notices.—The Secretary 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 those procedures, and appeals of such determinations; or

(B) information concerning the number of prior determination requests and the reasons for those requests;
(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 for such visits is burdensome to physicians and beneficiaries.

(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term ‘advance beneficiary notice’ means a written notice furnished by the Secretary to allow for preparatory physicians (including both generalists and specialists) that would furnish the item or service and the term ‘beneficiary notice’ means a written notice provided under section 1395ww(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)) and lasts only for the duration of the pilot project and only as long as the provider is a participant in the pilot project.

(6) STUDY OF IMPACT.—Each pilot project shall examine the effect of the new evaluation and management documentation guidelines 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.

(f) DEFINITIONS.—In this section—
(1) the term ‘rural area’ has the meaning given that term in section 1861(s)(1) of the Social Security Act; and
(2) the term ‘observation setting’ means a setting that is not in an inpatient setting or an outpatient setting and does not involve the provision of health care services to the patient. Such setting includes a setting that is in a non-hospital facility.

SEC. 941. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT 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 a national advisory committee on physician services; and
(2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;

(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 in the subsection;

(2) LENGTH AND CONSULTATION.—Each pilot project under this subsection shall—
(A) be voluntary;
(B) be of such appropriate length as determined by the Secretary to allow for preparatory physicians and Medicare and Medicaid beneficiaries, whether it was timely, and whether the amount of information required for such visits is burdensome to physicians and beneficiaries.

(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 in accordance with the Peer Review Organization Program (as defined in section 1861(s)(10) of the Social Security Act).

(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;

(D) at least one shall be conducted in a setting where physicians bill under physicians’ services teaching settings and one of such projects shall be conducted in a teaching setting other than a teaching setting.

(E) ATTACHMENT OF PILOT PROJECT PARTICIPANTS.—Data collected under this subsection shall not be used as the basis for overpayment demands or post-payment audits except for 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.

(F) 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.

(G) CONSULTATION WITH PRACTICING PHYSICIANS.—The Secretary shall submit to Congress periodic reports on the results of the study under paragraph (1), 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 reduce the amount of time the physician spends with the patient.

(H) STUDY OF SIMPLER, ALTERNATIVE SYSTEMS OF DOCUMENTATION GUIDELINES 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 documentation guidelines 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.

(I) CONSULTATION WITH PHYSICIANS.—In designing and carrying out the study under paragraph (1), the Secretary shall consider any comments from physicians, including physicians who are part of group practices and including both generalists and specialists.

(J) 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.

(K) 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 submitted under paragraph (A) and 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 reduce the amount of time the physician spends with the patient.

(F) DEFINITIONS.—In this section—
(1) the term ‘rural area’ has the meaning given that term in section 1861(s)(1) of the Social Security Act; and
(2) the term ‘teaching settings’ are those settings described in section 415.150 of title 42 of the Code of Federal Regulations.
'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 payments, to receive such comments and recommendations (and data on which the recommendations are based); 

'iv) after such public hearing, the Secretary shall—

(i) set forth the criteria for making determinations under this subsection (A); and 

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

'D) The Secretary may convene such further public meetings to receive public comments and 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 and suggestions received from the public.

To this paragraph:

(i) The term 'HCP's' refers to the Health Care Procedure Coding System.

(ii) A code shall be considered to be 'substantially related' if it has a substantial change to the definition of the test or procedure to which the code applies (such as a new analytic or a new methodology for measuring an existing specific test).

(iii) The Telecommunications Study of the 10th Revision, Procedure Coding System ('ICD-10-PCS'), and the International Classification of Diseases, 10th Revision, Procedure Coding System ('ICD-10-PCS') as a standard under this part for the reporting of diagnoses, the Secretary may implement ICD-10-PCS as a primary source to facilitate improved communication with Medicare beneficiaries and other patients, 

'iv) the procedure or other process for each such code, together with an explanation of the reasons for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

'v) the procedure or other process for each such determination, the data on which the determinations are based, and responses to comments and suggestions received from the public.

'E) For purposes of this section, the Secretary shall—

(i) set forth the criteria for making determinations under this subsection (A); and

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(iii) The Secretary may convene such further public meetings to receive public comments and suggestions received from the public.

(iv) The Secretary shall—

(a) set forth the criteria for making determinations under this subsection (A); and

(b) make available to the public the data (other than proprietary data) considered in making such determinations.

(v) The Secretary may convene such further public meetings to receive public comments and suggestions received from the public.

(f) The Secretary shall—

(i) set forth the criteria for making determinations under this subsection (A); and

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(g) The Secretary may convene such further public meetings to receive public comments and suggestions received from the public.

(h) The Secretary shall—

(i) set forth the criteria for making determinations under this subsection (A); and

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(iii) The Secretary may convene such further public meetings to receive public comments and suggestions received from the public.

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) that would constitute a violation of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-191) or otherwise interfere with patient rights afforded by law.

(b) REIMBURSEMENT.—The Secretary shall—

(i) set forth the criteria for making determinations as to the reimbursement of items and services furnished by an independent laboratory.

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(iii) not less than 30 days after publication of such determinations, the Secretary shall—

(a) set forth the criteria for making determinations as to the reimbursement of items and services furnished by an independent laboratory.

(b) make available to the public the data (other than proprietary data) considered in making such determinations.

SEC. 944. EMTALA IMPROVEMENTS.

(a) PAYMENT FOR EMTALA-MANDATED SCREENING AND DIAGNOSTIC TESTS.—

(1) IN GENERAL.—Section 1867(b)(4)(D) (42 U.S.C. 1395y(b)(4)(D)) is amended by inserting before the end the following new paragraph:

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall be effective on the date of the enactment of this Act.

(b) APPLICATION OF EMTALA.—

(1) IN GENERAL.—The Secretary shall not require a hospital to perform a medical screening examination in order to determine whether a patient is eligible for treatment or to determine the appropriate treatment for a patient who is eligible for treatment.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall be effective on the date of the enactment of this Act.

(c) GENERAL RESPONSIBILITIES.—The Secretary shall—

(i) set forth the criteria for making determinations as to the reimbursement of items and services furnished by an independent laboratory.

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(iii) not less than 30 days after publication of such determinations, the Secretary shall—

(a) set forth the criteria for making determinations as to the reimbursement of items and services furnished by an independent laboratory.

(b) make available to the public the data (other than proprietary data) considered in making such determinations.

(c) in determining the amount of reimbursement, the Secretary shall—

(i) set forth the criteria for making determinations as to the reimbursement of items and services furnished by an independent laboratory.

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(iii) not less than 30 days after publication of such determinations, the Secretary shall—

(a) set forth the criteria for making determinations as to the reimbursement of items and services furnished by an independent laboratory.

(b) make available to the public the data (other than proprietary data) considered in making such determinations.

(i) set forth the criteria for making determinations as to the reimbursement of items and services furnished by an independent laboratory.

(ii) make available to the public the data (other than proprietary data) considered in making such determinations.

(iii) not less than 30 days after publication of such determinations, the Secretary shall—

(a) set forth the criteria for making determinations as to the reimbursement of items and services furnished by an independent laboratory.

(b) make available to the public the data (other than proprietary data) considered in making such determinations.

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 representatives of the Administrator of the Centers for Medicare & Medicaid Services and the Inspector General of the Department of Health and Human Services and organized as follows:

(1) 4 shall be representatives of hospitals, including at least one public hospital, that have experience with the application of EMTALA and at least one hospital that have not been cited for EMTALA violations;

(2) 7 shall be practicing physicians drawn from the fields of emergency medicine, cardiology, obstetrics and gynecology, orthopedic surgery, neurosurgery, pediatrics or a pedi- atric subspecialty, obstetrics-gynecology, and psychiatry, with not more than one phy- sician from any particular field;

(3) 2 shall represent patients;

(4) 2 shall be staff involved in EMTALA investi- gations 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 shall be from a peer review organization, both of whom shall be from areas other than the regions represented under paragraph (4).

(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 hospital services;

(3) shall solicit comments and recommendations from hospitals, physicians, and the public regarding the implementation of such regulations and their application to hospital services;

(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 meet at the direction of the Secretary. The Secretary shall conduct at least one meeting each year and at such other times as the Advisory Group determines.

(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 group members in the Federal Register (within the Department of Health and Human Services or otherwise).

SEC. 946. Authorizing use of funds to core hospice services in certain circumstances.

(a) in general.—Section 1861(dd)(5) (42 U.S.C. 1395tbb(dd)(5)) is amended by adding at the end the following:

"(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated events that may result in high 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)(iii)(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 provided non-routinely and so infrequently so that the provision of such services directly would be impracticable or imposing an unnecessarily excessive burden.

(b) conforming payment provision.—Section 1814(i)(4) (42 U.S.C. 1395tbb(i)(4)) is amended by adding at the end the following new paragraph:

"(4) In the case of a hospice program that made the arrangements shall bill and be paid under this section.

(c) effective date.—The amendments made by this subsection (a) shall apply to hospices as of July 1, 2004.

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 paragraph (R), by striking "and"

(B) in subparagraph (S), by striking "or (ii) (where the service was provided in a contractual arrangement between such physician 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 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 the facility as defined in the Secretary to the entity if, under the contractual arrangement, the entity submits the bill for such service and the contract meets such other program integrity and other safeguards as the Secretary may determine to be appropriate.

(c) effective date.—The amendments made by this subsection shall apply to payments made on or after the date of the enactment of this Act.

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 section:

"(h) Choice of contractor.—If the Secretary enters into a contract for the performance of dental services, the Secretary shall require the contractor to assure that the contractor is in compliance with the requirements of this section.

(c) effective date.—The amendments made by this subsection shall apply to claims submitted on or after the date of the enactment of this Act.

SEC. 951. furnishing hospitals with information to compute dsh formula.

Beginning not later than 1 year after the date of the enactment of this Act, the Secretary shall furnish to hospital as of July 1, 2004.

SEC. 952. revisions to reassignment provisions.

(a) in general.—Section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking "(ii) (where the service was provided in a contractual arrangement between such physician 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 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 the facility as defined in the Secretary to the entity if, under the contractual arrangement, the entity submits the bill for such service and the contract meets such other program integrity and other safeguards as the Secretary may determine to be appropriate.

(c) effective date.—The amendments made by this subsection shall apply to payments made on or after the date of the enactment of this Act.

SEC. 953. other provisions.

SEC. 954. reports on the physician compensation.

(a) in general.—Section 1842(b)(5) (42 U.S.C. 1395u(b)(5)) is amended by adding at the end the following new paragraph:

"(6) The Secretary shall conduct a study of the global market for the services provided by the physician in the section (f) of such section for 2002 and succeeding years. Such report shall examine the stability and predictability of such updates and rate and alternative uses for the purpose.

(b) effective date.—Not later than 12 months after the date of enactment of this Act.
the enactment of this Act, the Comptroller General shall submit to Congress a report on all aspects of physician compensation for services furnished under title XVIII of the Social Security Act and the extent to which hospitals interact and the effect on appropriate compensation for physician services. Such report shall review alternatives for the physician fee schedule under section 1848 of such title (42 U.S.C. 1395w-4).

(b) ANNUAL PUBLICATION OF LIST OF NATIONAL COVERAGE DETERMINATIONS.—The Secretary, in an appropriate annual publication available to the public, a list of national coverage determinations made under title X of the Social Security Act in the previous year and information on how to get more information with respect to such determinations.

(c)�能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 of 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 any set of criteria for monitoring the quality of care provided to such recipients.

(d) 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 requirements before they use the 60 lifetime reserve days described in section 1812(a)(1) of the Social Security Act (42 U.S.C. 1395l(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. 1001. IMPORTATION OF PRESCRIPTION DRUGS

(a) In General.—Chapter VIII of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 381 et seq.) is amended by striking section 384 and inserting the following:

"SEC. 384. IMPORTATION OF PRESCRIPTION DRUGS.

"(a) Definitions.—In this section:

(1) IMPORTER.—The term 'importer' means a person licensed by a State to practice pharmacy.

(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) an infused drug (including a peritoneal dialysis solution);

(B) an injectable drug; or

(C) a drug that is taken during surgery.

(4) QUALIFYING LABORATORY.—The term 'qualifying laboratory' means a laboratory in the United States that has been approved by the Secretary for the purposes of this section.

(5) WHOLESALER.—

(A) IN GENERAL.—The term 'wholesaler' means a person licensed by a State to distribute prescription drugs in the United States under section 201(a)(2)(A).

(B) EXCLUSION.—The term 'wholesaler' does not include a person authorized to import prescription drugs under section 801(a)(1).

(6) OIG 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 of the application of the medicare conditions of participation for home health agencies with respect to such determinations.

(c) LIMITATION.—The regulations under subsection (b) require that safeguards be in place to ensure that each prescription drug imported under the regulations complies with section 506 (including with respect to being safe and effective for the intended use of the prescription drug), with sections 501 and 502, and with other applicable requirements of this Act.

(d) INFORMATION AND RECORDS.—

(1) IN GENERAL.—The regulations under subsection (b) shall require that each importer of a prescription drug under these regulations (including the manufacturer) submit to the Secretary the following information and documentation:

(A) The name and quantity of the active ingredient of the prescription drug.

(B) A description of the dosage form of the prescription drug.

(C) The date on which the prescription drug is shipped.

(D) The quantity of the prescription drug that is shipped.

(E) The point of origin and destination of the prescription drug.

(F) The price paid by the importer for the prescription drug.

(G) Documentation from the foreign seller specifying—

(i) the original source of the prescription drug; and

(ii) the quantity of each lot of the prescription drug received by the seller from that source.

(H) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

(I) The name, address, telephone number, and professional license number (if any) of the importer.

(J)(i) In the case of a prescription drug that is shipped directly from the foreign recipient of the prescription drug from the manufacturer:

(1) Documentation demonstrating that the prescription drug was received by the recipient from the manufacturer and subsequently shipped by the first foreign recipient to the importer.

(II) Documentation of the quantity of each lot of the prescription drug received by the 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 imported shipment, documentation demonstrating that each batch of the prescription drug in the shipment was statistically sampled and tested by an independent laboratory.

(bb) In the case of any subsequent shipment, documentation demonstrating that a statistically valid sample of the shipment was tested for authenticity and degradation.

(2) MAINTENANCE BY THE SECRETARY.—The Secretary shall require that importations of prescription drugs being imported under subsection (b) be immediately suspended on discovery of a pattern of importation of that specific prescription drug or by that specific importer of prescription drugs being tested; and

(i) confirm that the labeling of the prescription drug complies with labeling requirements under this Act;

(ii) authenticate the prescription drug being tested; and

(iii) if the investigation is completed and the Secretary determines is necessary to ensure the protection of the public health or as a safeguard to protect the public health or as a means to facilitate the importation of prescription drugs, as the Secretary determines to be necessary.

(e) TESTING.—The regulations under subsection (b) shall require that testing described in subparagraphs (J) and (L) of section (b) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory.

(f) REGISTRATION OF FOREIGN SELLERS.—

Any establishment within Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment.

(g) FEDERAL INSPECTION 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 approved written authorization to the importer to use, at no cost, the approved labeling for the prescription drug.
"(i) Prohibition of Discrimination.—

"(1) IN GENERAL.—It shall be unlawful for a manufacturer of a prescription drug to discriminate against, or cause any other person to discriminate against, a pharmacy or other wholesaler that purchases or offers to purchase a prescription drug from the manufacturer or from any person that distributes a prescription drug manufactured by the pharmacy or other wholesaler.

"(2) Discrimination.—For the purposes of paragraph (1), a manufacturer of a prescription drug that discriminates against a pharmacy or other wholesaler if the manufacturer enters into a contract for sale of a prescription drug, places a limit on supply, or denies any other material that has the effect of—

"(A) providing pharmacists or wholesalers access to prescription drugs on terms or conditions that are less favorable than the terms or conditions provided to a foreign purchaser (other than a charitable or humanitarian organization) of the prescription drug; or

"(B) restricting the access of pharmacists or wholesalers to a prescription drug that is permitted to be imported into the United States under section 804(b).

"(j) Charitable Contributions.—Notwithstanding any other provision of this section, section 801(d)(1) continues to apply to a prescription drug, whether or not that drug 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 its affiliated organizations) or to a government of a foreign country.

"(k) Waiver Authority for Importation by Individuals.—

"(1) DECLARATIONS.—Congress declares that in the enforcement against individuals of the prohibition of importation of prescription drugs and devices, the Secretary should—

"(A) focus enforcement on cases in which the importation by an individual poses a significant threat to public health; and

"(B) exercise discretion to permit individuals to make such importations in circumstances in which—

"(i) the importation is clearly for personal use; and

"(ii) the prescription drug or device imported does not appear to present an unreasonable risk to the individual.

"(2) WAIVER AUTHORITY.—

"(A) IN GENERAL.—The Secretary may grant to individuals, by regulation or on a case-by-case basis, a waiver of the prohibition of importation of a prescription drug or device or class of prescription drugs or devices, under such conditions as the Secretary determines to be appropriate.

"(B) GUIDANCE ON CASE-BY-CASE WAIVERS.—The Secretary shall publish, and update as necessary, guidance that accurately describes circumstances in which the Secretary will consider granting waivers on a case-by-case basis under subparagraph (A), so that individuals may know with the greatest practicable degree of certainty whether a particular importation for personal use will be permitted.

"(3) Drugs imported from Canada.—In particular, the Secretary shall by regulation grant individuals a waiver to permit individuals to import into the United States a prescription drug that—

"(A) is imported from a licensed pharmacy for personal use by an individual, not for resale, in quantities that do not exceed a 90-day supply;

"(B) is accompanied by a copy of a valid prescription; and

"(C) is imported from Canada, from a seller registered with the Secretary.

"(D) is a prescription drug approved by the Secretary under chapter V;

"(E) is in the form of a final finished dosage that was manufactured in an establishment certified under chapter V; and

"(F) is imported under such other conditions as the Secretary determines to be necessary to ensure public safety.

"(j) STUDY.—

"(1) BY THE INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMY OF SCIENCES.—

"(A) STUDY.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct a study of—

"(i) the importations of prescription drugs made under the regulations under subsection (b); and

"(ii) information and documentation submitted under subsection (d).

"(B) 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, adulterated, or misbranded, and compare that number with the number of shipments made during the study period within the United States that are determined to be counterfeit, adulterated, or misbranded; and

"(iii) consult with the Secretary, the United States Trade Representative, and the Commissioner of Patents and Trademarks to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under federal law.

"(2) REPORT.—Not later than 18 months 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 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).

"(m) Construction.—Nothing in this section limits the authority of the Secretary to regulate the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

"(n) Effectiveness of Section.—

"(1) IN GENERAL.—If, after the date that is 1 year after the effective date of the regulations under subsection (b) and before the date that is 18 months after the effective date of the regulations under subsection (b), the Secretary submits to Congress a certification that, in the opinion of the Secretary, based on substantial evidence obtained after the effective date, the benefits of implementing this section do not outweigh any detriment of implementation of this section, this section shall cease to be effective as of the date that is 30 days after the date on which the Secretary submits the certification.

"(2) PROCEDURE.—The Secretary shall not submit a certification under paragraph (1) unless, not later than the date on which the Secretary submits to Congress the certification, the Secretary submits to Congress a report describing the findings of the study conducted under section 801(a).

"(o) Authorization of Appropriations.—

"(1) IN GENERAL.—This title may be cited as the "Greater Access to Affordable Pharmaceuticals Act".

"(2) CONFORMING AMENDMENTS.—The Federal Food, Drug, and Cosmetic Act is amended—

"(A) 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

"(B) 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)".

"(p) Title XI—Access to Affordable Pharmaceuticals

SEC. 1101. SHORT TITLE.

This title may be cited as the "Greater Access to Affordable Pharmaceuticals Act".

SEC. 1102. 30-MONTH STAY-OF-EFFECTIVENESS PERIOD.

(a) Abbreviated New Drug Applications.—Section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)) is amended—

"(1) in paragraph (2), by striking subparagraph (B) and inserting the following:

"(B) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—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 submission of the application; or

"(II) if the certification is in an amendment to a 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; and

(iii) **Recipient 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 holder designated to receive such a notice); and

(II) 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.

(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)(vi)”; 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 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—

(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 holder under subsection (b) or (c) on 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 is invalid or not infringed.”;

(bb) 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—

(aa) if the judgment of the district court is appealed, the approval shall be made effective on—

(1) the date on which the court enters judgment reflecting the decision;

(2) the date of a settlement order or consent decree signed and entered by the court stating 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) by striking clause (II) and inserting the following:

“I II 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—

(A) the date on which the court enters judgment reflecting the decision; or

(B) the date of a settlement order or consent decree signed and entered by the court stating that the patent is invalid or not infringed.”

(E) the date of a settlement order or consent decree signed and entered by the court stating that the patent is invalid or not infringed; or

(bb) by striking clause (II) and inserting the following:

“I II 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—

(A) the date on which the court enters judgment reflecting the decision; or

(B) the date of a settlement order or consent decree signed and entered by the court stating that the patent is invalid or not infringed.”

(bb) by striking clause (II) and inserting the following:

“I II 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—

(A) the date on which the court enters judgment reflecting the decision; or

(B) the date of a settlement order or consent decree signed and entered by the court stating that the patent is invalid or not infringed.”
be entitled to damages in a civil action

was approved; or

delete the patent information submitted by
the holder under subsection (b) or this sub-
section that on its face is sufficiently

a declaratory judgment under sec-

if the judgment of the district court is
not appealed or is affirmed, the approval
shall establish an actual controversy be-
tween the applicant and the patent owner

if the proceeding was commenced or is

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 subsection 505A,
or there is a 7-year period of exclusivity for the listed drug under section 527.

A drug that is granted tentative approval by the Secretary does not receive effective approval until the Secretary issues an approval after any necessary additional review of the application.

(iii) EFFECTIVENESS OF APPLICATION.—Sub-
ject to subparagraph (D), if the application contains a certification described in para-
graph (2)(A)(viii)(V) and is for a drug for which a first applicant has submitted an ap-
plication 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.

(D) FORFEITURE OF 180-DAY EXCLUSIVITY
PERIOD.—

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:

(ii) FAILURE TO MARKET.—The first appli-
cant fails to market the drug by the later of

(bb) with respect to the first applicant or
any other applicant (which other applicant
has received tentative approval), the date
is 75 days after the date as of which, as to such applicant, the requirements of this subparagraph are met.

(a) the earlier of the date that is—

"AA" 75 days after the date on which
the approval of the application of the first appli-
cant is made effective under subparagraph (B)(ii) or

"BB" 30 months after the date of submis-
sion of the application of the first applicant;
or

"CC" the patent expires.

(DD) The patent is withdrawn by the
holder of the application approved under sub-
section (b); or

"DD" IN GENERAL.—The term 'general
application' 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 subsection 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 does not receive effective approval until the Secretary issues an approval after any necessary additional review of the application.

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(iii) EFFECTIVENESS OF APPLICATION.—Sub-
ject to subparagraph (D), if the application contains a certification described in para-
graph (2)(A)(viii)(V) and is for a drug for which a first applicant has submitted an ap-
plication 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.

"BB" LIMITATION.—A drug that is granted tentative approval by the Secretary does not receive effective approval until the Secretary issues an approval after any necessary additional review of the application.

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"BB" LIMITATION.—A drug that is granted tentative approval by the Secretary does not receive effective approval until the Secretary issues an approval after any necessary additional review of the application.
to which that applicant submitted a certification qualifying the applicant for the 180-day exclusivity period.

"(IV) FAILURE TO OBTAIN TENATIVE APPROVAL.—If the drug application fails to receive 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 amendment 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 patent owner.—The first applicant enters into an agreement with another applicant under this subsection for the drug, the holder of the right to the listed drug for which the applicant obtained a certification qualifying it for the patents as to which the applicant submitted a certification described in 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 respect 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 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.

"(VII) 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.

"(VIII) SUBSEQUENT APPLICANT.—If all first applicants forfeit the 180-day exclusivity period under the provisions of paragraph (c)(1)(A)(i), by striking "(j)(5)(D)(ii)" each place it appears and inserting "(j)(5)(D)(i)" each place it appears.

"(IX) NO APPLICANT SHALL BE ELIGIBLE FOR A 180-DAY EXCLUSIVITY PERIOD.".

(b) EFFECTIVE DATE.—In general.—Except as provided in paragraph (2), the amendment made by subsection (a) shall be effective only with respect to the patents as to which the applicant submitted a certification described in paragraph (2)(A)(vii)(IV), the Federal Trade Commission Act (21 U.S.C. 355(j)) after the date of enactment of this Act (15 U.S.C. 45).

(c) AMENDMENTS.—The amendment made by subsection (a) does not alter the standard for determining whether a patent is valid, if the applicant relies on the patent in the litigated drug in safety and therapeutic effect.

"(d) EFFECT OF AMENDMENT.—The amendment made by subsection (a) does not alter the standards under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

1105. REMEDIES FOR INFRINGEMENT.—Section 287 of title 35, United States Code, is amended by adding at the end the following:

"(d) CONSIDERATION.—In making a determination as to whether infringement of a patent that claims a drug or a method of using a drug, 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.

"1106. CONFORMING AMENDMENTS.—Section 505A of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355a) is amended—

"(1) in subsections (b)(2)(A)(ii) and (c)(1)(A)(i), by striking "(j)(5)(D)(ii)" each place it appears and inserting "(j)(5)(D)(i)" each place it appears

"(2) in subsections (b)(2)(A)(ii) and (c)(1)(A)(i), by striking "(j)(5)(D)(ii)" each place it appears and inserting "(j)(5)(F)(ii)" each place it appears

"(3) in subsections (e) and (I), by striking "(j)(5)(S)(D)" each place it appears and inserting "(j)(5)(F)(ii)" each place it appears.

The SPEAKER pro tempore. Pursuant to House Resolution 299, the gentleman from New York (Mr. RANGEL) and the gentleman from Louisiana (Mr. TAUZIN) each will control 30 minutes.

Mr. TAUZIN. Mr. Speaker, I yield 15 minutes to the gentleman from California (Mr. THOMAS) or his designee, and ask unanimous consent that he may control that time.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California (Mr. THOMAS)?

There was no objection.

The SPEAKER pro tempore. The gentleman from New York (Mr. RANGEL) is recognized for 15 minutes.

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

The SPEAKER pro tempore. The statement made by the gentleman from Louisiana (Mr. TAUZIN) that we all are concerned about our older citizens and those that are to follow, and certainly we all have to appreciate the fact that it will be based on someone else’s shoulders, someone else who made the sacrifice, and I am very proud to share the responsibility of this bill with the gentleman from Michigan (Mr. DINGELL), who has dedicated his entire life, and his dad before him, in making certain that he and those of us who support him and what he believes in improves the quality of life not only of the seniors today.

It took us a long time to get where we are where people feel some degree of comfort that the Federal Government will be there for them, whether it is Social Security, whether it is Medicaid, whether it is Medicare. It has not been without the support of this government, this wonderful government which gave me the GI bill, this government which allowed older citizens to have some degree of pride in having Social Security to cushion themselves from poverty, and this government that provided health care for the very poor, and under Medicare we had hoped that we would have provided prescription drugs for them.

I do not know when this animosity came, or if the government, or we felt we had to starve these programs which some of us have been so proud of. Somebody asked how do you pay for your bill? This is a strange thing to ask, especially when the chairman of the Committee on the Budget is on the floor. He has been able to do magic with numbers over there. He started out with a $5.6 trillion surplus, and with magic converted it to a $3.4 trillion deficit. He can take $9 trillion and find a way to pay those cuts. Even tonight, some $173 billion, $300 billion just found last night, and we will get $400 billion from what they have allocated, but we think that it takes twice that much. How that asking to do, is that something that we have to go to the Committee on the Budget for and ask? Can you sprinkle your magic powder on us and make it possible for the older people to have prescription services? Is it asking too much to treat them, not that they are wealthy in dollars and cents, but they are wealthy in terms of the investment they made in this country to make it possible for the multi-generations that have to get the tax breaks that they are getting, and it seems to me since compassion is not there, that maybe we can look at it as a cost savings vehicle.

How many senior citizens will not have to go to the hospitals which are so expensive, how much of a part of our health expenses is a part of the institutions which our seniors are forced to go
into? If you have to make a decision and you are in doubt, why not make the doubt in favor of the senior citizens? Everything that is missing in the Republican bill that is good, we put in our bill to make certain that it is better.

One thing that we are saying is this, do not hate the government until you do not have any need for it. And senior citizens when they read the difference of the bills, and you bet your life they can read, they may be old but they are not stupid. Mr. Speaker, we pick up the newspapers, and if they do not go to the pharmaceutical corporations but rather go to the local drugstore, they will find out in short order who is their best friend.

Do not knock the government. It is not as bad as some Members think. Give the people an opportunity so that we can say citizens, we appreciate all that you have done for us, and we in the Congress believe that the least we can do is to go to the doctor that at least you will be able to get the drugs that are prescribed for your illness.

Mr. Speaker, I do not have to challenge each other's integrity, but I tell Members this, that there are Members on the other side of the aisle that hold Social Security in utter contempt. There are Members who talk about Medicare as though the communists created the package, and resented it when it started, and they think it is worse than ever today.

What I am saying is let us do what they tell doctors to do, and do no harm. Let us leave here saying that at least on this day there was a substitute, they did not have to do it the way the majority would want.

Mr. Speaker, I yield the balance of my time to the gentleman from California (Mr. Stark), the ranking member of the Subcommittee on Health, and I ask unanimous consent that he may further allocate that time.

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

Mr. WILSON of South Carolina asked and was given permission to speak out of order and to revise and extend his remarks.

Mr. WILSON of South Carolina. Mr. Speaker, it is with great sadness tonight that I announce that Senator Strom Thurmond passed away at 9:45. I was a former staff member of Senator Thurmond, my wife was a staff person for Senator Thurmond, and our three sons have been pages with his office.

With the death of Strom Thurmond, South Carolina has lost its greatest statesman of the 20th century, just as John C. Calhoun was the most revered South Carolinian of the 19th century. Strom Thurmond will never be replaced in the countless hearts of those who loved and respected him.

The entire Wilson family mourns this profound loss and we extend our sympathy to the Thurmond family.

Senator Strom Thurmond will endure as the leading example of a public servant due to his love and devotion to all the people of South Carolina regardless of status, race, politics or region.

He was our living legend. Strom's life was dedicated to achieving peace through strength, as shown by his military service in liberating Europe from Nazi fascists, his tireless work in fighting for the defense of our nation, and his 36 years in Congress which ultimately led to the defeat of Soviet communism.

He pioneered the development of the South Carolina Republican Party from effective nonexistence in the 1960s to majority status by the end of the century. He has been a role model of service to South Carolina's young people who look up to him and his family for three generations on his staff: my wife's two uncles were staff attorneys, my wife and I were interns, and our three oldest sons were pages. A distinguished highlight for our family was to host Senator Strom Thurmond and my wife before his last election in 1996 at the First Presbyterian Church in Columbia.

The legacy of Strom Thurmond will always be felt in South Carolina because of his steadfast integrity and the meaningful, thoughtful constituent service. He was my personal hero, and I will miss him dearly.

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

Let me join in expressing the sorrow of the folks in Louisiana for your loss in South Carolina. We will pray for his soul.

Mr. Speaker, the Democratic substitute in this debate can be summed up rather easily. According to CBO, it would save $200 billion. It busts the budget. Therefore, it is on the floor with a budget waiver. It at the same time excludes and does not contain any of the reforms that the base bill includes, that are designed to save Medicare from failure, from insolvency. I am not predicting Medicare's failure or insolvency. CBO is. CRS is. Everyone who has estimated the strength of our Medicare system predicts very soon, in our lifetimes, it will go insolvent. None of the reforms that are designed to save Medicare from insolvent are here. In fact, the Democratic substitute piles on a trillion dollars' worth of expenses to the Medicare system with no reforms to make sure the system is saved.

When I mentioned earlier that you ought to test the credibility of arguments on this floor by what is said and what is fact and what is of record, let me take you back to the statements of the distinguished gentleman from California when it voted on his base bill because CBO said it might mean that as much as 30 percent or so of employers might drop their retiree coverage under the base bill in favor of the plans we offer. CBO estimated the Democratic substitute, too, on that point.

How credible is an argument against the base bill that claims about a potential 30 percent loss of employer coverage when CBO estimates that 100 percent of employees might lose their retiree coverage under the Democratic substitute? That all taxpayer dollars will be used to substitute private dollars? And the Medicare system, already crushed and about to go into insolvent, will have to assume all that responsibility, too? If you really believe in Medicare, why would you burden it so? Why would you eliminate private coverage in America, as CBO estimates would happen under the Democratic substitute?

This substitute busts our budget. It purports to provide more drug coverage than the base bill but no reforms, it does not save Medicare; and on top of that it virtually eliminates private retiree coverage in America. Why would the majority favor that direction? We rejected that direction during the Clinton years when Mrs. Clinton presented us with one-size-fits-all health care for all Americans. We recognized then that if you do not have the competitive choice in America in health care, just as we do with so many other services, that things go bad in this country and that sooner or later the crushing weight of benefits added upon benefits added upon benefits means the working people of America have to pay more and more and more taxes. In fact, it is estimated that within 70 years, if we do not begin today making decisions like we ask the House to make, entitlements in America will eat up every tax dollar paid into the Treasury by every citizen in America, and we will have no money for any other function in this country. That is where this substitute takes us, and that is why we need to reject it.

Mr. Speaker, I yield myself 3 minutes.

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

Mr. DINGELL. My dear friends and colleagues, I lay before you the Republican plan. I ask you to look at it with a straight face, because it is inexplicable, and I cannot explain it to you with a straight face. The argument which was offered by my dear friend, the gentleman from New York (Mr. Rangel), on behalf of him and me, does the following things: it gives and sets forth a very clear set of benefits. Seniors citizens pay $25 a month; they get what you get if you get the Republican plan. But that is not the worst you get. If you are a senior citizen, you fall into a straight flat fee. After you get $2,000 in drugs that you get under the plan, all of a sudden your payments by the government stop; you have to keep on paying premiums, but you get no benefit.
until you have got $5,100. They are going to privatize your Medicare in the year 2010. That is pretty bad.

But it is followed by other things: massive subsidies to the insurance companies which commence in 2 years, in 2004, not all the way through 2006. You are guarantee to what it costs you in terms of what you have to pay in the way of premiums, no assurance that you will get any particular level of benefits. The only person who is going to cut the fat hog out of this deal are those good-hearted, flinty-hearted, cold-hearted folk in the insurance business who are going to all of a sudden get a key to the United States Treasury, the right to collect any amount of money they want, and to suck out the Secretary of HHS any old way they are minded and to walk home and to pay the money perhaps to the senior citizens but possibly to their shareholders or in dividends or perhaps to pay it in salaries or in bonus to the corporate officers. That is what you get under the Republican plan. And privatization of Social Security as you know it today.

The Republicans have said that they intend to privatize Social Security. Well, this is what is happening here. The Democratic plan compels the drug houses to negotiate with the Federal Government and the Secretary. The Republicans preclude him by absolutely not allowing him from negotiating. We do not tolerate under the Democratic plan the Republican opportunity to privatize Medicare. And just wait till your senior citizens find out what you are doing to them with privatization and substituting in lieu of this the kind of plan that you talk about where there is no assurance of protection for the senior citizens. The Republicans say the bill costs too much. Well, it pays some $800 billion to 40 million senior citizens. Just last week, without a gasp of shame, my Republican friends set it up so that 200,000 families got the same amount of money that is time when they are done after the senior citizens and not the fat cats that my Republican colleagues and friends look after.

Vote for the Democratic plan. Vote down the Republican plan. Let us take care of the senior citizens. It is the right thing to do.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself such time as I may consume.

Mr. Speaker, let us look at the facts behind the rhetoric here. What is going to be the impact of this Democratic substitute on seniors? My colleague from Louisiana just reminded us that 100 percent of employers are going to drop it. There is no one left to serve your senior citizens say to me when I go into senior centers it is, look, help those who need it, but do not destroy my employer-provided retiree plan. Do not touch it. This amendment destroys it, wipes it out. That is not in the interest of your seniors.

But let us look at what it will do to premiums. You were concerned that we did not sock a premium into law. Look what you do in your bill. You sock the premium into law and then you have it rise according to drug inflation. Drug inflation is double-digit. Do you not get it? Those premiums are going to be the same. Why would you do that to our seniors?

And let us look at the effect on prices. There is one thing seniors say to you over and over again, the prices are going to go up. According to Dr. Holtz-Eakin’s testimony of April 9, 2003, he says, “If you subsidize 90 percent of any insurance product versus 70 percent of the product, the larger subsidy will lead to a lower incentive to control costs and will lead to higher prices and higher spending.” Yours is a giveaway to the pharmaceutical industry. It will drive prices up because there is no incentive for the PBMs or the plan to negotiate prices down and they can say that it will not have the Government, because we are going to pay it all. Yours is going to drive prices up, premiums up and employer plans out of the market. I do not know why you think you are doing the seniors a good service.

And look at the impact on their kids, because they care about their kids and their grandkids. We have heard testimony over and over again that if you have a 10-year-old child, in 20 years when that kid is 30 and trying to pay back college loans, trying to buy a house, trying to get established, having to buy a car, that child will live in a Nation in which three-quarters of all the Federal revenues will go to Social Security, Medicare and Medicaid.

What is that child to do about education for their children? What is that young person to do to make a living? You should so much debt on the next generation that is for more dangerous than the one we have known. This is utterly irresponsible. It is so irresponsible that when the other body proposed this plan in the Senate the last session of Congress, they could not write a budget resolution because they did not know how to handle the extraordinary debt that this creates in the decades ahead. I urge my colleagues to think that something that looks pretty for your seniors, in fact, will be terrible for their health.

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

Mr. TAUZIN. Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. GREENWOOD), the chairman of the Oversight and Investigations Subcommittee of the Committee on Energy and Commerce.

Mr. GREENWOOD. Mr. Speaker, I thank the chairman of the committee for yielding me this time.

The gentleman from Michigan (Mr. DINGELL) and others have presented a chart earlier that purported to show what the American people should see. It is not complicated. It is a complicated issue to provide prescription drug benefits to millions of Americans who have never had them.

Let me show another chart that describes our plan and it is not complicated at all. Today a senior citizen walks in to a drugstore and wants to buy Lopressor, 100 milligrams. She has to pay, for 30 tabs, $45.99 right out of her pocket. Under our bill the price first comes down because the group purchasing power. It is $36.79 and then what does she pay? She pays $7.36 and if she is low income she pays $5. That is a big difference from $46.

We have introduced a substitute. Unlike your bill, ours has specific benefits. Your bill, I would remind the gentlewoman from Connecticut, has no benefit in it. It is all estimates. It is all examples. There is no benefit in your bill and indeed in our substitute there is. You have heard it. It is simple. It is $25 a month, 20 percent coinsurance, no gaps; and we pay out of pocket after $2,000.

Yes, you will say it costs a lot of money. The gentlewoman from Connecticut forgets about the $5.6 trillion surplus that Bush had when he came into office and which he squandered on tax cuts in the meantime. But we do have an income transfer as well have been accused of. It is very simple. You can look at it this way. You have given $800 billion to 10,000 of the richest families each year when you did away with the inheritance tax. No question about it. What is it costs. Those are the millions. We turn our money as an alternative and give it to what will be in a short 10 years 100 million seniors. What you have given away to the richest seniors in this country amounts to paying a drug benefit of the magnitude that we offer, a standard Medicare drug benefit, and I suggest that that is a transfer worth making and that that defines the difference between us.
Let us look at Lipitor. An awful lot of Americans take Lipitor every day to keep their cholesterol down. I do. It costs $108.65 today because for 40 years the Democrats did not do anything about prescription drugs and for 8 years President Clinton did not do anything about prescription drugs but under our plan Lipitor goes down to $86.92 because of our purchasing power, but the beneficiary pays $13.80. Mr. Speaker, I yield myself 15 seconds.

I hope my colleagues look at that chart because it has the same factual value as Alice in Wonderland. There is no requirement that any of those drugs be made available. There is no requirement that they be made available at any particular price or that they have to be made available under the plan at any particular cost because of cost sharing with the insurance.

Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from California (Mr. WAXMAN). Mr. WAXMAN. Mr. Speaker, today the House should be considering a Medicare prescription drug benefit for all America's seniors and disabled citizens that would be a benefit that is certain, a benefit that is affordable, and a benefit that helps Medicare beneficiaries get the drugs that they need to get well. It should not have large gaps in coverage as the Republican bill does. It should not let private insurance companies charge whatever premium they want and cover whatever drugs they want as the Republican bill does. It should be available in every part of the country, not only in areas where private insurers decide they can make a profit, and it should not cost seniors more if they live in Iowa instead of Virginia or California. Instead of Rhode Island. Most importantly, it should be a part of the Medicare program, just as dependable as the rest of the Medicare is for seniors and disabled people today.

The Republican bill fails all of these tests. It forces them on one hand and then takes them away when we read the fine print. It claims to give special help to America's low-income seniors so that they can afford to pay for the prescription drug program, but then it makes seniors subject to a detailed and invasive assets test before they can get help.

If they have over $6,000 in the bank, they do not get any help. When we figure out what they have got if they send money today, it is worth more than $4,500, and what car is not? They do not get any help. They count the value of the clothes and furniture and appliances if they are worth more than $2,000. They can even count the value of their car and if it exceeds $1,500. So instead of making sure people of very modest income who need help to get in, they get the fine print eliminating a lot of these people who should be helped, and it makes all of them go through a demeaning and complex process to prove they have few assets.

This chart is pretty straightforward and pretty simple. This demonstrates what happens when good-minded people do very hard work with very smart staff, employing very good ideas. We bring the price down to $63.17. The beneficiary pays $12.63 a month and, if she is poor, she gets $9.50.

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All this to get help with their drug expenses. This is just wrong. Instead of spending the public's money to get the best possible drug benefit, this Republican bill spends our dollars to bribe insurance companies to sell a drug plan. It pays for profits for the insurance companies instead of the bills for our seniors. What we should be doing is using the purchasing power of America's seniors, 40 million of them, to get good prices on their drugs as they do in Canada and get good coverage. That is what the Democratic substitute does. I urge my colleagues to vote for the Democratic substitute and against the Republican bill.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 2 minutes to the gentleman from Iowa (Mr. NUSSEL), a member of the Committee on Ways and Means, and who understands that spending money to provide a decent drug benefit for seniors is not wasting money.

Mr. NUSSEL. Mr. Speaker, I thank the gentlewoman for yielding me this time. I would like to know where the new Democrat budget hawks are tonight, those new birds who seemed to have flown the coop, who have spent the last many months here on the floor talking about the debt tax, something that does not exist but they have sure got a lot of ink about it. All sorts of national debt charts have been coming across the floor. In fact, they even one day used the pages, these young high school students, to demonstrate the national debt. But where are they tonight? Where are they when we read the letter from the Congressional Budget Office that says that their so-called substitute would add $1 trillion to the deficit? Where are they? They were on the floor two nights ago hear-ing about the deficit all of a sudden. In fact, what we heard about is that tax cuts have caused all of the problems.

In fact, one gentleman even had the audacity to stand up and act as though Washington hands money out for free, money left in the pockets of people that they earned. We do not hand money out. Money comes from them. And if you are going to waste it on a $1 trillion program, that not only does not fit within the budget that controls tonight but did not even fit within your substitute budget of just 4 months ago.

In fact, if we add the Democrat budget together with the budget that Congress passed, you bust not only the Republican budget, you bust the Democrat budget, but you bust both budgets combined. That takes a lot of work, to be able to bust both budgets and add $1 trillion to the deficit and have all of the new deficit money come from those new birds who seem to have lost their way and are going to be delivered in 45 minutes.

But when you come to the floor with $1 trillion that says in the same letter that all the employers are going to drop their coverage for retirees, 100 percent are going to drop their coverage, and you have the audacity to present that kind of substitute that busts both budgets, do not come here any more this year and talk about the deficit.

Mr. NUSSEL. Mr. Speaker, I yield myself 30 seconds.

I have the same letter, and it says nothing about employers dropping coverage.

Mr. Speaker, I yield 2 minutes to the gentleman from Washington (Mr. MCDERMOTT), a member of the Committee on Ways and Means, who understands that spending money to provide a decent drug benefit for seniors is not wasting money.

Mr. MCDERMOTT. Mr. Speaker, Members of the House and those listening to this, I think you ought to take a moment of paper right now and write this down. The premium is $25. The deductible is $100 a year. The coinsurance means you pay 20 percent, the government pays 80 percent for your drugs, and there is a cap on how much you can spend out of pocket, $2,000. That is written into our bill.

In contrast, we have this magic pill that has been given to us where the other side says trust us. Remember, these are the people who told us that the taxpayers were wagons that were going to lug our heavy burden of reconstruction in Iraq. They were right there. They were going to be delivered in 45 minutes. And, in fact, the President of the United States stood right here and
said, Mr. Speaker, that he believed that they had tried to buy uranium from Niger. It was known that that was a lie. It was known. So now they come out here with this drug bill and they say listen, we think it will be about $35 and maybe you will get this and maybe you will get that, but nothing is written down. I want the people to remember those four things.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. Hastings of Washington). The Chair reminds the Member not to make personal remarks regarding the President of the United States.

Mr. TAUZIN. Mr. Speaker, it is almost like Minister of Information Baghdad Bob just arrived here.

Mr. Speaker, I yield myself 2 minutes.

PARLIAMENTARY INQUIRY

Mr. McDermott. Mr. Speaker, Parliamentary inquiry.

The SPEAKER pro tempore. The gentleman from Washington (Mr. McDermott) is not in order since the gentleman from Louisiana (Mr. Tauzin) has the time and such a point may not challenge debate.

Mr. TAUZIN. Mr. Speaker, I want to illustrate one of the real inadequacies of the Democratic substitute. In the main bill we reformed something called average wholesale price. I hope everyone knows what that is. I am going to illustrate it for you tonight. Under the average wholesale price systems built into Medicare by the Democratic Party all these years, this is what happens. A person goes in for cancer therapy, a senior citizen, and the doctor needs a drug that costs $10, so the doctor buys a chemotherapy drug for $10. The patient ought to have to pay $2 under that, 20 percent co-pay under law. But that is not what happens. Under the average wholesale price system devised by Democratic administrations in the past under Medicare, this is what happens. The government has a phony average wholesale price posted. It might be $200 for that drug that only costs the doctor $10, and the poor patient has to put up 20 percent, not of the $10 but 20 percent of the $200. The patient puts up $40 for a drug that only costs the doctor $10 when the patient should have put up $2. That is called the average wholesale price system. It is rotten. It stinks. Our bill gets rid of it.

Mr. MCDERMOTT. Mr. Speaker, $2. That is called the average wholesale price. I hope everyone understands as I go through the whole process of how the Democrats have put us in debt, because you are borrowing from the trust fund and making Medicare insolvent, which is what my Republican colleagues have been doing here all the time. Why are they putting us in debt, because you are borrowing from the trust fund and making Medicare insolvent, which is what my Republican colleagues have been doing here all the time.

Mr. Speaker, do not sell out to the HMOs and the insurance companies. That is what you are doing. You are selling out by saying everybody has got to go into an HMO because you are in bed with the insurance companies. You are selling out to the pharmaceutical industry because you want no price reductions, because you are going to get some benefit from the pharmaceutical industry.

And then you come up with: this is complicated. The gentleman from Pennsylvania (Mr. Greenwood) said, oh this is complicated. There is nothing complicated here. It is simple. We have had the program for years. We just add the prescription drug benefit, and we have a negotiated price. It is very simple.

Do not give me this chart. I mean, look at this garbage. How could anyone possibly understand it? I cannot even understand it myself, and you expect me to understand it? You are making it complicated. You are destroying Medicare. Do not insult us as Democrats. We have been out there protecting it for years.

Mrs. Johnson of Connecticut. Mr. Speaker, it is my pleasure to yield 2 1/2 minutes to the distinguished gentleman from Wisconsin (Mr. Ryan), a member of the Committee on Ways and Means.

Mr. Ryan of Wisconsin. Mr. Speaker, thank the gentleman for yielding me this time.

Mr. Speaker, I want to calm down a little bit. There has been a lot of shouting around here, a lot of heated rhetoric, a lot of hyperbole. Let us just look at a couple of facts.

It is a fact that the Medicare actuaries are telling us that Medicare is going insolvent in 13 years. The entire HMO and insurance companies. It is a fact that if we add more money on top of Medicare without doing any reforms, you are going to accelerate the insolventcy of Medicare. We can try and speak those facts away, but the fact remains that those are facts.

Now, what this Democrat substitute does is it costs over $1 trillion. It accelerates the bankruptcy of Medicare. The basic assumption in this CBO estimate is that every employer providing private drug coverage for the retirees is going to drop it. And why would they not? Why would they not drop it if the Federal Government is going to pay for it all?
What the facts are is that this plan is going to accelerate the bankruptcy of Medicare.

Now, what are we trying to achieve with the Republican bill? Mr. Speaker, there are parts of this bill that none of us are proud of on our own behalfs. But what we are trying to achieve is not only modernizing this program so it works for today’s seniors by giving them cheaper drugs and coverage of drugs, but we are also trying to modernize this program and save it for the baby boomers.

We have 77 million retirees coming in this country starting in 15 years; and if we accelerate the bankruptcy of this program as the Democrats are proposing to do, it is not going to be there for them.

So what we are doing with these market-based reforms and giving seniors more choices? We are giving them the chance that this program will be solvent for the boomers when they retire. That’s what it’s all about. Make this thing work for the future. The future is now. The responsible thing to do is to make it work for today’s seniors, make it work, make it comprehensive, work on prescription drug prices, work on prescription drug coverage, but give seniors more choices, use competition, use the things that have worked in the past so we can save this program for the future.

Mr. STARK. Mr. Speaker, I yield myself self 30 seconds for a couple of housekeeping things.

In 13 years, the revenues start to decline, but it does not go insolvent for 24 years. And I say to the gentleman from Ohio (Mr. Nussle), if he has indeed the same letter that we are informed we have from CBO dated June 26, it says nothing in there about employers turning back Medicare, so he either misspoke or made it up, which, in my State, we call telling a lie. Unless he has a different letter, which I am assured by CBO he does not, then he made that up.

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

Mr. MENENDEZ. Mr. Speaker, I rise on behalf of my 84-year-old mother and millions like her across this country. She worked her entire life in the factories of New Jersey. Today she has Alzheimer’s and spends over half of her social security check on prescription drugs. If it was not for my sister and me, she would not be able to live with the dignity she deserves.

Now, this Republican package is wrapped in a label that says, “I care,” but when you open it up, it contains nothing more than an empty promise.

This Republican bill, which lacks the compassion promised by the President and expected from our doctors, millions of seniors who want to stay in traditional Medicare will have no choice and could essentially be forced into HMOs and left without the choices they deserve. This bill is the road towards privatizing Medicare.

Republicans just cannot help themselves. Once again, they have chosen corporate interests over human interests. America’s seniors deserve our respect. They have worked too hard, sacrificed too much to be forced to choose between paying their rent, putting food on the table, having access to life-enhancing drugs.

Support the Democratic substitute that has a real prescription drug provision under Medicare.

Mr. TAUMA. Mr. Speaker, I am pleased to yield 2 minutes to the gentleman from California (Mr. Cunningham), our fighter pilot commander extraordinaire.

Mr. CUNNINGHAM. Mr. Speaker, I had pneumonia about 5 years ago, and I went to pick up the prescription drug and I looked at it. It was 120 bucks. As I picked it up, I sat there and I thought, how does a family with three or four children afford 120 bucks per bottle of Augmentin to help them with the flu or antibiotics? That is a real fact. It is hard.

But Mr. Speaker, I say to the gentleman from Michigan (Mr. Dingell), does he know the cost of my prescription drug? It cost me $17. Because my wife worked with the Encinitas school district and she had insurance. That is what we want, is a private-public partnership for those people that cannot afford prescription drugs to help them. Over 1.4 million people in California will have no insurance whatsoever. But it will help them in our bill.

I think that your bill, with its costs, is devastating in the long run. It will not help.

If Democrats can demonize pharmaceutical companies, then what is left? The government. If you can demonize insurance companies, what is left for health care? Government-controlled health care. We rejected that in 1993 when the then First Lady offered it. I quote her, “The government controlled health care, and maybe that is the difference in us, because it will drive this country in debt.”

I talked to some people from Canada. Do my colleagues know where they go to get their health care? They come down to Buffalo, New York to get it, because it is so bad with their government-controlled health care.

Let us defeat the Democratic substitute and support the primary bill.

Mr. STUPAK. Mr. Speaker, I yield 2½ minutes to the distinguished gentleman from Michigan (Mr. Stupak).

Mr. STUPAK. Mr. Speaker, the Republican prescription drug plan is bad for America and even worse for rural America.

Today I sent around a letter to Members explaining exactly why this GOP bill shortchanges rural areas like Northern Michigan, which I represent. The Rangel-Dingell substitute ensures that rural areas are treated fairly. The Republican plan continues to put citizens in these areas at a huge disadvantage. The Rangel-Dingell bill goes far beyond the meager provisions for rural health care providers included in the GOP bill. Our bill, the Democratic plan, provides over $10 billion in additional relief for rural areas and removing the harmful Medicare privatization provisions that just have not worked in rural America.

Instead of helping seniors with their prescription drug plan, the Republican plan subsidizes private insurance companies. This plan tends to bribe private insurance companies to provide service in rural districts like mine. These insurance companies have come before our Committee on Energy and Commerce and have testified that they will not be providing the service, and the Republican plan just will not work.

If insurance companies do change their minds, there is nothing in this bill that will prevent them from shifting the added costs to our seniors. I had an amendment in the Committee on Energy and Commerce that would have prevented increases in the monthly premiums for seniors no matter where they live. But unfortunately, it was voted down on a party line vote.

The GOP plan has a huge gap in coverage and does nothing to reduce the inflated prices big drug companies are charging for prescription drugs. In fact, the Republican plan has a non-interference clause that says the Health and Human Services Secretary will not, will not be allowed to negotiate lower prices for Americans.

The Rangel-Dingell bill will ensure that every senior, regardless of where they live, will be able to obtain the prescription drugs and the quality of health care they require to live a healthy life. This coverage will be provided through Medicare. Democrats are working to strengthen this program, not to do away with it, as the gentleman from California (Mr. Thomas) called for when he said, and I quote him, ‘‘To those who say the GOP bill will end Medicare as we know it, our answer is: We certainly hope to. Thus, the real motive behind the GOP plan is to do away with Medicare. Democrats proudly stand behind Medicare. Support the Rangel-Dingell substitute.

Ms. Johnson of Connecticut. Mr. Speaker, I yield 2 minutes to the gentleman from Arizona (Mr. Hayworth), a member of the Committee on Ways and Means.

Mr. HAYWORTH. Mr. Speaker, I thank my friend from Connecticut, and she has visited Alaska. I know that the hour grows late and the debate grows heated and sometimes well-intentioned efforts from some are thrown in the confusion.

Mr. Speaker, I rise to urge this House to reject the Democratic substitute and to vote “yes” for H.R. 1 for reasonable, rational, clear-cut reform of Medicare that will bring Medicare into the 21st century with prescription drug coverage.

Mr. Speaker, we have read even tonight in Europe the development of a
cardiac drug that is estimated to cut heart attacks by 80 percent. We have made great gains in pharmacology; but we do not continue those gains, Mr. Speaker, if we opt for a trillion dollar travesty. And make no mistake, that is what the Rangel-Dingell substitute is offering to us this evening.

It was interesting, my friend from Iowa, who pointed out that the deficit hawks on the other sides had flown the coop. It is interesting, so many on the left who are so quick to indict folks higher on the economic scale tonight are strangely silent when we offer a plan where we give the priorities to those who need the help first.

The irony is, my friends on the left in the trillion dollars travesty section say, do not worry. Let us break the bank. Let the good times roll. Take command and control, put it together with a trillion bucks. No worries. But we know what would happen under that plan. It is a prescription for bankruptcy. Add this: a prescription to mortgage the future of the working families that my friends purport to support.

People of good will can have different opinions, and we certainly have them here in the House tonight. The question often comes down to this, when is enough enough? With the left it is never enough.

Reject insanity. Vote for rationality, “yes” to H.R. 1; “no” to the Democratic substitute.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The Chair would remind Members of the time remaining. The gentleman from Louisiana (Mr. TAUZIN) has 4½ minutes remaining and the right to close. The gentleman from California (Mr. STARK) has 3½ minutes remaining and would be next in line to close. The gentlewoman from Connecticut (Mrs. JOHNSON) has 5½ minutes remaining and would be second to close. The gentleman from Michigan (Mr. DINGELL) has 4½ minutes remaining and would be the first to close.

The Chair recognizes the gentleman from California.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Ohio (Mr. KUCINICH).

Mr. KUCINICH. Mr. Speaker, everyone in America knows the price of drugs is too high. Seniors know it best. The Rangel-Dingell substitute will bring down the cost of the drugs. It allows Medicare to buy drugs in bulk and negotiate for lower prices, which the VA already does. Skyrocketing drug costs are not only driving up health care costs more, but are causing seniors to make cruel choices between prescriptions and food, prescriptions and clothing. Some seniors are even splitting pills to make prescriptions last.

Seniors are crying out for help, but their pleas are drowned out by the cash registers humming away at the majority party headquarters, while insurance and pharmaceutical company lobbyists rush to the great Medicare sellout of seniors. It is time to stand up for seniors.

Yes, some of our friends are indeed trying to take care of people in their old age. Themselves.

Mr. TAUZIN. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, I want to point out that despite what you may have heard on the floor tonight, our basic package contains $27.2 billion of assistance to rural health care. That is the largest package of rural health care we have ever voted on all the times we have voted on Medicare prescription drugs.

Mr. Speaker, I yield 2 minutes to the gentleman from Michigan (Mr. UPTON), the chairman of the Subcommittee on Telecommunications and the Internet of the Committee on Energy and Commerce.

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

Mr. UPTON. Mr. Speaker, I have heard a lot of criticism tonight about this drug bill; and I want to remind all of us as we go back to our districts, as we have heard for so many years at our town meetings and so many events, America wants and needs a prescription drug program for our seniors. I remind all of our colleagues here tonight that this program is voluntary. You do not have to participate if you do not want to, but Americans will want to participate. They are going to participate.

Mr. Speaker, I want to relate a little story that happened to me in my district last summer. I was at my son’s little league game. A woman ran up to me as I was getting in my car and packing up the gear. She said, My mom just had a stroke. It will cost her $600 a month to survive. We never had that in our budget. What can we afford it? Is the plan that you passed last week, this was last year, is that going to help my mom? I put my hands on her shoulders and I said, Yes, I believe that it will. She will be able to benefit from this plan. You will be able to use the assets that you have and to have her survive in a meaningful way.

Yet, the other body never came back. The other body never came back with a plan and, in fact, that woman and her family were very distraught.

This is a plan tonight that can pass with bipartisan support, not only in this Chamber but the other Chamber on the other side of the Capitol. The other Chamber will have this bill. It is within the budget. No, it is not perfect. But we can take a step to help the woman that I had talked to last year as well as the thousands of people that have come to our town meetings over the course of the last number of years.

Mr. Speaker, I yield 1 minute to the gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, once upon a time in 1989, a group of Americans of all political persuasions and persuasions, including the powerful chairman of the House Committee on Ways and Means, into his car because they wanted him to know that they did not like the catastrophic health care bill. What happens to be on the front page of the Chicago Tribune in August of 1989. This was a bill that passed this body with overwhelming bipartisan support and all of the national senior citizens organizations supported the bill. There was only one problem. No one had checked in with rank-and-file seniors around the country who sat down with their calculators and they figured out what the benefit would be that they would get and how much it would cost them, and they did not like the answer.

Now, I show you this photo not to revive the debate on catastrophic because within a couple of months the bill was repealed, something very unusual and usually very difficult. I show you this photo as a warning. If you pass H.R. 1 tonight, you better also go out and buy some running shoes because senior citizens are too smart to be fooled by Republican speeches or anybody else’s speeches. They will figure out on their own what this bill does, which is, as the current chairman of the powerful House Committee on Ways and Means hopes, destroy Medicare as we know it.

Seniors will get out their calculators and figure it out.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 1½ minutes to the gentleman from Ohio (Mr. PORTMAN).

Mr. PORTMAN. Mr. Speaker, it has been a very interesting debate, too, as related to this debate tonight. We had 3 hours of good debate on the Republican legislation, the underlying bill which provides historic prescription drug coverage and does so within the budget. Now is the opportunity for the Democrats to talk about their substitute. So what is your idea? And you know what we are having? More discussion of the underlying legislation. Again, historic legislation to add prescription drug coverage that is within the budget.

The Democrats are not talking about their bill. It adds $1 trillion to the deficit. That busts our budget. It busts their budget. In fact, it busts both budgets combined.

The Democrat legislation does so by loading up the bill, not by helping those seniors who need it the most. The underlying legislation provides for 30 percent of the seniors that need it most, those under 150 percent of poverty, no deductions, no deductible, no cost sharing, no surprise copays. When you go to the pharmacy, total subsidy for the prescription drug coverage. Instead, the Democrat plan by going to a
trillion dollars would provide coverage for those who do not even need it. It sounds like what they accuse Republicans of.

I was really interested to see, when you look at page 12 of the Democrat bill, there is all sorts of things that are interesting. They say we do not provide guaranteed access. We do provide guaranteed access. The government actually steps in when there are not plans available, negotiates down the risk which increases coverage.

If you look at page 12, what does the Democrat plan do? It says, “The Secretary shall develop procedures to ensure coverage.”

That will give you some comfort. I can see why they are not talking about their legislation. I would not either.

Vote for the underlying bill. Vote down this substitute that they will not talk about.

Mr. STARK. Mr. Speaker, I yield myself 1½ minutes.

Mr. Speaker, just to straighten out some of the figures, the Republicans do indeed add $26.7 billion for rural providers and $1 billion for rural providers. That is $2.5 billion more, and I would hope that the Republicans are not lying to the seniors.

You can lie to us because we are used to it. The White House has set the tone for that. But do not lie to the seniors. There is nothing in your bill. I say to the gentleman from Ohio (Mr. PORTMAN), there is nothing in your bill that guarantees anything, and to say that to the seniors is lying to the seniors.

There is nothing in your bill that guarantees a thing to the seniors and you know it. And if you do not know it, read it again. Otherwise, you are lying to the seniors.

Our bill provides a Medicare benefit which is definable. Yours does not. You do not require any benefits if no insurance company steps up to the plate and there is nothing that requires it. There is not one line in your bill that requires any company to provide anything. So it is all a fantasy. At least we are requiring the government to provide a benefit to the seniors in the same manner they are now familiar, under Medicare with a determined premium, a determined deductible, determined benefits, the same across the country. None of that is available through the Republican bill. To tell the seniors otherwise is lying. You have lied to us tonight and stop lying to the seniors. I would support our substitute and vote down the great Republican lie.

Mr. DINGELL. Mr. Speaker, I have an inquiry as to time before I yield the balance of my time. I believe the gentleman from Illinois (Ms. SCHAKOWSKY) did not get the full 2¼ minutes that I yielded to her. I would like to know how much time I have left and how much I can properly yield the gentleman from Illinois.

The SPEAKER pro tempore. The gentleman from Michigan has 3 minutes remaining.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentlewoman from Illinois (Ms. SCHAKOWSKY).

Ms. SCHAKOWSKY. Mr. Speaker, I thank the gentleman from Michigan (Mr. DINGELL) for yielding me time.

Again, this is just a warning, a friendly warning to you that if you pass H.R. 1 tonight, you better also go out and get your running shoes because the seniors are too smart to be fooled by your proposal. And you can trash Medicare all you want. You can call it an outdated program, antiquated; but I do not know you and I do not believe.

I do believe that you love your mothers, but it is obvious to me that you do not call them enough. You do not go to senior centers enough. Not the ones I have gone to in my 5 years as director of the State Council of Senior Citizens. Seniors love their Medicare. The only thing they do not like is that it does not cover prescription drugs. And that is why if you are smart or out of shape will not cover prescription drugs. And that is why is why if you are smart or out of shape and not able to be chased by seniors, you will vote for the Rangel-Dingell substitute.

The Democratic substitute is what seniors have been asking for and what every politician has been promising them, an understandable, defined, dependable Medicare prescription drug benefit. It has all the features of Medicare that our seniors know and love, a set premium, no copayments.

Vote for the substitute or start running.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield 1½ minutes to the gentleman from Virginia (Mr. TOM DAVIS).

Mr. TOM DAVIS of Virginia. Mr. Speaker, I would like to engage in a colloquy with my colleague.

Can she confirm that the language in H.R. 1 includes plans under the Federal Employee Retirement Plan as an employment base plan?

Mrs. JOHNSON of Connecticut. Mr. Speaker, will the gentleman yield?

Mr. TOM DAVIS of Virginia. I yield to the gentleman from Connecticut.

Mrs. JOHNSON of Connecticut. Mr. Speaker, yes, that is correct.

Mr. TOM DAVIS of Virginia. This will allow OPM to take advantage of the subsidies in the bill just as other employees and unions will?

Mrs. JOHNSON of Connecticut. That is correct.

Mr. TOM DAVIS of Virginia. Mr. Speaker, I appreciate the gentleman’s and the chairman’s willingness to work with us on this issue. I think that allowing the subsidies H.R. 1 provides for will result in lower premiums and improved benefits for all FEHBP enrollees.

Mrs. JOHNSON of Connecticut. I thank the gentleman, and I look forward to working with the gentleman on this issue as the bill moves to conference.

Mr. TOM DAVIS of Virginia. Mr. Speaker, as I said, I appreciate the willingness of the gentleman to clarify that.

I have another concern, that Federal employees are often treated differently from current Federal employees in ways that are not always equitable. Retirees are different from current Federal employees. For example, current Federal employees are able to pay their health insurance premiums from pre-tax dollars. Federal retirees are not.

FEHBP currently does not provide different benefits for retirees and current employees. One is simply a member of FEHBP. I think it is important that this dynamic remain once a Medicare prescription drug benefit is put into place, whichever plan passes.

As chairman of the Committee on Government Reform, I look at this from an employer’s perspective. We do not want private employers to drop the prescription drug coverage they provide for their retirees. H.R. 1 provides incentives so that they will not do so, but we as the Federal Government have to lead by example.

I have introduced legislation that simply states that Federal retirees will continue to be treated on par with current Federal employees when it comes to prescription benefits. I regret we were unable to include this language in H.R. 1, but I am grateful to have the commitment of the Speaker and the majority leader to bring this bill to the floor as soon as we return from recess.

Mr. TAUZIN. Mr. Speaker, may I inquire how many minutes are left for each one of the four who have allocated time.

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Louisiana (Mr. TAUZIN) has 2 minutes remaining and the right to close. The gentleman from California (Mr. STARK) has 1 minute remaining and would be next to close. The gentleman from Connecticut (Mrs. JOHNSON) has 2½ minutes remaining and the gentleman from Michigan (Mr. DINGELL) has 2 minutes remaining.

Mr. TAUZIN. Mr. Speaker, we reserve the balance of our time. If anyone wants to use some more time at this time would be a good time to do it.

Mr. DINGELL. Mr. Speaker, I reserve the balance of my time, and I want to yield it to our leader.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I yield myself 30 seconds.

This is a historic evening. It is our opportunity tonight to provide prescription drugs to all seniors under Medicare as an entitlement and to do it in a way that is fair, simple and generous and sustainable. It is our opportunity tonight to modernize the benefit program under Medicare to deal with chronic care for our seniors, a big concern for them, and to structure Medicare in such a way that it will be sustainable, the dollars will be there and Medicare will be able to provide the health retirement security in the future that it has in the past.

I urge support of H.R. 1 and defeat of the substitute.
Mr. SPEAKER pro tempore. A quorum is not present.

The SPEAKER pro tempore. The call of the House.

The call was taken by electronic device, and the following Members responded to their names: [Roll No. 329]

ANSWERED "PRESENT"—421 Members have recorded their presence by electronic device, a quorum is not present.

Under the rule, further proceedings under the call are dispensed with.

MEDITERRANEAN SEA - The SPEAKER pro tempore.

The SPEAKER pro tempore. The call of the House.

Our great Nation was founded, and has here this evening on a very serious point.

I think this is far too serious, this business programs that you do not like. The Republicans are in charge. We have publicly proclaimed you are proud of it. I think some of you, and I have seen it, have publicly proclaimed you are proud of it. My dilemma is, why would you want to do what you are doing to try to influence this by public money in the business, and what would you want to see happen here this evening. As I said earlier, the Republicans are in charge. We do not want to see you do what you are trying to do tonight and turned it over to my generation. I had a little remark in there, but I am not going to use it because I think this is far too serious a business, and we took up this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge. We do not want to see what happened here this evening. As I said earlier, the Republicans are in charge.