The House met at 10 a.m.

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

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

PLEDGE OF ALLEGIANCE

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

Mr. COOPER, led the Pledge of Allegiance as follows:

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

MESSAGE FROM THE SENATE

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

H.R. 825. An act to redesignate the facility of the United States Postal Service located at 7401 West 100th Place in Bridgeview, Illinois, as the "Michael J. Healy Post Office Building".

H.R. 917. An act to designate the facility of the United States Postal Service located at 1830 South Lake Drive in Lexington, South Carolina, as the "Floyd Spence Post Office Building".

H.R. 925. An act to redesignate the facility of the United States Postal Service located at 1859 South Ashland Avenue in Chicago, Illinois, as the "Cesar Chavez Post Office".

H.R. 961. An act to designate the facility of the United States Postal Service located at 141 Erie Street in Linesville, Pennsylvania, as the "James R. Merry Post Office".

H.R. 965. An act to designate the facility of the United States Postal Service located at 111 West Washington Street in Bowling Green, Ohio, as the "Delbert L. Latta Post Office Building".

H.R. 1055. An act to designate the facility of the United States Postal Service located at 1901 West Evans Street in Florence, South Carolina, as the "Dr. Roswell N. Beck Post Office Building".

H.R. 1368. An act to designate the facility of the United States Postal Service located at 7704 Pacific Avenue in Stockton, California, as the "Norman D. Shumway Post Office Building".

H.R. 1465. An act to designate the facility of the United States Postal Service located at 4832 East Highway 27 in Iron Station, North Carolina, as the "Cesar Chavez Post Office Building".

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

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

S. 498. An act to authorize the President to posthumously award a gold medal on behalf of Congress to Joseph A. De Laine, in recognition of his contributions to the Nation.

S. 867. An act to designate the facility of the United States Postal Service located at 120 Baldwin Avenue in Paia, Maui, Hawaii, as the "Patsy Takemoto Mink Post Office Building".

ANNOUNCEMENT BY THE SPEAKER

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

WELCOMING RABBI MILTON BALKANY

(Mrs. KELLY asked and was given permission to address the House for 1 minute.)
Mrs. KELLY. Mr. Speaker, Rabbi Milton Balkany, Dean of Bais Yaakov in Brooklyn, New York, is an acquaintance of mine. He has been an active participant and leader in the Jewish community in New York City for many, many years. Rabbi Balkany has worked hard to bring the community together in order to continue traditional religious and cultural values. Not only does he help younger generations understand the intrinsic and extraordinary Jewish culture to which they belong, but he also welcomes others of all religions to engage in prayer, meditation and community.

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

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

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

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

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

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

MEDICARE MODERNIZATION
(Mr. DEFAZIO asked and was given permission to address the House for 1 minute.)

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

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

HONORING THE 40TH ANNIVERSARY OF THE NATIONAL DRAFT GOLDWATER RALLY
(Mr. WILSON of South Carolina asked and was given permission to address the House for 1 minute and to revise and extend his remarks.)

Mr. WILSON. Madam Speaker, yesterday was the 40th anniversary of the National Draft Goldwater Rally held at the Washington National Guard Armory. I was honored as a young teenager to come on a bus from South Carolina with Senator Barry Goldwater. He founded the Republican Party, Drake Edens, Floyd Spence and Rudy DePass. This failed presidential campaign actually was spectacularly successful in launching a political revolution for limited government and expanded freedom. Especially in the South, the Republican conservatism has risen from virtual nonexistence to majority status on the local, State and Federal level.

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

In conclusion, God bless our troops.

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

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

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

Mr. PENCE. Madam Speaker, as Congress considers the prescription drug legislation today, I think it is important for all Americans to remember a few simple facts. This would be the biggest new federal entitlement since 1965 when Medicare was created.
Medicare currently costs seven and a half times what this Congress said it would cost when they invented it. Seventy-six percent of seniors in America today already have prescription drug coverage and according to the CBO under some versions of this legislation more than a third of those Americans who enjoy coverage from a private employer from whom they have retired could lose that coverage. If this legislation be destroyed, what can the righteous do? Let us not in this Congress today sow the seeds to destroy the foundation of a free market system by creating a universal drug benefit in Medicare. The answer is the reforms the President called for giving Americans the same choices that the Members of Congress have. It is not to create a massive new Federal entitlement.

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

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

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

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

INTELLIGENCE AUTHORIZATION ACT FOR FISCAL YEAR 2004

The SPEAKER pro tempore (Mr. BUTLER) of the House moved to suspend the rules and order the passage of the bill (H.R. 2417) to authorize appropriations for fiscal year 2004 for intelligence and counterintelligence-related activities of the United States Government, the Intelligence Community Management Account, and the Central Intelligence Agency Retirement and Disability System, and for other purposes, with Mrs. BIGGERT (Chairman pro tempore) in the chair.

The Clerk read the title of the bill.

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

SEQUENTIAL VOTES POSTPONED IN COMMITTEE OF THE WHOLE

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

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

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

HONORING SERGEANT JACOB BUTLER

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

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

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

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

AMENDMENT NO. 4 OFFERED BY HASTINGS OF FLORIDA

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

The Clerk will redesignate the amendment.

The text of the amendment is as follows:

Amendment No. 4 offered by Mr. HASTINGS of Florida: At the end of subtitle D of title III, insert the following new section:

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

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

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

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

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

The report shall include—

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

(e) DIVERSITY PLAN.—(1) Not later than February 15, 2004, the Director of Central Intelligence shall submit to Congress a report which describes the plan of the Director, entitled the “DCI Diversity Strategic Plan”, and any subsequent revision to that plan, to increase diversity of officers and employees in the intelligence community, including the short- and long-term goals of the plan.

The report shall also provide a detailed description of the progress that has been made by each element of the intelligence community in implementing the plan.

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

(f) DEFINITION.—In this section, the term “intelligence community” has the meaning given that term in section 34 of the National Security Act of 1947 (50 U.S.C. 401(4)).

RECORDED VOTE

The CHAIRMAN pro tempore. A recorded vote has been demanded.
A recorded vote was ordered. The vote was taken by electronic device, and there were—aye 248, no 106, not voting 15. The result of the vote was announced as above recorded.

## New Section: Prevailed by Voice Vote

The CHAIRMAN pro tempore. The CHAIRMAN pro tempore. This will be a 5-minute vote. The vote was taken by electronic device, and there were—aye 248, no 106, not voting 15. The result of the vote was announced as above recorded.

### Amendment No. Offered by Mr. Kucinich

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

### The text of the amendment is as follows:

- Amendment No. 5 offered by Mr. KUCINICH: At the end of title III, add the following new section:

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

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

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

## Recorded Vote

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

The CHAIRMAN pro tempore. This will be a 5-minute vote. The vote was taken by electronic device, and there were—aye 248, no 106, not voting 15. The result of the vote was announced as above recorded.

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**NOT VOTING—16**

<table>
<thead>
<tr>
<th>Ayes</th>
<th>Noes</th>
<th>Not Voting</th>
</tr>
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<tbody>
<tr>
<td>248</td>
<td>106</td>
<td>15</td>
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**ANNOUNCEMENT BY THE CHAIRMAN PRO TEMPORE**

The CHAIRMAN pro tempore (Mrs. BIGGERT) (d)uring the vote. The vote is remained there are 2 minutes remaining in the vote.
Ms. DE LAURO and Mr. REYNOLDS changed their vote from "aye" to "no." So the amendment was rejected.

The report of the vote was announced as above recorded.

AMENDMENT NO. 6 OFFERED BY MS. LEE

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

The Clerk will redesignate the amendment.

The text of the amendment is as follows:

Amendment No. 6 offered by Ms. LEE:

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

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

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

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

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

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

(d) REPORT.—Not later than 12 months after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall be submitted in unclassified form, but may contain a classified annex.

RECORDED VOTE

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

The recorded vote was ordered.

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

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

Abercrombie
Ackerman
Allen
Baca
Baird
Ballard
Balance
Becerra
Belen
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boesch
Boucher
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Cardin
Carson (IN)
Case
Clay
Clayburn
Costello
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeGette
DeHart
DeLay
Deutsch
DeVito
Doggett
Dodd
Dooley
Edwards
Emuel
Eshoo
Etheridge
Evans
Farr
Filner
Ford
Frank (MA)
Frost
Gonzalez
Green (TX)
Grijalva

AYES—185

Abercrombie
Ackerman
Allen
Baca
Baird
Ballard
Balance
Becerra
Belen
Berkley
Berman
Berry
Bishop (GA)
Bishop (NY)
Blumenauer
Boesch
Boucher
Brady (PA)
Brown (OH)
Brown, Corrine
Capps
Cardin
Carson (IN)
Case
Clay
Clayburn
Costello
Crowley
Cummings
Davis (AL)
Davis (CA)
Davis (FL)
Davis (IL)
Davis (TN)
DeGette
DeHart
DeLay
Deutsch
DeVito
Doggett
Dodd
Dooley
Edwards
Emuel
Eshoo
Etheridge
Evans
Farr
Filner
Ford
Frank (MA)
Frost
Gonzalez
Green (TX)
Grijalva

NOES—239

Aderhold
Akin
Alexander
Bachus
Baker
Ballenger
Barrett (SC)
Bartlett (MD)
Barton (TX)
Bass
Beauprez
Bellew
Biggers
Bilirakis
Bish (NY)
Blackburn
Blunt
Boehner
Bonilla
Bono
Boozman
Bradley (NH)
Brady (TX)
Brown (SC)
Burns
Burton (IN)
Buyer

[Roll No. 330]
Mr. GOSS. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days to revise and extend their remarks and include extraneous material on H. R. 2417. The SPEAKER pro tempore. Is there objection to the request of the gentleman from Florida?

There was no objection.

PROVIDING FOR CONSIDERATION OF MOTIONS TO SUSPEND THE RULES

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

The Clerk read the resolution, as follows:

H. RES. 297

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

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

Mr. LINDER. Mr. Speaker, for the purposes of debate on H. Res. 297, I yield the customary 30 minutes to the gentleman from Massachusetts (Mr. McGovern), pending which I yield myself such time as I may consume. During consideration of this resolution, all time yielded is for the purpose of debate only.

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

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

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

By way of background, when the House convened on January 7, 2003, we adopted H. Res. 5, the House rules for the 108th Congress. Specifically, clause 1 of rule XV provides that it is in order to the House to join with me in approving this measure.

H. RES. 297

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

The SPEAKER pro tempore. That during the remainder of the One Hundred Eighth Congress, the Speaker may entertain motions to suspend the rules on Wednesdays as though under clause 1 of rule XV.

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

Entertaining motions to suspend the rules on Wednesdays has been a valuable and helpful tool for the House leadership. In fact, just a few weeks ago, the minority showed how much clout they can have actually in defeating these suspensions when they opposed two Senate-passed public lands bills and both measures failed under suspension of the rules. Eventually, we brought both measures back to the floor, and the House adopted a unanimous consent agreement that the Committee on Rules would hold an emergency meeting an hour later to consider this bill, and we reported the rule at 5 a.m. this morning.

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

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

This process is awful, Madam Speaker; and this resolution will make it worse. The question is quite simple. Rather than naming more post offices to honor the brave who have served our nation, why not let the publicans need to force it through the House, then call it back, but please do not claim that this is fair and balanced when it is clearly not. Americans are better served with an open democratic process. It is in the public interest to allow the full and free debate and to have many people and many different points of view heard and considered by Members of the people's House.

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

Madam Speaker, I reserve the balance of my time.

Mr. FroST. Madam Speaker, I thank the gentleman from Georgia for yielding me this time, and I yield myself 5 1/2 minutes.

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

Madam Speaker, I am rising today to strongly oppose this resolution, and I urge my colleagues to vote "no" and defeat the resolution. I have serious concerns about not only the suspension process but also the way about this House is being managed. The suspension process should be reserved for noncontroversial items that do not require lengthy debate by the full House. Controversial issues or substantive issues should not be brought to the House floor under the suspension process; a process that allows little debate and no amendments. But, Madam Speaker, this House is becoming a place where trivial issues get debated passionately and important ones not at all. The majority of this House already allows a famous little debate on critical issues facing the American people. Later today, we will debate the most sweeping changes to Medicare since the program was created 38 years ago. Two days ago, I asked the chairman of the Committee on Rules when he could examine this hugely important bill, and I was told emphatically that it would be available online yesterday morning. So I got up early yesterday morning, and I logged on at home; but there was no bill. I checked again during the day, but again no bill. Finally at 11:50 p.m. last night, we were given a copy of the bill and told to withdraw it. I attended an emergency meeting an hour later to consider this bill, and we reported the rule at 5 a.m. this morning.

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

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

This process is awful, Madam Speaker; and this resolution will make it worse. The question is quite simple. Rather than naming more post offices to honor the brave who have served our nation, why not let the publicans need to force it through the House, then call it back, but please do not claim that this is fair and balanced when it is clearly not. Americans are better served with an open democratic process. It is in the public interest to allow the full and free debate and to have many people and many different points of view heard and considered by Members of the people's House.

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

Madam Speaker, I reserve the balance of my time.

Mr. FroST. Madam Speaker, I thank the gentleman from Texas (Mr. FroST), the ranking member on the House Committee on Rules.

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

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

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

Mr. McGOVERN. Madam Speaker, I yield 3½ minutes to the distinguished gentleman from Florida (Mr. HASTINGS), another member of the Committee on Rules, Mr. HASTINGS of Florida. Madam Speaker, I thank the gentleman from Massachusetts (Mr. McGOVERN) for yielding me this time. And the gentleman from Florida (Mr. FRANK), the ranking member who is a most distinguished member of the Committee on Rules, is very generous to my colleagues on other side when he says they will bring up nonsubstantive matters on the suspension calendar under the rule that is proposed now, to add a day where suspension matters of the rules can be brought to our attention.

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

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

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

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

My friend just mentioned the fact that measures that are considered under suspension of the rules are nonsubstantive and his concern is the fact that we may bring up substantive measures under suspension of the rules. The fact of the matter is major substantive matters should not come up under suspension of the rules. They can only pass if there is a two-thirds vote. The only requirement is that in fact 61 Democrats joined with every Republican to pass the measure. I thank the gentleman for yielding. I just wanted to make that clear.

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

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

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

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

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

Mr. McGOVERN. Madam Speaker, I yield 2 minutes to the distinguished member of the Committee on Rules until 5 a.m. this morning trying to amend this bill. I thought: “What a punitive process.” Yet this is how they are treating the American people, too. It will be harder on them than it was obviously on us staying up all night on this measure that is so vastly important to grandmothers, grandfathers, to older citizens across this country.

They want to privatize Medicare. They want to take this prescription drug benefit and put our seniors into Medicare HMOs. Try to find one that is so vastly important to grandmothers, grandfathers, to older citizens across this country. They want to privatize Medicare. They want to take this prescription drug benefit and put our seniors into Medicare HMOs. Try to find one that is so vastly important to grandmothers, grandfathers, to older citizens across this country.

So that brings us to where we are today trying to create a filibuster rule in the House. We are going to permit the Republican leadership to filibuster, to use our time, our valuable floor time, by bringing noncontroversial bills commending people for things they have done, naming facilities, all kinds of things. We used to just do those in a day or two. Now we are going to have 3 days of those bills and now, “Oh, by the way, we will not have any time for you to offer your amendment an extra day, we will not have any time for you to offer your amendment on prescription drugs. We have used up all our time. We have created another suspension day.”
person's drugs cost over $2,000 a year, well, it's just too bad. Seniors will have to pay between $2,000 and $4,000 for what they cannot afford. How many seniors earning $8,000 a year on Social Security can afford that?

Mr. LINDER. Madam Speaker, I yield now to the gentleman from Texas (Mr. GREEN).

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

Mr. LINDER. Madam Speaker, I yield 2 minutes to the gentleman from Texas (Mr. GREEN).
Mr. FRANK of Massachusetts. Madam Speaker, reclaiming my time, I thank the gentleman for confirming my point. He said the Clerk has read it twice. You have shrunk, as in sessions, and increased the amount for suspensions.

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

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

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

Well, here is what happens. In fact, the chairman of the Committee on Rules said previously, 25 years ago the Democrats went from 1 day to 2. That was 2 days out of 4 days. You have shrunk, as in sessions, and increased the amount for suspensions.

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Here is why: there are people on the Republican side who campaign in their own districts on one set of principles and then come here and enable exactly the opposite to become the law of the land. And here is how they do it. They say to people, oh, I would not vote on that. You can get a majority for the end result, the debate process gets collapsed; and whether or not there are amendments, whether or not there is any modification, that is not allowed.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

The point of no quorum is considered withdrawn.

RECESS

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

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

This rule provides for consideration of H.R. 1 under a modified closed rule, an appropriate rule for such a delicate, complex, and historic piece of legislation. The rule provides for three hours of general debate equally divided between the chairman and ranking minority members of the Committee on Energy and Commerce on the ways and means, and for the purposes of debate only.

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

Section 2 of this rule provides for the consideration of H.R. 2596, the Health Savings and Affordability Act of 2003, in the following order: first, the legislative day of June 26, or tomorrow, June 27, under a closed rule. The rule provides 1 hour of general debate in the House equally divided and controlled by the chairman and ranking minority member of the Committee on Ways and Means; and 1 motion to recommit.

Since 1965, Medicare has provided a guarantee of health care coverage for more than 40 million seniors. Today, our seniors are counting on the stability, longevity, and integrity of this program for their secure retirement.

Our inaction will have sealed the fate before us today, the future of Medicare for their secure retirement.

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for one of our Nation’s most trusted programs.

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

The prescription drug package the House is considering here today will provide the same universal guaranteed Medicare health services as those that currently exist. If you are 65 or older, you qualify for Medicare, and you qualify for this benefit. It is that simple.

And we provide significant and immediate savings for seniors on their medications. Specifically, this plan provides Medicare beneficiaries with a prescription drug discount card offering over 25 percent in savings, catastrophic protections, giving seniors 100 percent coverage for out-of-control drug costs beyond $3,500 year, and full assistance for our neediest citizens.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

We are not naming a post office here. We are considering, as I said, the most important change to Medicare since its creation. This decision will affect so many people. It is no simple undertaking, and it certainly deserves more debate than allowed by this rule. To add even more confusion to the messy process, the Committee on Rules incorporated the so-called Health Savings Account bill into the rule for the Medicare overhaul legislation, so what we are doing here are two rules. So-called health savings accounts would create a new tax advantage, personal savings accounts, used to pay the out-of-pocket medical expenses. At first glance, perhaps it sounds innocuous. But when you look at the fine print, you see that it will cost the American people a $2 billion tax cut over the next 10 years while the Federal deficit continues to grow out of control. Even worse, it is a tax break with a destructive purpose: to threaten the traditional employer-based health care by actually encouraging companies to reduce their employees’ health coverage.

Mr. Speaker, perhaps the most egregious problem with the legislation before us is it does nothing to address the skyrocketing price of prescription drugs. Oh, sure, they will tell you that we can import drugs from Canada, but the fact of the matter is that an amendment inserted into the Senate
bill by one of our Senators says that it cannot be done unless it is certified by the Secretary of HHS, who has stated already that he will not do it. Therefore, any debate today about being able to import drugs is absolutely a farce.

The true index not so good: Social Security cost-of-living adjustments are based rose 96 percent, and the prescription drug costs that are crippling older Americans rose even higher. Seniors on Medicare are expected to spend $1.8 trillion on prescription drugs over the next decade.

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

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

At the same time, we hoped that we might do what the Veterans Administration has done with great success. By negotiating for the people that they represent with the drug companies, they have been able to save many of their veterans a great deal of money. Seniors fear this bill is a rush to privatize Medicare. We saw the flop of Medicare+Choice when many, many private insurance companies pulled out with one hand, trying to balance the responsibility of the prices charged in the American market. We had dozens of people interested than we could accommodate, but those who went saved anywhere from $100 to $650 on a 3-month supply of medication.

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

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

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

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

I support the Democratic proposal that will guarantee affordable drug prices to seniors. The legislation we have before us is the Democrats' proposal makes drugs more affordable by allowing the safe reimportation of drugs from Canada and makes lower cost generic drugs available more quickly. Unlike the Republican bill, there are no gaps in coverage in the Democratic proposal. Coverage is provided for any drug a senior's doctor provides. Seniors would be able to choose where to fill their prescriptions and would not have to join an HMO or private insurance plan to get drug coverage. This is the proposal seniors have been asking for, not one full of complexities and gaps in coverage like the Republican plan we will vote on shortly.

Today we are voting on a bill that is a sham. It is a sad mockery of what seniors in our country deserve. Instead of providing a comprehensive Medicare prescription drug benefit for America's seniors, the Republicans have decided to make sure this bill suits the big drug companies and leads down the road of privatizing Medicare. This is just plain wrong.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mr. Speaker, my constituents want an affordable prescription drug benefit that will be there when they need it. They do not want to privatize Medicare. However, the bill we will discuss dismantles Medicare and does nothing to lower prescription drug prices. This proposal eliminates the security of traditional Medicare and forces it to compete with private plans in 2010. It would transform Medicare from a defined benefit to a defined contribution program and ultimately eliminate Medicare as we know it. Because, private Medicare plans tend to aggressively reject younger and healthier seniors, open competition will mean rising out-of-pocket costs for the vast majority who would choose the stable benefits and premiums of traditional Medicare.

The result of open competition will be the transformation of today’s universal, national risk pool into a multitude of regional pools segmented by age, income, residence and health status. To many, this transformation sounds more like a scheme than meaningful reform.

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

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

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

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

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

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

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

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

Mrs. MALONEY. Mr. Speaker, I oppose this Republican Medicare bill, and I urge every woman, man, every American to read the fine print. There are gaping holes. There are problems. I will put this into the Record and I am totally opposed to this bill. Mr. Speaker, the health of America’s older women is at serious risk. Whatever Medicare Prescription Drug bill we pass will have an enormous impact on older women, both now and in the future, and women are concerned.

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

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

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

The height of hypocrisy in the Republican bill is the fact that it actually discourages employers from continuing to offer drug coverage for retired seniors who have already paid health insurance premiums throughout their working years. Senator Durbin and I introduced legislation to provide retiree drug benefits. But the Republicans prohibit the Secretary of HHS from negotiating for lower drug prices on behalf of seniors.

The Democrats believe prescription drugs should be affordable for seniors—but our amendments to have the Secretary negotiate on seniors’ behalf were defeated. Frankly, the Republican Medicare Prescription Drug bill is cruel. This is not compassionate conservatism. It is blatant bias against senior women with disabilities.

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

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

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

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

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

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

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

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

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

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

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

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

Ms. SLAUGHTER. Mr. Speaker, I re- serve the balance of my time.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

But Mr. Speaker, if you want Medicare to offer reliable, selective, discriminate coverage, you will support H.R. 1. If you want Medicare to offer limited coverage to seniors in Appalachian, Ohio, less coverage than seniors on Park Avenue or anywhere else, you will vote for H.R. 1. If you want Medicare to offer

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rural seniors coverage, but at three or four times the price, then you will vote for H.R. 1. If you want a plan written by the drug companies and by the insurance companies because of their huge contributions to the Republican Party, then you will vote for H.R. 1; and if you want a bill that will force people who now have prescription drug coverage, a bill that will force seniors who now have prescription drug coverage to drop that coverage, then you will vote for H.R. 1. The gentleman from New York (Mr. RANGEL) and the gentleman from Michigan (Mr. DINGELL) will offer a substitute amendment with a different version of Medicare. The Rangel-Dingell substitute strengthens Medicare by adding a prescription drug benefit, no unaffordable cost sharing, no gaps in coverage. The Rangel-Dingell substitute would maintain Medicare’s guaranteed coverage, remaining faithful to the trust Medicare has earned from seniors.

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

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

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

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

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

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

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

I am especially pleased to see that this bill enacts Medicare reforms that specifically affect California and my constituents in the 49th Congressional District. H.R. 1 includes language that allows the Secretary of Health and Human Services to designate plans that serve special needs beneficiaries as Specialized Medicare Advantage plans. This provision enhances the development of more effective approaches to chronic illness care by providing an opportunity for additional frail elderly demonstrations to move into mainstream Medicare.

One example of this type of demonstration is the SCAN program, which currently serves over 50,000 Southern Californians—including 10,000 who live inside the 49th Congressional District.

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

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

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

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

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

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

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

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

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

I believe that as we look at what is that we are trying to do here there are so many very important and positive developments that none of us should know my friend from Ohio has just mentioned the very important issue of the disproportionate share of hospitals that provide assistance under Medicaid. Increasing the level of funding for those hospitals that are struggling with that responsibility has been one of the challenges that the Los Angeles area, which I am honored to represent, has faced; and we, I believe, are going to be able to help deal with that.

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

I acknowledge that members of the majority we have been able under Speaker HASTERT’s leadership to put this package together; but anyone who claims that we are not giving an opportunity to the minority is certain to be considered is really wrong and we have provided the proposal which was submitted to us by the ranking minority member of the Committee.
Ms. SLAUGHTER. Mr. Speaker, I yield such time as she may consume to the gentlewoman from California (Mrs. NAPOLITANO).

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

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

I yield 2 minutes to the gentlewoman from California (Mrs. CAPPS).

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

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

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

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

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

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

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

The gentleman from Georgia (Mr. NORWOOD) and I submitted amendments originally in it some 12 percent; but it now includes an average sales price increase for oncology services that are provided by oncology nurses, the whole panoply of outpatient and clinic setting services that oncologists who are receiving chemotherapy, which is such a devastating treatment to go through, need in order to maintain.

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

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

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

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

Ms. SLAUGHTER. Mr. Speaker, I yield 1 minute to the gentlewoman from Rhode Island (Mr. LANGEVIN).
Mr. DEFAZIO. Mr. Speaker, I rise in opposition to the proposed rule providing for consideration of the Medicare Prescription Drug and Modernization Act.

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

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

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

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

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

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

Mr. Speaker, this should be a great day for this country. We should be on the verge of passing a real Medicare prescription drug benefit for our seniors. But, unfortunately, we are not. The Republican majority is rushing through a sham bill in this House in barely 24 hours. They tell nobody see a copy of this bill until 11:50 p.m. last night. The Committee on Rules' deliberations began at 12:50 a.m. last night and lasted, as has been mentioned, until 4 a.m. What are they afraid of? What are they hiding? And why would they not allow amendments like the Dooley amendment to be offered on this floor?

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

But not only is the Republican majority hiding the real substance of this bill, they have failed to learn the lessons of past efforts of this House to reform the health care system. Number one, health care legislation that works must not be partisan. This bill is almost an entirely Republican-only bill. That dooms it to failure from the start. Second, real health care reform must not be overly complex. This is one of the most complex bills that seniors could ever imagine facing. The red tape is incredible. And, third, this bill should not be overly burdensome to seniors, but it is. Watch out when your seniors back home realize they have to pay $35 a month for a very questionable benefit.
There is a donut hole in coverage, and that is almost too complex to explain in the 2 minutes I am allowed here, but this bill is so inferior to the Dooley bill, which solves these problems in a simple, clear and fair fashion. Under the Dooley bill, there is a zero monthly premium.

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

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

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

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

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

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

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

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

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

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

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

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

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

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

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

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

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

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

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

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

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

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

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

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

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

Ms. CARSON of Indiana asked and was given permission to revise and extend his remarks.

Mr. THOMPSON of California. Mr. Speaker, I rise today against this rule. Members should have an opportunity to vote on an enhanced version of the bipartisan Senate bill. That is the Blue Dog prescription drug benefit bill. Unfortunately for seniors across this country, our friends across the aisle have allowed it to be watered down, and it is a far lower tier. It is a far lower tier.

Mr. Speaker, I rise today against this rule. Members should have an opportunity to vote on an enhanced version of the bipartisan Senate bill. That is the Blue Dog prescription drug benefit bill. Unfortunately for seniors across this country, our friends across the aisle have allowed it to be watered down, and it is a far lower tier. It is a far lower tier.

Mr. KIND. Mr. Speaker, I rise in opposition to the rule, and encourage my colleagues to vote "no" on the previous question so we can have a real and honest debate today, and make in order the Dooley substitute.
body will never consider the Blue Dog substitute, because the Rules Committee denied us the opportunity to debate our proposal and have a vote on the House floor.

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

The Coalition has come together to develop a strong bipartisan benefit. It is not perfect. But, in recent years, the perfect has become the enemy of the good and, unfortunately, the perfect is out of our price range. The Senate offers America’s seniors a good benefit. It carries a monthly premium of $35. A deductible of $275. A 50 percent cost-share through the first $4500 of drug spending. And, it offers a catastrophic benefit that kicks in after beneficiaries have spent $3700 out of pocket. Furthermore, we have made to the already-scored Committee. However, the majority of the legislation prior to the convening of the Rules budget allocation.

But, Members with questions about the Blue Dog substitute will never have the opportunity to pose them because the rule has prevented all debate on this alternative. Medicare is a complex bill. There is $13,400 on the addition of a new prescription drug benefit cannot be a simple one. Voices should be heard, debate should be had, and all options should be fully explored before one course of action is decided upon. Unfortunately—to the detriment of this body and America’s seniors—that is not happening.

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

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

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

I have delivered probably 50,000 or more babies over a 30-year medical career; but I will be prouder today of this delivery that we are giving to our seniors, that we have promised them for the last 2 years. Finally today that delivery will occur. This will be the best delivery that I have ever given because what we are talking about is not just a prescription drug benefit; we are also talking about modernizing Medicare so that it will not be going bankrupt by the year 2030.

With the prescription drug benefit, we will have an opportunity for our seniors to avoid prolonged hospital stays and prolonged nursing home stays, difficult expensive surgery. Let them take those medicines that I have ever given because what we are talking about is not just a prescription drug benefit; we are also talking about modernizing Medicare so that it will not be going bankrupt by the year 2030.

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Mr. Speaker, I am sure the gentleman from Georgia (Mr. Gingrey) is pleased that the Democrats tried to make the gentlemen’s amendment in order to please Mr. Speaker. I yield 2 minutes to the gentlewoman from California (Mrs. Tauscher).

Mrs. TAUSCHER. Mr. Speaker, I rise today to strongly do my duty and my colleagues do not vote against the rule and to defeat the previous question. This will allow us to debate a much more realistic and fiscally responsible Medicare bill.

It is clear that the status quo is not working to make prescription drugs affordable for seniors. It is also clear that our country’s economic situation does not give Congress a lot of options for solving this growing problem. Unquestionably, Democrats—senior beneficiaries do not have to pay a premium, and the generous low-income benefit far exceeds the one offered by the majority. For seniors whose income is 150 percent of the Federal poverty level, roughly the seniors do not have to pay a premium, and the generous low-income benefit far exceeds the one offered by the majority.

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

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

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

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

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

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

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

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

Mr. DOOLEY of California. Mr. Speaker, I rise to ask that the previous question be defeated so we can offer a real prescription drug benefit to seniors. Costs seniors who the bills being offered by our Republican colleagues is one that seniors are going to find is so complex that it is going to result in taxpayers displacing a lot of funding.
private sector contributions which are already providing prescription drug benefits.

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

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

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

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

The Republican plan that we are going to be considering on the floor today, it fails the beneficiaries. It is no help to the beneficiaries if they are low-income, but not if they have $5,000 in assets or a car that is too valuable. We need a plan that seniors can understand, that they do not need to be an accountant to figure out; and that is what our alternative would provide.

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

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

This is a meaningful plan. It is going to provide basically free medicines for any senior citizen on Medicare who is at 125 percent of the poverty level and below. The only thing they will be expected to pay is a small $2 copay for generic drugs and a small $5 copay for name-brand drugs.

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

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

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

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

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

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

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

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

There was no objection.

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

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

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

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

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

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

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

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

"Sec. 7. The further amendment in the nature of a substitute specified in section 7 of this resolution is as follows:" Strike all after the enacting clause and insert the following:

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

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

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

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

Sec. 1. Short title; table of contents.

TITLE I—MEDICARE RX NOW

Sec. 100. Purpose.

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

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

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

Subtitle B—Benefits for Low-income Beneficiaries

Sec. 111. Benefits for low-income beneficiaries.
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Sec. 112. Improving enrollment process under medicaid.

TITILE II—RURAL HEALTH CARE IMPROVEMENTS

Sec. 201. Fairness in the Medicare disproportionate share to 20 rural hospital (DSH) adjustment for rural hospitals.

Sec. 202. Immediate establishment of uniform standardized amount in small urban areas.

Sec. 203. Establishment of essential rural hospital classification.

Sec. 204. More frequent update in weights in hospital market basket.

Sec. 205. Improvements to critical access hospital program.

Sec. 206. Redefinition of unused resident positions.

Sec. 207. Two-year extension of hold harmless provisions for small rural hospitals and sole community hospitals under prospective payment system for hospital outpatient department services.

Sec. 208. Exclusion of certain rural health clinic and Federally qualified health center services from the prospective payment system for skilled nursing facilities.

Sec. 209. Recognition of attending nurse practitioners as attending physicians to serve hospice patients.

Sec. 210. Improvement in payments to retain emergency capacity for ambulance services in rural areas.

Sec. 211. Three-year increase for home health services furnished in a rural area.

Sec. 212. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.

Sec. 213. GAO study of geographic differences in payments for physicians' services.

Sec. 214. Treatment of missing cost reporting periods for sole community hospitals.

Sec. 215. Extension of telemedicine demonstration project.

Sec. 216. Adjustment to the medicare inpatient hospital PPS wage index to revise the labor-related share of such index.

Sec. 217. Establishment of floor on geographic adjustments of payments for physicians' services.

TITLE I—MEDICARE RX NOW

SEC. 100. PURPOSE.

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

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

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

(3) The benefits are provided through medicare-approved prescription drug plans. These plans may be current plans, such as Medicare+Choice, employer-based retiree coverage, medigap plans, State assistance programs, medicaid, drug discount card plans, and other qualified plans (as determined by the Secretary).

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

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

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

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

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

(a) COVERAGE.—Section 1855(a) (42 U.S.C. 1395k(a)) is amended—

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

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

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

“(3) entitlement to have access to a prescription drug plan that provides discounts on purchases for outpatient prescription drugs and, effective beginning with 2006, for payment made in behalf (subject to the provisions of this part) for high-deductible outpatient prescription drug coverage under section 1855.”;

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

“OUTPATIENT PRESCRIPTION DRUG COVERAGE.

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

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

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

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

(2) ANNUAL DEDUCTIBLE.—

(A) ANNUAL DEDUCTIBLE.—The annual deductible under this subdivision shall be—

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

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

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

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

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

(3) COST-SHARING.—

(A) THREE-TIERED COPAYMENT STRUCTURE.—Subject to the succeeding provisions of this paragraph, in the case of a covered outpatient drug that is dispensed in a year to an eligible individual, the individual shall be responsible for—

(i) generic drugs, in the case of a generic covered outpatient drug, the base copayment amount specified in accordance with subparagraph (B) for the drug, and times the copayment amount applied under clause (i) for each prescription (as so defined) of such drug;

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

(iii) preferred brand name drug.—In the case of a preferred brand name covered outpatient drug, 50 percent of the copayment amount applied under clause (iii) for each prescription (as so defined) of such drug.

(iv) presumptive pharmacy access services.—In the case of each prescription service provided under this section, the Secretary shall establish a copayment amount equal to the amount provided under this section to the aggregate copayments under this paragraph for each year that shall be approximately equal to 5 percent.

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

(D) TREATMENT OF MEDICALLY NECESSARY NONPREREFERRED DRUGS.—A nonpreferred brand name drug shall be treated as a preferred brand name drug under this paragraph if such nonpreferred brand drug is determined (pursuant to procedures established under subsection (c)(8) to be medically necessary.

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

(F) PAYMENT OF BENEFITS BEYOND DEDUCTIBLE.—

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

(B) COUNTERING OF INCURRED EXPENSES.—Expenses with respect to covered outpatient prescription drug for which benefits are payable under this section shall—

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

(ii) be treated as incurred unless the expenses were incurred during a period in which the individual was covered under this part; and

(iii) be treated as incurred unless information concerning the transaction giving rise to such expenses has been electronically
transmitted by the pharmacy or other entity dispensing the covered outpatient prescription drugs to the Medicare-approved prescription drug plan consistent with electronic claims standards established under subsection (c)(3).”.

SEC. 102. PROVISION OF BENEFITS THROUGH A MEDICARE-APPROVED PRESCRIPTION DRUG PLAN.

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

"(b) Provision of Benefits Through a Medicare-Approved Prescription Drug Plan.

"(1) In General. In the case of an individual entitled to benefits for high-deductible prescription drugs under this section, the individual may designate a prescription drug discount card plan that is designed under this subsection.

"(2) Designation Process. The Secretary shall provide for a process for designation of Medicare-approved prescription drug plans consistent with the following:

"(A) Frequency of Designations. The Secretary shall permit individuals, on an annual basis and at such other times during a year as the Secretary may specify, to change the plan designated.

"(B) Dissemination of Information. The Secretary shall provide for the dissemination of information relating to the electronic prescription drug plans under this subsection. Such dissemination may be coordinated with the dissemination of information on Medicare-Choice plan selection under section 1927(c).

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

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

"(E) Standards. In this section, the term ‘designee’ means such an individual who makes such a designation and, with respect to a plan, an individual who has designated such plan under this subsection.

"(F) Medicare-Approved Prescription Drug Plans. "(i) In General. For purposes of this part, the term ‘Medicare-approved prescription drug plan’ means a health plan or program described in paragraph (2) that—

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

"(IB) meets the applicable requirements of paragraphs (3) and (4) of subsection (b) of this section with respect to such designees;

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

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

"(2) Types of Plans and Programs That May Qualify. The types of plans and programs that may qualify as a Medicare-approved prescription drug plan are the following:

"(IA) A Medicare-Choice plan.

"(IB) A group health plan, including a reinsurance health plan, that provides prescription drug coverage.

"(IC) A State plan under title XIX.

"(ID) A health benefits plan under the Federal employee health benefits program under chapter 89 of title 5, United States Code.

"(IE) A Medicare supplemental policy.

"(IF) A State pharmaceutical assistance program.

"(IG) A prescription drug discount card plan.

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

"(3) Administration Through Card-Based Electronic Mechanism. —

"(IA) Use of Medicare Prescription Drug Card. — Claims for benefits under this section under a Medicare-approved prescription drug plan may only be made electronically through the use of an electronic prescription drug card system (in this paragraph referred to as the ‘system’).

"(IB) Standards for Electronic Prescription Card System. — The Secretary shall establish standards for the system, including the following:

"(i) Cards. Standards for claims cards to be used by designees under the system.

"(ii) Information. Standards for the real-time transmission among pharmacies, Medicare-approved prescription drug plans, and the Secretary (including an appropriate data clearinghouse operated by or under contract with the Secretary) of information on expenses incurred for covered outpatient prescription drugs by designees.

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

"(II) Electronic Transmittal of Prescriptions. — Prescriptions must be written and transmitted electronically (other than by facsimile), except in emergency cases and other exceptional circumstances recognized by the Secretary.

"(III) Provision of Information to Prescription Professionals. — The program provides for the electronic transmittal to the prescribing health care professional of information that includes—

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

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

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

"(IV) Standards. —

"(I) Development. The Secretary shall provide for the development of uniform standards relating to the electronic prescription drug program described in subparagraph (A) that may include a 90-day supply of drugs (which may include a 90-day supply of generic equivalents at reduced cost to the designee) and systems reduce medication errors and their impact on implementation of computerized prescribing.

"(II) Advisory Task Force. — In developing standards relating to the following:

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

"(b) The extent to which such standards and systems reduce medication errors and are readily implemented by physicians, pharmacists, and hospitals.

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

"(IV) Efforts to develop and promote uniform accreditation by the American National Standards Institute (ANSI) and shall be compatible with standards established under part C of title XI.

"(3) Acceptance of Claims Through All Qualifying Pharmacies. — A Medicare-approved prescription drug plan shall—

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

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

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

"(4) Requirement to Negotiate Discounts and Generic Equivalents. — A Medicare-approved prescription drug plan shall provide discounts to the plan with the following:

"(A) Negotiated Prices. — Access to negotiated prices (including applicable discounts) used for payment for covered outpatient prescription drugs, regardless of the fact that no benefits or only partial benefits may be payable with respect to such drugs because of the application of the deductible under subsection (a)(2) or any other payment under this part, or because the drugs are procured before January 1, 2006.
"(B) GENERIC EQUIVALENTS.—Information on the availability of generic equivalents at reduced cost to such designees.

"(6) TREATMENT OF NONPREFFERED BRAND NAME DRUGS.—

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

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

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

"(ii) to have a significant adverse effect on the individual.

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

"(B) PROCEDURES REGARDING APPEAL RIGHTS WRT DENIALS OF COVERAGE.—Such a plan shall have in place procedures to ensure a timely internal review (and timely independent external review) for resolution of denials of coverage under subsection (a) in accordance with the medical exigencies of the case in accordance with requirements established by the Secretary and applicable to such requirements for MedicareChoice organizations under part C and to ensure notice to designees regarding such procedures. A designee shall have the further right to an appeal of any such a denial of coverage in the same manner as is provided under section 1852(g)(5) in the case of a failure to receive health services under a MedicareChoice plan.

"(7) PROMPT PAYMENT OF PHARMACIES FOR COVERAGE BENEFITS.—Medicare-approved prescription drug plans shall provide for payment to pharmacies for covered prescription drugs in accordance with rules no less generous than the rules applicable under section 1852(c)(2)(B).

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

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

"(B) instances or patterns of substandard care;

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

"(D) inappropriate use of antibiotics;

"(E) appropriate use of generic products; and

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

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

"(10) PROVISION OF DATA.—The entity offering a Medicare-approved prescription drug plan shall provide the Secretary with any such information as is required to make payments to the entity under this section.

"(11) PRESCRIPTION DRUG DISCOUNT CARD PLANS.—

"(A) IN GENERAL.—The Secretary shall solicit bids from entities to offer prescription drug discount card plans to individuals enrolled under this part either nationwide or in large geographic areas. The Secretary shall award bids in a manner so that each plan is awarded in all areas of the United States. The Secretary may not award a contract based on such a bid to an entity with respect to a plan unless the entity and the Secretary are able to enter into a Medicare-approved prescription drug plan under this section.

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

"(e) PAYMENT OF PLANS.—

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

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

"(f) COVERED OUTPATIENT PRESCRIPTION DRUGS DEFINED.—

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

"(A) a drug that may be dispensed only upon a prescription and that is described in paragraph (A) or (A) of section 1927(k)(2); or

"(B) a biological product described in clauses (i) through (iii) of paragraph (B) of such section as described in paragraph (C) of such section, and such term includes a vaccine licensed under section 351 of the Public Health Service Act and any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(1)).

"(2) EXCLUSIONS.—

"(A) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1395w(a)(1), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1397d(3), as the Secretary may specify and does not include such other medicines, classes, and uses as the Secretary may specify consistent with the goals of providing quality care and containing costs under this section.

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

"(c) NO EFFECT ON PART B PREMIUM.—

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

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

"(A) Section 1837 (42 U.S.C. 1395p) is amended—

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

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

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

"(iv) IN THE CASE OF AN INDIVIDUAL WHO ENROLLED PUNCTUALLY TO SUBSECTION (k) OF SECTION 1837, JANUARY 1, 2006.

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

"(3) GOVERNMENT CONTRIBUTION.—Section 1842(a) (42 U.S.C. 1395w(a)(1)) is amended—

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

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

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

"(D) A Government contribution equal to the aggregate amount of any contribution from the Trust Fund for benefits and administrative expenses attributable to the prescription drug coverage provided under section 1865, plus

"(2) EXCLUSION OF OUTPATIENT PRESCRIPTION DRUG BENEFIT.—The previous provisions of this subsection shall not apply to benefits provided under section 1865.

Subtitle B—Benefits for Low-Income Beneficiaries

SEC. 111. BENEFITS FOR LOW-INCOME BENEFICIARIES.

(a) IN GENERAL.—First Dollar Coverage for Certain Low-Income Individuals.—

"(1) IN GENERAL.—Section 1802(b) (42 U.S.C. 1395y(b)) is amended by adding at the end the following new subsection:

"(2) EXCEPTION FOR OUTPATIENT PRESCRIPTION DRUG BENEFIT.—The previous provisions of this subsection shall not apply to the benefits provided under section 1805.

"(B) First Dollar Coverage for Certain Low-Income Individuals.—

"(1) IN GENERAL.—In the case of a subsidy eligible individual (as defined in paragraph (3)(B)) who would otherwise be a covered outpatient prescription drug plan under this section, there shall be a subsidy that is applied as if the annual deductible were equal to zero but, with respect to costs incurred before the amount of the annual deductible otherwise applicable under section (a)(3), which reflects an average or otherwise restricted under section 1395w(a)(1), as the Secretary may specify, and does not include such other medicines, classes, and uses as the Secretary may specify consistent with the goals of providing quality care and containing costs under this section.

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

"(B) 50 PERCENT COVERAGE FOR INDIAN AND ALASKA Natives WITH INCOMES ABOVE 150 PERCENT OF POVERTY LINE.—The Secretary in subsection (a) of this section (including subparagraph (B) and inserting "plus");

"(c) MEDICARE AS PRIMARY PAYOR.—Section 1839(b) of title 42, United States Code, is amended by striking "or a general enrollment period under section 1837(k)" after "not pursuant to a special enrollment period under section 1837(h)(4)

"(1) IN GENERAL.—In the case of a subsidy eligible individual (as defined in paragraph (3)(B)) who would otherwise be a covered outpatient prescription drug plan under this section, there shall be a subsidy that is applied as if the annual deductible were equal to zero but, with respect to costs incurred before the amount of the annual deductible otherwise applicable under section (a)(3), which reflects an average or otherwise restricted under section 1395w(a)(1), as the Secretary may specify, and does not include such other medicines, classes, and uses as the Secretary may specify consistent with the goals of providing quality care and containing costs under this section.

"(2) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered outpatient prescription drug under this section shall not be considered a covered prescription drug if available under part A or under this part (other than under this section)."
the copayments amounts specified in subsection (a)(3) increased by 150 percent, which reflects an average benefit percentage of 50 percent, but in no case shall such copayment amount exceed the price negotiated for the drug involved.

``(2) DETERMINATION OF ELIGIBILITY.—

(A) SUBSIDY ELIGIBLE INDIVIDUAL DEFINED.—For purposes of this section, provided in 1845(g) of the Social Security Administration, and defined in the appropriate paragraph of subsection (d), the term 'subsidy eligible individual' means an individual who—

(i) is enrolled under the plan;

(ii) is below 150 percent (or such higher percent, not to exceed 200 percent, as a State may specify under subparagraph (B) of this section), and

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

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

(B) COVERAGE OF INDIVIDUALS WITH INCOME UP TO FEDERAL POVERTY LINE AT STATE OPTION.—One of the 50 States or the District of Columbia may, at its option and subject to section 1936(c), specify a percent of income, that is not income tested but does not exceed 200 percent, that will apply for purposes of this subsection to individuals residing in the State.

(C) DETERMINATIONS.—The determination of whether an individual residing in a State is a subsidy eligible individual shall be determined under the State medicare plan for the State under section 1903(a) and by the Social Security Administration. There are authorized to be appropriated to the Social Security Administration such sums as may be necessary for the determination of eligibility under this subparagraph.

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

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

(ii) the Federal poverty line means the official poverty line (as defined by the Office of Management and Budget, and reclassified in accordance with section 673.2 of the Federal Register (1983) applicable to a family of the size involved.

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

(F) ADMINISTRATION OF SUBSIDY PROGRAM.—The Secretary that shall provide information with respect to the extent of such benefits and the amount of such assistance over the subsequent year. any other provision of such section, the applicable Federal matching rate shall be increased by 10 percent of the percentage otherwise payable (but for this subsection) by the State.

(G) For expenditures attributable to costs incurred during 2007, the otherwise applicable Federal matching rate shall be increased to 100 percent.

(2) COORDINATION.—The State shall provide the Secretary with such information as may be necessary for the determination of eligibility under this paragraph (1) that may otherwise be made for similar eligibility determinations.

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

(i) 100 percent less the enhanced FMAP described in section 2105(b) for that State and 

(ii) the additional amount of payment made under section 1945 because of the application of such specification.

(D) PHASED-IN FEDERAL ASSUMPTION OF MEDICARE RESPONSIBILITY FOR COST-SHARING SUBSIDIES FOR Dually ELIGIBLE INDIVIDUALS.—

PRESUMPTION GENERAL.—Section 1903(a)(1) (42 U.S.C. 1396(a)(1)) is amended by inserting before the semicolon the following: ‘‘the amount computed under section 1945, reduced by the amount computed under section 1936(d)(3) for the State and the quarter and

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

(D) FEDERAL ASSUMPTION OF MEDICARE PRESCRIPTION DRUG COSTS FOR Dually ELIGIBLE BENEFICIARIES.—

GEN..—For purposes of section 1935(a)(1), for a State that is one of the 50 States or the District of Columbia for a calendar quarter in a year (beginning with 2006) the amount computed under this subsection is equal to the sum of the product described in paragraph (3) plus the product of the following:

(1) MEDICARE BENEFITS FOR MEDICARE ELIGIBLES.—The total amount of payments made in the quarter because of the operation of section 1945 which are attributable to individuals who are eligible for medical assistance with respect to prescription drugs under this title. For purposes of this subparagraph, an individual is considered to be eligible for medical assistance with respect to prescription drugs under title XIX (including under a
waiver under section 1115) only if, with respect to such assistance, the individual is charged a copayment greater than a nominal amount (as described in section 1916(e)(3) and that payment is not likely to result in impoverishment or a similar dollar limit established for the amount of such assistance over any period of time.

"(B) STATE MATCHING RATE.—A proportion computed for the State and applied to the Federal medical assistance percentage (as defined in section 1905(b)) applicable to the State for the waiver.

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

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

"(A) 2006 is 90 percent;

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

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

"(3) PRODUCT.—The product described in this paragraph for a State for a calendar quarter is the State matching rate described in paragraph (1)(B) for that State and quarter multiplied by the additional expenditures made under section 1454 as a result of the following:

"(A) REDUCTIONS IN CATACLYSMIC COPAYMENTS.—The application of subsection (a)(5) thereof.

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

"(C) MEDICAID PROVIDING WRAP-AROUND BENEFITS.—Section 1955, as so inserted and amended, is further amended by adding at the end of such subsection the following:

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

"(4) CLARIFYING AMENDMENTS.—Section 1905(s)(1) (42 U.S.C. 1396s(s)(1)) is amended—

"(A) in subparagraph (B), by inserting ", but not including any copayments under section 1454, after ‘‘section 1113’’;

"(B) in subparagraph (C), by inserting "but not including any deductible under section 1454 after ‘‘section 1113’’;

"(C) in subparagraph (D), by inserting "in the case of a State, other than the 50 States and the District of Columbia—

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

"(B) if the State establishes a plan described in paragraph (2) for providing medical assistance with respect to the provision of prescription drugs to medicare beneficiaries under section 1454(g), the amount otherwise determined under section 1102(f) (as insertions in 1102(f)) for the State shall be increased by the amount specified in paragraph (3)."

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

"(A) provides medical assistance under section 1945(g) with respect to the provision of prescription drugs to medicare beneficiaries whose income does not exceed an income level specified under the plan; and

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

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

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

"(ii) the amount specified in section 1102(f)(1) for that State and quarter divided by the sum of the amounts specified in such section for all such States.

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

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

"(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the year preceding by an annual percentage increase specified in section 1454(s)(2)(B) for the year involved.

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

"(2) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1396d(f)) is amended by inserting "as provided in section 1905(p)(10)" before "except":

"(2) OUTSTANDING OF STATE ELIGIBILITY WORKERS AT SSA FIELD OFFICES.—Section 1102(a)(5) (42 U.S.C. 1396a(a)(5)) is amended—


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

"TITLE II—RURAL HEALTH CARE IMPROVEMENTS

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

(a) EQUALIZING DSH PAYMENT AMOUNTS.—

"(1) IN GENERAL.—Section 1886(d)(5)(F)(vi) (42 U.S.C. 1395ww(d)(5)(F)(vi)) is amended—

"(1) in clause (iv), after "April 1, 2001,"; and

"(2) by inserting "or, for discharges occurring on or after October 1, 2003, for any other hospital described in clause (iv)," after "clause (iv)(II)," in the matter preceding subclause (I).

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

"(a) in clause (iv)—

"(i) in subclause (III),

"(b) by inserting "or, for discharges occurring on or after October 1, 2003, for any other hospital described in clause (iv)," after "clause (iv)(II)," in the matter preceding subclause (I).

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

"(a) in clause (iv)—

"(i) in subclause (II),

"(b) by inserting "or, for discharges occurring on or after October 1, 2003, for any other hospital described in clause (iv)," after "clause (iv)(II)," in the matter preceding subclause (I).

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

"(a) in clause (iv)—

"(i) in subclause (II),

"(b) by inserting "or, for discharges occurring on or after October 1, 2003, for any other hospital described in clause (iv)," after "clause (iv)(II)," in the matter preceding subclause (I).

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

"(a) in clause (iv)—

"(i) in subclause (II),

"(b) by inserting "or, for discharges occurring on or after October 1, 2003, for any other hospital described in clause (iv)," after "clause (iv)(II)," in the matter preceding subclause (I).

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

"(a) in clause (iv)—

"(i) in subclause (II),

"(b) by inserting "or, for discharges occurring on or after October 1, 2003, for any other hospital described in clause (iv)," after "clause (iv)(II)," in the matter preceding subclause (I).

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

"(a) in clause (iv)—

"(i) in subclause (II),

"(b) by inserting "or, for discharges occurring on or after October 1, 2003, for any other hospital described in clause (iv)," after "clause (iv)(II)," in the matter preceding subclause (I).

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

"(a) in clause (iv)—

"(i) in subclause (II),

"(b) by inserting "or, for discharges occurring on or after October 1, 2003, for any other hospital described in clause (iv)," after "clause (iv)(II)," in the matter preceding subclause (I).

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

"(a) in clause (iv)—

"(i) in subclause (II),

"(b) by inserting "or, for discharges occurring on or after October 1, 2003, for any other hospital described in clause (iv)," after "clause (iv)(II)," in the matter preceding subclause (I)."
under subparagraph (B), and adjusted or re-

(c) E FFECTIVE DATE.—The amendments

made by this section shall apply to cost re-

porting periods beginning on or after October 1, 2004.

SEC. 204. MORE FREQUENT UPDATE IN WEIGHTS

USED IN HOSPITAL MARKET BASKET.

(a) MORE FREQUENT UPDATES IN WEIGHTS.—

After revising the weights used in the hospital market basket under section 1886(d)(3)(A) (42 U.S.C. 1395ww(d)(3)(A)) and (B) (42 U.S.C. 1395ww(d)(3)(B)) to reflect the most current data available, the Secretary shall establish a frequency for revising such weights, including an explanation of the reasons for, and options considered, in determining such frequency.

SEC. 205. IMPROVEMENTS TO CRITICAL ACCESS

HOSPITAL PROGRAM.

(a) INCREASE IN PAYMENT AMOUNTS.—

(1) IN GENERAL.—Sections 1834(g)(1), 1395g(f)(1), and 1395m(g)(1) (42 U.S.C. 1395m(g)(1); 1395f(g)(1); and 1395p(g)(1)) are each amended by inserting "equal to 102 percent of" before "the reasonable costs".

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to payments for services furnished during cost reporting periods beginning on or after October 1, 2003.
(II) by striking "PHYSICIANS" and inserting "PROVIDERS";

(B) by striking "emergency room physicians who are on-call (as defined by the Secretary)" and inserting "physicians, physician assistants, nurse practitioners, and clinical nurse specialists who are on-call (as defined by the Secretary) to provide emergency services not otherwise provided"

(C) by striking "physician's" and inserting "services covered under this title".

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

(3) MODIFICATION OF THE ISOLATION TEST FOR SICK-BED CAMPS AMBULANCE SERVICES.—

(1) IN GENERAL.—Section 1834(i)(8) (42 U.S.C. 1395m(i)(8)), as added by section 205(a) of BIPA (114 Stat. 2613a–402), is amended by adding at the end the following: "The limitation described in the matter following subparagraph (B) in the previous sentence shall not apply if the ambulance services are furnished by such a provider or supplier of ambulance services who is a first responder to emergencies (as determined by the Secretary)."

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

(b) REIMSTATEMENT OF PERIODIC INTERIM PAYMENT (PIP) PROCEDURE.—

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

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

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

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

"(E) Inpatient critical access hospital services;"

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

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

(2) in subparagraph (F)(ii), by inserting "subject to subparagraph (I)," after "October 1, 1997;"

(2) by adding "and" at the end of subparagraph (G); and

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

"(E) by adding at the end the following new subparagraph:

"(I) REDISTRIBUTION OF UNUSED RESIDENT POSITIONS.—

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

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

(iii) REFERENCE RESIDENT LEVEL.—Subject to subclause (I), the reference resident level specified in this subclause for a hospital is the highest resident level for the hospital during the reference periods.

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

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

(III) REDISTRIBUTION.—

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

(IV) EFFECTIVE DATE.—No increase under subclause (I) shall be permitted or taken into account for a hospital for any portion of a cost reporting period that occurs before July 1, 2004, or before the Secretary's application for an increase under this clause. No such increase shall be permitted for a hospital unless the hospital has applied to the Secretary for such increase by December 31, 2001.

(III) CONSIDERATIONS IN REDISTRIBUTION.—

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

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

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

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

"(4) FUNDING.—

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

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

(H) ANNUAL AGGREGATE LIMITATION.—The amendment made by this subsection shall apply with respect to the first sentence of this subsection during fiscal years 2004 through 2008.

(2) DEVELOPMENT OF ALTERNATIVE METHODS OF PERIODIC INTERIM PAYMENTS.—With respect to payment for grants made under this subsection during fiscal years 2004 through 2008, the Secretary shall, in consultation with the States, develop alternative methods of periodic interim payments to hospitals to ensure that such payments reflect the costs of services provided by hospitals.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall apply to the first sentence of this subsection during fiscal years 2004 through 2008.

(IV) PRIORITY FOR RURAL AND SMALL URBAN AREAS.—In determining for which hospitals the Secretary will make grants under this subsection, the Secretary shall take into account the need for such an increase by specialty and locality involved, considering—

(A) the number of full-time equivalent residents in rural areas or in urban areas that are not large urban areas (as defined for purposes of paragraphs (B) and (C)) on a first-come-first-served basis (as determined by the Secretary) based on the hospital's need, the hospital's ability to establish new residency positions, and the availability to fill the positions made available under this clause.

(B) the importance of the hospital to the community in which it is located.

(2) IN GENERAL.—If a hospital is determined by the Secretary to be a single hospital or is a member of an affiliated group, the term "hospital" shall be construed as referring to such hospital or affiliated group to be a single hospital.

(3) AFFILIATION.—The provisions of this section shall be applied with respect to the first sentence of this subsection in the same manner as it applies with
respect to subparagraph (F) of such subsection.

(c) Report on Extension of Applications Under Redistribution Program.—Not later than July 1, 2003, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend the deadline for applications for an increase in resident medical malpractice insurance costs under section 1886(h)(4)(I)(ii) of the Social Security Act (as added by subsection (a)).

SEC. 207. Two-Year Extension of Hold Harmless Provisions for Small Rural Hospitals and Sole Community Hospitals Under Proposed Payment System for Hospital Outpatient Department Services.—

(a) Hold Harmless Provisions.—

(1) In general.—Section 1831(t)(7)(d)(ii) (42 U.S.C. 1395t(i)(7)(d)(ii)) is amended—

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

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

(C) by striking "2001" and inserting "2005".

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

(b) Study.—

(1) Study.—The Secretary shall conduct a study to determine if, under the prospective payment system for hospital outpatient department services under section 1831(t) of the Social Security Act (42 U.S.C. 1395t), costs incurred by rural providers of services by ambulance payment classification groups (APCs) exceed those costs incurred by urban providers of services.

(2) Adjustment.—Insofar as the Secretary determines under paragraph (1) that costs incurred by rural providers exceed those costs incurred by urban providers of services, the Secretary shall provide for an appropriate adjustment under such section 1831(t) to reflect those higher costs by January 1, 2005.

SEC. 208. Exclusion of Certain Rural Health Clinic and Federally Qualified Health Center Services from the Prospective Payment System for Skilled Nursing Facilities.—

(a) In general.—Section 1886(e)(2)(A) (42 U.S.C. 1395y(e)(2)(A)) is amended—

(1) in clause (ii), by striking "clauses (ii) and (iii)" and inserting "clauses (ii), (iii), and (iv)"; and

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

"(iv) Exclusion of certain rural health clinic and federally qualified health center services.—Services described in this clause are—"

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

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

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

(b) Certain Services Furnished by an Entity Jointly Owned by Hospitals and Critical Access Hospitals.—For purposes of applying subparagraph (ii) of section 1861(a)(32) of the Code of Federal Regulations, the Secretary shall treat an entity that is 100 percent owned by a joint venture by 2 Medicare-participating hospitals or critical access hospitals as a Medicare-participating hospital or a critical access hospital.

(c) Technical Amendments.—


"(I) Rural health clinic services (as defined in paragraph (1) of section 1861(a)); and"

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

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

"(c) Technical Amendments.—


"(I) Rural health clinic services (as defined in paragraph (1) of section 1861(a)); and"

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

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

"(c) Technical Amendments.—


"(I) Rural health clinic services (as defined in paragraph (1) of section 1861(a)); and"

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

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

"(c) Technical Amendments.—


"(I) Rural health clinic services (as defined in paragraph (1) of section 1861(a)); and"

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

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

"(c) Technical Amendments.—


"(I) Rural health clinic services (as defined in paragraph (1) of section 1861(a)); and"

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

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

"(c) Technical Amendments.—


"(I) Rural health clinic services (as defined in paragraph (1) of section 1861(a)); and"

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

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

"(c) Technical Amendments.—


"(I) Rural health clinic services (as defined in paragraph (1) of section 1861(a)); and"

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

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

"(c) Technical Amendments.—


"(I) Rural health clinic services (as defined in paragraph (1) of section 1861(a)); and"

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

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

"(c) Technical Amendments.—


"(I) Rural health clinic services (as defined in paragraph (1) of section 1861(a)); and"

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

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

"(c) Technical Amendments.—


"(I) Rural health clinic services (as defined in paragraph (1) of section 1861(a)); and"

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

that would be described in clause (ii) if such services were not furnished by an individual affiliated with a rural health clinic or a Federally qualified health center.
SEC. 214. TREATMENT OF MISSING COST REPORTING PERIODS FOR SOLE COMMUNITY HOSPITALS.

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

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

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

SEC. 215. EXTENSION OF TELEMEDICINE DEMONSTRATION PROJECT.

Section 401 of Balanced Budget Act of 1997 (Public Law 105-33) is amended—

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


(A) in subparagraph (A), by striking ‘‘subparagraph (B) and inserting ‘‘subparagraphs (B) and (C)’’;

(B) in subparagraph (B), by striking ‘‘4-year’’ and inserting ‘‘8-year’’; and

(C) in subparagraph (C), by striking ‘‘January 1, 2003’’ and inserting ‘‘October 1, 2004’’.

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

“(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED.—In the case of a hospital that had not been enacted.’’.  

SEC. 216. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

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

(1) by striking ‘‘wage levels—’’ and inserting ‘‘wage levels—’’

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

“(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2004.—The proportion of wage index to be adjusted for the purposes of clause (i), for the purposes of this subsection shall be one hundred and ten percent.’’

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to wages paid in or after January 1, 2004, and before January 1, 2005, and before January 1, 2006.

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

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

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

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

(E) FLOOR FOR WORK GEOGRAPHIC INDICES.—

“(i) IN GENERAL.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2006, latitude and longitude data in 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 clauses (i), the term ‘‘work floor index’’ means—

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


“(iii) FLOOR FOR PRACTICE EXPENSE AND MALPRACTICE GEOGRAPHIC INDICES.—For purposes of payment for services furnished on or after January 1, 2004, the Secretary shall assume that the geographic index in such subparagraph (B), the Secretary shall increase such index to 1.00 for any locality for which such index is less than 1.00."

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

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

The vote was taken by electronic device, and there were—yeas 226, nays 6, as follows:

[Roll No. 321]
The Speaker pro tempore [of the House] announced that the ayes appeared to have it.

The question was taken; and the resolution agreed to, by a vote of 221 ayes, 203 noes, as follows:

AYES—221

Mr. SANDLIN and Mr. TURNER of Texas changed their vote from "yea" to "nay." So the previous question was ordered reconsidered.

The result of the vote was announced as above recorded.

The Speaker pro tempore [of the House] announced that the ayes appeared to have it.

The resolution was agreed to. So the result of the vote was announced as above recorded.

The motion to reconsider was laid on the table.

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

Mr. McGOVERN, Mr. Speaker, I demand a recorded vote. A recorded vote was ordered.

The Speaker pro tempore [of the House] announced that the ayes appeared to have it.
Mr. Speaker, H.R. 2559 recognizes the dedication and commitment of our troops by providing for their most basic needs: improved military facilities, including the previously mentioned housing and medical facilities.

Mrs. MYRICK. Mr. Speaker, the Committee on Rules, I call up House Resolution 298 and ask for its immediate consideration.

Resolved, That at any time after the adoption of this resolution the Speaker may, pursuant to clause 2(b) of rule XVIII, declare the House resolved into the Committee of the Whole on the state of the Union for the consideration of this resolution, all time yielded upon which I yield myself such time as may be necessary for debate on this resolution.
themselves a decent quality of life so as to sustain the commitment and professionalism of America’s all voluntary armed services and the families that support them.

While our men and women in uniform have bravely displaced our enemies abroad, they face increasingly complex personal and professional challenges here at home. We must do more to take care of those who are putting their lives on the line to defend our freedoms and for the families who support them in their efforts. And I am really glad we are getting this done before we head home for the July 4th week break.

Mr. Speaker, I urge my colleagues to support the rule and to support the conference report.

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

Mr. McGovern. Mr. Speaker, I yield myself 65 minutes.

Mr. Speaker, thank the gentleman from North Carolina (Mrs. Myrick) for yielding me the customary 30 minutes.

Mr. Speaker, the rule under consideration for H.R. 2559, the Fiscal Year 2004 Military Construction Appropriations Act, is an open rule. It provides for one hour of general debate, waives all points of order against consideration of the bill, allows for germane amendments and provides for one motion to recommit with or without instructions.

Mr. Speaker, I would like to express my appreciation for the work of the gentleman from Michigan (Chairman Knollenberg) and the ranking member, the gentleman from Ohio (Mr. Hobson) and the ranking member, the gentleman from Wisconsin (Mr. Obey) for continuing the tradition of bipartisanship on this bill and for doing the best with a terrible allocation.

Mr. Speaker, I have a terrible feeling of deja vu. Almost exactly 1 year ago, on June 27 of 2002, I stood on this House floor as the minority manager of the rule on the fiscal year 2003 military construction bill. Along with the then-chairman, the gentleman from Ohio (Mr. Hobson) and the ranking member, the gentleman from Massachusetts (Mr. Oliveira), we all bemoaned the inadequacy of that bill. We all pledged to do better next year and called upon President Bush to increase the budget for desperately needed military construction, housing, base realignment and base closure.

Well, 1 year later none of that has happened. This year is even worse. If last year’s appropriations bill was inadequate, this one is woefully inadequate, to quote the gentleman from Michigan (Chairman Knollenberg). In fact, the fiscal year 2004 bill is $1.5 billion less than last year’s bill. Let me repeat that. This bill is $1.5 billion less than the fiscal year 2003 funding levels. It is even $41 million less than the chairman’s request.

Mr. Speaker, I would ask my colleagues what in the world are we doing? How can we stand on this House floor day after day, week after week and declare how much we support our uniformed men and women when the funding provided for family housing in this bill is $41 million less than last year? How can we stand on the floor of this House day after day, week after week and say that we are engaged in a long-term struggle against a global enemy when funding for military construction in this bill is $1 billion less than last year?

Mr. Speaker, poor facility conditions are not only unsafe, they hamper readiness and decrease troop retention. According to the Pentagon, 180,000 of the 300,000 units of military housing are substandard. According to the Pentagon, 68 percent of the Department’s facilities have deficiencies so serious that they might impede mission readiness or they are so deteriorated that they cannot support mission requirements. The current reductions in funding for construction in these facility categories means that the rate at which buildings are renovated or replaced has just increased from 83 years to 150 years.

This is a national scandal. And let us be clear, this bill is not only about new housing, it is about the operation and maintenance of existing family housing. One of the few increases in family housing in this bill is the Army which receives an $81 million increase. Unfortunately, funding for the operation and maintenance of existing Army family housing is cut by $63 million, allowing more and more current housing units to deteriorate and fall into substandard condition.

Mr. Speaker, I keep hearing that since the events of September 11 we live in a changed world. I keep on hearing how much we owe to our Armed Forces, how much we appreciate their sacrifice and service. Then why do we keep cutting and cutting and cutting the military construction appropriations bill? We obviously do not appreciate them enough to give them decent housing. We obviously do not admire them enough to give them quality facilities. Are we going to be on the floor of this House next year expressing our disappointment over how inadequate the military construction appropriations bill is and then vote to recommit with or without instructions?

Now, I have been told that we should just wait until the 2005 round of base closings, then we will see some modest increases for housing at the bases that survive the next round of closures. That is an example of short-sightedness that I have never heard. Do we honestly believe that inadequate housing and facilities exist only on bases likely to be closed down?

Mr. Speaker, this crisis in funding for family housing and military construction is nationwide. It exists at nearly every single base and installation across the land and overseas, and it affects every branch of our Armed Forces. And if base closure is somehow magically supposed to balance the ledgers, then why are we in such a housing and construction crisis right now?

Mr. Speaker, it does not have to be this way. Mr. Speaker, and there is a remedy. The ranking member of the Committee on Appropriations, the gentleman from Wisconsin (Mr. Obey), tried to provide an extra $958 million above the allocations for military construction and housing. His solution is not hard to accept. This House would simply scale back 5 percent of the scheduled tax cut for people with adjusted gross incomes of over $1 million for 1 year. This would mean that the tax refunds for these individuals would be reduced from about $88,000 to $83,000.

Now, Mr. Speaker, according to the most recent census, there are more than 280 million people in the United States. This modest change in the tax cut would affect about 200,000 individuals, or less than one-tenth of 1 percent of all taxpayers. Such a small adjustment, however, would provide nearly a billion dollars to base housing and more than 1.4 million men and women who serve our country on active duty have decent housing and workplaces for themselves and their families. But the Republicans on the Committee on Appropriations rejected the gentleman from Wisconsin’s (Mr. Obey) proposal, and last night the Republicans on the Committee on Rules refused to allow the gentleman from Wisconsin’s (Mr. Obey) amendment to even be debated and voted on in this House.

So we are faced with the results of what happens when we rob our Nation of the most basic revenue needed to adequately fund our Nation’s priorities. We rob our valiant military personnel and their families, we rob our veterans of their basic benefits. We cut back funding for schools and child care for military families. And we are faced with passing this woefully inadequate bill. I believe that for all the hard work of the gentleman from Michigan (Chairman Knollenberg) and the ranking member, the gentleman from Texas (Mr. Edwards), can only be viewed as a shameful scandal on the part of this House.

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

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

Mr. McGovern. Mr. Speaker, I yield 9 minutes to the distinguished gentleman from Wisconsin (Mr. Obey), the ranking Democrat on the Committee on Appropriations.

(Mr. Obey asked and was given permission to extend his remarks, and include extraneous material.)

Mr. Obey. Mr. Speaker, it would be so nice if the force of our rhetoric is matched by the force of our deeds. That certainly is not the case with this bill.

Just a few months ago this House passed this resolution and it said,
among other things, “Resolved by the House of Representatives, the Senate concurring, that the Congress express the unequivocal support and appreciation of the Nation to the members of the United States Armed Forces serving in Operation Iraqi Freedom who are carrying out their missions with excellence, patriotism and bravery and also to their families.”

Well, the sad news, unfortunately, is that the check is not in the mail. We have given them a resolution but we are still paying the piper in terms of things that military families need in order to make their life better. I do not understand why we are doing that. This bill shows the House’s “support and appreciation” by providing $1.5 billion less than we appropriated last year to provide the military with decent housing and work places.

The bill also thanks the military supposedly by cutting the President’s own request for the Pentagon by $180 million. This for hangers, offices, fitness centers and teaching facilities that even OMB and the administration said the military needed. But this bill cuts them out.

Many Members of this House have seen the problems for themselves. The Pentagon itself rates the readiness of most military facilities as marginal or worse. Over 225,000 service members and their families cannot get decent barracks or decent housing. This bill is not up to the job and we all know why. It is not the fault of the subcommittee chairman. It is the fault of every single Member of this House who voted for the budget resolution which said that the only priorities for this year was going to be tax cuts. And as you know, the lion’s share of the tax cuts went into the pockets of the most wealthy 1 percent of people in this country.

So as a result of that decision by the Republican leadership to put tax cuts as the primary goal of this Congress, the Pentagon itself rates the readiness of most military facilities as marginal or worse. Over 225,000 service members and their families cannot get decent barracks or decent housing. This bill is not up to the job and we all know why. It is not the fault of the subcommittee chairman. It is the fault of every single Member of this House who voted for the budget resolution which said that the only priorities for this year was going to be tax cuts. And as you know, the lion’s share of the tax cuts went into the pockets of the most wealthy 1 percent of people in this country.

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for E-1s, E-2s and O-1s at 2 percent, well below the average raise of 4.1 percent.

The Senate version of the defense bill rejects that idea, and would provide minimum 3.7 percent and higher targeted hikes for some. But the House version of the bill goes along with Bush, making this an issue still to be hashed out in upcoming negotiations.

All of which brings us to the latest indignity—Bush’s $92 billion military construction request for 2004, which was set a full $1.5 billion below this year’s budget on the expectation that Congress, as has become tradition in recent years, would add funding as it drafted the construction appropriations bill.

But we have left little elbow room in the 2004 federal budget that is taking shape, and the squeeze is on across the board.

The result: Not only has the House Appropriations military construction panel accepted Bush’s proposed $1.5 billion cut, it voted to reduce construction spending by an additional $41 million next year.

Rep. David Obey, D-Wis., senior Democrat on the House Appropriations Committee, took a stab at restoring $1 billion of the $1.5 billion subtracted in construction. He proposed to cover that cost by trimming recent tax cuts for the roughly 200,000 Americans who make more than $1 million a year. Instead of a tax break of $88,300, they would receive $83,500.

The Republican majority on the construction appropriations panel quickly shot Obey down.

And the outlook for fixing this pork next year in tackling the huge backlog of work that needs to be done on crumbling military housing and other facilities is bleak at best.

Taken piecemeal, all these corner-cutting moves might be viewed as mere flesh wounds to our troops and their families. A $15,000 infantryman might be able to fix his own clammy, cramped barracks that do not even meet very low DOD standards. The truth is that there are 128,680 military families, people that on this floor just a few minutes ago were called professional, the best, clearly dedicated, 128,680 of those families are living in housing that does not meet very low DOD standards.

By the way, just for the record, let me point out what is defined as meeting the quality standard required by the Department of Defense. In the bill that the —No. 1

The truth is, as the gentlewoman from North Carolina said, we ask a lot from our servicemen and -women; and I stand in this House today to say that this bill, despite the tremendous, valiant efforts of the gentleman from Texas (Mr. DELAY), the majority leader of the House Republican majority voted to cut those troops’ future veterans benefits by $28 billion. There is a clear record here; and, yes, it is a clear signal to our servicemen and -women.

It is that we are not cutting your benefits, your housing, your children’s education, your day care clinics, your health facilities in order to pay for the promise of the gentleman from Texas (Mr. DELAY), who said that in time of war, nothing is more important than tax cuts.

Unfortunately, the vast majority of the 44,000 Army soldiers that I have the privilege to represent at Fort Hood in Texas get very little. Texas gets tiny tattle at all out of those tax cuts, while the millionaires will average, not the millionaires but the people making over $1 million a year will average more than $88,000 in tax cuts.

How serious is the housing problem for our servicemen and -women? Maybe they already have quality housing. Perhaps there is a Member of this House or some member of the public, Mr. Speaker, that has not visited our installations recently. Maybe they think that’s the lap of luxury. Let me present the facts.

The fact is that there are 83,000 servicemen and -women living in inadequate barracks that do not even meet the lowest Department of Defense standards. The truth is that there are 128,680 military families, people that on this floor just a few minutes ago were called professional, the best, clearly dedicated, 128,680 of those families are living in housing that does not meet very low DOD standards.

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except for pro forma amendments or to a demand for a division of the question in the committee of the whole or in the House.

SEC. 3. The amendment referred to in section 2 is as follows:

On page 2, line 13, under the heading "Military Construction, Army", delete the dollar amount and insert $1,726,660,000.

On page 3, line 13, under the heading "Military Construction, Navy", delete the dollar amount and insert $1,311,907,000.

On page 4, line 5, under the heading "Military Construction, Air Force", delete the dollar amount and insert $962,500,000.

On page 4, line 21, under the heading "Military Construction, Defense Wide", delete the dollar amount and insert $872,110,000.

On page 5, line 20, under the heading "Military Construction, Army National Guard", delete the dollar amount and insert $231,960,000.

On page 7, line 19, under the heading "Family Housing Construction, Air National Guard", delete the dollar amount and insert $701,190,000.

And on page 9, line 6, under the heading "Family Housing Construction, Navy and Marine Corps", delete the dollar amount and insert $288,193,000.

And on page 11, under the heading "Family Housing Construction, Air Force", delete the dollar amount and insert $841,065,000.

At the end of the bill, add the following:

Section. In the case of taxpayers with adjusted gross income tax excess of $1,000,000 for the tax year beginning in 2003, the amount of tax reduction resulting from enactment of the Jobs and Growth Tax Relief Reconciliation Act of 2003 shall be reduced by five percent.

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

The SPEAKER pro tempore. The question is on ordering the previous question.

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

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

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

The Sergeant at Arms will notify absent Members.

Pursuant to clause 9 of rule XX, the Chair will reduce to 5 minutes the minimum time for electronic voting, if ordered, on the question of adoption of the resolution.

The vote was taken by electronic device, and there were—yes 220, nays 200, not voting 14, as follows:

[A roll call vote was taken.]

H5978  CONGRESSIONAL RECORD—HOUSE  June 26, 2003

\begin{table}[H]
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\begin{tabular}{ll}
\hline
Abercrombie & Crowley \\
Ackerman & Cummings \\
Alander & Davis (CA) \\
Allen & Davis (FL) \\
Anders & Davis (TX) \\
Andrews & DeFazio \\
Aran & Delahunt \\
Baca & Delahanty \\
Baird & DelBerto \\
Baldwin & DeSoto \\
Balcer & DeSoto \\
Bel & Deputy \\
Berman & Dingell \\
Berlingo & Dingell \\
Bishop (GA) & Doggett \\
Bishop (NY) & Doyle \\
Blumenauer & Emanuel \\
Boswell & Engel \\
Boucher & Ellison \\
Boyd & Etheridge \\
Brady (PA) & Farr \\
Brown (OH) & Farr \\
Brown, Corrine & Fattah \\
Bucks & Filer \\
Capps & Flores \\
Capuano & Ford \\
Card & Frank (MA) \\
Cardoz & Frost \\
Carson (IN) & Gonzalez \\
Case & Garamendi \\
Casey & Garamendi \\
Chabot & Hall \\
Bright & Hansen \\
Biggs & Hastings (FL) \\
Billikirk & Hill \\
B italia & Issakson \\
Bible & Itok \\
Bilirakis & John (CT) \\
Bilirakis & Johnson, Sam \\
Bilirakis & Jones (NC) \\
Bilirakis & Kelly \\
Bilirakis & King (NJ) \\
Bilirakis & Kirk \\
Bilirakis & LaHood \\
Bilirakis & Larson (WA) \\
Bilirakis & LaTourette \\
Bilirakis & Leach \\
Bilirakis & Lewis (NY) \\
Bilirakis & Linder \\
Bilirakis & Llobrido \\
Bilirakis & Lofgren \\
Bilirakis & Longworth \\
Bilirakis & Lon \\
Bilirakis & Lowey \\
Bilirakis & Lucas (KY) \\
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Bilirakis & Reynolds \\
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Bilirakis & Rogers (MI) \\
Bilirakis & Rohrabacher \\
Bilirakis & Roe \\
Bilirakis & Ryan (NY) \\
Bilirakis & Ryan (TX) \\
Bilirakis & Saxton \\
Bilirakis & Schakowsky \\
Bilirakis & Sessions \\
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Bilirakis & Wicker \\
Bilirakis & Wilson (NC) \\
Bilirakis & Wolf \\
Bilirakis & Porter \\
Bilirakis & Portman \\
Bilirakis & NAYS—200 \\
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The SPEAKER pro tempore. Is there objection to the request of the gentleman from Michigan? There was no objection.

MILITARY CONSTRUCTION APPROPRIATIONS ACT, 2004

The SPEAKER pro tempore. Pursuant to House Resolution 298 and rule XVIII, the Chair declares the House in the Committee of the Whole House on the State of the Union for the consideration of the bill, H.R. 2559.

Accordingly, the House resolved itself into the Committee of the Whole House on the State of the Union for the consideration of the bill (H.R. 2559) making appropriations for military construction, family housing, and base realignment and closure for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes, with Mr. Bass in the chair.

The Clerk read the title of the bill. The CHAIRMAN. Pursuant to the rule, the bill is considered as having been read the first time.

Under the rule, the gentleman from Michigan (Mr. KOLLENBERG) and the gentleman from Texas (Mr. EDWARDS) each will control 30 minutes.

The Chair recognizes the gentleman from Texas (Mr. BASS) in the chair.

Mr. BASS. Mr. Speaker, it is my pleasure to present to the House H.R. 2559, the fiscal year 2004 military construction appropriations bill. This legislation provides funds for all types of construction projects on military installations here in the U.S. and abroad. Projects range from barracks and housing to training ranges and runways.

I would like to thank my ranking member, the gentleman from Michigan (Mr. KOLLENBERG), and the gentleman from Texas (Mr. EDWARDS) for their hard work on this legislation.

Mr. KOLLENBERG. Mr. Chairman, it is my pleasure to present to the House the fiscal year 2004 military construction appropriations bill. This legislation provides funds for all types of construction projects on military installations here in the U.S. and abroad. Projects range from barracks and housing to training ranges and runways.

I would like to thank my ranking member, the gentleman from Texas (Mr. EDWARDS), for his advice and support and cooperation in producing this recommendation. He has been a good partner, and I appreciate having the gentleman there to work together on this bill.

I would also like to express my appreciation to all members of the subcommittee for their help in putting together this year's bill. I commend the good work done by the subcommittee staff, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldassarre, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldassarre, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldassarre, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldassarre, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldassarre, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldassarre, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldassarre, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldassarre, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldassarre, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldassarre, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldassarre, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldassarre, Tom Forhan, Brian Potts, Mary Arnold, Kim Reath, and Valerie Baldassarre.

I appreciate the long hours they have put in making this the best bill possible.

The bill presented today totals $9.196 billion, which complies with the 302(b) allocation for both budget authority and outlays. This recommendation is, however, $41 million below the President's request, a reduction of less than 1% of the President's request. Even though this allocation is provided in response to the Global War on Terrorism and Operation Iraqi Freedom, the bill is $605 million or 6 percent below fiscal year 2003 enacted levels.

For the first time in recent memory, this subcommittee has produced a recommendation that is below the President's request. This is the hand that we were dealt under current budgetary constraints, and we have tried to deal with it in a fair manner.

I assure Members the committee did due diligence to find, rather than to nourish, the results thus far, this is an exciting development. It means that we are living with our community without our families and children, and it will come at a cost, no cost to the family housing account in this bill.

The bottom line is that the funding in this bill does not slow down the effort to revitalize our military family housing. In fact, that effort is accelerating because of this privatization initiative.

I would like to take a moment to highlight some key areas in the bill. First, $1.24 billion is provided for troop barracks. This is a $62 million increase from last year's level. This sends a positive message to our unaccompanied personnel stationed all around the world that their quality of life is a priority.

The bill includes $319 million for hospital and medical facilities, an increase of $20 million above last year's level. This is another positive quality-of-life message, one intended for all service members as well as their families. $274 million is provided for community facilities, an increase of $6 million above the President's request. These facilities include child development centers, fire stations, schools, and physical fitness centers.
$465 million is provided for the Guard and Reserve components, an increase of $95 million above the President's request.

The bill fully funds the President's request of $1.2 billion for new family housing units and improvements to existing units, and $2.7 billion is provided for the operation and maintenance of existing family housing units.

I would like to highlight the overseas military construction program for just one moment. In support of a global repositioning effort, the President's amended budget submission and the recommendation before Members today rescinds and/or reduces overseas construction requirements by $327 million. Of these reductions, $279 million has been applied to construction requirements in the United States. It is my opinion additional cuts will adversely impact the quality of life and mission readiness of our troops living overseas, including those who are fighting the war against terrorism and also in Operation Iraqi Freedom. Therefore, I cannot recommend additional cuts in this area to my colleagues.

We have worked closely with the authorization committee in producing this legislation. I would like to take this opportunity to thank the gentleman from Colorado (Mr. Hefley) and his staff for their assistance.

In conclusion, we have focused our efforts on programs that directly support the men and women in our Armed Forces. We would like to do more. We always have and always will. But in my opinion, the recommendations in this bill are solid and fully fund projects that are vital to the security of the United States. The bottom line is this: with this bill, we meet the military's mission critical infrastructure needs and enable its efforts to improve the quality of life for our men and women in the Armed Forces. This is a fair bill. I encourage all my colleagues to support it.

Mr. Chairman, I include the following tabular material for the RECORD:
<table>
<thead>
<tr>
<th>Description</th>
<th>FY 2003 Enacted</th>
<th>FY 2004 Request</th>
<th>Bill</th>
<th>Bill vs. Enacted</th>
<th>Bill vs. Request</th>
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<td>896,136</td>
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<td>Military construction, Defense-wide</td>
<td>836,345</td>
<td>815,113</td>
<td>813,613</td>
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<td>Defense emergency response fund (DERF)</td>
<td>33,300</td>
<td>---</td>
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<tr>
<td>Subtotal</td>
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<td>815,113</td>
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<td>814,116</td>
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<td>Military construction, Army National Guard</td>
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<td>Total</td>
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<td>60,430</td>
<td>77,105</td>
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<td>Military construction, Army Reserve</td>
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<td>68,478</td>
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<td>Military construction, Naval Reserve</td>
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<td>28,032</td>
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<td>Defense emergency response fund (DERF)</td>
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<td>-7,117</td>
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<td>Budget Authority for 2003 and Budget Requests and Amounts Recommended in the Bill for 2004</td>
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<td>(Amounts in thousands) (H.R. 2559)</td>
<td>FY 2003</td>
<td>FY 2004 Request</td>
<td>Bill</td>
<td>Bill vs. Request</td>
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<td>Military construction, Air Force Reserve</td>
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<td>44,312</td>
<td>56,212</td>
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<td>Defense emergency response fund (DERF)</td>
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<tr>
<td>Subtotal</td>
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<td>44,312</td>
<td>56,212</td>
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<td>+11,190</td>
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<td>Total, Reserve components</td>
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<td>Total, Military construction</td>
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<td>(662,641)</td>
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<td>---</td>
<td>(662,641)</td>
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<td>Recissions</td>
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<td>North Atlantic Treaty Organization Security Investment Program</td>
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<td>81,455</td>
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<td>Rescission</td>
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<td>180,608</td>
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<td>Rescission</td>
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<td>682,062</td>
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<td>-29,631</td>
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<td>834,468</td>
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<td>-8,394</td>
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<td>Supplemental appropriations (P.L. 108-11)</td>
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<tr>
<td>Total</td>
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<td>836,268</td>
<td>826,074</td>
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<td>Family housing construction, Defense-wide</td>
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<td>350</td>
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<td>Department of Defense Family Housing Improvement Fund</td>
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<td>Base realignment and closure account</td>
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<td>370,427</td>
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<td>General provision (sec. 118)</td>
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<td>55,000</td>
<td>55,000</td>
<td>+55,000</td>
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<tr>
<td>Grand total: New budget (obligational) authority</td>
<td>10,696,800</td>
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<td>(9,536,541)</td>
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<td>---</td>
<td>(-692,232)</td>
<td>---</td>
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<tr>
<td>Recissions</td>
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<td>(-153,373)</td>
<td>(-340,541)</td>
<td>(-238,614)</td>
<td>(-187,168)</td>
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</table>
Mr. Chairman, I reserve the balance of my time.

Mr. EDWARDS. Mr. Chairman, I yield myself such time as I may consume.

Mr. Chairman, I am going to vote for this military construction bill for one reason and for one reason alone. I believe the gentleman from Michigan, the chairman of our committee, has worked very hard and in a fair and bipartisan manner from day one on this bill. He and his capable staff have worked diligently and professionally to deal with a $1.5 billion military construction cut. This grossly inadequate funding level was not the decision of the gentleman from Michigan or myself. The gentleman from Michigan has a deep and genuine commitment to supporting a high quality of life for our servicemen and -women and their families. I know that firsthand. This decision was made above his pay grade and above mine. As the chairman and the ranking member of the Subcommittee on Military Construction, our responsibility is to take whatever funding level is given to us and invest those resources in a way that will fund the highest possible military construction priorities. I believe that is what the gentleman from Michigan, our subcommittee, and I have done; and that is why I will vote for this bill.

However, Mr. Chairman, I would be remiss and I believe it would be the height of irresponsibility for me not to speak honestly to our colleagues about what I consider to be the serious implications of cutting military construction funding by $1.5 billion. By the way, that is before the consideration of inflation. In my opinion, cutting military quality of life and military training investments during a time of war breaks faith with America's servicemen and -women and their families. I am deeply disappointed that the administration and the House leadership and the Senate leadership and the ranking members of the Appropriations Committee, and I say to my colleagues, as they have worked diligently and professionally to deal with this, that massive tax cut that we have already signed into law.

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

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

June 26, 2003

CONGRESSIONAL RECORD — HOUSE

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Mr. Chairman, that is a statement not from a Democrat or Republican in this House, but from the “Army Times” editorial. I think we should listen to the words and spirit of that editorial. I do not think our servicemen and -women are going to accept lip service, including the risking of their lives. It is time for us to give them more than lip service when it comes to committing to making tough choices, committing to ensure that they can have a better life for their children. Housing, have day care for their children and quality schools for their families.

Mr. KNOLENBERG. Mr. Chairman, I have no further requests for time, and I reserve the balance of my time.

Mr. EDWARDS. Mr. Chairman, I yield 6 minutes to the distinguished gentleman from Florida (Mr. OBEY), the ranking Democrat on the full Committee on Appropriations who made an effort earlier this day to offer an amendment that was closed off by the Republican leadership to add nearly $1 billion of commitment to our servicemen and -women and our quality of life programs.

Mr. OBEY. Mr. Chairman, I thank the gentleman for yielding me this time.

I want to express my agreement with the comments made by the gentleman from Florida (Mr. YOUNG), the distinguished chairman of this committee. And then I want to say this: Budgets are not just presentations of numbers. Budgets really reflect and define and exhibit our priorities and our values. And that is why this bill is such a sad commentary on the nature of this House.

When President Bush came into office, thanks in part to the fiscal discipline demonstrated by the previous administration, we expected to see at least $6 trillion worth of surpluses over the next decade. We were in the best shape that we had been fiscally in more than a generation. So the President decided that we could afford to provide very large tax cuts, and he estimated we would still have billions left over for other purposes, and the House passed those tax cuts. My point is that then something happened that was totally unexpected. We got hit by 9/11 and the economic downturn that followed that. Any person of prudence in my view, having seen such a shocking change, would have been careful about the next step that they took, but this Congress and this White House, alas, was not. So despite the fact that the bottom was falling out of the economy and the bottom was falling out of Government revenues, the White House and this Congress decided they were going to push on with even larger tax cuts. We said that we needed to do it in order to create jobs.

But, not a single job has been created during the tenure of the Bush administration. In fact, we have lost almost 3 million jobs since President Bush took office. Part of that is not his responsibility; part of it in my view is, and the Congress’s as well. My point is that when conditions change one would think that their approach and their recommendations also would change. We have gotten only one answer out of the administration in terms of dealing with the economy: Tax cuts, tax cuts, tax cuts, no matter how badly they are skewed to the upper reaches of the income distribution, and no matter how they cost to the other people in this society. And this bill is one of the examples of what it costs.

When this House passes these tax cuts, it pretends that there is no cost to anyone else. Let me just spell out what some of the costs are. Those tax cuts mean that we will be paying $23 billion more in interest payments next year than we would otherwise be paying. Before these tax cuts play out we will be spending more on interest payments in the Federal budget than we will be spending on all domestic appropriation items reported by this committee, and it will be a gargantuan share of the Federal budget. We ought to be able to make better judgments than that.

But there are other costs as well. We passed the “No Child Left Behind Act” for education, sent mandates out to the States and said we would send cash out to help pay for those mandates. I’ve news for you, the appropriations bill that is going to come out will short sheet those education programs by $8 billion. Nobody knows that, but that is what is going to happen. And this is happening at a time when budget crunches all over the country are going to be squeezing States and squeezing local governments. We are also having to squeeze down on what we provide in health care. There are thousands and thousands of families being pushed off health care in many States in the Union. And this bill represents what is going to happen to military families, because we are cutting $1.5 billion below the deliverable amount in the previous year’s budget for military families under military construction. And we wind up making only token progress in improving the housing for military families and for single enlisted people.

The cost of the estate tax elimination, which this House just passed: For the cost of that money it took to take millionaires off the tax roll when we passed that estate tax change, that is going to cost $800 billion—for that $800 billion, we could close one-third of the gap in financing that will be existing in the Social Security system. We should have done that first. But we did not. We passed another huge tax cut for the high rollers.

So there are consequences, and there are costs to those tax cuts. The gentleman from Florida (Mr. YOUNG) is right. He cannot perform a miracle.
Neither can the gentleman from Michigan (Mr. KNOLLENBERG). Appropriations are the table scraps that are left over after this House has decided to plunge ahead, promising all of those out-sized tax cuts to the American people while robbing those same tax cuts to the American people who are the backbone of this country. It is not much to be gained personally or politically by defending quality of life commitments overseas, because those folks are not living in our districts at this time. The gentleman from Michigan (Mr. KNOLLENBERG) said no to that kind of cut because he knew that would have been the wrong thing to do. I salute him and I hope with his dedication and the gentleman's (Mr. YOUNG) and the gentleman from Wisconsin's (Mr. OBEY) and other Members of this House's dedication, we will see before this year ends we can pass a military construction bill that we can look our servicemen and women in the eye and say we are proud of them and we do salute them with more than just words.

So I ask my colleagues, despite my reservations, to support the tremendous efforts of the gentleman from Michigan (Mr. KNOLLENBERG) and our subcommittee.

Mr. ORTIZ. Mr. Chairman, I rise this evening in support of our men and women in the Armed Services. For many weeks now, we have all declared our gratitude to those who make over a million dollars a year, so we can restore funding and adequate quality of life and training investments to our military and the facilities and have observed the substandard conditions and facilities in my district that have paid this price. I, myself, have had more than my share of fathers or mothers or spouses present on a daily basis because of numerous, long, and dangerous deployments, or even worse, if their loved one has paid the ultimate sacrifice. I am glad that we are able to work across party lines to ensure that military construction spending by $1.5 billion from last year's funding, we can still do the right thing at this time by voting for the Previous Question. We must support the Ranking Member's efforts and truly show our gratitude to our troops.

Mr. DICKS. Mr. Chairman, I would like to commend Chair Mr. KNOLLENBERG and Ranking Member EDWARDS for their work on this bill. They have done their best with an unreasonable and unacceptable allocation. I know they share my deep disappointment over this level of funding, which is $1.5 billion less than was appropriated for Military Construction & Family Housing last year.

Unfortunately this cut makes a bad situation worse. When the Bush administration came into office, they found a Department of Defense with facilities for service members and women overseas, because I know there was an effort made to make additional cuts in some of those facilities. There is not much to be gained personally or politically by defending quality of life commitments overseas, because those folks are not living in our districts at this time. The gentleman from Michigan (Mr. KNOLLENBERG) said no to that kind of cut because he knew that would have been the wrong thing to do. I salute him and I hope with his dedication and the gentleman's (Mr. YOUNG) and the gentleman from Wisconsin's (Mr. OBEY) and other Members of this House's dedication, we will see before this year ends we can pass a military construction bill that we can look our servicemen and women in the eye and say we are proud of them and we do salute them with more than just words.

So I ask my colleagues, despite my reservations, to support the tremendous efforts of the gentleman from Michigan (Mr. KNOLLENBERG) and our subcommittee. 
Appropriations Act for Fiscal Year 2004. It is the second bill we are considering pursuant to the 302(b) allocations adopted by the Appropriations Committee on June 17th. I am pleased to report that it is consistent with the levels established in H. Con. Res. 95, the House continuing resolution on the budget for fiscal year 2004, which Congress adopted on April 10. The budget resolution provided $400.1 billion in discretionary budget authority for national defense. This bill funds the military construction and family housing portion of that commitment to our men and women in uniform.

H.R. 2559 provides $9.196 billion in new budget authority and $10.282 billion in outlays for fiscal year 2004. It is therefore identical to its 302(b) allocation to the House Subcommittee on Military Construction Appropriations. It does not contain emergency-authorized new BA. It does include $340.5 million in rescissions of previously enacted BA. Although budget authority in the bill declines by 12.8 percent from the previous year, it is $81 million above the President's request. This mainly because H.R. 2559 contains a procurement appropriation of $120 million that, according to CBO, was part of the administration's request for the Defense appropriation bill rather than this bill.

The bill complies with section 302(f) of the Budget Act which prohibits consideration of bills in excess of an appropriations subcommittee's 302(b) allocation of budget authority and outlays established in the budget resolution.

H.R. 2559 represents this House's solemn commitment to assure that our men and women in uniform put their lives on the line for freedom. It not only addresses the long-term infrastructure problems at military bases, it sustains barracks, family housing, medical facilities, and child support centers across the country and overseas. It also provides infrastructure funding for National Guard and Reserve troops who now find themselves on the front lines of the war against terrorism. Finally, it incorporates the results of real-world national security policy changes: The redeployment south of U.S. military forces away from the North Korean border to better protected bases, and the gradual drawdown of troops from some Central European bases.

In conclusion, I express my support for H.R. 2559.

Mr. FRELINGHUYSEN. Mr. Chairman, I rise in strong support of H.R. 2559, making appropriations for military construction for fiscal year 2004. This legislation is a strong product for tough times and I want to commend the Subcommittee Chairman, the gentleman from Michigan, Mr. KLOLOGELBER, and the Gentlemen from Texas, Mr. Edwards.

This legislation provides $9.2 billion in funding for military construction and family housing projects across the country.

While no one is satisfied with the bottom line on this bill and we all wish that it could not do more, this is a solid product. It satisfies our obligation to ensure that our men and women in uniform live in, train at, and deploy from adequate facilities. This bill shows our commitment to our service members by constructing and upgrading military installations, and supporting family housing in the United States and overseas.

Improving the quality of life for our men and women in uniform throughout the world is critically important. If we are asking these brave men and women to protect our national security, then we must ensure that they have the tools and the facilities to protect themselves. America's armed forces have been charged with developing the capabilities to fight jointly and with coalition partners to secure victory in the future, transforming the transition to a more flexible, more agile, lighter and more lethal force.

In this context, I am pleased the Committee has included funding for a state-of-the-art explosives loading facility at the Army's "Honor of Lethality"—Picketary Arsenal in New Jersey.

In Afghanistan and Iraq, the achievements of our young men and women in uniform are due in part to the incredible technological advances employed by our military, much of which has been researched and developed by Picketary Arsenal—the only Army-owned, Army-operated facilities for the research and development of energetic materials (mines, armor, warheads, artillery, etc.) in the nation. The new facility will mark an important step in strengthening traditional explosives and process controls that will benefit the other branches of the military that rely on Army research and development expertise.

Mr. Chairman, once again I commend Mr. KLOLOGELBER and Mr. Young and I urge support for this.

Mr. FRANKS of Arizona. Mr. Chairman, today I urge your consideration of the authorization of $14.3 million for land acquisition to preserve access to the Barry M. Goldwater Range. This land acquisition would serve to prepare the region for future development and encroachment, and to increase the margin of safety in the Live Ordnance Departure Area located southwest of Lake Air Force Base.

The Barry M. Goldwater Range, a 2.7 million acre land and airspace area in southwest Arizona, is the crown jewel of all flight ranges, providing the Air Force with the space necessary to conduct live-fire training and simulating realistically the dimensions of a modern battlefield.

Luke Air Force Base—with its year-round idealic weather—is the training home to the F-16 Fighting Falcon. With an average of 170 sorties flown each day, access to the Barry M. Goldwater Range is an essential part of the advanced training and practice required of the Air Force fighter pilots. The southern departure corridor from Luke Air Force Base is the only air corridor where live ordnance can be carried out by F-16 Fighters. The threat of advancement and increased pressure of residential development from what has traditionally been isolated farmland places the mission and the future of Luke Air Force Base at risk.

The Senate Appropriations Committee also made this $14.3 million request stating, "Continued residential development of the departure corridors could impair Luke [Air Force Base]'s ability to support sorties carrying live ordnance and to fully utilize the [Barry M. Goldwater Range]. . . . and further encompassingLuke [Air Force Base]'s access to the [Barry M. Goldwater Range] may adversely impact Luke's mission and result in a degradation to the national security."

Mr. EDWARDS. Chairman, I yield back the balance of my time.

Mr. KLOLOGELBER. Mr. Chairman, I yield back the balance of my time.

Mr. Chairman. All time for general debate has expired.
Mr. OBEY. Mr. Chairman, I ask unanimous consent that the amendment be considered as read and printed in the RECORD.

The CHAIRMAN. The point of order is reserved.

Mr. OBEY. Mr. Chairman, I have already explained to the House what the intention of this amendment is. This amendment would restate the $360 million of tax cuts from the President's budget for hangers, maintenance shops, office space, physical fitness facilities for the military that even the White House thought were crucial. It adds $480 million for family housing to help at least 2,500 military families. There are 134,000 inadequate units that service those families to date. It would add $318 million for new barracks. It would help get 5,300 single service personnel into decent housing. The Pentagon says there is a need for over 83,000 unit fix-ups. And it would pay for that by reducing the expected tax cut for those with adjusted gross incomes of more than $1 million dollars annually. We would adjust their tax cuts from $88,000 to $53,000, thus enabling them to keep 55 percent of the tax cut. That would free up enough money to meet these military needs, and I would urge the House, despite the action of the Committee on Rules, to allow this amendment to go forward.

Motion to Concede a Point of Order

The CHAIRMAN. Does the gentleman from Michigan (Mr. KNOLENBERG) insist on his point of order?

Mr. KNOLENBERG. Mr. Chairman, I do. I make a point of order against the amendment because it proposes to change the existing law and constitutes legislation in an appropriations bill and therefore violates clause 2 of rule XXI, which states in part: "An amendment to a general appropriations bill shall not be in order if changing existing law."

At this time I ask for a ruling from the Chair.

Mr. OBEY. Mr. Chairman, I would like to be heard on the point of order. The CHAIRMAN. The gentleman from Wisconsin.

Mr. OBEY. Mr. Chairman, what has been happening in this House is that the Committee on Rules has routinely been waiving points of orders for the majority but denying those same waivers to the minority. That puts us in an uneven position on the House floor. We are in that kind of position on this amendment. I want to simply say in conceding the point of order that I will continue to make this motion on this bill. I will hold it in my motion to recommit. I will try at every stage of the process to get this matter before the House so we can make these priority judgments, and it is up to the majority whether it wants to knock them off the floor or not.

The CHAIRMAN. The gentleman's point of order is conceded and sustained.

The Clerk will read.

Mr. KNOLENBERG. Mr. Chairman, I ask unanimous consent that the remainder of the bill, through page 19, line 19 be considered as read, printed in the RECORD and open to amendment at any point.

The CHAIRMAN. Is there objection to the gentleman from Michigan?

There was no objection.

The text of the remainder of the bill, from page 3, line 5, though page 19, line 19 is as follows:

**Military Construction, Navy (Including Recission)**

For acquisition, construction, installation, and equipment of temporary or permanent public works, naval installations, facilities, and real property for the Navy as currently authorized by law, and for the Naval Facilities Engineering Command and other personal services necessary for the purposes of this appropriation, $1,211,077,000, to remain available until September 30, 2008:

Provided, That of this amount, not to exceed $65,612,000 shall be available for study, planning, design, architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor:

MILITARY CONSTRUCTION, AIR FORCE (INCLUDING RESCISSION AND TRANSFER OF FUNDS)

For acquisition, construction, installation, and equipment of temporary or permanent public works, military installations, facilities, and real property for the Air Force as currently authorized by law, $866,136,000, to remain available until September 30, 2008:

Provided, That of this amount, not to exceed $80,543,000 shall be available for study, planning, design, architect and engineer services, as authorized by law, unless the Secretary of Defense determines that additional obligations are necessary for such purposes and notifies the Committees on Appropriations of both Houses of Congress of his determination and the reasons therefor.

MILITARY CONSTRUCTION, DEFENSE-WIDE (INCLUDING RESCISSION AND TRANSFER OF FUNDS)

For acquisition, construction, installation, and equipment of temporary or permanent public works, installations, facilities, and real property for activities and agencies of the Department of Defense (other than the military departments), as currently authorized by law, $831,613,000, to remain available until September 30, 2008: Provided, That such amounts of this appropriation as may be determined by the Secretary of Defense may be transferred to such appropriations of the Department of Defense available for military construction or family housing as he may designate, to be merged with and to be available for the same purposes, and for the same periods, as the funds to which such transfers are made.

MILITARY CONSTRUCTION, ARMY NATIONAL GUARD

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Army National Guard, and contributions therefor, as authorized by chapter 1903 of title 10, United States Code, and Military Construction Authorization Acts, $208,033,000, to remain available until September 30, 2008.

MILITARY CONSTRUCTION, ARMY RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Army Reserve as authorized by chapter 1903 of title 10, United States Code, and Military Construction Authorization Acts, $84,999,000, to remain available until September 30, 2008.

MILITARY CONSTRUCTION, NAVAL RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Naval Reserve as authorized by chapter 1903 of title 10, United States Code, and Military Construction Authorization Acts, $80,309,000, to remain available until September 30, 2008.

MILITARY CONSTRUCTION, AIR FORCE RESERVE

For construction, acquisition, expansion, rehabilitation, and conversion of facilities for the training and administration of the Air Force Reserve as authorized by chapter 1903 of title 10, United States Code, and Military Construction Authorization Acts, $82,914,000, to remain available until September 30, 2008.

NORTH ATLANTIC TREATY ORGANIZATION SECURITY INVESTMENT PROGRAM

For the United States share of the cost of the North Atlantic Treaty Organization Security Investment Program for the acquisition and construction of military facilities and installations (including international military headquarters, training and equipment expenses for the collective defense of the North Atlantic Treaty Area as authorized in Military Construction Authorization Acts and section 2806 of title 10, United States Code, $169,300,000, to remain available until expended.
For expenses of family housing for the Army for construction, including acquisition, replacement, addition, expansion, extension and alteration, as authorized by law, $409,191,000, to remain available until September 30, 2008: Provided, That the funds appropriated for "Family Housing Construction, Army" under Public Law 107–249, $52,300,000 are rescinded.

For expenses of family housing for the Army for construction, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $1,043,028,000.

For expenses of family housing for the Navy and Marine Corps for construction, including acquisition, replacement, addition, expansion, extension and alteration, as authorized by law, $184,193,000, to remain available until September 30, 2008: Provided, That the funds appropriated for "Family Housing Construction, Navy and Marine Corps" under Public Law 107–249, $3,585,000 are rescinded.

For expenses of family housing for the Air Force for construction, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $852,778,000.

For expenses of family housing for the Air Force for construction, including acquisition, replacement, addition, expansion, extension and alteration, as authorized by law, $657,065,000, to remain available until September 30, 2008: Provided, That the funds appropriated for "Family Housing Construction, Air Force" under Public Law 107–249, $19,347,000 are rescinded: Provided further, That the funds appropriated for "Family Housing Construction, Air Force" under Public Law 107–249, $3,585,000 are rescinded.

For expenses of family housing for the Air Force for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $825,074,000.

For expenses of family housing for the Air Force for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $49,440,000.

For expenses of family housing for the Army for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $826,280,000.

For expenses of family housing for the Army for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $300,000, to remain available until expended, for family housing initiatives undertaken pursuant to section 2883 of title 10, United States Code, providing alternative means of acquiring and improving family housing and supporting facilities.

For expenses of family housing for the Army for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $1,043,028,000.

For expenses of family housing for the Army for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $52,300,000.

For expenses of family housing for the Army for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $1,043,028,000.

For expenses of family housing for the Army for operation and maintenance, including debt payment, leasing, minor construction, principal and interest charges, and insurance premiums, as authorized by law, $826,280,000.
the appropriation “Foreign Currency Fluctuations, Construction, Defense’’ to be merged with and to be available for the same time period and for the same purposes as the appropriation to which it is transferred.

SEC. 119. The Secretary of Defense is to provide the Committees on Appropriations of the Senate and the House of Representatives with an annual report by February 15, containing details of the specific actions proposed to be taken by the Department of Defense during the current fiscal year and to encourage contributions of the North Atlantic Treaty Organization, Japan, Korea, and United States allies bordering the Arabian Sea to assume a greater share of the communal defense of such nations and the United States.

(TRANSFER OF FUNDS)

SEC. 120. During the current fiscal year, in addition to any other transfer authority provided at the Department of Defense, proceeds deposited to the Department of Defense Base Closure Account established by section 207(a)(1) of the Department Authorization Amendments and Base Closure Act of 2003 (Public Law 108-136) pursuant to section 207(a)(2)(C) of such Act, may be transferred to the account established by section 1022 of the Department Authorization Act of 1991, to be merged with, and to be available for the same purposes and the same time period as that account.

(TRANSFER OF FUNDS)

SEC. 121. Subject to 30 days prior notification to the Committees on Appropriations, such additional amounts as may be determined by the Secretary of Defense may be transferred to the Department of Defense Family Housing Improvement Fund from amounts appropriated for construction in “Family Housing Construction, Navy” to be merged with and to be available for the same purposes and for the same time period as amounts appropriated directly to the Department of Defense pursuant to the provisions of subchapter IV of chapter 169, title 10, United States Code, pertaining to alternative means of acquiring and improving military family housing and supporting facilities.

SEC. 122. None of the funds appropriated or made available by this Act may be obligated for Partnership for Peace Programs in the New Independent States of the former Soviet Union.

(TRANSFER OF FUNDS)

SEC. 123. During the current fiscal year, in addition to any other transfer authority made available to the Department of Defense, amounts may be transferred to the Department of Defense pursuant to the provisions of section 502(6) of the Congressional Budget Act of 1974, of direct loans or loan guarantees and direct credits by the Department of Defense pursuant to the provisions of section 1013(d) of the Demonstration Cities and Metropolitan Development Act of 1966 (42 U.S.C. 3374) to nonprofit organizations associated with the Homeowners Assistance Program. Any amounts transferred shall be merged with and to be available for the same purposes and for the same time period as the fund to which transferred.

SEC. 124. Notwithstanding this or any other provision of law, funds appropriated in Military Construction Appropriations Acts for operations and maintenance of family housing shall be the exclusive source of funds for repair and maintenance of all family housing units, including general or flag officer quarters, and for any other repair, maintenance, or improvement of any general or flag officer quarters for more than $35,000 per unit may be spent annually for the maintenance and repair of any general or flag officer quarters within 30 days advance prior notification to the appropriate committees of Congress, except that an after-the-fact notification shall be submitted if the limitation is exceeded solely due to costs associated with environmental remediation that could not be reasonably anticipated at the time of the transfer. Provided further, that the Secretary of Defense (Comptroller) is to report annually to the Committees on Appropriations all operations and maintenance of family housing projects at Camp Humphreys in the Republic of Korea until the Secretary of Defense certifies and reports to the appropriate committees of Congress that the United States and the Republic of Korea have entered into an agreement on the availability and use of land sufficient for such projects. The certification must be presented to the committees no later than September 30, 2004, or the funds expire.

The CHAIRMAN. Are there any amendments? If not, the Clerk will read the bill. The Clerk reads as follows: This Act may be cited as the “Military Construction Appropriations Act, 2004.”

The CHAIRMAN. Are there further amendments?

If not, under the rule, the Committee rises. Accordingly, the Committee rose; and the Speaker pro tempore, Mr. TORSWENBERG, having assumed the chair, Mr. BASS, Chairman of the Committee of the Whole House on the State of the Union, reported that the Committee, having had under consideration the bill (H.R. 2559) making appropriations for military construction, family housing, and base realignment and closure for the fiscal year ending September 30, 2004, and for other purposes, pursuant to House Resolution 298, he reported the bill back to the House.

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

The question is on the engrossment and third reading of the bill. The bill was ordered to be engrossed and read a third time, and was read the third time.

MOTION TO RECOMMIT OFFERED BY MR. OBEY

Mr. OBEY. Mr. Speaker, I offer a motion to recommit.

The SPEAKER pro tempore. Is the gentleman opposed to the motion to recommit?

Mr. KNOLENSBERG. Mr. Speaker, I reserve a point of order against the motion to recommit.

The SPEAKER pro tempore. A point of order is reserved.

Mr. OBEY. Mr. Speaker, I will not take the 5 minutes. This is simply the same motion I offered before. If this House were operating on the basis of any degree of fairness today, it would be before the House, and I would simply ask that the majority refrain from offering the point of order against it. I know they have their marching orders. They have to do what they have to do, and I have to do what I have to do.

Mr. OBEY. Mr. Speaker, I make a point of order against the motion to recommit because it proposes to change existing law and constitutes legislation in an appropriations bill, and, therefore, violates clause 2 of rule 388.

The rule states, in pertinent part, “An amendment to a general appropriation bill shall not be in order if changing existing law.” The amendment proposes to alter the application of existing law.

The SPEAKER pro tempore. Does the gentleman from Wisconsin wish to be heard on the point of order?
Mr. OBEY. Yes, I do, Mr. Speaker. As I said earlier, this is the same motion I made before. What is happening here is that because of a technical difference in the way the rules are being applied to the majority and the minority, we are being prevented from offering a motion which would strike a much better balance between the needs of our military and the needs of the most well-off people in this society. With that, I concede the point of order.

The SPEAKER pro tempore. The gentleman from Wisconsin concedes the motion.

Mr. OBEY. Mr. Chairman, I offer a motion to reconsider.

Mr. OBEY. I am, Mr. Speaker.

Mr. OBEY. I offer a motion to reconsider the bill, H.R. 2599, to the Committee on Appropriations.

The motion was rejected.

Mr. OBEY. Mr. Chairman, I offer a motion which would strike a much better balance between the needs of our military and the needs of the most well-off people in this society. With that, I concede the point of order.

The SPEAKER pro tempore. The SPEAKER pro tempore.

The question is on the motion to reconsider the bill, H.R. 2599, to the Committee on Appropriations.

The motion was rejected.

Mr. OBEY. Mr. Chairman, I offer a motion which would strike a much better balance between the needs of our military and the needs of the most well-off people in this society. With that, I concede the point of order.

The SPEAKER pro tempore. The SPEAKER pro tempore.

Mr. OBEY. Mr. Chairman, I offer a motion which would strike a much better balance between the needs of our military and the needs of the most well-off people in this society. With that, I concede the point of order.

The SPEAKER pro tempore. The SPEAKER pro tempore.

The question is on the motion to reconsider the bill, H.R. 2599, to the Committee on Appropriations.

The motion was rejected.

Mr. OBEY. Mr. Chairman, I offer a motion which would strike a much better balance between the needs of our military and the needs of the most well-off people in this society. With that, I concede the point of order.

The SPEAKER pro tempore. The SPEAKER pro tempore.

The question is on the motion to reconsider the bill, H.R. 2599, to the Committee on Appropriations.

The motion was rejected.

Mr. OBEY. Mr. Chairman, I offer a motion which would strike a much better balance between the needs of our military and the needs of the most well-off people in this society. With that, I concede the point of order.

The SPEAKER pro tempore. The SPEAKER pro tempore.

The question is on the motion to reconsider the bill, H.R. 2599, to the Committee on Appropriations.

The motion was rejected.

Mr. OBEY. Mr. Chairman, I offer a motion which would strike a much better balance between the needs of our military and the needs of the most well-off people in this society. With that, I concede the point of order.
The SPEAKER pro tempore (Mr. SWEENEY). Pursuant to clause 8 of rule XX, the pending business is the question of the Speaker's approval of the JOURNAL of the last day's proceedings.

The question is on the Speaker's approval of the JOURNAL, on which the yeas and nays are ordered.

This is a 5-minute vote.

The vote was taken by electronic device, and there were—yeas 357, nays 68, not voting 9, as follows:

[Roll No. 327]

YEAS—357

The vote was taken by electronic device, and there were—yeas 357, nays 68, not voting 9, as follows:
MAKING IN ORDER ON TUESDAY, JULY 8, 2003, CONSIDERATION OF DEPARTMENT OF DEFENSE APPROPRIATIONS ACT, 2004

Mr. LEWIS of California. Mr. Speaker, I ask unanimous consent that it be in order on Tuesday, July 8, 2003, for the Speaker, as though pursuant to clause 2(b) of rule XVIII, to declare the House resolved into the Committee of the Whole House on the State of the Union for consideration of a bill reported pursuant to section 6 of House Resolution 299 making appropriations for the Department of Defense for the fiscal year ending September 30, 2004, and for other purposes, which shall proceed according to the following order:

The first reading of the bill shall be dispensed with.

All points of order against consideration of the bill are waived.

General debate shall be confined to the bill and shall not exceed 1 hour equally divided and controlled by the chairman and ranking minority member of the Committee on Appropriations.

After general debate, the bill shall be considered for amendment under the 5-minute rule.

Points of order against provisions in the bill for failure to comply with clause 2 of rule XXI are waived.

During consideration of the bill for amendment, the Chairman of the Committee of the Whole may accord priority in recognition on the basis of whether the Member offering an amendment has caused it to be printed in the portion of the CONGRESSIONAL RECORD designated for that purpose in clause 8 of rule XVIII. Amendments so printed shall be considered as read.

At the conclusion of consideration of the bill for amendment, the Committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California? There was no objection.

HEALTH SAVINGS AND AFFORDABILITY ACT OF 2003

Mr. THOMAS. Mr. Speaker, pursuant to House Resolution 299, I call up the bill (H.R. 2596) to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements, and for other purposes. I ask for its immediate consideration.

The Clerk read the title of the bill.

The text of H.R. 2596 is as follows:

<table>
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<tr>
<th>Fiscal Year</th>
<th>Additional Contribution Amount</th>
</tr>
</thead>
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<tr>
<td>2004</td>
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</tr>
<tr>
<td>2005</td>
<td>$600</td>
</tr>
<tr>
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<td>2007</td>
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</tr>
<tr>
<td>2008</td>
<td>$900</td>
</tr>
<tr>
<td>2009 and thereafter</td>
<td>$1,000</td>
</tr>
</tbody>
</table>

(A) LIMITATION BASED ON ADJUSTED GROSS INCOME.

"(A) SELF-ONLY COVERAGE.—The dollar amount in paragraph (2)(A) (as increased under paragraph (3)) shall be reduced (but not below zero) by an amount which bears the same ratio to such dollar amount as—

(i) the amount (if any) by which the taxpayer's adjusted gross income for such taxable year exceeds $75,000 ($150,000 in the case of a joint return), bears to

(ii) $20,000 ($40,000 in the case of a joint return), bears to

(B) FAMILY COVERAGE.—The dollar amount in paragraph (2)(B) (as increased under paragraph (3)) shall be reduced (but not below zero) by an amount which bears the same ratio to such dollar amount as—

(i) the amount (if any) by which the taxpayer's adjusted gross income for such taxable year exceeds $150,000, bears to

(ii) $20,000.

(C) NO REDUCTION BELOW $200 UNTIL COMPLETE PHASE-OUT.—No dollar amount shall be reduced below $200 under paragraph (A) or (B) unless (without regard to this subparagraph) such limitation is reduced to zero.

(D) ROUNDING.—Any amount determined under paragraph (3) which is not a multiple of $10 shall be rounded to the next lowest $10.

(E) ADJUSTED GROSS INCOME.—For purposes of this paragraph, adjusted gross income shall be determined:

(i) without regard to this section or section 911, and

(ii) after application of sections 86, 125, 132, 137, 221, 222, and 669.

(5) COORDINATION WITH OTHER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the sum of—

(A) the aggregate amount paid during such taxable year to Archer MSAs of such individual,

(B) the aggregate amount paid during such taxable year to health savings security accounts of such individual, and

(C) the aggregate amount paid during such taxable year to health savings accounts of such individual by persons other than such individual.

(6) SPECIAL RULES FOR MARRIED INDIVIDUALS, DEPENDENTS, AND MEDICARE ELIGIBLE INDIVIDUALS.—Rules similar to the rules of...
(c) Definitions.—For purposes of this section—

(1) Eligible individual.—

(A) In general.—The term 'eligible individual' means, with respect to any month, any individual who is covered by insurance which constitutes minimum deductible medical care, vision care, or long-term care.

(B) Certain coverage disregarded.—Subparagraph (A) shall be applied without regard to—

(i) coverage for any benefit provided by permitted insurance under paragraph (2) of section 219(f),

(ii) coverage (whether through insurance or otherwise) for accidents, disability, dental care, vision care, or long-term care.

(C) Minimum deductible plan.—

(A) In general.—The term 'minimum deductible plan' means a plan—

(i) in the case of self-only coverage, which has an annual deductible which is not less than $5,000, and

(ii) in the case of family coverage, which has an annual deductible which is not less than twice the dollar amount in clause (i) as increased under subparagraph (B).

(B) Cost-of-living adjustment for annual deductible.—

(i) In general.—In any case of taxable year beginning in a calendar year after 2004, the amount of the annual deductible under paragraph (A)(i) shall be increased by an amount equal to—

(I) such dollar amount, multiplied by

(ii) the cost-of-living adjustment determined under section 258(f)(3) for the calendar year in which such taxable year begins by substituting 'calendar year 2003' for 'calendar year 1992' in subparagraph (B) thereof.

(ii) Rounding.—If any increase under clause (I) results in a multiple of $50, such increase shall be rounded to the nearest multiple of $50.

(C) Special rules.—

(i) Exclusion of certain plans.—Such term does not include a health plan if substantially all of its coverage is coverage described in paragraph (1)(B).

(ii) Safe harbor for absence of preventive care deductible.—A plan shall not fail to be treated as a minimum deductible plan by reason of failing to have a deductible for preventive care services.

(iii) Uninsured.—An individual shall be treated as uninsured if such individual is not covered by insurance which constitutes medical care or disability coverage, as the case may be, any sentence shall be applied without regard to the coverage described in paragraph (1)(B).

(iv) Excess insurance.—The term permitted insurance has the meaning given such term in section 220(c).

(v) Family coverage.—The term 'family coverage' has the meaning given such term in section 220(d).

(vi) Archer MSA.—The term 'Archer MSA' has the meaning given such term in section 220(d).

(vii) Health savings account.—The term 'health savings account' means a trust created or organized in the United States as a health savings security account which is not in commingled with other property except in a common trust fund or common investment fund.

(viii) Tax treatment of distributions.—Subparagraph (A) shall apply for purposes of this section.

(ix) Amounts used for qualified medical expenses.—Any amount paid or distributed out of a health savings security account which is used exclusively to pay qualified medical expenses of any account beneficiary shall not be includable in gross income.

(2) Inclusion of amounts not used for qualified medical expenses.—

(A) In general.—Any amount paid or distributed out of a health savings security account which is not used exclusively to pay the qualified medical expenses of the account beneficiary shall be includable in the gross income of such account beneficiary in the manner provided under section 72.

(B) Special rules for applying section 72.—For purposes of applying section 72 to amounts paid or distributed from such accounts, (i) all health savings security accounts shall be treated as 1 contract, and

(ii) all distributions during any taxable year shall be treated as a distribution.

(3) Excess contributions returned before due date of return.—

(A) In general.—If any excess contribution is contributed for a taxable year to any health savings security account of an individual, paragraph (2) shall not apply to distributions from the health savings security account taken into account under this section with respect to such contribution, to the extent that such distribution, when added to all previous distributions from the health savings security account taken into account under this section with respect to such contribution, do not exceed the aggregate contributions from members of such family.

(4) Treatment of excess contributions.—

(A) Date of return.—Subparagraph (A) shall apply only to distributions of such contributions made before the last day prescribed by law (including extensions of time) for filing the account beneficiary's return for such taxable year.

(B) Inclusion of amounts.—Any amount described in subparagraph (A) shall not apply to any such distribution.

(C) Exclusion of amounts.—Any amount described in subparagraph (A) shall apply only to distributions of such contributions made before the last day prescribed by law (including extensions of time) for filing the account beneficiary's return for such taxable year.

(D) Treatment of distributions.—Subparagraph (A) shall apply to distributions to a person only to the extent of the contributions of such person to such account during such taxable year.

(E) Treatment of distributions.—Subparagraph (A) shall apply only to distributions of such contributions which are made in the following order—

(i) first, to members of the family of the account beneficiary,

(ii) second, to the account beneficiary,

(iii) third, to contributors to the account beneficiary with respect to contributions under section 125(h), and

(iv) fourth, to employers of the account beneficiary with respect to contributions under section 125(d).

(F) Treatment of distributions.—Subparagraph (A) shall apply to any distribution of such contributions which is made in the following order—

(i) to the account beneficiary,

(ii) to contributors to the account beneficiary with respect to contributions under section 125(h), and

(iii) to employers of the account beneficiary with respect to contributions under section 125(d), and

(iv) any other distribution to a person other than the account beneficiary.
most recent excess contribution which has not been distributed to the contributor.

(3) TREATMENT of NET INCOME.—Any net income described in subparagraph (A)(iii) shall be included in gross income of the person receiving the distribution for the taxable year in which received.

(4) EXCESS CONTRIBUTION.—For purposes of subparagraph (A)(i), the term ‘excess contribution’ means any contribution (other than a rollover contribution from another health savings security account, or from an Archer MSA, which is not includable in gross income) to the extent such contribution results in the aggregate contributions to health savings security accounts of the account beneficiary for any taxable year to exceed—

[(a) deduction allowed.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a health savings account of such individual.

(b) limitations.—(1) IN GENERAL.—The amount allowed as a deduction under subparagraph (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual for such month.

(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 15 percent of the individual’s coverage under the high deductible health plan.

(3) COORDINATION WITH OTHER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this section to an individual for any taxable year shall be reduced (but not below zero) by the sum of—

[(A) the aggregate amount paid during such taxable year to Archer MSAs of such individual.

(B) the aggregate amount paid during such taxable year to health savings security accounts of such individual, and

(C) the aggregate amount paid during such taxable year to health savings security accounts of such individual with respect to contributions, distributions, and such other matters as the Secretary may prescribe by regulations.

(4) SPECIAL RULES.—(i) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

(ii) EXCEPTION FOR DISEASE OR DISABILITY.—Subparagraph (B) shall not apply if the payment or distribution is made after the account beneficiary becomes disabled within the meaning of section 1811 of the Social Security Act.

(5) ROLLOVER CONTRIBUTION.—(A) IN GENERAL.—Paragraph (2) shall not apply to any amount paid or distributed from a health savings security account to the account beneficiary to the extent the amount received is paid into a health savings security account, or a health savings account, for the benefit of such beneficiary not later than the 60th day after the day on which the account beneficiary receives the payment or distribution.

(B) LIMITATION.—This paragraph shall not apply to any amount described in subparagraph (A) if the amount paid or distributed from a health savings security account to a beneficiary is paid into a health savings security account if, at any time during the 1-year period ending on the day of such receipt, such individual received any other amount described in subparagraph (A) from a health savings security account which was not includable in the individual’s gross income because of the application of this paragraph.

(6) SPECIAL RULES.—Rules similar to the rules of paragraphs (6), (7), and (8) of section 220(f) shall apply for purposes of this section.

(7) REPORTS.—The Secretary may require the trustee of a health savings security account to provide such reports to the Secretary as the Secretary may prescribe by regulations.

(h) REGULATIONS.—The Secretary may issue regulations to carry out the purposes of this section, including regulations regarding the proper treatment of distributions described in section (f)(3) and nondeductible contributions by members of the family of the account beneficiary.

SEC. 224. HEALTH SAVINGS ACCOUNTS.

(a) DEDUCTION ALLOWED.—In the case of an individual who is an eligible individual for any month during the taxable year, there shall be allowed as a deduction for the taxable year an amount equal to the aggregate amount paid in cash during such taxable year by such individual to a health savings account of such individual.

(b) LIMITATIONS.—(1) IN GENERAL.—The amount allowable as a deduction under section (a) to an individual for the taxable year shall not exceed the sum of the monthly limitations for months during such taxable year that the individual is an eligible individual for such month.

(2) MONTHLY LIMITATION.—The monthly limitation for any month is the amount equal to 15 percent of the individual’s coverage under the high deductible health plan.

(3) COORDINATION WITH OTHER CONTRIBUTIONS.—The limitation which would (but for this paragraph) apply under this section to the taxpayer for any taxable year shall be reduced (but not below zero) by the sum of—

[(A) the aggregate amount paid during such taxable year to Archer MSAs of such individual.

(B) the aggregate amount paid during such taxable year to health savings security accounts of such individual, and

(C) the aggregate amount paid during such taxable year to health savings security accounts of such individual with respect to contributions, distributions, and such other matters as the Secretary may prescribe by regulations.

(4) SPECIAL RULES.—(i) EXCEPTION FOR DISABILITY OR DEATH.—Subparagraph (A) shall not apply if the account beneficiary becomes disabled within the meaning of section 72(m)(7) or dies.

(ii) EXCEPTION FOR DISEASE OR DISABILITY.—Subparagraph (B) shall not apply if the payment or distribution is made after the date on which the account beneficiary becomes disabled within the meaning of section 1811 of the Social Security Act.

(iii) SPECIAL RULES.—(A) IN GENERAL.—The term ‘health savings security account’ means a trust created or organized in the United States as a health savings account under a high deductible health plan, such plan shall not fail to be a high deductible health plan because—

(1) the individual deductible for services provided outside such network exceeds the applicable maximum dollar amount described in clause (i) or (ii) of subparagraph (A), or

(2) the annual out-of-pocket expenses required to be paid for services provided outside such network exceeds the applicable dollar amount in subparagraph (A).

(B) ANNUAL DEDUCTIBLE.—The annual deductible taken into account under subsection (a) with respect to a plan which is a high deductible health plan by reason of clause (i) or (ii) shall be the annual deductible for services provided within such network.

(C) SPECIAL RULES.—(i) SECURITY ACCOUNTS.—Subparagraph (A) shall apply with regard to—

(1) the coverage for any benefit provided by permitted insurance, and

(2) any other amount described in subparagraph (B)(ii) if the coverage for such benefit is provided by permitted insurance.

(ii)Any other amount described in subparagraph (B)(ii) if the coverage for such benefit is provided by permitted insurance.

(iii) Special Rules.—The term ‘high deductible health plan’ has the meaning given such term in section 220(c)(3).

(5) ARCHER MSA.—The term ‘Archer MSA’ has the meaning given such term in section 220(c)(3).

(6) HEALTH SAVINGS SECURITY ACCOUNT.—The term ‘health savings security account’ has the meaning given such term in section 223(c).

(7) HEALTH SAVINGS SECURITY ACCOUNT.—The term ‘health savings account’ means a trust created or organized in the United States as a health savings account account exclusively for the purpose of paying the qualified medical expenses of the account beneficiary, or the written governing instrument creating the trust meets the following requirements:
"(A) Except in the case of a rollover contribution from an Archer MSA, a health savings security account, or a health savings account, which is not includable in gross income, any amount which will be includable in the gross income of such beneficiary shall be included in the gross income of such beneficiary.

"(B) In general.—If any excess contribution is contributed for a taxable year to any health savings account of an individual, paragraph (2) of section 223(d)(5) (relating to the limitations) is amended by inserting in section 223(d), or a health savings account of such individual for such year if—

"(i) such distribution is made on or before the last day prescribed by law (including extensions of time) for filing the account beneficiary with respect to contributions for such calendar year.

"(ii) such contribution is not attributable to any account beneficiary with respect to contributions for such calendar year.

"(iii) such contribution is accompanied by the amount of net income attributable to such excess contribution.

"(iv) such distribution satisfies the requirements of subparagraph (B).

"(3) DISTRIBUTIONS LIMITED TO CONTRIBUTIONS.—Subparagraph (A) shall apply only to distributions of contributions which are made in the following order:

"(i) first, to the account beneficiary,

"(ii) second, to employers of the account beneficiary with respect to contributions under section 125(h), and

"(iii) third, to employers of the account beneficiary with respect to contributions under section 408(e).

"(C) Exception for distributions after a participant’s death.—Subparagraph (A) shall not apply to any distribution of an amount described in subparagraph (A) from a health savings account which was not includible in the gross income of such beneficiary which is includible in gross income of such beneficiary for the taxable year in which such distribution is made.

"(D) Exception.—For purposes of subparagraph (A), the term ‘excess contribution’ means any contribution (other than a rollover from another health savings account, a health savings security account, or from an Archer MSA, which is not includable in gross income from such contributions) that results in the aggregate contributions to health savings accounts of the account beneficiary for the taxable year to be in excess of the limitations described in section 223(d), and

"(E) Tax Treatment of Distributions.—

"(1) In general.—A health savings account is exempt from taxation under this subtitle unless such account has ceased to be a health savings account. Notwithstanding the preceding sentence, any such account is subject to the taxes imposed by section 511 (preceding sentence, any such account is subject to the taxes imposed by section 511).

"(b) DEDUCTION ALLOWED WHETHER OR NOT OTHER DEDUCTIONS LIMIT THE AMOUNTS.—Subsection (a) of section 62 of such Code is amended by inserting after paragraph (18) the following new paragraph:

"(19) HEALTH SAVINGS SECURITY ACCOUNTS.—The deduction allowed by section 223(d)...

"(20) HEALTH SAVINGS ACCOUNTS.—The deduction allowed by section 221(a).

"(c) Coordination With Archer MSAs.—

"(1) Rollovers from Archer MSAs permitted.—Subparagraph (A) of section 220(f)(5) of such Code (relating to rollover contributions) is amended by striking ‘the Secretary’ and to the account beneficiary to the extent the amount received is paid into a health savings account account beneficiary to the extent the amount received is paid into a health savings account account beneficiary to the extent the amount received is paid into a health savings account...

"(2) Archer MSA Limitation for Contributions to Health Savings Security Accounts.—Subsection (b) of section 225(f)(1) of such Code is amended by inserting ‘a health savings security account, or from an Archer MSA, which is not includable in gross income from such contributions’ after ‘an Archer MSA, which is not includable in gross income from such contributions’.

"(3) Coordination With Health Savings Security Accounts and Health Savings Accounts.—The limitation which would (but for this paragraph) apply under this subsection to the taxpayer for any taxable year shall be reduced (but not below zero) by the sum of—

"(A) the aggregate amount paid during such taxable year to health savings security accounts of such individual, and

"(B) the aggregate amount paid during such taxable year to health savings accounts of such individual.

"(d) Exclusions from Employer Contributions to Health Savings Security Accounts and Health Savings Accounts.—

"(1) Exclusion from income tax.—Section 106 of such Code (relating to contributions by employer to accident and health plans) is amended by striking at the end the following new subsections:

"(2) Exclusions From Employment Contributions to Health Savings Security Accounts and Health Savings Accounts.—

"(A) In general.—In the case of an employee who is an eligible individual, amounts contributed by such employee’s employer to...
any health savings security account of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amount does not exceed the limitation under section 223(b) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

"(2) Special rules.—Rules similar to the rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection.

"(3) Definitions.—For purposes of this subsection, the terms ‘eligible individual’ and ‘health savings security account’ have the respective meanings given to such terms by section 223.

"(4) Cross reference.—

For penalty on failure by employer to make comparable contributions to the health savings security accounts of comparable employees, see section 5976.

"(e) Contributions to Health Savings Accounts.—

"(1) In general.—In the case of an employee who is an eligible individual, amounts contributed by such employee’s employer to any health savings account of such employee shall be treated as employer-provided coverage for medical expenses under an accident or health plan to the extent such amount does not exceed the limitation under section 223(b) (determined without regard to this subsection) which is applicable to such employee for such taxable year.

"(2) Special rules.—Rules similar to the rules of paragraphs (2), (3), (4), and (5) of subsection (b) shall apply for purposes of this subsection.

"(3) Definitions.—For purposes of this subsection, the terms ‘eligible individual’ and ‘health savings security account’ have the respective meanings given to such terms by section 223.

"(4) Cross reference.—

For penalty on failure by employer to make comparable contributions to the health savings accounts of comparable employees, see section 4980C.

(2) Exclusion from employment taxes.—

(A) Railroad retirement tax.—Subsection (e) of section 3231 of such Code is amended by adding after such section the following new paragraph:

"(1) Health Savings Security Accounts and Health Savings Accounts Contributions.—The term ‘compensation’ shall not include any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under paragraph (d) or (e) of section 106.

(B) Unemployment tax.—Subsection (b) of section 3301 of such Code is amended by striking ‘or’ at the end of paragraph (16), by striking the period at the end of paragraph (17) and inserting ‘; or,’ and by inserting after paragraph (17) the following new paragraph:

"(18) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under subsection (d) or (e) of section 106.

(C) Special rule.—Subsection (a) of section 3401 of such Code is amended by striking ‘or’ at the end of paragraph (20), by striking the period at the end of paragraph (22) and inserting ‘; or,’ and by inserting after paragraph (21) the following new paragraph:

"(22) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under subsection (d) or (e) of section 106.

(D) Employee contributions.—Subsection (a) of section 401(b) of such Code is amended by striking ‘and’ at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting ‘; or,‘ and by inserting after paragraph (16) the following new paragraph:

"(17) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under subsection (d) or (e) of section 106.

(E) Special rule.—Subsection (a) of section 401(h) of such Code is amended by striking ‘or’ at the end of paragraph (18), by striking the period at the end of paragraph (20) and inserting ‘; or,’ and by inserting after paragraph (20) the following new paragraph:

"(20) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under subsection (d) or (e) of section 106.

(F) Health savings security accounts.—Subsection (a) of section 401(k) of such Code is amended by striking ‘and’ at the end of paragraph (17), by striking the period at the end of paragraph (18) and inserting ‘; or,’ and by inserting after paragraph (18) the following new paragraph:

"(18) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under subsection (d) or (e) of section 106.

(G) Special rule.—Subsection (a) of section 401(m) of such Code is amended by striking ‘or’ at the end of paragraph (15), by striking the period at the end of paragraph (16) and inserting ‘; or,’ and by inserting after paragraph (16) the following new paragraph:

"(16) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under subsection (d) or (e) of section 106.

(H) Excess contributions.—Subsection (a) of section 401(n) of such Code is amended by striking ‘or’ at the end of paragraph (18), by striking the period at the end of paragraph (19) and inserting ‘; or,’ and by inserting after paragraph (19) the following new paragraph:

"(19) any payment made to or for the benefit of an employee if at the time of such payment it is reasonable to believe that the employee will be able to exclude such payment from income under subsection (d) or (e) of section 106.
of section 669(a) of such Code (relating to reports) is amended by redesignating subparagraphs (C) and (D) as subparagraphs (E) and (F), respectively, and by inserting after subparagraph (B) the following new subparagraphs:

"(C) section 223(g) (relating to health savings security accounts)."

"(D) section 224(g) (relating to health savings accounts)."

(h) Exception From Capitalization of Policy Account Expenditures.—Subparagraph (B) of section 840(e)(1) of such Code (defined specified insurance contract) is amended by striking "and" at the end of clause (iv) thereof, (by striking the period at the end of clause (iv) and inserting a comma, and by adding at the end the following new clause:

"(v) any contract which is a health savings security account (as defined in section 223(d))."

"(vi) any contract which is a health savings account (as defined in section 224(d))."

SEC. 3. DISPOSITION OF UNSED HEALTH BENEFITS IN CATERFIA PLANS AND PLANNED SPENDING ARRANGEMENTS.

(a) In General.—Section 125 of the Internal Revenue Code of 1986 (relating to cafeteria plans) is amended by redesignating sections (h) and (i) as sections (i) and (j), respectively, and by inserting after section (g) the following:

"(h) Contributions of Certain Unused Health Benefits.—

"(1) In General.—For purposes of this title, if a plan or other arrangement does not fail to be treated as a cafeteria plan solely because any benefits under such plan include a health flexible spending arrangement under which not more than $500 of unused health benefits may be preserved, the value preserved during any calendar year for which the return under section 104 shall be furnished on or before June 26, 2003,

"(2) the information required to be shown to each employee to a health savings account of the employee, and

"(3) the information required to be shown to each employee to a health savings security account (as defined in section 223(d)), or a health savings account (as defined in section 224(d)), maintained for the benefit of such employee, or

"(i) of section 223 if made directly by the employee to a health savings security account of the employee (determined without regard to any other contributions made by the employee), and

"(ii) of section 224 if made directly by the employee to a health savings account of the employee (determined without regard to any other contributions made by the employee).

(b) Special Rules for Treatment of Contributions to Retirement Plans.—For purposes of this title, contributions to a qualified retirement plan (as defined in section 401(k)), or an eligible deferred compensation plan (as defined in section 457(b)) of an eligible employer described in section 457(e)(1)(A), but only to the extent such amount would not be allowed as a deduction under—

"(i) of section 223 if made directly by the employee to a health savings security account of the employee (determined without regard to any other contributions made by the employee), and

"(ii) of section 224 if made directly by the employee to a health savings account of the employee (determined without regard to any other contributions made by the employee).

(c) Contributions to a Qualified Retirement Plan (as Defined in Section 401(k)) or an Eligible Deferred Compensation Plan (as Defined in Section 457(b)).

"(A) shall be treated as elective deferrals (as defined in section 401(k)(3)) in the case of contributions to a qualified cash or deferred arrangement (as defined in section 401(k)) or to an annuity contract described in section 403(b),

"(B) shall be treated as employer contributions to which the employee has a nonforfeitable right in the case of a plan (other than a qualified stock bonus plan or stock profit-sharing plan described in subparagraph (A)), which is described in section 401(a) which includes a trust exempt from tax under section 501(a) or

"(C) shall be treated as deferred compensation in the case of contributions to an eligible deferred compensation plan (as defined in section 457(b)), and

"(D) shall be treated in the manner designated for purposes of section 408 or 408A in the case of contributions to an individual retirement plan.

(3) Health Flexible Spending Arrangement.—For purposes of this subsection, the term ‘health flexible spending arrangement’ means a flexible spending arrangement (as defined in section 125(d)) which has the following characteristics:

"(A) is an eligible deferred compensation plan (as defined in section 457(b)),

"(B) is a qualified benefit and only permits reimbursement for expenses for medical care (as defined in section 106)."

SEC. 4. EXCEPTION TO INFORMATION REPORTING REQUIREMENTS RELATED TO CERTAIN HEALTH ARRANGEMENTS.

(a) In General.—Section 6011 (relating to information at source) is amended by adding at the end the following new subsection:

"(d) No Requirement of Information Reporting.—For purposes of this title, no information reporting by or to the Secretary shall be required with respect to any information reported to, by, or from any employer or plan sponsor with respect to any account described in section 223(d) (relating to health savings accounts), or section 224(d) (relating to health savings security accounts), in any case in which such account is established on behalf of the employee and the contributions to such account are made by the employee, or the contributions to such account are otherwise allocable to the employee.

(b) Effective Date.—The amendment made by subsection (a) shall be effective beginning on January 1, 2004.

SEC. 5. MISCELLANEOUS.

(a) In General.—Section 221(b)(2)(C) (relating to health savings accounts) is amended by inserting at the end the following new paragraph:

"(C) contributed to a qualified retirement plan (as defined in section 401(k)), or an eligible deferred compensation plan (as defined in section 457(b)) of an employer described in section 457(e)(1)(A), but only to the extent such amount would not be allowed as a deduction under—

"(i) of section 223 if made directly by the employee to a health savings security account of the employee (determined without regard to any other contributions made by the employee), and

"(ii) of section 224 if made directly by the employee to a health savings account of the employee (determined without regard to any other contributions made by the employee).

(b) Effective Date.—The amendment made by subsection (a) shall be effective beginning on January 1, 2004.

SEC. 6. EFFECTIVE DATE.

The amendment made by section 221(b)(2)(C) shall apply to taxable years beginning after December 31, 2003.
which you have to make all of the contributions paid out of the health savings account. It is literally lifetime assistance. Why is that important? Because today, as we pass the new Medicare modernization with prescription drug benefits, we add tremendous new benefits, but there are other costs associated with the bill, both in acquiring prescription drugs and in making sure that seniors can pay for those additional costs.

It is important to say that every additional benefit provided to seniors should be paid for by taxpayers. We are already in the midst of the greatest intergenerational transfer of wealth in the history of the world. But it is also not fair to some Americans that when they retire they should pay out of their own pockets if we have not provided an easily affordable method to accumulate those dollars.

That is exactly what we have in front of us today: A health savings account that has a multiple number of ways in which money can be placed in to be paid for health needs not only while you are working but when you retire. There is no tax shelter, the best favor he can do for Americans oftentimes when you are sick or to put money away. Oftentimes that money, in its transfer, is taxable. There is no possibility of gimmicking the system.

The concern is that we have told Americans oftentimes that they have to pay for particular costs, and yet we do not provide an easy and affordable way for them to do so. One of the big concerns we have today is chronic or long-term care costs for seeing Americans that the value of money is the best way to address a problem that is going to face most Americans. That is exactly what health savings accounts allow you to do. It is a nearly an affordable health care cost if you have planned for it. Unfortunately, too often today’s seniors did not plan. There was not a program convenient and easy for them to plan. This allows them, in a prudent way, to put money away. Oftentimes we may want to help our parents, senior children. This is a way, through a health savings account, that they can place money available for seniors to be readily used for health savings accounts that provide a positive, tax-free environment for accumulating those dollars.

In so many ways, Mr. Speaker, this particular program will blend not only with the Medicare changes that we are going to make but in terms of meeting the needs of today’s workers as well. It is completely portable, it is a fund that accumulates tax free, and it belongs to the individual. They can take it with them wherever they may want to work.

Mr. Speaker, I ask unanimous consent that the control of the balance of my time be by the gentleman from Wisconsin (Mr. Ryan) and the SPEAKER pro tempore. Without objection, the gentleman from Wisconsin (Mr. Ryan) will control the balance of the time.

There was no objection.

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

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

The chairman of the Committee on Ways and Means has filed with senior citizens’ inability to plan for their future. Well, I am glad he is sending them a signal, because after what they intend to do with seniors with the Medicare bill, somebody might have planned for their futures. I remember in the good old days when Republicans used to say that they were going to travel around the country and pull the Tax Code up by the roots. That meant they were going to close loopholes, get rid of shelters, and to have a system that people did not have to hire accountants and lawyers in order to know what their tax liability would be. I even volunteered to drive around with them on these buses to see just how they intended to put back a Code that was more equitable and fair and one could understand.

But while the gentleman from California (Mr. Stark) still thinks that some of them are on the level as realities to the American, I asked for the opportunity to at least open up this debate just so that people who are not on the floor would understand that this has nothing to do with health. It has a heck of a lot to do with wealth and how to do it. They have to find ways to make certain that the deficit gets larger and that there is no money in the Treasury to take care of the problems that we used to say was a Federal responsibility. How do you do it? Just using creative.

Why, they do not even need a chair of a Committee on the Budget because there are no budget restrictions. Last night, this bill was supposed to be going over to the Committee on Rules at a cost of $71 billion over 10 years. What happened? Creativity, when just overnight they found out that the bill really costs $171 billion. How can Republicans be so smart that just overnight, without hearings, without checking with Treasury, without talking with OMB they can find $300 billion? Now, what is the cost of $171 billion? It is simple: It means that people who make up to $150,000 and are well do not have to pay taxes on storing away $150,000, you never have to pay taxes on the money, whether you are sick or whether or not you retire with the money. This is really just a tax-free grant to some of the people who are friendly to people on the other side.

But what about the people that do not have the $4,000? Now, that is the problem, because you are not eligible for this unless you do not have expenses that are paid for for $1,000. So if an employee really cares for you and wants to have you eligible for this tax shelter, the best favor he can do for you is to take away your health insurance. And, of course, you make the killing on your savings by not paying taxes. And so once he does you this favor, he has to do it for the lesser-income people, and lo and behold, we will find that those who cannot afford to stash away this money, because they do not have disposable income, end up with no insurance and no savings account.

Oh, one might say this is cruel, but sensitivity never bothered the majority party, because at the end of the day, they want to know how much of the people’s money did you leave with them. Or to put it another way, how much did you take away from the Federal Government so that we cannot provide basic services.

So the gentleman from California (Mr. Stark) need not worry. This savings account has nothing to do with health. It has everything to do with shelter.

Mr. Speaker, I ask unanimous consent that the balance of my time be turned over to the gentleman from California (Mr. Stark) and that he be given the authority to allocate time.

Mr. SPEAKER pro tempore. The gentleman from California (Mr. Stark) need not worry. This savings account has nothing to do with health. It has everything to do with shelter.

Mr. Speaker, I just heard the ranking member say this is not a health bill, that this is a tax shelter. I beg to differ. Number one, what we are talking about here is really novel and revolutionary. We are saying that employers and employees can together contribute to their own savings account with pretax dollars, with tax-deductible dollars to purchase health care spending and to have a catastrophic plan.

Mr. Speaker, the gentleman from New York said, what about the people who do not have $4,000 to put in their health security savings account? Well, their employer can put $4,000 into their account. The purpose of this reform, Mr. Speaker, is to get at some of the big issues that are really hurting this country, and that is the cost of health insurance, the affordability, and the accessibility of health insurance.

So what this reform does is it equips the individual in the family with the ability to go out into the health care marketplace with tax-deductible dollars to act like good consumers and buy their health insurance. It gives incentives. It actually requires, on health savings accounts, that employers provide catastrophic health insurance, or individuals who have their own health savings accounts have catastrophic health insurance. So it makes sure that people have health insurance if they really run into problems. But it also provides people with their health care expenditures themselves.

You know, it is often said that we spend more time shopping for cars or
Mr. STARK. Mr. Speaker, I yield myself 3 minutes. (Mr. STARK asked and was given permission to revise and extend his remarks.)

Mr. STARK. Mr. Speaker, I will start with an apology to all my Republican colleagues. For, oh, at least the 30 years or so I have been here, I have been accusing the Republicans of not being inclusive, just dealing with the rich and forgetting about the minorities and the working people in this country. With this bill they have become broadly inclusive. Later on tonight, they are going to take the first step in destroying health care for seniors and then, because they are being so inclusive with this bill, they are going to destroy health care for the workers who get their health insurance from employers.

As the distinguished ranking member of our committee pointed out, $200 billion was added to this in the middle of the night, and the bill will be funded by borrowing, by increasing the national debt and worsening deficits. And all it really does, if you cut through all the Mickey Mouse stuff that they have the tax credit, they have the tax credit, the high-deductible insurance, is that it creates some new tax-exempt savings accounts. Tax shelters for the wealthy and the healthy. And it advances the objective of undercutting employer-provided health coverage.

It is no secret that the distinguished chairman of the Committee on Ways and Means has expressed his desire to dismantle the employment-linked health insurance system, and I have noted that he believes it encourages overutilization of health care because individuals are shielded from knowing the true cost.

Now, the argument that the bill will assist the uninsured is not true. Most of the uninsured have incomes too low to be eligible for any tax benefits contained in H.R. 2596. And as was stated earlier, few, if any, have the $4,000 a year in additional savings required to utilize the benefits contained. There is nothing in this bill that requires the employer to put any money to make up for that gap that will be created by the higher deductibles. It merely gives them the opportunity, if they have any money, to add to savings accounts.

Not surprisingly, the 6 million families who were deliberately excluded by the Republicans from the recent tax bill for child tax credit are the same families that they are excluding from benefiting in this bill. So for families with insurance, it provides tax benefits only if the insurance requires them to pay the first thousand dollars; and employers will be encouraged by this nonsense to increase health insurance deductibles, which lowers their costs and leaves most of their employees' health insurance.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 2 minutes to the gentlewoman from Washington (Ms. DUNN), a member of the Committee on Ways and Means.

Ms. DUNN. Mr. Speaker, I am very happy that we have this bill on the floor finally. I think it serves a real need, and it provides total flexibility to people who want to provide for the care of their health care expenses.

One particular provision that appeals to me is one that we used to refer to as a catch-up health savings account contribution. We now call it a health savings security account, and these are accounts that are designed particularly for people who are age 55 or older. It gives them the right to contribute additional dollars every year into their health savings accounts because of particular situations they might have faced in the past.

The flexibility of HSAs is widely known. These dollars can be used for any health-related expense as long as it is not reimbursed. For example, they can be used to pay for long-term care or for health coverage policy or doctors' bills or for prescription drugs; but what is special about the health savings security accounts is in the way it applies to people like me. Many people, particularly women, during their child-raising years, or for those who work in the workplace and often did not add money into accounts like IRAs, or actually Social Security accounts, and ended up with big goose eggs when the time came to calculate their benefits.

In this case, the health savings accounts provide for folks who took time off during their child-raising years, or to look after an ill parent; and it allows them to add up to 25 percent in additional dollars each year to their health savings account. This will begin in operation as soon as this bill is enacted. An individual age 55 or older can contribute $500 a year in addition to the total health savings account. That amount will grow to $1,000 in 2009, and I think it is a very sensibly written provision to help folks who have been away from the workforce or need this additional provision.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Michigan (Mr. LEVIN), a member of the Committee on Ways and Means who understands that with this $174 billion that we are wasting in this bill, we could help States maintain Medicaid coverage as they weather their fiscal crisis.

Mr. LEVIN. Mr. Speaker, this came out of the wee hours of this morning, but I want Members to realize how radical a move this is. We are going to have later today a radical effort to dismantle Medicare. What this is a radical effort to dismantle our employer-based system in this country. So now we are going to take a step toward a kind of voucher for health insurance in the form of a tax credit. That is what we are going to do.

Those who can afford to use the tax credit will have that voucher, and they will go out into the marketplace. The consumer, each individual one, is going to try to swim as best as they can. But for those who do not, who do not have the money to put in this account, who have no benefit from the tax credit, they are going to continue not to swim as an individual consumer, but to sink. That is what is going to happen. That is why this is so radical.

Now, the other side of the aisle said we want to add money into Medicare in the prescription drug proposal. They are darn right. We did not create this deficit. Their answer to a deficit that is deep is to dig it deeper. In the middle of the night or early morning, you add $100 billion to the deficit; and I want to quickly read what this looks like.

We were supposed to have with the March baseline a deficit of $377 billion. We added $484 billion through what was called a technical reestimate. Then through legislation, we added what was it, 700 to $800 billion. Now the projected deficit, $1.5 trillion, four times what was projected a few months ago, and this does not include the bill that is going to be brought up later or additional military expenditures. It does not include this $100 billion. I tell the gentleman from Wisconsin (Mr. RYAN), this is fiscally irresponsible. You Republicans have zero fiscal responsibility in your political veins. Zero. This is radical because it is going to dismantle the employer-based system.
try to dismantle the employer-based health care system in this country; but what you are doing is digging a deeper, deeper hole of debt in this country. This is a radical proposal on all accounts, and it should be rejected.

Mr. HAYWORTH. Mr. Speaker, is it appropriate for a Member to address his remarks directly to another Member, or should those comments be directed through the Chair addressing the Member?

The SPEAKER pro tempore. The gentleman will state it.

Mr. HAYWORTH. Mr. Speaker, is it appropriate for a Member to address his remarks directly to another Member, or should those comments be directed through the Chair addressing the Member?
money which can be used to pay for out-of-pocket health care expenses and copayments and deductibles. Under the current system, unfortunately, employees forfeit money not used at the end of the year. Currently, this discourages employees from saving for health care, because employees, knowing that they will forfeit unused account balances, engage in end-of-the-year spending sprees on services they may not need like extra eyeglasses, shades or unnec-

essary exams. So eliminating the use-

it-or-lose-it provision solves this prob-

lem because then the employee will be able to roll over the balance from year to year. That is the attempt in this bill on that provision.

Preventing some forfeiture also increases the savings rate by increasing the disposable income of those employees in the program, and it also empowers them to make their own health care decisions. I urge my colleagues to pass this legislation.

Mr. STARK. Mr. Speaker, I yield myself 30 seconds. I have a couple of let-
ters, one from the AFL-CIO which suggests that this legislation would estab-
lish an enormous tax shelter for wealthy individuals and at the same time undermine employer-based health coverage and shift costs onto workers. I have a letter from Families USA which, among other things, says that this bill also threatens the employer-provided health insurance system par-
ticularly among smaller employers who will be able to take deductions in the top brackets and who will then no longer be interested in providing cov-

erage for their employees.

Mr. Speaker, I include both letters for the record.

American Federation of Labor and Congress of Industrial Or-


Dear Representative: The AFL-CIO opposes H.R. 2351, the Health Savings Accounts Act. This legislation would eliminate the employer-provided health insurance system particularly among smaller employers who will be able to take deductions in the top brackets and who will then no longer be interested in providing coverage for their employees.

Under H.R. 2351, employers could offer Health Savings Accounts as long as they are provided in conjunction with high-deductible health insurance policies, defined as at least $500 for an individual policy and $1,000 for a family plan. The deductible is expected to be $748 in 2006. Despite proponents’ claims, this bill would fail to expand cov-

erage to the uninsured and would be espe-
cially harmful to those low-income, older and sicker workers who now have com-

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Furthermore, those workers and other in-

sured individuals who have traditional, more comprehensive coverage will see their pre-
miums rise. Younger, healthier workers will make worse late night in the Rules Com-

mittee. Among the changes made in Rules, the income threshold has been raised to $175,000 for joint filers. The cost of the re-

vised bill is estimated to be $174 over ten years—more than twice the estimated cost of the bill that passed Ways and Means last week—and makes clear that this legislation is first and foremost another tax shelter, not a bill to cover the uninsured.

This legislation was slipped through the Ways and Means committee last week, and made worse late night in the Rules Com-

mittee. Among the changes made in Rules, the income threshold has been raised to $175,000 for joint filers. The cost of the re-

vised bill is estimated to be $174 over ten years—more than twice the estimated cost of the bill that passed Ways and Means last week—and makes clear that this legislation is first and foremost another tax shelter, not a bill to cover the uninsured.

H.R. 2351 was raised just last week with lit-
tle notice and certainly without any hear-
ings, despite the bill’s far-reaching implica-
tions and significant cost. And now the House leadership has called for it to be joined with the Medicare prescription drug legislation before the House. I urge you to vote against H.R. 2351.

Sincerely,

William Samuel,
Director, Department of Legislation.

Families USA


Hon. Charles Rangel,
Rayburn House Office Building,
Washington, D.C.

Dear Representative Rangel, On behalf of Families USA, the national advocacy group for health care consumers, I am writ-
ing to oppose the Health Savings and Afford-
ability act of 2003 (H.R. 2351). I am writing to oppose the Health Savings and Afford-
ability act of 2003 (H.R. 2351). Implementation of the Health Savings Accounts (HSAs) and Health Savings Security Accounts (HSSAs) will do little to expand health in-

surance coverage to the 41 million Ameri-
cans who are uninsured.

This bill creates two programs loosely modeled after existing Archer Medical Sav-

ings Accounts (CMSAs), which allow tax-

ers to get limited federal funds to provide help for the lowest-income uninsured, this bill creates tax-free accounts, the HSSA’s, which can be accessed by families with tax shelters, funds that come up to $150,000 before starting to phase-out. The total cost of this bill is over $169 billion over ten years—a huge federal investment that will do little or nothing to cover the low-in-

come uninsured. The people who deserved to be helped in any health legislation are being ignored by this legislation. If this huge com-
miment of resources were applied to an ex-
pansion of the Children’s Health Insurance Program or to Medicaid, we could cover and send them to school, and then this Congress has already told you that the past generation has been irresponsible, they did not plan for their future and you better. So put money away for your retirement in an IRA and a 401(k). And you say, yes, because Social Secu-

rity probably will not be enough, I will do that. Then this Congress said, col-

gel education is going up, mom and dad, start saving for your kids’ edu-
cation. And so you say, yeah, I will put a couple of thousand away a year for J ohnny’s and Sally’s education.

Now we are saying to you, after all this, we have got another one, start saving for your health care. Then you say, Mr. Republican Congressman, I am out of money. I do not make that much. I do not have any more dispos-
able income. And so when your em-
ployer changes your health plan and you do not get the $2,000 or $4,000 away when you get sick, you are out of luck. That is what is going on here. Make no mistake about it.

Mr. STARK. Mr. Speaker, I yield 4 minutes to the distinguished gent-

leman from Texas (Mr. Doggett), a
member of the Committee on Ways and Means.

Mr. DOGGETT. Mr. Speaker, once again Republicans insist on a fiscally irresponsible bill that will benefit the wealthiest and in this case the healthiest at the cost of at least $174 billion added to our already soaring national debt.

Mr. Speaker, despite the bright sunshine outside, it really is a dark day for some Americans who are working hard just to make ends meet. This bill is the natural companion to a measure written by the same folks that are presenting this bill, which previously denied a child tax credit to poor working families. Tax cuts, not matter what the economic conditions, no matter how pressing are the other priorities we have in our country, such as protecting our families from terrorism, tax cuts, we are always told, can cure any as well as for many working families you are poor and working, in which case your kids are not worthy of a child tax credit.

Thanks to the intransigence of the House Republican leadership, there are now more than 6 million working Americans, they are folks like cafeteria workers and teachers’ aides, nursing home employees, those working at our hospitals doing the tough work, they will receive no check for their children this year. Some of these Americans. Their ability to gain a little economic independence, to share in the economic benefits of the American Dream, it will come and go on July 4 unfulfilled because of the refusal of this House Republican leadership and their desire to go on recess not only for July 4 but to continue their recess from reality.

For these same families that were deliberately excluded from the recent tax cut and many other working families, House Republicans add more insult to injury by encouraging employers to terminate or to weaken any group health insurance coverage through which some of these employees may be covered. This bill is also the natural companion to the next bill that we are about to take up, the bill to repeal Medicare as we have known it, since President Lyndon B. Johnson signed it into law. We know this is not new. They have opposed Medicare since before President Johnson wrote his signature to make it a reality. Newt Gingrich wanted it to wither on the vine. Earlier this month, Mr. Gingrich declared, much as our colleagues are here today, despite the very same words that they got from Newt Gingrich, that it was an “obsolete government monop-

Only yesterday we heard the same language from the sponsors of this measure: “To those who say that the bill would end Medicare as we know it, our answer is, ‘We certainly hope so.’”

“Old-fashioned Medicare isn’t very good,” said Bill Thomas, the sponsor of this legislation and the companion measure to repeal Medicare tonight.

Some of us think old-fashioned Medicare has worked pretty well for the millions of Americans that it has served since 1965, and we want to strengthen it, not see it undermined through privatization.

The bill before us this afternoon does something very similar to what the Republicans did to Medicare and, that is, to weaken, at great cost to our Treasury, our employer-based health care system. By totally excluding employees unless they are in plans that deny any assistance on at least the first $1,000 in medical bill coverage, this bill will encourage even higher deductibles. And it will be a struggle for a cafeteria worker to pay their first $1,000 or their first $2,000 or more-thousand under these new high-deductible plans.

The same plans will encourage more small employers to stop providing coverage at all and to protect themselves individually through these MSAs and to terminate costly health insurance for their other employees. It will encourage groups with plans to reduce covered services, increase copayments.

In short, through these three bills, we see Republican indifference from cradle to grave for children, for workers, for seniors.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 3 minutes to the gentleman from Pennsylvania (Mr. ENGLISH) to talk about this legislation that we are debating, health savings accounts.

Mr. ENGLISH. Mr. Speaker, I really wish more of the American public were watching this debate because they would be able to fully appreciate how marginal the left has become to any serious debate about the problems facing this country. What we are going to be doing tonight is not voting to repeal Medicare, but instead voting to pass this bill, which is a bill that would provide more medical security for uninsured Americans as well as many low- and middle-income workers.

This legislation actually creates two new instruments to meet health care needs by rewarding Americans who open either type of account with tax advantages and maximum flexibility, so as the other side has noted, even the healthy can have a greater role in man-

Only yesterday we heard the same language from the sponsors of this measure: “To those who say that the bill would end Medicare as we know it, our answer is, ‘We certainly hope so.’”

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Second, insured workers with high-deductible plans will also see similar incentives. Both savings accounts give individuals a potent incentive to save for health care costs that do not fit within their deductible, giving them another option and perhaps some peace of mind about unanticipated medical expenses. The medical expenses that qualify for tax-free distributions are very far reaching and include expenses from preventive care to long-term care.

The two bills to create MSAs and to repeal Medicare tonight do not know how many tricks or hoaxes the Republican leadership is going to play on us tonight and on the American people. It is unbelievable. I listen to the gentleman from Pennsylvania (Mr. STARK) has 9 minutes remaining and the gentleman from Wisconsin (Mr. RYAN) has 12 minutes remaining.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. PALLONE), who understands that we could cover the parents of low-income children who are eligible for Medicaid and CHIP with the same amount of money.

Mr. PALLONE. Mr. Speaker, I just do not know how many tricks or hoaxes the Republican leadership is going to play on us tonight and on the American people. It is unbelievable. I listened to the gentleman from Pennsylvania. He said there is going to be Medicare reform tonight. There is not going to be Medicare reform. It is just going to be an effort to kill Medicare and destroy Medicare. And then they say they are going to bring up a pre-

This is commonsense legislation that makes health insurance and health care more affordable and tax advantaged for Americans. It does not destroy our health care system and it does not dismantle Medicare. Accordingly, I urge my colleagues to give workers control of their own health care and vote for the creation of health savings accounts.

The SPEAKER pro tempore (Mr. SWEENEY). The Chair advises Members that the gentleman from California (Mr. STARK) has 9 minutes remaining and the gentleman from Wisconsin (Mr. RYAN) has 12 minutes remaining.

Mr. RYAN. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. PALLONE), who understands that we could cover the parents of low-income children who are eligible for Medicaid and CHIP with the same amount of money.
Mr. Speaker, although we would like to provide health coverage for those who are uninsured, this bill does little or nothing to help the low-income uninsured. Individuals eligible for the tax credit under the Thomas bill would have to be uninsured or in high deductible plans, but according to the bill, starting in 2004, those individuals could set aside up to $2,000 tax free into a new health savings account to supposedly help pay for health insurance. But because the bill will insist the uninsured simply is not true. Most uninsured have incomes that are too low to owe Federal income tax liability, let alone have $2,000 to set aside for this purpose. In addition, self-employed individuals, the other large segment of the uninsured, may already deduct 100 percent of the health insurance costs.

The only consequence of this bill is to undercut the provision of employer-sponsored health coverage or encouraging employers to raise deductibles or potentially drop their coverage and raise the cost of health care for low income, older and sick workers with higher co-payments and premiums.

And, lastly, as many of the speakers on our side have said, this legislation will cost the government over $173 billion, another in a series of fiscally irresponsible tax cuts passed by the House. The entire cost of the bill will be funded by borrowing, increasing the national debt.

Where does this end? We have a national debt $4-$500 billion. Where is it going to end?

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 2 minutes to the gentleman from Nebraska (Mr. TERRY).

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

Mr. TERRY. Mr. Speaker, when will it end? I am saddened by the arguments from the left that fail to recognize the more people in America that want to have choices. They do not want just the offering of a government program one size fits all. Not everyone thinks that the government is the answer to everything. So I am proud to support bills that allow the market to provide opportunities and choices, and that is what tonight is about. I am wondering sitting here listening to the debate what some of our Founding Fathers would think of today’s debate about health care in America that want to have choices. They do not want just the offering of a government program one size fits all. Not everyone thinks that the government is the answer to everything. So I am proud to support bills that allow the market to provide opportunities and choices.

The interesting thing is there are two issues that are driving health care inflation at 25, 30 percent for the public. One is the cost of prescription drugs. Two is the 42 million uninsured who show up in our emergency rooms, driving up hospital costs which insurance companies pass on to employers and employers pass on to employees. And if we wanted to insure the uninsured, we could do it for a lot less expensive than this. Expand Kid Care. In Illinois we have a program known as Kid Care, insurance for the children of working parents, that expands the kid care to families. These are not the years that we came here to represent.

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 30 seconds to the gentleman from Louisiana (Mr. McCrery), from the committee.

Mr. McCrery. Mr. Speaker, the immediate preceding speaker, the gentleman from Illinois (Mr. Emanuel), spoke about the free market and letting the market forces work with respect to prescription drugs, and his solution is either import drugs from other countries and sell them here of course at lower prices or let us adopt the prices that are paid in those other countries here in our country, and he could not count on the free market.

What he failed to point out is those drugs and those prices that he would be importing or adopting the prices out here are set by government price controls, not the free market.

Mr. Emanuel. Mr. Speaker, will the gentleman yield?

Mr. McCrery. I yield to the gentleman from Illinois.

Mr. Emanuel. Mr. Speaker, the fact is that he would have great difficulty. It is a Gutknecht-Emanuel bill with a number of the gentleman’s colleagues on his side and a number of colleagues on my side. The three provisions to this bill, A, allow generics to come to market quicker so name brand pharmaceutical companies could not be involved in frivolous lawsuits.

Mr. McCrery. Mr. Speaker, reclaiming my time, the issue of generics is addressed in the underlying bill that we will be debating later tonight, but the gentleman spoke about bringing drugs in from other countries and selling them at prices that have been imposed by governments, not by the free market.

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

Mr. RYAN of Wisconsin. Mr. Speaker, I yield 2 minutes to the gentleman from Texas (Mr. Burgess).

Mr. Burgess. Mr. Speaker, I thank the gentleman from Wisconsin for yielding me this time. H.R. 2596 will increase access to consumer-based health coverage to all Americans regardless of income. Under H.R. 2596 the availability of health savings accounts will assist those that live outside health coverage and give Americans more options when it comes to their health. Health savings accounts will promote savings and more direct health purchasing.

The character of these accounts will also simplify the complex patient relationship. As a physician, I know firsthand the difficulty some patients have working through their insurance companies and trying to figure out what services are covered by their policies. With a health savings account, patients can focus their attention on their medical care. They can discuss their needs with their doctors frankly and honestly, and they can proceed with appropriate medical treatments that they need.

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or the purchasing power to make decisions for themselves. I myself have had a medical saving account since 1997, that is, until I came to Congress, and it was coverage that I made available to everyone in my practice as a choice. It was not a requirement. If someone wanted the chance to be in charge of their medical decisions and a chance to build wealth in one of these accounts for future medical expenses, I thought it was only prudent as an employer to provide that opportunity.

Mr. Speaker, we talk about the evils of HMOs, and the Members on the other side of the aisle are frequently mentioning the evils of HMOs, but this is the anti-HMO. Put the purchasing power back in the hand of the patient. These plans are centered on the concept of personal choice. These accounts make more money available to purchase health coverage. We need to be serious about the solutions when addressing the problems of the uninsured in this country. An individual will make rational decisions when they have the ability to spend their own money on their health services. I ask my colleagues, I implore my colleagues, not to stand in the way. Give Americans the freedom to make this decision.

Mr. STARK. Mr. Speaker, I yield 2 minutes to the gentleman from Washington (Mr. INSLEE).

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

Mr. INSLEE. Mr. Speaker, in regard to the Medicare bill we will be considering this evening, I thought about coming down to the House and asserting that this bill was a Trojan horse, but I think it is worse than a Trojan horse. I do not think it would be fair to say that this bill was a Trojan horse, to the Medicare bill we will be considering this evening. I ask my colleagues, I implore my colleagues, not to stand in the way. Give Americans the freedom to make this decision.

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Mr. Speaker, what is fiscally irresponsible is the substitute prescription drug bill that the minority is bringing today. And this is paid for. The budget resolution that passed this House balances the budget within the term of the budget resolution, within 10 years. And this is paid for and budgeted for in the budget resolution.

Mr. Speaker, at the end of the day, after we have heard all of these arguments, it kind of comes down to two things, two different philosophies: socialism versus consumerism. They want to give consumers more power, and let us help bring down health care costs. Mr. Speaker, I urge passage of this bill.

Ms. JACKSON-LEE of Texas. Mr. Speaker, it is about giving power to consumers versus giving power to bureaucrats in Washington. Let us give Americans more freedom, let us give consumers more power, and let us help bring down health care costs. Mr. Speaker, I urge passage of this bill.

This does not take anything away from anybody, Mr. Speaker. This gives people more choices. This says to people, if you are going to have a hard time saving for your retirement, you are going to make it easier for you to do that. If you are a small business and you cannot afford health care for your employees right now, we are giving you a new option to do just that.

We are going to give employers the ability to try, look, you can put money in an account that you can deduct it from in your employee’s name. Your employees contribute to this account. If you do it, you have to have catastrophic health care coverage for them. So we are making sure with health care savings accounts that there is health insurance. And the beautiful part of this proposal, Mr. Speaker, is that this is the employee’s money; it is their money that is at stake when they get health care and they are not going to act like real consumers. They can take this money with them when they leave their job and go to another job. They can take this money with them into retirement throughout their life, but if they die, this money can go to their spouse. This money becomes the individual’s money.

One of the big problems we have in health care today is we do not act like real consumers. We have third-party payers paying the bills, and so when we go and pay for health care, someone else is paying the bills, so we really do not care how much it costs. That is one of the reasons why the costs of health care are going up through the roof.

This puts in place 280 million brains on behalf of bringing down health care costs and 280 million sets of eye balls watching this industry to make sure that doctors are charging the right kind of prices, that hospitals are not overcharging, and that they are getting the best quality for their dollar.

Mr. Speaker, it is about giving power to consumers versus giving power to bureaucrats in Washington. Let us give Americans more freedom, let us give consumers more power, and let us help bring down health care costs.

Mr. Speaker, I urge passage of this bill.

Pursuant to House Resolution 299, the bill is considered read for amendment and the previous question is ordered.

The question is on the engrossment and thirds reading of the bill.

The bill was ordered to be engrossed and read a third time, and was read the third time.

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

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

Mr. STARK. Mr. Speaker, I object to the vote on the ground that a quorum is not present and make the point of order that a quorum is not present.
Mr. STRICKLAND and Mr. GUTIERREZ changed their vote from "yea" to "nay."

Mr. BISHOP of Georgia changed his vote from "nay" to "yea."

So the bill was passed.

The result of the vote was announced as above recorded.

A motion to reconsider was laid on the table.

EXTENDING AVAILABILITY OF SCHIP ALLOTMENTS FOR FISCAL YEARS 1998 THROUGH 2001

Mr. TAUSIN. Mr. Speaker, I ask unanimous consent that the Committee on Energy and Commerce be discharged from further consideration of the bill (H.R. 531) to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children’s Health Insurance Program (SCHIP), and ask for its immediate consideration in the House.

The Clerk read the title of the bill.

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

There was no objection.

The Clerk read the bill as follows:

(a) RETAINED AND REDISTRIBUTED ALLOTMENTS FOR FISCAL YEARS 1998 AND 1999—Paragraphs (2)(A)(i) and (2)(A)(ii) of section 2104(g) of the Social Security Act (42 U.S.C. 1397dd(g)) are each amended by striking “fiscal year 2002” and inserting “fiscal year 2001”,

(b) EXTENSION AND RETENTION OF PORTION OF FISCAL YEAR 2000 ALLOTMENT.—Paragraph (2) of such section 2104(g) is amended—

(c) FISCAL YEAR 2000 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2000 that were not expended by the State by the end of fiscal year 2002, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2004.

(d) REDISTRIBUTED ALLOTMENTS.—Paragraph (1) of such section 2104(g) is amended—

(e) in subparagraph (A), by inserting “or for fiscal year 2001 by the end of fiscal year 2002,” after “(iii) fiscal year 2001 allotment;”; and

(f) in subparagraph (B), by striking “1998 or 1999” and inserting “1998, 1999, or 2000”; and

(g) in subparagraph (C), by striking “or” at the end of subclause (i),

(h) by striking the period at the end of subclause (I) and inserting “; and”;

(i) by adding at the end the following new subclause:—

(2) REDISTRIBUTED ALLOTMENTS.—The amounts used in computing redistributed allotments are—

(i) the amount specified in clause (2)(A)(ii) of section 2104(g); and

(ii) 50 percent of the total amount remaining in clause (2)(A)(i) of section 2104(g) at the end of fiscal year 2002, less the total amount remaining in clause (2)(A)(i) of section 2104(g) at the end of fiscal year 2001.

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

Mr. Speaker, I want to announce that the bill (H.R. 531) to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 1999 under the State Children’s Health Insurance Program (SCHIP), and ask for its immediate consideration in the House.
expenditures under this title in fiscal years 2000, 2001, and 2002 exceed the State's allotment for fiscal year 2000 under subsection (b); and

"(ii) the amount specified in this clause is the sum, for all States entitled to a redistribution under subparagraph (A) from the allotments for fiscal year 2000, of the amounts specified in clause (i).

(3) CONFORMING AMENDMENTS.—Such section 2104(g) is further amended—
(A) in its heading, by striking "AND 1999" and inserting "AND 2000"; and
(B) in paragraph (3)—
(i) by striking "or fiscal year 1999" and inserting "fiscal year 1999, or fiscal year 2000;"; and
(ii) by striking "or November 30, 2001," and inserting "November 30, 2001, or November 30, 2002," respectively.

(c) EXTENSION AND REVISION OF RETAINED AND REDISTRIBUTED ALLOTMENTS FOR FISCAL YEAR 2001.—
(1) PERMITTING AND EXTENDING RETENTION OF PORTION OF FISCAL YEAR 2001 ALLOTMENT.—
Paragraph (2) of such section 2104(g), as amended in subsection (b)(ii), is further amended—
(A) in the heading, by striking "2000" and inserting "2001"; and
(B) by adding at the end of subparagraph (A) the following:
"(iv) FISCAL YEAR 2001 ALLOTMENT.—Of the amounts allotted to a State pursuant to this section for fiscal year 2001 that were not expended by the State by the end of fiscal year 2003, 50 percent of that amount shall remain available for expenditure by the State through the end of fiscal year 2005.

(2) REDISTRIBUTED ALLOTMENTS.—
Paragraph (1) of such section 2104(g), as amended in subsection (b)(2), is further amended—
(A) in paragraph (A), by inserting "or for fiscal year 2001 by the end of fiscal year 2003," after "fiscal year 2002,"; (B) in subparagraph (A), by striking "1999, or 2000" and inserting "1999, 2000, or 2001;" (C) in subparagraph (A)(i)—
(i) by striking "or" at the end of clause (ii) (D) by striking "and" at the end of clause (ii); (E) by striking the period at the end of clause (iii) and inserting "; or;"; and (iii) by adding at the end the following new clause:
"(iv) the fiscal year 2001 allotment, the amount specified in subparagraph (D)(i) (less the total of the amounts under clause (ii) for such fiscal year), multiplied by the ratio of the amount specified in subparagraph (D)(ii) for the State to the amount specified in subparagraph (D)(iii);"
(D) in subparagraph (A)(ii), by striking "or 2000" and inserting "2000, or 2001;" (E) in subparagraph (B)—
(i) by striking "and" at the end of clause (iii); (ii) by redesignating clause (iii) as clause (iv); and (iii) by inserting after clause (ii) the following new clause:
"(iii) notwithstanding subsection (e), with respect to fiscal year 2001, shall remain available for expenditure by the State through the end of fiscal year 2005; and
(F) by adding at the end the following new subparagraph:
"(D) AMOUNTS USED IN COMPUTING REDISTRIBUTIONS FOR FISCAL YEAR 2001.—For purposes of subparagraph (A)(i)(IV)—
(i) the amount specified in this clause is the amount specified in paragraph (2)(B)(i)(I) for fiscal year 2001, less the total amount remaining available pursuant to paragraph (2)(A)(iv); and
(ii) the amount specified in this clause for a State is the amount by which the State's expenditures under this title in fiscal years 2001, 2002, and 2003 exceed the State's allotment for fiscal year 2001 under subsection (b); and
"(iii) the amount specified in this clause is the sum, for all States entitled to a redistribution under subparagraph (A) from the allotments for fiscal year 2001, of the amounts specified in clause (ii).

(3) CONFORMING AMENDMENTS.—Such section 2104(g) is further amended—
(A) in its heading, by striking "AND 2000" and inserting "2000, AND 2001;" and
(B) in paragraph (3)—
(i) by striking "or fiscal year 2000," and inserting "fiscal year 2000, or fiscal year 2001;" and
(ii) by striking "or November 30, 2002," and inserting "November 30, 2002, or November 30, 2003," respectively.

(d) EFFECTIVE DATE.—This section, and the amendments made by this section, shall be effective as if this section had been enacted on September 30, 2002, and amounts under title XXI of the Social Security Act (42 U.S.C. 1397aa et seq.) from allotments for fiscal years 1998 through 2000 are available for expenditure on and after October 1, 2002, under the amendments made by this section as if this section had been enacted on September 30, 2002.

The bill was ordered to be engrossed and read a third time, was read the third time, and passed, a motion to reconsider was laid on the table.

GENERAL LEAVE
Mr. TAUNZI. Mr. Speaker, I ask unanimous consent that all Members may have 5 legislative days within which to revise and extend their remarks on H.R. 531, the bill just passed. The SPEAKER pro tempore. Is there objection to the request of the gentleman from Louisiana? There was no objection.

MEDICARE PRESCRIPTION DRUG AND MODERNIZATION ACT OF 2003
Mr. THOMAS. Mr. Speaker, pursuant to House Resolution 299, I call up the second section of title XXVII of the Social Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program, and for other purposes, and ask for its immediate consideration.

The Clerk read the title of the bill.

"The SPEAKER pro tempore (Mr. LAHOOD). Pursuant to House Resolution 299, the bill is considered read for amendment.

The text of H.R. 1 is as follows:

H.R. 1

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

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

(a) SHORT TITLE.—This Act may be cited as the "Medicare Prescription Drug and Modernization Act of 2003".

(b) AMENDMENTS TO SOCIAL SECURITY ACT.—Except as otherwise specifically provided, whenever in this Act an amendment is expressed in terms of an amendment to or repeal of a section or other provision, the reference shall be considered to be made to that section or other provision of the Social Security Act.
Sec. 410. Improvement in payments to retain patients.

Sec. 409. Recognition of attending nurse practitioners as attending physicians to serve hospice patients.

Sec. 408. Confidentiality of records concerning care of hospice patients.

Sec. 407. Two-year extension of hold harmless provisions for small rural hospitals and sole community hospitals.

Sec. 406. Improvement in payments to retain emergency capacity for ambulatory services in rural areas.

Sec. 405. Improved payment for critical access hospitals.

Sec. 404. More frequent update in weights used in hospital market basket.

Sec. 403. Establishment of floor on wage index for rural and small urban areas.

Sec. 402. Immediate establishment of uniform standardized amount in hospital (DSH) treatment for biologicals.

Sec. 401. Enhanced disproportionate share hospital (DSH) treatment for rural hospitals and urban hospitals with fewer than 100 beds.

Sec. 400. Improved payment for certain prescription drugs and biologics.

Sec. 399. Two-year increase for home health services furnished in a rural area.

Sec. 398. Providing safe harbor for certain collaborative efforts that benefit medically underserved populations.

Sec. 397. GAO study of geographic differences in payments for physicians' services.

Sec. 396. Treatment of missing cost reports.

Sec. 395. Demonstration project for coverage of certain prescription drugs and biologics.

TITLES VII—MEDICARE BENEFITS

Sec. 711. Extension of update limitation on hospital payment updates.

Sec. 710. Reconsideration of Medicare shared savings program.

Sec. 709. Increase in Federal rate for hospitals in Puerto Rico.

Sec. 708. Adjustment to payments for hospital outpatient department (HOPD) payment reform.

Sec. 707. Payment for ambulance services.

Sec. 706. Payment for certain shoes and inserts under the fee schedule for orthotics and prosthetics.

Sec. 705. Waiver of part B late enrollment penalty for certain military retirees; special enrollment period.

TITLES VIII—MEDICARE BENEFITS ADMINISTRATION

Sec. 801. Establishment of Medicare Benefits Administration.

TITLES IX—REGULATORY REDUCTION AND CONTRACTING REFORM

Sec. 901. Construction; definition of supplier.

Sec. 902. Issuance of regulations.

Sec. 903. Compliance with changes in regulations and policies.

Sec. 904. Reports and studies relating to regulatory reform.

Sec. 905. Increased flexibility in Medicare administration.

Sec. 906. Requirements for information security for Medicare administrative contractors.

Sec. 907. Education and Outreach.

Sec. 908. Provider education and technical assistance.

Sec. 909. Small provider technical assistance demonstration program.

Sec. 910. Medicare+Choice Ombudsman; Medicare Beneficiary Ombudsman.
Sec. 1115. Enforcement.
Sec. 1116. Rulemaking.
Sec. 1117. Savings clause.
Sec. 1118. Effective date.

Subtitle C—Importation of Prescription Drugs
Sec. 1121. Importation of prescription drugs.

Title I—MEDICAID PRESCRIPTION DRUG BENEFIT

Sec. 101. Establishing a Medicaid prescription drug benefit.
(a) In general.—Title XVIII is amended—
(1) by redesignating part D as part F; and
(2) by inserting after part C the following new part:

"PART D—VOLUNTARY PRESCRIPTION DRUG BENEFIT PROGRAM"

"SEC. 1860D–1. BENEFITS; ELIGIBILITY; ENROLLMENT; COST SHARING; COVERAGE PERIOD.

"(a) PROVISION OF QUALIFIED PRESCRIPTION DRUG COVERAGE THROUGH ENROLLMENT IN PLANS.—Subject to the succeeding provisions of this part, each individual who is entitled to benefits under part A or is enrolled under part B is entitled to obtain qualified prescription drug coverage (described in section 1860D–2(a)) as follows:

"(1) MEDICARE-RELATED PLANS.—

"(A) MEDICARE ADVANTAGE.—If the individual is eligible to enroll in a Medicare Advantage plan that provides qualified prescription drug coverage under section 1851(j), the individual may enroll in such plan and obtain coverage through such plan.

"(B) EFFS RX PLAN.—If the individual is eligible to enroll in an EFFS plan that provides qualified prescription drug coverage under part E under section 1866–2(d), the individual may enroll in such plan and obtain coverage through such plan.

"(C) MA-EFFS PLAN; MA-EFFS RX PLAN.—For purposes of this part, the term 'MA-EFFS plan' means a Medicare Advantage plan under part C and an EFFS plan under part E and the term 'MA-EFFS Rx plan' means a MA-EFFS plan insofar as such plan provides qualified prescription drug coverage.

"(2) PRESCRIPTION DRUG PLAN.—If the individual is not enrolled in a MA-EFFS plan, the individual may enroll under this part in a prescription drug plan (as defined in section 1860D–10(a)(5)) of the individual had elected or is provided

"(b) GENERAL ELECTION PROCEDURES.—

"(1) IN GENERAL.—An individual eligible to elect qualified prescription drug coverage since the date the individual becomes eligible to enroll in a prescription drug plan or MA-EFFS Rx plan at a time during which elections are accepted under this part with respect to the plan shall not be denied enrollment in, or changes in, the plan based on any statutorily related factor (described in section 2702(a)(1) of the Public Health Service Act) or any other factor.

"(2) ELECTION PERIODS.—

"(A) IN GENERAL.—Except as provided in this paragraph, the election periods under this subsection shall be the same as the coverage election periods under the Medicare Advantage and EFFS programs under section 1851(e), including—

"(i) annual coordinated election periods; and

"(ii) special election periods.

"(B) INITIAL ELECTION PERIOD.—

"(i) INDIVIDUALS CURRENTLY COVERED.—In the case of an individual who is entitled to benefits under part A or enrolled under part B as of October 1, 2005, there shall be an initial election period of 6 months beginning on that date.

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

"(C) ADDITIONAL SPECIAL ELECTION PERIODS.—

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

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

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

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

"(3) INFORMATION ON PLANS.—Information described in section 1860D–3(b)(1) on prescription drug plans and MA-EFFS plans shall be made available during election periods.

"(4) ADDITIONAL INFORMATION.—In order to promote the efficient marketing of prescription drug plans and MA-EFFS plans, the Administrator may provide information to the sponsors and organizations offering such plans about individuals eligible to enroll in such plans.

"(5) GUARANTEED ISSUE; COMMUNITY RATING; AND NONDISCRIMINATION.—

"(A) GUARANTEED ISSUE.—

"(B) COMPLIANCE WITH MEDICARE ADVANTAGE LIMITATIONS PERMITTED.—The provisions of paragraphs (2) and (3) (other than subparagraph (C)(i), relating to default enrollment of section 1851(g) (relating to priority drug rebate program) pertain to priority drug rebate program).

"(C) COMMUNITY-RATED PREMIUM.—

"(D) IN GENERAL.—In the case of an individual who enrolls under a prescription drug plan or in a MA-EFFS Rx plan during the individual's initial enrollment period under this part or maintains enrollment in such a plan under subparagraph (C) continuous prescription drug coverage since the date the individual first qualified to elect prescription drug coverage under this part, a PDP sponsor or entity offering a prescription drug plan or MA-EFFS Rx plan and in which the individual is enrolled may not deny, limit, or condition the coverage or provide prescription drug benefits or vary or increase the premium under the plan based on any
health status-related factor described in section 2702(a)(1) of the Public Health Service Act or any other factor.

(B) LATE ENROLLMENT PENALTY.—In the case of an individual who does not maintain such continuous prescription drug coverage (as described in subparagraph (C)), a PDP sponsor or an entity offering a MA-EFFS Rx plan may (notwithstanding any provision in this title) adjust the premium otherwise applicable with respect to qualified prescription drug coverage in a manner that reflects additional actuarial risk involved. Such a risk shall be established through an appropriate actuarial opinion of the type described in subparagraph (A) through section 2103(c)(4). The Administrator shall provide a mechanism for assisting such sponsors and entities in identifying eligible individuals who have not maintained such continuous prescription drug coverage.

(C) CONTINUOUS PRESCRIPTION DRUG COVERAGE.—An individual is considered for purposes of this part to be maintaining continuous prescription drug coverage on and after the date the individual first qualifies to elect prescription drug coverage under this part if the individual establishes that at any time after such date the individual is covered under any of the following prescription drug coverage and before that date that is the last day of the 60-day period beginning on the date of termination of the particular prescription drug coverage involved (regardless of whether the individual subsequently obtains any of the following prescription drug coverage).

(i) Coverage under prescription drug plan or MA-EFFS Rx plan.—Qualified prescription drug coverage under a prescription drug plan or under a MA-EFFS Rx plan.

(ii) Medicaid prescription drug coverage.—Prescription drug coverage under a Medicaid prescription drug plan.

(3) Application of section to qualified prescription drug coverage. —Any amount determined under subparagraph (B) that is not a multiple of $10 shall be rounded to the nearest multiple of $10.

(4) Catastrophic protection. —The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (5)) that is equal to 20 percent; or

(ii) Actuarially equivalent (using processes established under subsection (e)) to an average expected payment of 20 percent of such costs.

(B) USE OF TIERS.—Nothing in this paragraph shall be construed as preventing a PDP sponsor or organization under this part or part C or E from applying tiered copayments, so long as such tiered copayments are consistent with subparagraph (A).

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

(A) for 2006, that is equal to $2,000; or

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

Any amount determined under subparagraph (B) that is not a multiple of $25 shall be rounded to the nearest multiple of $10.

(3) 20 PERCENT COVERAGE.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (5)) that is—

(i) equal to 20 percent; or

(ii) actual equivalent (using processes established under subsection (e)) to an average expected payment of 20 percent of such costs.

(A) for 2006, that is equal to $2,000; or

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

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

(C) CATASTROPHIC PROTECTION.—(A) In general.—Notwithstanding paragraph (3), the ‘annual out-of-pocket threshold’ specified in subparagraph (B) is equal to the annual out-of-pocket threshold specified in subparagraph (B).
shall be increased by the annual percentage increase described in paragraph (5) for the year involved. Any amount determined under the previous sentence that is not a multiple of $100 shall be rounded to the nearest multiple of $100.

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

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

"(ii) such costs shall be treated as incurred only if they are paid by the individual (or by another individual, such as a family member, on behalf of the individual), under section 1860D–7, under title XIX, or under a State pharmaceutical assistance program and the individual (or other individual) is not reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement (other than under such title or such program) for such costs.

"(D) ADJUSTMENT OF ANNUAL OUT-OF-POCKET THRESHOLD.—

"(i) IN GENERAL.—Subject to clause (vii), for each enrollee in a prescription drug plan or in a MA-EFFS Rx plan whose adjusted gross income is less than or equal to the income threshold as defined in clause (ii) for a year, the annual out-of-pocket threshold otherwise determined under subparagraph (B) for such year shall be increased by the amount equal to the percentage specified in clause (iii), multiplied by the lesser of—

"(I) the amount of such excess; or

"(II) the amount by which the income threshold limit exceeds the income threshold.

Any amount determined under the previous sentence that is not a multiple of $100 shall be rounded to the nearest multiple of $100.

"(ii) INCOME THRESHOLD.—For purposes of clause (i)—

"(I) IN GENERAL.—Subject to subsection (ii), the term 'income threshold' means $5,000, and the term 'income threshold limit' means $200,000.

"(II) INCOME INFLATION ADJUSTMENT.—In the case of a year beginning after 2006, each of the dollar amounts in subsection (ii) shall be increased by an amount equal to such dollar amount increased by the amount determined under section 1860D–7(c)(3) for calendar year 2002, as determined and adjusted under section 1804(a) for calendar year 2001.

"(iii) PERCENTAGE.—The percentage specified in this clause for a year is a fraction (expressed as a percentage) equal to—

"(I) the annual out-of-pocket threshold for a year under subparagraph (B) (determined without regard to this subparagraph), divided by—

"(II) the income threshold under clause (ii) for that year.

If any percentage determined under the previous sentence that is not a multiple of $4 of 1 percentage point, such percentage shall be rounded to the nearest multiple of $4 of 1 percentage point.

"(iv) USE OF MOST RECENT RETURN INFORMATION.—For purposes of clause (i) for an enrollee for a year, except as provided in clause (v), the adjusted gross income of an individual shall be based on the most recent information disclosed to the Secretary under section 6109(l)(19) of the Internal Revenue Code of 1986 before the beginning of that year.

"(v) INDIVIDUAL ELECTION TO PRESENT MOST RECENT INFORMATION REGARDING INCOME.—The Secretary shall provide, in coordination with the Secretary of the Treasury, a procedure under which, for purposes of applying this subparagraph for a calendar year, instead of using the information described in clause (iv), an enrollee may elect to use such procedure for obtaining more current information with respect to a taxable year ending in such calendar year. Such procedure shall—

"(I) require the enrollee to provide the Secretary with a copy of applicable information from the most recent return

"(II) provide for the Medicare Beneficiary Ombudsman (under section 1800) offering assistance to such enrollees in presenting such information and the toll-free number under such section being a point of contact for beneficiaries to inquire as to how to present such information;

"(III) provide for the verification of the information in such return by the Secretary of the Treasury under section 6109(l)(19) of the Internal Revenue Code of 1986; and

"(IV) provide for the payment by the Secretary (in a manner specified by the Secretary) to the enrollee of an amount equal to the excess of the benefit payments that would have been payable under the plan if the more recent return information were used, over the actual benefits payments that were made under the plan.

In the case of a payment under subparagraph (III) for an enrollee under a prescription drug plan, the PDP sponsor of the plan shall pay to the Secretary the amount so paid, less the applicable reimbursement amount that would have applied under section 1860D–7(c)(3)(B) if such payment had been treated as an allowable cost under such section. Such plan payment shall be deposited in the Treasury to the credit of the Medicare Prescription Drug Account of the Federal Supplementary Medical Insurance Trust Fund (under section 1841).

"(vi) DISSEMINATION OF INFORMATION ON PROCESS.—The Secretary shall provide, through the annual Medicare handbook under section 1804(a), for a general description of the adjustment of annual out-of-pocket threshold under this subparagraph, including the process for adjustment based upon more recent information and the confidentiality provisions of subparagraphs (F) and (G).

"(vii) ENROLLEE OPT-OUT.—The Secretary shall provide a procedure whereby, if an enrollee elects to have the maximum annual out-of-pocket threshold under this subparagraph for a year, the Secretary shall not request any information regarding the enrollee under subparagraph (E) for that year.

"(E) REQUESTING INFORMATION ON ENROLLLEES.—

"(i) IN GENERAL.—The Secretary shall, periodically as required to carry out subparagraph (A), transmit to the Secretary of the Treasury a list of the names and TINs of enrollees in prescription drug plans (or in MA-EFFS Rx plans) and request that such Secretary disclose to the Secretary information under subparagraph (A) of section 6103(i)(19) of the Internal Revenue Code of 1986 with respect to such enrollee for a specified taxable year for application in a particular calendar year.

"(ii) DISCLOSURE TO PLAN SPONSORS.—In the case of specified taxpayer (as defined in standards set by the Administrator) that offers a MA-EFFS Rx plan to the United States for Medicare beneficiaries, as determined by the Administrator for the 12-month period ending in July of the previous calendar year.

"(F) MAINTAINING CONFIDENTIALITY OF INFORMATION.—

"(i) IN GENERAL.—The amount of any increase in an annual out-of-pocket threshold under subparagraph (D) may not be disclosed by the Secretary except to offer a MA-EFFS Rx plan to the extent necessary to carry out this part.

"(ii) C RIMINAL AND CIVIL PENALTIES FOR UNAUTHORIZED DISCLOSURES.—In addition to any other penalty otherwise provided under law, any person who makes an unauthorized disclosure of information disclosed under section 6103(i)(19) of the Internal Revenue Code of 1986 (including any increase in any annual out-of-pocket threshold under subparagraph (D)) shall be subject to penalty to the extent provided under—

"(I) section 7213 of such Code (relating to criminal penalty for unauthorized disclosure of information);

"(II) section 7213A of such Code (relating to criminal penalty for unauthorized inspection of returns or return information);

"(III) section 7431 of such Code (relating to civil damages for unauthorized inspection of returns or return information);

"(IV) any other provision of the Internal Revenue Code of 1986;

"(V) any other provision of law.

"(ii) APPLICATION OF ADDITIONAL CIVIL MONETARY PENALTY FOR UNAUTHORIZED DISCLOSURES.—In addition to any other penalty otherwise provided under law, any person who makes an unauthorized disclosure of such information shall be subject to a civil monetary penalty of not exceeding $10,000 for each such unauthorized disclosure. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to civil monetary penalties under this subparagraph in the same manner as they apply to a penalty or proceeding under section 1128A (a).

"(G) INFORMATION REGARDING THIRD-PARTY REIMBURSEMENT.—In order to ensure compliance with the requirements of subparagraph (C)(ii), the Administrator is authorized to establish procedures, in coordination with the Secretary of the Treasury and the Director of the Office of Labor, for determining whether costs for individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payer, and for alerting the sponsors and organization that offer the plans in which such individuals are enrolled about such reimbursement arrangements. A PDP sponsor or Medicare Advantage or EFFS organization may also periodically ask individuals enrolled in a prescription drug plan or MA-EFFS Rx plan offered by the sponsor or organization whether the individuals have or expect to receive such third-party reimbursement. A material misrepresentation of the information described in the preceding sentence by an individual (as defined in standards set by the Administrator and determined through a process established by the Administrator) (or entity that offers a MA-EFFS Rx plan to the United States for Medicare beneficiaries, as determined by the Administrator for the 12-month period ending in July of the previous calendar year) shall constitute grounds for termination of enrollment under section 1860D–1(d)(3).

"(H) DISCLOSURE OF INFORMATION RELATING TO ANIMALS.—

"(i) IN GENERAL.—For purposes of this part, the annual percentage increase specified in this paragraph for a year is equal to the annual percentage increase in average per capita aggregate expenditures (as defined in standards set by the United States for Medicare beneficiaries, as determined by the Administrator for the 12-month period ending in July of the previous calendar year).

"(ii) ALTERNATIVE COVERAGE REQUIREMENTS.—A prescription drug plan or MA-EFFS Rx plan.
EFFS Rx plan may provide a different prescription drug benefit design from the standard coverage described in subsection (b) so long as the Administrator determines that such a plan meets the requirements described in this paragraph.

(3) AUDITS AND REPORTS.—To protect against fraud and abuse and to ensure proper utilization of such prescription drug coverage under this part, in addition to any protections against fraud and abuse provided under section 1906D-4(b)(3)(C), the Administrator may periodically review and examine the records and financial statements and records of PDP sponsors or entities offering a MA-EFFS Rx plan.

(4) ACTUARIAL VALUATION AND DETERMINATION OF ANNUAL PERCENTAGE INCREASES.—

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

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

(i) an actuarial valuation of standard coverage and of the reinsurance subsidy payments under section 1906D-8; and

(ii) the use of generally accepted actuarial principles and methodologies (including the use of actuarial opinions certified by independent, qualified actuaries); and

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

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

Such methods for determining actuarial valuation shall take into account methods of alternative coverage on drug utilization.

(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), PDP sponsors and entities offering MA-EFFS Rx plans may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values, but the Administrator shall determine whether such actuarial values meet the requirements under subsection (c)(1)."
(B) Discounts allowed for network pharmacies.—A prescription drug plan and a MA-FFS Rx plan may, notwithstanding subparagraph (A), reduce coinsurance or copayment to beneficiaries, and in exercising such discretion, consider the level otherwise provided for covered outpatient drugs dispensed through in-network pharmacies, but in no case shall such a reduction in coinsurance or copayment exceed 5 percent of the amount otherwise payable under the plan.

(C) CONVENIENT ACCESS FOR NETWORK PHARMACIES.—The PDP sponsor of the prescription drug plan and the entity offering a MA-FFS Rx plan shall secure the participation in such plans of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (consistent with rules of the Administrator). The Administrator shall establish convenient access rules under this subparagraph that are no less favorable to enrollees than the rules for convenient access to pharmacies of the Secretary of Defense established as of June 1, 2003, for purposes of the TRICARE Retail Pharmacy (TRRx) program. Such rules shall include adequate emergency access for enrolled beneficiaries.

(D) LEVEL PLAYING FIELD.—Such a sponsor shall permit enrollees to receive benefits (which may include a 90-day supply of drugs or biologicals) through a community pharmacy, rather than through mail order, with any differential in charge paid by such enrollees.

(E) NOT REQUIRED TO ACCEPT INSURANCE RISK.—The terms and conditions under subparagraph (A) may not require participating pharmacies to accept insurance risk as a condition of participation.

(2) Use of standardized technology.—

(A) IN GENERAL.—The PDP sponsor of a prescription drug plan and an entity offering a MA-FFS Rx plan shall issue (and reissue, as appropriate) such a card (or other technology) that may be used by an enrollee to assure access to negotiated prices under section 1980c-2(d) for the purchase of prescription drugs for which coverage is not otherwise provided under the plan.

(B) STANDARDS.—

(I) DEVELOPMENT.—The Administrator shall ensure, in developing the development and implementation of uniform standards relating to a standardized format for the card or other technology referred to in subparagraph (A), that such a card (or other technology) be compatible with standards established under part C of title XI.

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

(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a PDP sponsor of a prescription drug plan or an entity offering a MA-FFS Rx plan fails to include in the applicable formulary, the following requirements must be met:

(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—The sponsor or entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary. Such committee shall include at least one practicing physician and at least one practicing pharmacist independent and free of conflict with respect to the committee both with expertise in the care of elderly persons and a majority of its members shall consist of individuals who are practicing physicians or practicing pharmacists (or both).

(B) PHARMACY AND THERAPEUTIC DEVELOPMENT.—In developing and reviewing the formulary, the committee shall—

(ii) base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, such as randomized clinical trials, and other evidence-based outcomes research data, and on such other information as the committee determines to be appropriate; and

(iii) [omitted].

(C) INCLUSION IN ALL THERAPEUTIC CATEGORIES.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs (as defined in section 1903) with such a drug not being excluded from such categories and classes. In establishing such categories, the committee shall take into account the standards published in the United States Pharmacopeia-Drug Information. The committee shall make available to the enrollees under the plan through the Internet or otherwise the bases for the exclusion of coverage of any drug from the formulary.

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

(E) NOTICE BEFORE REMOVING DRUG FROM FORMULARY FOR CHANGING PREFERRED OR TIER STATUS OF DRUG.—Any removal of a covered outpatient drug from a formulary and any change in the preferred or tier cost-sharing status of such a drug shall take effect only after appropriate notice is made available to beneficiaries and physicians.

(F) PERIODIC EVALUATION OF PROTOCOLS.—In connection with the formulary, a prescription drug plan shall provide for the periodic evaluation and analysis of treatment protocols and processes.

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

(3) ELECTRONIC PRESCRIPTION PROGRAM.—

(A) IN GENERAL.—An electronic prescription program described in this paragraph is a program that includes at least the following components, consistent with uniform standards established under subpart A of this section.

(i) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—Prescriptions must be written and transmitted electronically (other than by mail) for each prescription, including those in emergency situations and other exceptional circumstances recognized by the Administrator.

(ii) PROMOTION OF PRESCRIPTION DRUG USE.—The program provides for the electronic transmittal to the prescribing health care professional of information that includes—

(A) information (to the extent available and feasible) on the drug or drugs being prescribed for each patient, including clinical and other information that may influence the prescribing health care professional to select the appropriate drug or drugs and other relevant related information on an interactive, real-time basis.

(B) INDICATIONS AND CONTRAINDICATIONS.—The Administrator shall provide for the development of uniform standards relating to the electronic prescription drug program described in subparagraph (A)(i) that are consistent with standards established under part C of title XI.

(C) NOT REQUIRED TO ACCEPT INSURANCE RISK.—The PDP sponsor of a prescription drug plan shall have in place, direct or through appropriate arrangements, with respect to covered outpatient drugs—

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

(ii) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including side-effects, and improve medication use, including a medication therapy management program described in paragraph (2) and for years beginning with 2007, an electronic prescription program described in paragraph (3); and

(B) STANDARDS.—The Administrator shall provide for the development of uniform standards relating to the electronic prescription drug program described in subparagraph (A) that are consistent with standards established under part C of title XI.

(C) PROVIDER AND PATIENT EDUCATION.—The PDP sponsor or entity offering a MA-FFS Rx plan shall secure the participation in the program of information that includes—

(i) enhanced beneficiary understanding to promote the appropriate use of medications by beneficiaries and to reduce the risk of potential adverse events or dispensing errors through beneficiary education, counseling, case management, disease state management programs, and other appropriate means;

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

(iii) detection of patterns of overuse and underuse of prescription drugs.
“(ii) ADVISORY TASK FORCE.—In developing such standards and the standards described in subsection (c)(2)(B)(i) the Administrator shall establish a task force that includes representatives from plans, hospitals, pharmacies, beneficiaries, pharmacy benefit managers, individuals with expertise in information technology, and pharmacy benefit experts in the development and promulgation of standards on veterans affairs and Defense and other appropriate Federal agencies to provide recommendations to the Administrator on such standards, including recommendations relating to the following:

(1) The range of available computerized prescribing software and hardware and their costs.

(2) The extent to which such standards and systems reduce medication errors and can be readily implemented by physicians, pharmacists, and systems.

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

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

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

(II) Implementation issues as they relate to plans, pharmacies, and systems in the range of hospital and physician office settings and pharmacies, including the secure electronic exchange of such information.

(VI) Implementation issues as they relate to the development and promulgation, by not later than June 26, 2003, of standards relating to the electronic prescription information technology, and pharmacy benefit exchange systems in the range of hospital and physician office settings and pharmacies, including the secure electronic exchange of such information.

(E)范围的可用计算机开具处方软件和硬件及其成本。

(II)实施此类标准和系统在医疗机构和医生办公室设置和药房中的实施，包括硬件、软件和培训成本。

(II)实施问题，它们与计划、药房和系统在医疗机构和医生办公室设置和药房中有关。

(VI)实施问题，与开发和实施，不超过6月26日，6月2003日，有关电子处方信息技术，和药房福利交换系统在医疗机构和医生办公室设置和药房中，包括安全电子交换这样的信息。

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standards established under subsection (d).

For purposes of this subsection, in applying (G) of section 1855(a)(2) shall apply.

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

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

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

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

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

(6) SOLVENCY STANDARDS FOR NON-LICENSED SPONSORS.—

(1) ESTABLISHMENT.—The Administrator shall establish, by not later than October 1, 2004, financial solvency and capital adequacy standards that an entity that does not meet the requirements of subsection (a)(1) must meet to qualify as a PDP sponsor under this part.

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

(e) RELATION TO STATE LAWS.—

(1) IN GENERAL.—The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency and capital adequacy standards) that apply to prescription drug plans which are offered by PDP sponsors under this part.

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

SEC. 1860D–5. PROCESS FOR BENEFICIARIES TO SELECT QUALIFIED PRESCRIPTION DRUG COVERAGE.

(a) IN GENERAL.—The Administrator shall establish a process for the selection of the prescription drug plan or MA-EFFS Rx plan through which eligible individuals elect qualified prescription drug coverage under this part.

(b) ELEMENTS.—Such process shall include the following:

(1) Annual, coordinated election periods, in which such individuals can change the qualifying plans through which they obtain coverage, in accordance with section 1860D–3(b)(2).

(2) Active dissemination of information to promote an informed selection among qualifying plans based upon price, quality, and other considerations as described in (and in coordination with) section 1851(d), including the provision of annual comparative information, maintenance of a toll-free hot line and the use of non-Federal entities and to Federal entities.

(3) Coordination of elections through filing with the entity offering a MA-EFFS Rx plan or a PDP sponsor, in the manner described in (and in coordination with) section 1851(c)(2).

(4) Informing each enrollee before the beginning of each year of the annual out-of-pocket threshold applicable to the enrollee for that year under section 1860D–2(b)(4) at such time.

(5) MA-EFFS RX ENROLLEE MAY ONLY OBTAIN BENEFITS THROUGH THE PLAN.—An individual who is enrolled under a MA-EFFS Rx plan may only elect to receive qualified prescription drug coverage under this part through such plan.

(6) ASSURING ACCESS TO A CHOICE OF QUALIFIED PRESCRIPTION DRUG COVERAGE.—

(1) CHOICE OF AT LEAST TWO PLANS IN EACH AREA.—

(A) IN GENERAL.—The Administrator shall assure that each individual who is entitled to benefits under part A or enrolled under part B and who is residing in an area in the United States has available, consistent with subparagraph (B), a choice of enrollment in at least two qualifying plans (as defined in paragraph (3)) in the area in which the individual resides, at least one of which is a prescription drug plan.

(B) REQUIREMENT FOR DIFFERENT PLAN SPONSORS.—The requirement in subparagraph (A) is not satisfied with respect to an area if only one PDP sponsor or one entity that offers a MA-EFFS Rx plan offers all the qualifying plans in the area.

(2) GUARANTEEING ACCESS TOVERAGE.—In order to assure access under paragraph (1) and consistent with paragraph (3), the Administrator shall establish a process under which a PDP sponsor is required, in writing of risk for a PDP sponsor to expand the service area under an existing prescription drug plan to adjoining or additional areas or to establish such a plan (including such a plan on a regional or national-wide basis), but only so long as (and to the extent necessary) to assure the access guaranteed under paragraph (1).

(3) LIMITATION ON AUTHORITY.—In exercising authority under this subsection, the Administrator—

(A) shall not provide for the full underwriting of financial risk by PDP sponsors; and

(B) shall seek to maximize the assumption of financial risk by PDP sponsors or entities offering a MA-EFFS Rx plan.

(4) REPORTS.—The Administrator shall, in each annual report to Congress under section 1890(g), include information on the exercise of authority under this subsection. The Administrator also shall include such recommendations as may be appropriate to minimize the exercise of such authority, including minimizing the assumption of financial risk.

(5) QUALIFYING PLAN DEFINED.—For purposes of this subsection, the term ‘qualifying plan’ means a prescription drug plan or a MA-EFFS Rx plan.

SEC. 1860D–6. SUBMISSION OF BIDS AND PREMIUMS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

(a) SUBMISSION OF BIDS, PREMIUMS, AND RELATED INFORMATION.—

(1) IN GENERAL.—Each PDP sponsor shall submit to the Administrator the information described in paragraph (2) in the same manner as information is submitted by an organization under section 1850(a)(2).

(2) INFORMATION SUBMITTED.—The information described in this paragraph is the following:

(1) COVERAGE PROVIDED.—Information on the qualified prescription drug coverage to be provided.

(b) ACTUARIAL VALUE.—Information on the actuarial value of the coverage.

(c) BID AND PREMIUM.—Information on the bid and the premium for the coverage, including an actuarial costing using (i) the actuarial basis for such bid and premium;

(ii) the portion of such bid and premium attributable to benefits in excess of standard coverage;

(iii) the reduction in such bid resulting from the reinsurance subsidy payments provided under section 1860D–8(a)(2); and

(iv) the reduction in such premium resulting from the direct and reinsurance subsidy payments provided under section 1860D–8.

(2) ADDITIONAL INFORMATION.—Other information as the Administrator may require to carry out this part.

(3) REVIEW OF INFORMATION; NEGOTIATION AND APPROVAL OF PREMIUM.—

(A) IN GENERAL.—Subject to subparagraph (B), the Administrator shall review the information filed under paragraph (2) for the purpose of conducting negotiations under section 1860D–4(b)(4) (relating to using OPM-like authority under the FEHBP). The Administrator, using the information provided (including the actuarial certification under paragraph (2)(C)) shall approve the premium submitted under this subsection only if the premium accurately reflects both (i) the actuarial value of the benefits provided, and (ii) the 73 percent average subsidy provided under section 1860D–5 for the standard benefit. The Administrator shall apply actuarial principles to approval of a premium under this part in a manner similar to the manner in which those principles are applied in establishing the monthly part B premium under section 1839.

(B) EXCEPTION.—In the case of a plan described in section 1851(a)(2)(C), the provisions of paragraph (A) shall not apply and the provisions of paragraph (5)(B) of section 1854(a), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply. Such information described in this paragraph is the following:

(1) COVERAGE PROVIDED.—Information on the qualified prescription drug coverage to be provided under section 1860D–1(c)(1)(B).

(2) UNIFORM BID AND PREMIUM.—

(A) IN GENERAL.—The bid and premium for a prescription drug plan under this section shall not vary among enrollees in the plan in the same service area.

(B) CONSTRUCTION.—Nothing in paragraph (1) shall be construed as preventing the imposition of a late enrollment penalty under section 1860D–1(c)(1)(B).

(3) COLLECTION.—

(1) BENEFICIARY’S OPTION OF PAYMENT THROUGH WITHHOLDING FROM SOCIAL SECURITY PAYMENT OR USE OF ELECTRONIC FUNDS TRANSFER MECHANISM.—In accordance with regulations, a PDP sponsor shall permit each enrollee, at the enrollee’s option, to make payment of premiums under this part to the sponsor through withholding from benefit payments in the manner provided under section 1860D–3(b)(2)(C) with respect to premiums under section 1839 or through an electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit card account) or otherwise. All premium payments that are withheld under this paragraph shall be...
credited to the Medicare Prescription Drug Trust Fund and shall be paid to the PDP sponsor involved.

(2) Offsetting.—Reductions in premiums for cost-sharing under parts A and B as a result of a selection of a MA-EFFS Rx plan may be used to reduce the premium otherwise imposed under paragraph (1).

(3) Reference Premium Amount as Full Premium for Subsidized Low-Income Individuals If No Standard (or Equivalent) Coverage in an Area.—(A) In general.—If there is no standard prescription drug coverage (as defined in paragraph (2)) offered in an area, in the case of an individual who is eligible for a premium subsidy amount (as defined in paragraph (3)) for prescription drug plans offered in the area, the PDP sponsor of any prescription drug plan offered in the area (and any entity offering a MA-EFFS Rx plan in the area) shall accept the reference premium amount (under paragraph (3)) as payment in full for the premium charge for qualified prescription drug coverage.

(B) Standard Prescription Drug Coverage Defined.—For purposes of this subsection, the term ‘standard prescription drug coverage’ means qualified prescription drug coverage the actuarial value of which is equivalent to the actuarial value of standard coverage.

(4) Reference Premium Amount Defined.—For purposes of this subsection, the term ‘reference premium amount’ means, with respect to qualified prescription drug coverage—

(A) a prescription drug plan that—

(i) provides standard coverage (or alternative prescription drug coverage the actuarial value of which is equivalent to that of standard coverage) under a plan’s PDP premium;

(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the plan’s PDP premium, or that has an actuarial value equivalent to the actuarial value for standard coverage.

(B) an EFS plan, the EFS monthly prescription drug beneficiary premium (as defined in section 1860c–4(a)(3)(B)); or

(C) a Medicare Advantage, the Medicare Advantage monthly prescription drug beneficiary premium (as defined in section 185b(2)(B)).

For purposes of subparagraph (A), the term ‘PDP’ with respect to a prescription drug plan, the premium amount for enrollment under the plan under this part (determined without regard to any low-income subsidy under section 1906c or any late enrollment penalty under section 1860d–1(c)(2)(B)).

SEC. 1860c–7. PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS.

(a) Income-Related Subsidies for Individuals With Income Below 150 Percent of Federal Poverty Level.—

(1) Full Premium Subsidy and Reduction of Cost-Sharing for Individuals With Income Below 150 Percent of Federal Poverty Level.—The use of a subsidy eligible individual (as defined in paragraph (4)) who is determined to have income that does not exceed 135 percent of the Federal poverty level, the individual is entitled under this section—

(A) to an income-related premium subsidy equal to 100 percent of the amount described in paragraph (2)(A) and

(B) subject to subsection (c), to the substitution for the beneficiary cost-sharing described in paragraphs (1) and (2) of section 1860c–1(b)(3)(B)(iv) the initial coverage limit specified in paragraph (3) of such section of amounts that do not exceed $2 for a multiple source or generic drug (as described in section 1927(k)(7)(A)) and $5 for a non-preferred drug.

(2) Sliding Scale Premium Subsidy for Individuals With Income Above 135% But Below 150 Percent of Federal Poverty Level.—In the case of a subsidy eligible individual who is determined to have income that does not exceed 150 percent of the Federal poverty level, the individual is entitled under this section to a subsidy.

(B) For 2007.—The dollar amounts applied under paragraphs (1)(B) for 2007 shall be the dollar amounts specified in such paragraph increased by the annual percentage increase described in section 1860c–8(b)(4).

(B) For Subsequent Years.—The dollar amounts applied under paragraph (1)(B) for a subsequent year shall be the dollar amounts specified in such paragraph (relating to growth in Medicare prescription drug costs per beneficiary) for the year involved.

(3) Construction.—Nothing in this section shall be construed as preventing a PDP sponsor or entity offering a MA-EFFS Rx plan from reducing the cost-sharing otherwise applicable to generic drugs.

(4) Determination of Eligibility.—

(A) Subsidy Eligible Individual Defined.—For purposes of this section, subject to subparagraph (D), the term ‘subsidy eligible individual’ means an individual who—

(i) is eligible to elect and has elected, to obtain qualified prescription drug coverage under this part;

(ii) has income below 150 percent of the Federal poverty line; and

(iii) meets the resources requirement described in subparagraph (D).

(B) Determining Whether an Individual Is a Subsidy Eligible Individual.—(i) In general.—The determination of whether an individual residing in a State is a subsidy eligible individual and the amount of such individual’s income shall be determined under the State medical assistance program (including otherwise applicable to generic drugs.

(5) Indexing Dollar Amounts.—

(a) In General.—The dollar amounts described in clause (i) multiplied by the ratio of the applicable dollar amounts specified in such paragraph (relating to growth in Medicare prescription drug costs per beneficiary) for the year involved.

(b) Premium Subsidy Amount.—(i) In general.—The premium subsidy amount described in this subsection for an individual residing in an area is the benchmark premium amount (as defined in paragraph (2)) for qualified prescription drug coverage offered by the prescription drug plan or the MA-EFFS Rx plan in which the individual is enrolled.

(6) Benchmark Premium Amount Defined.—For purposes of this subsection, the term ‘benchmark premium amount’ means, with respect to qualified prescription drug coverage offered under this part—

(A) a prescription drug plan that—

(i) provides standard coverage (or alternative prescription drug coverage the actuarial value of which is equivalent to that of standard coverage), the premium amount for enrollment under the plan under this part (determined without regard to any low-income subsidy under section 1906c or any late enrollment penalty under section 1860d–1(c)(2)(B)); or

(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the premium amount described in clause (i) multiplied by the ratio of the actuarial value of standard coverage, the dollar amounts specified in clause (i) multiplied by the ratio of the actuarial value of the alternative coverage; or

(B) a MA-EFFS Rx plan, the portion of the premium amount that is attributable to statutory drug benefits (described in section 1853(a)(3)(A)(ii)(II))

(c) Rules in Applying Cost-Sharing Subsidies.—

(1) In General.—In applying subsection (a)(1)(B), nothing in this paragraph shall be construed as preventing a plan or provider from waiving or reducing the amount of cost-sharing otherwise applicable.

(2) Limitation on Charges.—In the case of an individual receiving cost-sharing subsidies under subsection (a)(1)(B), the PDP sponsor or entity offering a MA-EFFS Rx plan may not charge more than $5 per prescription.

(3) Application of Indexing Rules.—The provisions of subsection (a)(5) shall apply to the dollar amount specified in paragraph (2) in the same manner as they apply to the dollar amounts specified in subsections (a)(1)(B).

(d) Administration of Subsidy Program.—The Administrator shall provide a payment to an entity offering a MA-EFFS Rx plan to individuals who is determined to be a subsidy eligible individual and who is enrolled in prescription drug plan or is enrolled in a MA-EFFS Rx plan.

(1) The Administrator provides for a notification of the PDP sponsor or the entity offering the MA-EFFS Rx plan involved that the dollar amount specified in such paragraph increased by the annual percentage increase described in section 1860c–8(b)(4) to the year involved.

(2) The dollar amount applied under paragraph (1)(B) for a subsequent year shall be the dollar amounts specified in such paragraph (relating to growth in Medicare prescription drug costs per beneficiary) for the year involved.

(3) Construction.—Nothing in this section shall be construed as preventing a PDP sponsor or entity offering the MA-EFFS Rx plan from reducing the cost-sharing otherwise applicable.
(2) The sponsor or entity involved reduces the premiums or cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Administrator information of such reduction.

(3) The Administrator periodically and on a timely basis reimburses the sponsor or entity for the amount of such reductions.

The reimbursement under paragraph (3) with respect to drug subsidies may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the populations actually involved.

(e) RELATION TO MEDICAID PROGRAM.—(1) IN GENERAL.—For provisions providing for the coordination of prescription drug benefits under the Medicare program, see section 1905(d)(1).

(2) MEDICAID PROVIDING WRAP AROUND BENEFITS.—The coverage provided under this part is primary payor to benefits for pre-scribed drugs provided under the medicaid program under title XIX consistent with section 1902(a)(11).

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

§ 1860D-8. SUBSIDIES FOR ALL MEDICARE BENEFICIARIES FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.

(a) Subsection (b)(3) of section 1860D-1 allows premium levels applicable to qualified prescription drug coverage for all medicare beneficiaries consistent with an overall subsidy level sufficient to reduce subsidy levels paid under the medicaid program under title XIX, and with appropriate adjustments to reflect differences in the populations actually involved.

(b) RELATION TO MEDICAID PROGRAM.—For purposes of this section, the term "medicaid program" means the medicaid program under title XIX, as provided by title XIX of this Act, and any amendments made by this Act and title XIX of this Act, as in effect under section 1903(b) of this Act.

(c) DETERMINATION OF SUBSIDY.—In the case of a participant or beneficiary (as defined in subsection (g)) for that month.

(1) A PDP sponsor offering a prescription drug plan under this part.

(2) An entity that offers a MA-EFFS Rx plan.

(3) The sponsor of a qualified retiree prescription drug plan (as defined in subsection (f)).

(4) REINSURANCE PAYMENT AMOUNT.—(i) IN GENERAL.—Subject to subsection (d)(1)(B) and paragraph (4), the reinsurance payment amount under this subsection for a qualifying entity (as defined in subsection (f)(1)) for a coverage year (as defined in subsection (h)(2)) is equal to the sum of the following:

(A) REINSURANCE BETWEEN INITIAL REINSURANCE THRESHOLD AND THE INITIAL COVERAGE LIMIT.—For the portion of the individual's gross covered prescription drug costs (as defined in paragraph (2)) for the year that exceeds the initial reinsurance threshold specified in paragraph (4), but does not exceed the initial coverage limit specified in section 1860D–2(b)(1)(D) for the year that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

(B) ALLOWABLE COSTS.—For purposes of this section, the term 'allowable costs' means, with respect to gross covered prescription drug costs under a plan described in paragraph (2), the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) under the plan, in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were standard coverage.

(C) GROSS COVERED PRESCRIPTION DRUG COSTS.—For purposes of this section, the term 'gross covered prescription drug costs' means, with respect to a qualifying entity under a plan described in subsection (b) during a coverage year, the costs incurred under the plan (including costs attributable to administrative costs) for covered prescription drugs dispensed during the year, including costs relating to the deductible, whether paid by the enrollee or under the plan, regardless of whether the coverage under the plan exceeds standard coverage and regardless of when the payment for such drugs is made.

(d) INITIAL REINSURANCE THRESHOLD.—The initial reinsurance threshold specified in this paragraph—

(1) for 2006, is equal to $1,000 or

(2) for subsequent years, is equal to the payment threshold specified in this paragraph for the previous year, increased by the annual percentage increase described in section 1860D–2(b)(4)(A) of this title.

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

(5) QUALIFYING COVERED INDIVIDUAL DEFINED.—For purposes of this subsection, the term 'qualifying covered individual' means an individual who—

(A) is enrolled with a prescription drug plan under this part;

(B) is enrolled with a MA-EFFS Rx plan;

(c) ADJUSTMENT OF PAYMENTS.—(1) ADJUSTMENT OF REINSURANCE PAYMENTS TO ASSURE 30 PERCENT LEVEL OF SUBSIDY THROUGH REINSURANCE.—(A) ESTIMATION OF PAYMENTS.—The Administrator shall proportionally adjust the payments made under subsections (a)(2) and (c) for a coverage year in such manner that the payments made for qualified entities for standard coverage under plans described in subsection (b) during the year.

(B) ADJUSTMENT.—The Administrator shall proportionally adjust the payments made under subsections (a)(2) and (c) for a coverage year in such manner so that the payments made for qualified entities for standard coverage under plans described in subsection (b) during the year.

(C) RELATION TO ADJUSTMENTS.—To the extent the Administrator determines it appropriate to avoid risk selection, the payments made for direct subsidies under subsection (a)(1) are subject to adjustment based upon risk factors specified by the Administrator. Any such risk adjustment shall be designed in a manner as not to result in a change in the aggregate payments made under such subsection.

(D) PAYMENT METHODS.—(1) IN GENERAL.—Payments under this section shall be made by the Medicare Prescription Drug Trust Fund.

(2) RULES RELATING TO QUALIFIED RETIREE PRESCRIPTION DRUG COVERAGE.—(i) DEFINITION.—For purposes of this section, the term "qualified retiree prescription drug plan" means employment-based retiree health coverage (as defined in paragraph (A)(i) if, with respect to an individual who is a participant or beneficiary under such coverage and is eligible to be enrolled in a prescription drug plan or a MA-EFFS Rx plan under this part, the following requirements are met:

(A) ACTUARIAL EQUIVALENT TO STANDARD COVERAGE.—The Administrator determines the actuarial equivalent (based on an actuarial analysis approved by the Administrator) that coverage provides at least the same actuarial value as standard coverage. Such determination may be made on an annual basis.

(B) AUDITS.—The sponsor (or the administrator, if designated by the sponsor) and the administrator shall maintain, and the administrator shall access to, such records as the Administrator deems necessary to ensure the adequacy of prescription drug coverage and the accuracy of payments made.

(C) PROVISION OF CERTIFICATION OF PRESCRIPTION DRUG COVERAGE.—The plan shall provide for issuance of certifications of the type described in section 1860D–1(c)(2)(D).

(D) LIMITATION ON BENEFIT ELIGIBILITY.—No payment shall be provided under this section with respect to a participant or beneficiary in a qualified retiree prescription drug plan unless the individual is—

(A) covered under the plan; and

(B) eligible to obtain qualified prescription drug coverage under section 1860D–1 but not under such part of such plan (either through a prescription drug plan or through a MA-EFFS Rx plan).
Any such supplemental coverage (not including payment of any premium referred to in subparagraph (B)) shall be treated as primary coverage to which section 1860D–2(b)(2)(A) is applied. 

(g) COMPUTATION OF NATIONAL AVERAGE MONTHLY BID AMOUNT.—

(1) IN GENERAL.—For each year (beginning with 2006) the Administrator shall compute a national average monthly bid amount equal to the average of the benchmark bid amounts for each prescription drug plan and MA-EFFS Rx plan, except that, as computed under paragraph (2), the benchmark bid amount for an entity that does not have a prescription drug plan or MA-EFFS Rx plan, except that

(B) a MA-EFFS Rx plan, the portion of the benchmark bid amount attributable to statutory drug benefits (described in section 1853(a)(1)(A)(i)(II)).

For purposes of subparagraph (A), the term 'bid amount' means, with respect to a prescription drug plan, the PDP bid multiplied by the ratio of (I) the actuarial value of standard coverage, to (ii) the actuarial value of the alternative coverage; or

(ii) the cost limit under this subparagraph in the case of such drugs, regardless of when the claim is covered.

(i) the deductible under this subparagraph is equal to $250 for plan years that end in 2006, and

(ii) the cost limit under this subparagraph is equal to $5,000 for plan years that end in 2006.

(C) Indexing.—The deductible and cost limit amounts specified in subparagraphs (B) for a plan year after 2006 shall be increased annually at a rate determined without regard to any low-income subsidy payments under section 1860D–7 or any late enrollment penalty under section 1903(a)(2)(B).

(2) BENCHMARK BID AMOUNT DEFINED.—For purposes of this subsection, the term 'benchmark bid amount' means, with respect to a qualified prescription drug coverage offered under—

(A) a prescription drug plan that—

(i) provides standard coverage (or alternative prescription drug coverage the actuarial value of which is equivalent to that of standard coverage), the PDP bid; or

(ii) provides alternative prescription drug coverage the actuarial value of which is greater than that of standard coverage, the PDP bid multiplied by the ratio of (I) the actuarial value of standard coverage, to (ii) the actuarial value of the alternative coverage; or

(B) a MA-EFFS Rx plan, the portion of the benchmark bid amount attributable to statutory drug benefits (described in section 1853(a)(1)(A)(i)(II)).

(3) WEIGHTED AVERAGE.—

(A) IN GENERAL.—The monthly national average monthly bid amount computed under paragraph (1) shall be a weighted average, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the previous year.

(B) SPECIAL RULE FOR 2006.—For purposes of applying this subsection for 2006, the Administrator shall establish procedures for determining the weighted average under subparagraph (A) for 2005.

(4) ADJUSTMENT TO ADD BACK IN VALUE OF INCREASED ADMINISTRATIVE COSTS.—The Administrator shall make an adjustment under this paragraph, to take into account increases in administrative expenses under this part in accordance with, a contract between the Administrator and the entity under—

(a) DEFINITIONS.—For purposes of this part—

(1) COVERED OUTPATIENT DRUGS.—The term 'covered outpatient drugs' is defined in section 1860D–2(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

(2) NATIONAL AVERAGE COVERAGE LIMIT.—The term 'national average coverage limit' means such limit as established under section 1860D–2(b)(3), or, in the case of coverage that is not standard coverage, the comparable limit (if any) established under the coverage.

(3) MEDICARE PRESCRIPTION DRUG TRUST FUND.—The term 'Medicare Prescription Drug Trust Fund' means the Trust Fund created under section 1860D–9(a).

(4) PDP SPONSOR.—The term 'PDP sponsor' means an entity that is certified under a contract with the Administrator as meeting applicable Federal standards and standards of this part for such a sponsor.

(5) PRESCRIPTION DRUG PLAN.—The term 'prescription drug plan' means health benefit coverage that—

(A) is offered under a policy, contract, or plan by a PDP sponsor pursuant to, and in accordance with, a contract between the Administrator and the sponsor under section 1860D–4(b);

(B) provides qualified prescription drug coverage, and

(C) satisfies the applicable requirements of the section 1860D–3 for a prescription drug plan.
"(6) Qualified prescription drug coverage.—The term 'qualified prescription drug coverage' is defined in section 1860D–2(b).

(7) Standard coverage.—The term 'standard coverage' is defined in section 1860D–2(b).

(8) Insurance risk.—The term 'insurance risk' means, with respect to a participating pharmacy, risk of the type commonly assumed only by insurers licensed by a State and does not include payment variations designed to provide performance-based measures of activities within the control of the pharmacy, such as formulary compliance and drug utilization.

(b) Offer of qualified prescription drug coverage under Medicare Advantage and EFS programs.—

(1) Part of Medicare Advantage plan.—Medicare Advantage organizations are required to offer Medicare Advantage plans that include qualified prescription drug coverage under part C pursuant to section 1851(a).

(2) As part of EFS plan.—EFS organizations are required to offer EFS plans that include qualified prescription drug coverage under part E pursuant to section 1860D–2(d).

(c) Application of part C provisions under this part.—For purposes of applying provisions of part C under this part with respect to a prescription drug plan and a PDP sponsor, unless otherwise provided in this part, such provisions shall be applied as if:

(1) any reference to a Medicare Advantage or other plan included a reference to a prescription drug plan;

(2) any reference to a provider-sponsored organization included a reference to a PDP sponsor;

(3) any reference to a contract under section 1851(a) included a reference to a contract under section 1860D–4(b); and

(4) any reference to part C included a reference to this part.

(d) Report on pharmacy services provided to long-term care facility patients.—

(1) Review.—Within 6 months after the date of the enactment of this section, the Secretary shall review the current standards of practice for pharmacy services provided to patients in nursing facilities and other long-term care facilities.

(2) Evaluations and recommendations.—Specifically in the review under paragraph (1), the Secretary shall:

(A) assess the current standards of practice, clinical services, and other service requirements generally utilized for pharmacy services in the long-term care setting;

(B) evaluate the impact of those standards with respect to patient safety, reduction of medication errors and quality of care; and

(C) recommend (in the Secretary's report under paragraph (3)) necessary actions and appropriate reimbursement to ensure the necessary services, drugs to beneficiaries residing in nursing facilities and other long-term care facilities in a manner consistent with existing patient safety and quality of care standards under applicable State and Federal laws.

(3) Report.—The Secretary shall submit a report to the Congress on the Secretary's findings and recommendations under this subsection, including a detailed description of the Secretary's plans to implement this part in a manner consistent with applicable State and Federal laws designed to protect the safety and quality of care of patients of nursing facilities and other long-term care facilities.

(1) Conforming references to previous part D.—Any reference in law (in effect before the date of the enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

(2) Conforming amendments permitting waiver of cost-sharing.—Section 11228(b)(3) (42 U.S.C. 1320a–7b(b)(3)) is amended—

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

(B) by striking the period at the end of subparagraph (F) and inserting '; and'; and

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

'(G) the waiver or reduction of any cost-sharing imposed under part D of title XVIII.'

(3) Submission of legislative proposal.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal for each such technical and conforming amendments in the law as are required by the provisions of this subsection.

(c) Study on transitioning part B prescription drug coverage.—Not later than 6 months after the date of the enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a study examining the extent to which the requirements of part B of title XVIII of the Social Security Act for outpatient prescription drugs for which benefits are provided under part B of such title.

Sec. 102. Offering of qualified prescription drug coverage under Medicare Advantage and end-stage renal disease fee-for-service programs.

(a) Medicare Advantage.—Section 1851 (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

'(j) Availability of prescription drug coverage.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given in sections 1860D–2.

(b) Offering of qualified prescription drug coverage under Medicare Advantage and end-stage renal disease fee-for-service programs.—

(1) Medicare Advantage.—Section 1860D–1(b) is amended by adding at the end the following new subsection:

'(2) Requirement for election of part D coverage to obtain qualified prescription drug coverage.—For purposes of this part, an individual who has not elected qualified prescription drug coverage under section 1860D–1(b) shall be treated as being ineligible to enroll in a Medicare Advantage plan under this part that offers such coverage.

(3) Compliance with certain additional beneficiary protections for prescription drug coverage.—With respect to the offering of qualified prescription drug coverage by a Medicare Advantage organization under this part on and after January 1, 2006, the organization and plan shall meet the requirements of subsections (a) through (d) of section 1860D–3 in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D and shall submit to the Administrator such information described in section 1860D–6(a)(2). The Administrator shall waive such requirements to the extent the Administrator determines that such requirements otherwise apply to the organization or plan under this part.

(4) Availability of premium and cost-sharing subsidies.—In the case of low-income individuals who are enrolled in a Medicare Advantage plan that provides qualified prescription drug coverage, premium and cost-sharing subsidies are provided for such coverage under section 1860D–7.

(5) Availability of direct and reinsurance subsidies to reduce premiums.—Medicare Advantage organizations are provided direct and reinsurance subsidy payments for providing qualified prescription drug coverage under this part under section 1860D–8.

(6) Consolidation of drug and non-drug premiums.—In the case of a Medicare Advantage plan that includes prescription drug coverage, with respect to an enrollee in such plan there shall be a single premium for both drug and non-drug coverage provided under the plan.

(7) Transition in initial enrollment period.—Notwithstanding any other provision of this part, the annual, coordinated election period under subsection (e)(3)(B) for 2006 shall be the 6-month period beginning with November 2005.

(8) Qualified prescription drug coverage; standard coverage.—For purposes of this part, the terms 'qualified prescription drug coverage' and 'standard coverage' have the meanings given in sections 1860D–2.

(9) Special rules for private fee-for-service plans.—With respect to a Medicare Advantage plan described in section 1851(a)(2) that offers qualified prescription drug coverage—

(A) requirements regarding negotiated prices.—Subsections (a)(1) and (d)(1) of section 1860D–2 shall not be construed to require the plan to negotiate prices or discounts but shall apply to the extent the plan does so.

(B) Modification of actuarial determination requirement.—If the plan provides access, without charging additional copayments, to all pharmacies without regard to whether they are participating pharmacies in a network, section 1860D–3(c)(3)(A)(ii) shall not apply to the plan.

(C) Drug utilization management program not required.—The requirements of section 1860D–3(c)(1)(D)(ii) shall not apply to the plan.

(D) Non-participating pharmacy disclosure.—If the plan provides for coverage for drugs purchased from all pharmacies, without entering into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, section 1860D–3(c)(3)(B) shall not apply to the plan.

(10) Offering of qualified prescription drug coverage.—An EFS plan offered by the organization in that area includes qualified prescription drug coverage—

(A) if the plan to negotiate prices or discounts but shall apply to the extent the plan does so.

(B) if the plan provides access, without charging additional copayments, to all pharmacies without regard to whether they are participating pharmacies in a network, section 1860D–3(c)(3)(A)(ii) shall not apply to the plan.

(C) if the plan provides for coverage for drugs purchased from all pharmacies, without entering into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, section 1860D–3(c)(3)(B) shall not apply to the plan.

(D) if the plan provides for coverage for drugs purchased from all pharmacies, without entering into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, section 1860D–3(c)(3)(B) shall not apply to the plan.

(E) if the plan provides for coverage for drugs purchased from all pharmacies, without entering into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, section 1860D–3(c)(3)(B) shall not apply to the plan.

(F) if the plan provides for coverage for drugs purchased from all pharmacies, without entering into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, section 1860D–3(c)(3)(B) shall not apply to the plan.

(G) if the plan provides for coverage for drugs purchased from all pharmacies, without entering into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, section 1860D–3(c)(3)(B) shall not apply to the plan.

(H) if the plan provides for coverage for drugs purchased from all pharmacies, without entering into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, section 1860D–3(c)(3)(B) shall not apply to the plan.

(I) if the plan provides for coverage for drugs purchased from all pharmacies, without entering into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, section 1860D–3(c)(3)(B) shall not apply to the plan.

(J) if the plan provides for coverage for drugs purchased from all pharmacies, without entering into contracts or agreements with pharmacies to provide drugs to enrollees covered by the plan, section 1860D–3(c)(3)(B) shall not apply to the plan.
to enroll in an EFFS plan under that part that offers such coverage.

"(3) Compliance with certain additional beneficiary protections for prescription drug coverage. With respect to the offering of qualified prescription drug coverage by an EFFS organization under this part, the organization and plan shall meet the requirements of paragraphs (a) through (d) of section 1860D–3 in the same manner as they apply to a PDP sponsor and a prescription drug plan under part D and shall submit to the Administrator the information described in section 1860D–6(a)(2). The Administrator shall waive such requirements to the extent the Administrator determines that such requirements are otherwise applicable to the organization or plan under this part.

"(4) Availability of premium and cost-sharing subsidies. In the case of low-income individuals who are enrolled in an EFFS plan that provides qualified prescription drug coverage, premium and cost-sharing subsidies are provided for such coverage under section 1860D–7.

"(5) Availability of direct and reinsurance subsidies to reduce BIDS and premiums. Prior to January 1, 1998, no provisions are provided for direct and reinsurance subsidy payments for providing qualified prescription drug coverage to an enrollee in such plan who may otherwise be covered by a single premium or a non-drug and non-drug coverage provided under the plan.

"(6) Qualified prescription drug coverage. For purposes of this part, the term 'qualified prescription drug coverage' and 'standard coverage' have the meanings given such terms in section 1860D–2.

"(c) Conforming Amendments. Section 1860D–1(c)(2) is amended—

"(1) in subsection (a)—

"(II) by inserting '(other than qualified prescription drug benefits)' after 'benefits';

"(2) by striking the period at the end of subparagraph (B) and inserting a comma; and

"(3) by adding after and below subparagraph (B) the following:

"(A) By striking 'and'

"(B) by striking the period at the end of section 1860D–1(c)(2)(B) after "in this subsection";

"(d) Effective Date. The amendments made by this section apply to coverage provided on or after January 1, 2000.

SEC. 103. Medicaid Amendments.

(a) Determinations of Eligibility for Low-Income Subsidies.

"(1) Requirement. Section 1935(a)(2)(A) is amended—

"(A) by striking "6-2/3 percentage points" and inserting "6-2/3 percentage points in the previous year decreased by 6-2/3 percentage points"; and

"(B) by striking "the amount computed under this subsection" and inserting "the amount computed under this subsection are used"

"(c) Conforming Amendments. Section 1935(c)(1) is amended—

"(A) by redesignating subsection (a) as section 1935(a)(1), for a State that is one of the 50 States or the District of Columbia—

"(B) by redesignating section 1935(c)(2) as section 1935(c)(1)(B), notwithstanding section 1916 for the operations of this subsection are used to the product of—

"(c) Medicaid as Secondary Payor. In the case of an individual who is entitled to qualified prescription drug coverage under a prescription drug plan under part D of title XVIII (or under a MA-EFFS Rx plan under section 1860D–7(a)(3)(A}), the otherwise applicable Federal matching rate shall be 100 percent.

"(2) Coordination. The State shall provide the Administrator with such information as may be necessary to allocate administrative expenditures described in paragraph (1) for the provision of covered outpatient drugs to individuals who are entitled to qualified prescription drug coverage under a prescription drug plan under part D of title XVIII (or under a MA-EFFS Rx plan under the individual who is entitled to such coverage under section 1860D–1)."
(i) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

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

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

(ii) a subsequent year, is equal to the aggregate amount specified in this subparagraph for the previous year increased by an annual percentage increase specified in section 1808D–2(b)(5) for the year involved.

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

(2) CONFORMING AMENDMENT.—Section 1108(f)(2) (42 U.S.C. 1395ss) is amended by inserting “and (ii)” after “Subject to subsection (g),”.

(a) AMENDMENT TO BEST PRICE.—Section 1927(c)(3)(C)(i) (42 U.S.C. 1396–8c(3)(C)(i)) is amended—

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

(2) by striking the period at the end of subclause (IV) and inserting “; and”;

and

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

“(V) any prices charged which are negotiated by a prescription drug plan under part D of title XVIII, by a MA–EFS Rx plan under part C or E of such title with respect to any prescription drugs, or by a qualified individual retiree prescription drug plan (as defined in section 1808D–2(b)(1)) with respect to such drugs on behalf of individuals entitled to benefits under part A or enrolled under part B of such title.”

SEC. 104. MEDIQAP TRANSITION.

(a) IN GENERAL.—Section 1882 (42 U.S.C. 1395f) is amended by adding at the end the following new subsection:

“(iv) COVERAGE OF PRESCRIPTION DRUGS.—

“(1) IN GENERAL.—Notwithstanding any other provision of law, except as provided in paragraph (3) no new medicare supplemental policy that provides coverage of expenses for prescription drugs may be issued under this section or on or after January 1, 2006, to an individual unless it replaces a medicare supplemental policy that was issued to that individual prior to January 1, 2006, and which provided some coverage of expenses for prescription drugs. Nothing in this subsection shall be construed as preventing the policy holder of a medicare supplemental policy from being issued a new policy under this subsection on or after January 1, 2006, from continuing to receive benefits under such policy on and after such date.

“(2) ISSUANCE OF SUBSTITUTE POLICIES FOR BENEFICIARIES ENROLLED WITH A PLAN UNDER PART D.—

“(A) IN GENERAL.—The issuer of a medicare supplemental policy

“(i) may deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as ‘A’, ‘B’, ‘C’, ‘D’, ‘E’, ‘F’, or ‘G’ under the standards established under section (p)(2) and that is offered and is available for issuance to new enrollees by such issuer;

“(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

“(iii) shall not impose an exclusion of benefits based on a pre-existing condition under such policy

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy not later than 63 days after the date of the termination of enrollment described in such paragraph and who submits evidence of the existence of such condition, along with the application for such medicare supplemental policy.

“(B) INDIVIDUAL COVERED.—An individual described in this subparagraph is an individual who—

“(i) enrolls in a prescription drug plan under part D;

“(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as ‘A’ under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

“(C) ENFORCEMENT.—The provisions of paragraph (4) of subsection (s) shall apply to requirements of this paragraph in the same manner as they apply to the requirements of such subsection.

“(3) NEW STANDARDS.—In applying subsection (p)(1)(E) (including permitting the NAIC to revise its model regulations in response to changes in law) with respect to the change in benefits resulting from title I of the Medicare Prescription Drug and Modernization Act of 2003, with respect to policies issued to individuals who are enrolled in a plan under part D, the changes in standards that provide for servicing for the benefit packages described in paragraph (2)(B)(iii) that included coverage for prescription drugs two benefit packages that may provide for coverage of cost-sharing (other than the prescription drug deductible) with respect to qualified prescription drug coverage under such part. The two benefit packages shall be consistent with the following:

“(A) FIRST NEW POLICY.—The policy described in this subparagraph has the following benefits, notwithstanding any other provision of this section relating to a core benefit package:

“(i) Coverage of 50 percent of the cost-sharing otherwise applicable under parts A and B, except coverage of 100 percent of any cost-sharing otherwise applicable for preventive benefits.

“(ii) No coverage of the part B deductible.

“(iii) Coverage for all hospital coinsurance for long stays (as in the current core benefit package).

“(iv) A limitation on annual out-of-pocket expenditures under parts A and B to $4,000 in 2005 (or, in a subsequent year, to such limit as the Secretary shall begin—

“(A) the card endorsement part of the program under paragraph (1)(A) as soon as possible, but in no case later than September 2004.

“(B) the prescription drug account part of the program under paragraph (1)(B) as soon as possible, but in no case later than September 2004.

“(3) TRANSITION.—The program under this section shall remain in effect through 2005 throughout the United States. The Secretary shall provide for an appropriate transition and termination of such program on January 1, 2006.

“(4) VOLUNTARY NATURE OF PROGRAM.—Nothing in this section shall be construed as compelling an eligible beneficiary to enroll in the program under this section.

“(B) ELIGIBLE BENEFICIARY; ELIGIBLE ENTITY; PRESCRIPTION DRUG ACCOUNT.—For purposes of this section:

“(i) ELIGIBLE BENEFICIARY.—The term ‘eligible beneficiary’ means an individual who is eligible for benefits under part A or enrolled under part B and who is not enrolled in a Medicare Advantage plan that offers qualified prescription drug coverage.

“(ii) ELIGIBLE ENTITY.—The term ‘eligible entity’ means any entity that the Secretary determines to be appropriate to provide the benefits under this section, including—

“(A) a pharmaceutical benefit management companies;

“(B) wholesale and retail pharmacy delivery systems;

“(C) insurers;

“(D) Medicare Advantage organizations;

“(E) other entities; or

“(F) any combination of the entities described in subparagraphs (A) through (E).

“(3) PRESCRIPTION DRUG ACCOUNT.—The term ‘prescription drug account’ means, with respect to an eligible beneficiary, an account established for the benefit of that beneficiary under section 1807A.

“(B) ENROLLMENT IN ENDORSED PLAN.—

“(1) ESTABLISHMENT OF PROGRAM.—

“(A) IN GENERAL.—The Secretary shall establish a program through which an eligible beneficiary may make an election to enroll under this section with an endorsed program.

“(B) REQUIREMENT OF ENROLLMENT.—An eligible beneficiary must enroll under this section for a year in order to be eligible to receive the benefits under this section for that year.

“(C) LIMITATION ON ENROLLMENT.—

“(1) IN GENERAL.—Except as provided under this subparagraph, in the event of a beneficiary such exceptional circumstances as the Secretary may provide, an eligible individual shall have the opportunity to enroll under this section during the initial, general enrollment period as soon as possible after the date of the enactment of this section and annually thereafter.
The Secretary shall specify the form, manner, and timing of such election but shall permit the exercise of such election at the time the individual is eligible to enroll. The annual open enrollment period shall be coordinated with those provided under the Medicare Advantage program under part C.

(2) OPEN ENROLLMENT PERIOD FOR CURRENT BENEFICIARIES.—The Secretary shall establish a period, which shall begin on the date on which the Secretary first begins to accept elections for enrollment under this section and shall end not earlier than 3 months later, during which any eligible beneficiary may enroll in the program under this part during any period after the beneficiary’s initial enrollment period under part B (as determined under section 1837).

(3) SPECIAL ENROLLMENT PERIOD IN CASE OF TERMINATION OF COVERAGE UNDER A GROUP HEALTH PLAN.—The Secretary shall provide for a special enrollment period under this section for any reason of the individual’s or the individual’s spouse’s current employment status shall be treated as being deleted.

(4) PERIOD OF COVERAGE.—

(1) IN GENERAL.—Except as provided in paragraphs (b) and (c) of this subsection, an eligible beneficiary may not enroll in the program under this part during any period after the beneficiary’s initial enrollment period under part B (as determined under section 1837).

(2) COLLECTION OF ENROLLMENT FEE.—The annual enrollment fee shall be collected under title XIX of the Social Security Act. The fee for 2003 in a Medicare Advantage program is 1% of the enrollment fee described in section 1852(c).

(3) PAYMENT OF ENROLLMENT FEE FOR BENEFICIARIES WITH RESPECT TO CERTAIN PRESCRIPTION DRUG COVERAGE.—

(1) IN GENERAL.—The Secretary shall establish an arrangement under which a State may provide for payment of some or all of the enrollment fee for some or all low-income enrollees in the State, as specified by the State under the arrangement. Insofar as such a payment arrangement is made with respect to an eligible beneficiary, the amount of the enrollment fee shall be paid directly by the State and shall not be collected under paragraph (2).

(4) ISSUANCE OF CARD AND COORDINATION.—

(1) IN GENERAL.—Each eligible entity shall—

(2) PROVIDE FOR ACTIVITIES UNDER THIS SECTION.—The Secretary shall provide for activities under this section to be performed in a coordinated manner. In establishing such process, the Secretary shall provide for activities under this section to be performed in a coordinated manner. In establishing such activity, the Secretary shall provide for activities under this section to be performed in a coordinated manner.

(5) ISSUANCE OF CARD AND COORDINATION.—

(1) IN GENERAL.—Each eligible entity shall—

(2) PROVIDE FOR ACTIVITIES UNDER THIS SECTION.—The Secretary shall provide for activities under this section to be performed in a coordinated manner. In establishing such process, the Secretary shall provide for activities under this section to be performed in a coordinated manner. In establishing such activity, the Secretary shall provide for activities under this section to be performed in a coordinated manner.
"(C) RESPONSE TO BENEFICIARY QUESTIONS.—Each eligible entity offering prescription drug coverage under this section shall have a mechanism (including a toll-free telephone number) providing, upon request specific information (such as negotiated prices, including discounts) to individuals who have selected the entity. The entity shall make such information available through an Internet website and in writing upon request, information on specific changes in its formulary.

"(D) COORDINATION WITH PRESCRIPTION DRUG ACCOUNTABILITY PROGRAMS.—Such eligible entity shall provide for coordination of such information as the Secretary may specify to carry out section 1807A.

"(E) ACCESS TO NEGOTIATED BENEFITS.—(A) ENSURING PHARMACY ACCESS.—The provisions of subsection (c)(1) of section 1906D–3 (other than payment provisions under section 1906D–8 with respect to sponsors under such subsection) shall apply to an eligible entity under this section in the same manner as they apply to a PDP sponsor under such section.

"(B) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—For requirements relating to the access of an eligible beneficiary to negotiated prices (including applicable discounts) for prescription drugs, section 3(c)(3), insofar as the Secretary determines that such requirements can be implemented on a timely basis.

"(F) COST AND UTILIZATION MANAGEMENT; QUALITY ASSURANCE; MEDICATION THERAPY MANAGEMENT PROGRAMS.—(A) IN GENERAL.—For purposes of providing access to negotiated benefits under subsection (i), the eligible entity shall have in place procedures for the measurement described in section 1906D–3(d), including an effective cost and drug utilization management program, quality assurance measures and systems, and a program to control fraud, abuse, and waste, as determined by the Secretary, that such programs can be implemented on a timely basis.

"(B) ACCREDITATION.—Section 1906D–3(e)(4) (relating to treatment of accreditation) shall apply to the requirements for an endorsed program under this section with the following requirements, in the same manner as they apply to Medicare Advantage plans under part C with respect to the requirements described in a clause of subsection (e)(4):

(i) Paragraph (3)(A) (relating to access to covered benefits).

(ii) Paragraph (7) (relating to confidentiality of enrollee records).

(iii) Paragraph (9) (relating to grievance mechanism).

(iv) Paragraph (10) (relating to coverage determinations and reconsiderations).

(v) Paragraph (11) (relating to formulary).

(vi) Paragraph (12) (relating to prohibition on charges for required services).

(vii) Paragraph (13) (relating to overcharge).

"(G) The Indian Health Care Improvement Program.—(C) IN GENERAL.—In the case of an individual enrolled under this section, the Secretary shall provide for arrangements with the Federal department or agency that is the principal Federal provider of health care to members of the uniformed services, or health insurance coverage.

"(H) Confidentiality and accuracy of enrollee records.—An eligible entity shall meet the requirements of section 1927(h) with respect to enrollees under this section. For purposes of such section, the Secretary shall be deemed to be entitled to receive such information as the Secretary determines to be necessary to the performance of the Secretary’s duties under this title.

"(I) Public disclosure of pharmaceutical prices for equivalent drugs.—For any individual enrolled under this section with respect to the provision of a discount under this section, the Secretary shall provide to an eligible entity offering equivalent drug prices for such enrollees only the prices that are available to the Secretary (in a manner specified by the Secretary) for the purpose of ensuring that enrollees are not charged more than 150 percent of the poverty line, the annual Federal contribution amount for a year is $150, or the annual Federal contribution amount for a year is $150.

"(2) Annual federal contribution amount.—Subject to paragraph (3), the annual Federal contribution amount for a year is $150.

"(3) Income eligibility determinations.—The determination of whether an individual residing in a State is a eligible for a contribution under paragraph (1) shall be made under the State medicare plan for the State under section 1902(a) or by the Social Security Administration. In the case of a State that does not operate such a medicare plan (either under title XIX or under a state-wide waiver granted under section 1115), such determination shall be made under arrangements made by the Secretary. There are authorized to make and spend such sums as may be necessary for the determination of eligibility under this paragraph.

"(4) Fiscal year.—Insofar as the provisions of this subsection and section 1807A are not subject to paragraphs (4) through (7) of section 1902(a) of title 42, the Secretary shall be authorized to accept contributions from the Secretary under section 1935(a) or by the Social Security Administration. In the case of a State that does not operate such a medicare plan (either under title XIX or under a state-wide waiver granted under section 1115), such determination shall be made under arrangements made by the Secretary. There are authorized to make and spend such sums as may be necessary for the determination of eligibility under this paragraph.

"(5) Restriction on contributions.—There shall be only an annual Federal contribution under paragraph (1) for an individual if the individual is not eligible for coverage of, or assistance for, outpatient prescription drugs under the following:

(A) A medicare plan under title XIX (including under any waiver approved under section 1115).

(B) Enrollment under a group health plan or health insurance coverage.

"(C) Enrollment under a medicare supplemental insurance policy.

"(D) Chapter 55 of title 10, United States Code (relating to medical and dental care for members of the uniformed services).

"(E) Chapter 17 of title 38, United States Code (relating to veterans' medical care).

"(F) Enrollment under a plan under chapter 89 of title 5, United States Code (relating to the Federal employees’ health benefits program).

"(G) The Indian Health Care Improvement Act (25 U.S.C. 1601 et seq.).
"(6) Appropriation to cover net program expenditures.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Secretary of Health and Human Services for the establishment by the Secretary of a Medical Insurance Trust Fund established under section 1841, an amount equal to the amount by which the benefits and administrative costs of the benefits provided under this section exceed the sum of the portion of the enrollment fees retained by the Secretary.

(k) Definitions.—In this part and section 1807A—

"(I) Covered outpatient drug.—

"(A) General.—Except as provided in this paragraph, for purposes of this section, the term 'covered outpatient drug' means—

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

(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of each section or insulin described in subparagraph (C) of such section and medical supplies associated with the injection of insulin (as defined in regulations of the Secretary), and

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

"(B) Exclusions.—

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

"(II) Avoidance of duplicate coverage.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this section shall not be so considered if payment for such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

"(C) Application of formulary restrictions.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this section shall not be so considered if such drug is available under part A or B for an individual entitled to benefits under part A and enrolled under part B.

"(D) Application of general exclusion provisions.—An eligible entity offering an endorsed program shall not be so considered under an endorsed program if the eligible entity offering the program excludes the drug under a formulary and a review of such formulary has been successfully resolved under subsection (h)(5).

"(E) By whom established.—The term 'poverty line' means the income official poverty line (as defined by the Office of Management and Budget, and revised annually in accordance with section 6732 of the Omnibus Budget Reconciliation Act of 1981) applicable to a family of the size involved.

"(F) Authorization of appropriations.—There are authorized to be appropriated such sums as may be necessary to carry out this section and section 1807A.

"(g) Prohibitions and Regulatory Authority.—In order to carry out this section and section 1807A in a timely manner, the Secretary may promulgate regulations that take effect on a expedited basis, after notice and pending opportunity for public comment.

"Prescription drug accounts

"Sec. 1807A. (a) Establishment of accounts.—

"(1) in general.—The Secretary shall establish an account for each eligible beneficiary who is enrolled under section 1807 at the time of enrollment a prescription drug account (in this section and section 1807 referred to as a 'prescription drug account').

"(2) Reserve accounts.—In cases described in subsections (b)(3)(A), (b)(3)(B)(i), and (b)(3)(B)(ii)(I), the Secretary shall establish and maintain a reserve prescription drug account (in this section referred to as an 'reserve account').

"(c) Administration of accounts.—In this section and section 1807A, the term 'account holder' means an individual for whom an account or reserve account has been established.

"(d) Expenditures from account.—Nothing in this section shall be construed as requiring the Federal Government to obligate funds for amounts in any account until such time as a withdrawal from such account is authorized under this section.

"(e) Application of account.—Except as provided in this subsection, amounts credited to an account shall only be used for the purchase of a covered outpatient drug for the account holder. Any amounts remaining at the end of a year remain available for expenditures in succeeding years.

"(f) Accounts for public and private contributions.—The Secretary shall establish a ongoing process for the determination of the amount in each account that is attributable to public and private contributions (including spousal rollover contributions) based on the following rules:

"(A) Treatment of public contributions.—Expenditures from the account shall—

(i) first be counted against any public contribution; and

(ii) next be counted against private contributions.

"(B) Treatment of spousal rollover contributions.—With respect to any spousal rollover contribution, the portions of such contribution that were attributable to public and private contributions at the time of its distribution under subsection (b)(3) shall be treated as if such contribution was distributed directly or in a spousal rollover contribution, respectively, into the account of the spouse.

"(1) Death of account holder.—In the case of the death of an account holder, the balance in any account (taking into account liabilities accrued before the time of death) shall be distributed as follows:

"(A) Treatment of public contributions.—If the account holder is married at the time of death, the amount in the account that is attributable to public contributions shall be credited to the account (if any) of the surviving spouse of the account holder or, if the surviving spouse is not an eligible beneficiary, the account shall be held for when that spouse becomes an eligible beneficiary.

"(B) Treatment of private contributions.—The amount in the account that is attributable to private contributions shall be distributed as follows:

(i) Designation of distributee.—If the account holder has made a designation, in a form and manner specified by the Secretary, for the distribution of some or all of such amount, such amount shall be distributed in accordance with such designation. Such designation may provide for the distribution into an account (including a reserve account) of a surviving spouse.

(ii) No designation.—Insofar as the account holder has not made such a designation—

"(2) Survival spouse.—If the account holder was married at the time of death, the remaining shall be credited to an account (including a reserve account) of the surviving spouse's surviving spouse.

"(3) No surviving spouse.—If the account holder was not so married, the remaining shall be distributed to the estate of the account holder and distributed as provided by law.

"(c) Use of account for premium for enrollment in Medicare Advantage plan.—During any period in which an account holder is enrolled in a Medicare Advantage plan under part C, the balance in the account may be used and applied to reimburse the amount of the premium (if any) established for enrollment under the plan.

"(d) Application to Medicaid expenses in certain cases.—

"(A) In general.—Except as provided in this paragraph, an account shall be treated as an asset for purposes of establishing eligibility for medical assistance under title XIX.

"(B) Application towards spenddown.—In the case of an account holder who is applying for such medical assistance and who, but for the application of subparagraph (A), be eligible for such assistance—

(i) paragraph (A) shall not apply; and

(ii) the account shall be available (in accordance with a procedure established by the Secretary) to the State to reimburse the State for any expenditures made under the plan for such medical assistance.

"(C) Amounts credited in account.—The Secretary shall credit to a prescription drug account of an eligible beneficiary the following contributions

"(1) Public contributions.—The following contributions (each referred to in this section as a 'public contribution'):

"(A) Federal contributions.—Federal contributions provided under subsection (d).

"(B) State contributions.—Contributions made by a State under subsection (f).

"(C) Contributions by nonprofit organizations.—Contributions made by a charitable, not-for-profit organization (that may be a religious organization).

"(2) Spousal rollover contribution.—A distribution from a deceased spouse under subsection (b)(3) (referred to in this section as a 'spousal rollover contribution').

"(3) Private contributions.—The following contributions (each referred to in this section as a 'private contribution'):

"(A) Employer and individual contributions.—Contributions made under section (e).

"(B) Other individual contributions.—Contributions made by another individual under section (e).

"(C) Contributions by nonprofit organizations.—Contributions made by a charitable, not-for-profit organization (that may be a religious organization).

"(4) Use of account for premium for enrollment in Medicare Advantage plan.—During any period in which an account holder is enrolled in a Medicare Advantage plan under part C, the balance in the account may be used and applied to reimburse the amount of the premium (if any) established for enrollment under the plan.

"(e) Employer and individual contributions.—

"(1) Employment-related contribution.—

"(A) In general.—In the case of any account holder who is a beneficiary or participating in a group health plan (including a multi-employer plan), whether as an employee, former employee or otherwise, including as a dependent of an employee or former employee, the plan may make a contribution into the account holder's account (but not into a reserve account of the account holder).

"(B) Limitation.—The total amount that may be contributed under subparagraph (A) under an plan to an account during any year may not exceed $50.

"(C) Condition.—A group health plan may condition a contribution with respect to an
acountholder under this paragraph on the acountholder's enrollment under section 1807 with an eligible entity that is recognized or approved by that plan.

"(2) Other individuals.—

"(A) IN GENERAL.—Any individual may also contribute to the account of that individual or the account of any other individual under this paragraph on the enrollment of the acountholder under section 1807 with an eligible entity that is recognized or approved by that plan.

"(B) LIMITATION.—The total amount that may be contributed to an account under subparagraph (A) during any year may not exceed $5,000, regardless of who makes such contribution.

"(3) NO CONTRIBUTION PERMITTED TO RESERVE ACCOUNT.—No contribution may be made under this subsection to a reserve account.

"(4) FORM AND MANNER OF CONTRIBUTION.—

(i) The Secretary shall specify the form and manner of contributions under this subsection.

(ii) STATE CONTRIBUTIONS.—

(A) IN GENERAL.—A State may enter into arrangements with the Secretary for the crediting of amounts for acountholders.

(B) FORM AND MANNER OF CONTRIBUTION.—

The Secretary shall specify the form and manner of contributions under this subsection.

(iii) MEDICAID TREATMENT.—

Amounts credited under this paragraph shall not be treated as medical assistance for purposes of title XIX or child health assistance for purposes of title XXI for individuals who are not qualified for medical assistance under such标题.

(iv) EXCLUSION OF COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—

Section 1839(g) (42 U.S.C. 1395gg) is amended—

(1) by striking ''attributable to the application of section'' and inserting ''attributable to'' the application of section''; and

(2) by striking paragraph (B) of section 7213A(a)(1) of such Code and inserting ''(B) SPECIFIED TAXPAYER.—For purposes of this paragraph, the term 'specified taxpayer' means any taxpayer who—

(I) is identified by the Secretary of Health and Human Services in the request referred to in subparagraph (A), and

(ii) has an adjusted gross income for the taxable year referred to in subparagraph (A) in excess of the income threshold specified in section 1860B–2(b)(4)(D)(ii) of such Act for the calendar year referred to in such subparagraph, or

(iii) is identified by such Secretary under subparagraph (A) as being an individual who is required to disclose information under section 1860B–2(b)(4)(D)(iv) of such Act.

"(C) J OINT RETURNS.—In the case of a joint return, the Secretary shall, for purposes of this paragraph, treat each spouse as a separate taxpayer having an adjusted gross income equal to one-half of the adjusted gross income determined with respect to such return.

"(D) RESTRICTION ON USE OF DISCLOSED INFORMATION.—Return information disclosed under subparagraph (A) may be used by officers and employees of the Department of Health and Human Services only for the purpose of administering the prescription drug benefit under title XVIII of the Social Security Act. Such officers and employees may disclose the annual out-of-pocket threshold which applies to an individual under such part to the entity that the plan referred to in section 1860B–2(b)(4)(D)(ii) of such Act in which such individual is enrolled. Such sponsor may use such information only for purposes of administering such benefit.

"(E) UNAUTHORIZED DISCLOSURE.—

Paragraph (B)(1) of section 7213A(a)(1) of such Code is amended by striking ''(B) LIMITATION.—The total amount that may be contributed to an account under subparagraph (A) during any year may not exceed $5,000, regardless of who makes such contribution.

"(F) STATE ELIGIBILITY DETERMINATIONS.—

Section 1935, as added by section 103(a)(2), is amended—

(1) in subsection (a)(1), by inserting ''and of'' before section 1802(a)(1), as added by section 103(a)(2), is amended—

(1) in section (l)(16), (17), or (19)'' each place it appears.

(2) by striking ''or (16)'' and inserting ''(16), or''

(b) C OMPONENT.—

The Commission shall develop a 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 least disruptive of the program and that includes a single point of contact for enrollment and processing of benefits.

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

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

(c) REPORT.—

By not later than January 1, 2005, the Commission shall submit a report to Congress on the progress that has been made in implementing the prescription drug benefit under this title. The report shall include recommendations as the Commission deems appropriate.

(d) SUPPORT.—

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

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

SEC. 107. STATE PHARMACEUTICAL ASSISTANCE TRAVEL COMMISSION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—There is established, as of the first day of the month beginning after the date of 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 transitional issues facing State pharmaceutical assistance programs, and program participants, due to the implementation of the medicare prescription drug program under part D of title XVIII of the Social Security Act.

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

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

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

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

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

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

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

(e) REPRESENTATIVES OF MEDICARE ADVANTAGE ORGANIZATIONS.—Representatives of Medicare Advantage organizations and other private health insurance plans, as appointed by the Secretary.

(f) REPRESENTATIVES OF THE SOCIAL SECURITY ACT.—The Secretary (or the Secretary’s designee) and such other members as the Secretary may specify.

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

(g) 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 least disruptive of the program and that includes a single point of contact for enrollment and processing of benefits.

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

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

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

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

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

SEC. 108. ADDITIONAL REQUIREMENTS FOR ANNUAL FINANCIAL REPORT AND OVERSIGHT OF PHARMACY PROGRAM, INCLUDING PRESCRIPTION DRUG SPENDING.

(a) IN GENERAL.—Section 1317 (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:
"(II) COMBINED REPORT ON OPERATION AND STATUS OF THE TRUST FUND, THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND, AND MEDICARE PRESCRIPTION DRUG TRUST FUND.—" 

"(1) IN GENERAL.—In addition to the duty of the Board of Trustees to report to Congress under subsection (b), on the date the Board submits the report required under subsection (b)(2), the Board shall submit to Congress a report on the operation and status of the Trust Fund, the Federal Supplementary Medical Insurance Trust Fund established under section 1841, and the Medicare Prescription Drug Trust Fund under section 1860D-9(a) (in this subsection collectively referred to as 'Trust Funds'). Such report shall include the following information:

"(A) OVERALL SPENDING FROM GENERAL REVENUES TO THE TRUST FUNDS.—A statement of total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury to the Trust Funds for payment for benefits covered under this title, stated in the total amount and in terms of the percentage such amount bears to all other amounts obligated from such General Revenues during such fiscal year.

"(B) REVIEW OF SPENDING.—From the date of the inception of the program of insurance under this title through the fiscal year involved, a statement of the total amounts referred to in subparagraph (A).

"(C) 10-YEAR AND 75-YEAR PROJECTIONS.—An estimate of total amounts referred to in subparagraph (A) required to be obligated for payment for benefits covered under this title for each of the 10 fiscal years succeeding the fiscal year involved and for the 75-year period beginning with the succeeding fiscal year.

"(D) RELATION TO GDP GROWTH.—A comparison of the rate of growth of the total amounts referred to in subparagraph (A) to the rate of growth in the gross domestic product for the same period.

"(2) PUBLICATION.—Each report submitted under paragraph (1) shall be published jointly by the Committee on Ways and Means and the Committee on Energy and Commerce as a public document and shall be made available by both Committees on the Internet.

"(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to payments covering costs incurred after the date of the enactment of this Act.

TITLE II—MEDICARE ENHANCED FEE-FOR-SERVICE AND MEDICARE ADVANTAGE PROGRAMS; MEDICARE COMPETITION

SEC. 200. MEDICARE MODERNIZATION AND REVISIONALIZATION.

This title provides—

(1) establishment of the Medicare enhanced fee-for-service (EFFS) program under which Medicare beneficiaries are provided access to a range of enhanced fee-for-service (EFFS) plans, Medicare Advantage plans, and preferred provider organizations to offer an enhanced range of benefits.

(2) establishment of a Medicare Advantage program that offers improved managed care plans with coordinated care and competitive bidding, in the style of the Federal Employees Health Benefits program (FEHBP), among enhanced fee-for-service plans.

(3) competitive bidding, in the style of the Federal Employees Health Benefits program, among preferred provider organizations to take into consideration maximum full access for all EFFS-eligible individuals, especially those residing in rural areas.

SEC. 201. ESTABLISHMENT OF ENHANCED FEE-FOR-SERVICE (EFFS) PROGRAM UNDER MEDICARE.

(a) In General.—Section 1851, as amended by section 102(a)(1), is amended—

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

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

"PART E—ENHANCED FEE-FOR-SERVICE PROGRAM

OFFERING OF ENHANCED FEE-FOR-SERVICE PLANS THROUGHOUT THE UNITED STATES

SEC. 1860E–1. (a) ESTABLISHMENT OF PROGRAM.

"(1) IN GENERAL.—The Administrator shall establish under this part beginning January 1, 2006, an enhanced fee-for-service program, under which enhanced fee-for-service plans (as defined in subsection (b)) are offered to EFFS-eligible individuals (as so defined) in EFFS regions throughout the United States.

"(2) EFFS REGIONS.—For purposes of this part the Administrator shall establish EFFS regions throughout the United States by determining how the regions should be established. The regions shall be established in a manner to take into consideration maximizing full access for all EFFS-eligible individuals, especially those residing in rural areas.

"(C) 10-YEAR AND 75-YEAR PROJECTIONS.—An estimate of total amounts referred to in subparagraph (B) shall be published jointiy by the Committee on Ways and Means and the Committee on Energy and Commerce as a public document and shall be made available by both Committees on the Internet.

"(b) SUBMISSION OF BID AMOUNTS.—Such bid amounts shall be made available by both Committees on the Internet.

"(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to payments covering costs incurred after the date of the enactment of this Act.

Title II—Medicare Enhanced Fee-For-Service Program

SEC. 1860E–2. (a) PLAN REQUIREMENTS.—No EFFS plan may be offered under this part in an EFFS region unless the requirements of this part are met with respect to the plan and EFFS organization offering the plan.

(b) AVAILABLE TO ALL EFFS BENEFICIARIES IN THIS TIERED REGION.—With respect to an EFFS plan offered in an EFFS region—

"(1) IN GENERAL.—The plan must be offered to all EFFS-eligible individuals residing in the region.

"(2) ASSURING ACCESS TO SERVICES.—The plan shall comply with the requirements of section 1852(d)(4).

"(c) BENEFITS.—

"(1) IN GENERAL.—Each EFFS plan shall provide to members enrolled in the plan under this part benefits, through providers and other persons that meet the applicable requirements of this title and part A of title XV.

"(A) for the items and services described in section 1828(a)(1);

"(B) that are uniform for the plan for all EFFS-eligible individuals residing in the same EFFS region;

"(C) that include a single deductible applicable to benefits under parts A and B and include a catastrophic limit on out-of-pocket expenditures for such benefits;

"(D) that include benefits for prescription drug coverage for each enrollee who elects under part D to be provided qualified prescription drug coverage under a plan.

"(2) DISAPPROVAL AUTHORITY.—The Administrator shall not approve a plan of an EFFS organization if the Administrator determines (pursuant to the last sentence of section 1852(d)(1)(A)) that the benefits are designed to substantially discourage enrollment by certain EFFS eligible individuals with low incomes.

"(D) OUTPATIENT PRESCRIPTION DRUG COVERAGE.—For rules concerning the offering of prescription drug coverage under EFFS plans, see the amendment made by section 102(b) of the Medicare Prescription Drug and Modernization Act of 2003.

"(e) OTHER ADDITIONAL PROVISIONS.—The provisions of section 1852 (other than section 1852(a)(1)) shall apply under this part to EFFS plans. For the application of chronic care improvement provisions, see the amendment made by section 722(b).

"(b) SUBMISSION OF BID; BENEFICIARY SAVINGS; PAYMENT OF PLANS

SEC. 1860E–3. (a) SUBMISSION OF BID.—

"(1) REQUIREMENT.—(A) EFFS MONTHLY BID AMOUNT.—For each year (beginning with 2006), an EFFS organization shall submit to the Administrator an EFFS monthly bid amount for each EFFS plan offered in each region. Each such bid shall be submitted for each such plan and region in a form and manner and time specified by the Administrator, and shall include information described in paragraph (2).

"(2) UNIFORM BID AMOUNTS.—Each EFFS monthly bid amount submitted under paragraph (1) by an EFFS organization under this part for an EFFS plan in an EFFS region may not vary among EFFS eligible individuals residing in the EFFS region involved.

"(b) SUBMISSION OF BID AMOUNT INFORMATION BY EFFS ORGANIZATIONS.—

"(A) INFORMATION TO BE SUBMITTED.—The information described in this subparagraph is:

"(i) The EFFS monthly bid amount for provision of all items and services under this
subject to an adjustment factor. An adjustment factor will improve the determination of actuarial equivalence. The Administrator may add to, modify, or substitute for such factors in an EFFS plan under this part, except as otherwise provided in this section.

(4) ADJUSTMENT FOR INTRA-REGIONAL GEOGRAPHIC VARIATION.—The Administrator shall also adjust such amounts in a manner to take into account variations in payment rates for part C among the different payment areas under such part included in each EFFS region.

(5) APPLICATION OF ADDITIONAL PAYMENT RULE.—The provisions of section 1860E–4(a)(1) (other than subsections (a)(1)(A), (d), and (e)) shall apply to an EFFS plan under this part, except as otherwise provided in this section.

PREMIUMS; ORGANIZATIONAL AND FINANCIAL REQUIREMENTS; ESTABLISHMENT OF STANDARDS; CONTRACTS WITH EFFS ORGANIZATIONS—SEC. 1860E–4. (a) PREMIUMS.—

(1) IN GENERAL.—The provisions of section 1860E–3(b) other than section 1860E–3(b)(h), including subsection (b)(5) relating to the consolidation of drug and non-drug beneficiary premiums and subsection (c) relating to the submission of bids and premiums, shall apply to an EFFS plan under this part, subject to paragraph (2).

(2) CROSS-WALK.—In applying paragraph (1), any reference in section 1854(b)(1)(A) or 1854(d) to—

(A) a Medicare Advantage monthly basic beneficiary premium is deemed a reference to the EFFS monthly basic beneficiary premium (as defined in paragraph (3)(A));

(B) a Medicare Advantage monthly prescription drug beneficiary premium is deemed a reference to the EFFS monthly prescription drug beneficiary premium (as defined in paragraph (3)(B)); and

(C) a Medicare Advantage supplemental beneficiary premium is deemed a reference to the EFFS monthly supplemental beneficiary premium (as defined in paragraph (3)(C)).

(3) DEFINITIONS.—For purposes of this section—

(A) EFFS MONTHLY BASIC BENEFICIARY PREMIUM.—The term ‘EFFS monthly basic beneficiary premium’ means, with respect to an EFFS plan—

(iii) described in section 1860E–3(c)(1)(A) (relating to plans providing rebates), zero; or

(ii) described in section 1860E–3(c)(1)(B), the amount (if any) by which the unadjusted EFFS statutory non-drug monthly bid amount exceeds the EFFS region-specific non-drug monthly benchmark amount (as defined in section 1860E–3(b)(3)).

(B) EFFS MONTHLY PRESCRIPTION DRUG BENEFICIARY PREMIUM.—The term ‘EFFS monthly prescription drug beneficiary premium’, means with respect to an EFFS plan, the amount submitted under clause (i) of section 1860E–3(a)(3)(A) for the year that is attributable under such section to the provision of statutory prescription drug benefits.

(C) EFFS MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term ‘EFFS monthly supplemental beneficiary premium’, means, with respect to an EFFS plan, the portion of the aggregate monthly bid amount submitted under clause (i) of section 1860E–
3(a)(3)(A) for the year that is attributable under such section to the provision of non-statutory benefits.

(b) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS.—The provisions of section 1855 shall apply to an EFFS plan offered by an EFFS organization under this part.

(c) The provisions of paragraphs (1), (3), and (4) of section 1856(b) shall apply to an EFFS plan offered by an EFFS organization under this part.

(1) APPLICABILITY OF EFFS ORGANIZATIONS.—The provisions of section 1857 shall apply to an EFFS plan offered by an EFFS organization under this part, except that any reference in such section to part C is deemed a reference to this part.

(b) APPLICATION OF MEDIGAP PROVISIONS TO EFFS PLANS.—Section 1856(c)(2) of the Social Security Act (42 U.S.C. 1395ss) shall be administered as if any reference to a Medicare+Choice organization offering a Medicare+Choice plan under part C of title XVIII of such Act were a reference both to a Medicare Advantage organization offering a Medicare Advantage plan under such part and an EFFS organization offering an EFFS plan under part E of such title.

Subtitle B—Medicare Advantage Program

CHAPTER 1—IMPLEMENTATION OF PROGRAM

SEC. 211. IMPLEMENTATION OF MEDICARE ADVANTAGE PROGRAM.

(a) IN GENERAL.—There is hereby established the Medicare Advantage Program. The Medicare Advantage program shall consist of the program under part C of title XVIII of the Social Security Act, as amended by this title.

(b) REFERENCES.—Any reference to the program under part C of title XVIII of the Social Security Act shall be deemed a reference to the Medicare Advantage program and, with respect to such part, any reference to “Medicare+Choice” is deemed a reference to “Medicare Advantage”.

SEC. 212. MEDICARE ADVANTAGE IMPROVEMENTS.

(a) EQUALIZING PAYMENTS WITH FEES-FOR-SERVICE.

(1) IN GENERAL.—Section 1833(c)(1) (42 U.S.C. 1395w-23(c)(1)) is amended by adding at the end the following:

“(D) PAID BASED ON 100 PERCENT OF FEES-FOR-SERVICE COSTS.—

“(i) IN GENERAL.—For 2004, the adjusted average per capita cost for the year involved, determined in accordance with subparagraph (A), shall be the Medicare Advantage payment area rate for services covered under part A and part B for individuals entitled to benefits under part A and enrolled under part B who are not enrolled in a Medicare Advantage plan for this year but who, for adjusted average per capita payments to providers under section 1886(h),

“(ii) IN GENERAL.—For the year 2005 and each subsequent year, the average per capita cost for the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense;

(2) CONFORMING AMENDMENT.—Such section is further amended, in the matter before subparagraph (A), by striking “(for a year other than 2004)” after “multiplied”;

(2) in paragraph (5), by inserting “(other than 2004)” after “for each year”;

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

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

(A) in subparagraph (A), by striking “The sum” and inserting “For a year before 2005, the sum”;

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

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

(D) by adding at the end of subparagraph (C) the following new subparagraph (v): For 2004 and each succeeding year, the greater of—

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

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

(2) CONFORMING AMENDMENT.—Section 1853(c)(6)(C) (42 U.S.C. 1395w-23(c)(6)(C)) is amended by striking “(other than 2004)” after “multiplied”;

(d) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES IN CALCULATION OF MEDICARE ADVANTAGE PAYMENT RATES.—Section 1853(c)(3) (42 U.S.C. 1395w-23(c)(3)) is amended—

(1) in subparagraph (A), by striking “subparagraph (B)” and inserting “subparagraphs (B) and (E)”;

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

“(E) INCLUSION OF COSTS OF DOD AND VA MILITARY FACILITY SERVICES TO MEDICARE-ELIGIBLE BENEFICIARIES.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 2004), the annual per capita rate of payment for 1997 determined under section 1886(3)(I) shall be adjusted to include in the rate calculated for 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;

(3) by adding at the end of subsection (a) the following:

“(2) EXTE##
(i) Such additional information as the Administrator may require to verify the actuarial bases described in clauses (i) and (ii).

(ii) STATUTORY BENEFITS DEFINED.—For purposes of this paragraph, the term ‘statutory benefits’ means benefits under section 1853(a)(1)

(iii) The term ‘statutory non-drug benefits’ means benefits under section 1853(a)(1).

(iv) The term ‘statutory prescription drug benefits’ means benefits under title I.

(v) The term ‘statutory non-drug monthly benchmark amount’ means the statutory non-drug monthly benchmark amount under such clause, the Administrator has negotiated under subparagraph (B)(ii), and for such purpose and subject to such clause, the Administrator has negotiation authority that the Director of the Office of Personnel Management has with respect to health benefits plans under chapter 89 of title 5, United States Code; and

(vi) The Administrator may reject such a bid amount or proportion if the Administrator determines that such amount or proportion is not supported by the actuarial bases provided under subparagraph (A).

(vii) EXCEPTION.—In the case of a plan described in section 1851(a)(2)(A), the provisions of clauses (i) through (vi) shall apply and the provisions of paragraphs (5)(A)(ii), prohibiting the review, approval, or disapproval of amounts described in such paragraph, shall apply to the determination and rejection of the monthly bid amounts and proportion referred to in subparagraph (A).

(b) Form of Rebate.—A rebate required under this subparagraph shall be provided—

(1) through the crediting of the amount of the rebate to the Medicare Advantage monthly supplementary benefit premium or the premium imposed for prescription drug coverage under part D;

(2) through a direct monthly payment (through electronic funds transfer or otherwise); or

(3) through other means approved by the Medicare Benefits Administrator, or any combination thereof.

(b) By adding at the end of paragraph (1) the following new subparagraph:

"(C) DETERMINATION OF AVERAGE PER CAPITA MONTHLY SAVINGS.—The average per capita monthly savings described in this subparagraph is equal to the amount (if any) by which—

(i) the risk-adjusted benchmark amount computed under subparagraph (B)(i), exceeds

(ii) the risk-adjusted bid computed under subparagraph (B)(ii).

(D) AUTHORITY TO DETERMINE RISK ADJUSTMENT FUNDING.—The Administrator may provide for the determination and application of risk adjustment factors under this paragraph on the basis of areas other than States.

(E) ADMINISTRATOR'S OPTION OF PAYMENT THROUGH WITHHOLDING FROM SOCIAL SECURITY PAYMENT OR USE OF ELECTRONIC FUNDS TRANSFER MECHANISM.—In accordance with regulations, a Medicare Advantage organization shall permit each enrollee, at the enrollee's option, to make payment of premiums under this clause (I) indirectly through withholding from benefit payments in the manner provided under section 1840 with respect to monthly premiums under section 1859 or through an electronic funds transfer mechanism (such as automatic charges of an account at a financial institution or a credit or debit card account) or otherwise. All premium payments that are withheld under this paragraph that are credited to the Federal Supplementary Medical Insurance Trust Fund shall be used by the Administrator to fund the Medicare Advantage area-specific premium assistance payment for that area. In the case of a plan for which there are no average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the Medicare Advantage statutory non-drug monthly benchmark amount, adjusted under clause (iv).

(F) FOR FEDERAL DRUG SUBSIDIES.—In the case in which an enrollee who elects under part D to provide qualified prescription drug coverage through the plan, the Medicare Advantage organization offering such plan also is entitled—

(i) to direct subsidy payment under section 1860D–8(a)(1);

(ii) to reinsurance subsidy payments under section 1860D–8(a)(2); and

(iii) to reimbursement for premium and cost-sharing reductions for low-income individuals under section 1860D–7(c)(3).

(G) DEMOGRAPHIC ADJUSTMENT, INCLUDING ADJUSTMENT FOR HEALTH STATUS.—The Administrator shall adjust the payment amount under clause (i), the adjusted Medicare Advantage statutory non-drug monthly bid amount under clause (ii), and the Medicare Advantage area-specific non-drug monthly benchmark amount under clause (iv) for such risk factors as age, disability status, gender, institutional status, and other factors the Administrator determines to be appropriate, including adjustment for health status under paragraph (3), so as to ensure actuarial equivalence. The Administrator may add to, modify, or substitute for such adjustment factors if such changes will improve the determination of actuarial equivalence.

(h) CONFORMING AMENDMENTS.—

(1) PROTECTION AGAINST BENEFICIARY SELECTION.—Section 1852(b)(1)(A) (42 U.S.C. 1395w-22(b)(1)(A)) is amended by adding at the end the following:

"The Administrator shall not approve a plan of an organization if the Administrator determines that the benefits are designed to substantially discourage enrollment by certain Medicare Advantage eligible individuals with the organization."

(2) CONFORMING AMENDMENT TO PREMIUM TERMINOLOGY.—Section 1854(b)(2) (42 U.S.C. 1395w–24(b)(2)) is amended by redesignating subparagraph (C) as subparagraph (D) and by striking subparagraphs (A) and (B) and inserting the following:

"(D) MEDICARE ADVANTAGE MONTHLY BASIC BENEFIT.—The term ‘Medicare Advantage monthly basic beneficiary premium means, with respect to a Medicare Advantage plan, an amount equal to 1⁄12 of the annual Medicare Advantage capitation rate under section 1853(c)(1) for the plan.

(3) PAYMENT OF PLANS BASED ON BID AMOUNTS.—

(i) In general.—Section 1853(a)(1)(A) (42 U.S.C. 1395w–23) is amended by striking "in an amount" and all that follows and inserting the following: "in an amount determined as follows:"

(ii) PAYMENT BEFORE 2006.—For years before 2006, the payment amount shall be equal to ½ of the annual Medicare Advantage plan capitation rate (as defined in subsection (c)(ii)) with respect to that individual for that area, reduced by the amount of any reduction elected under section 1854(f)(1)(E) and adjusted under clause (iv).

(iii) PAYMENT FOR STATUTORY NON-DRUG BENEFITS BEGINNING WITH 2006.—For years beginning with 2006—

"(I) PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are no average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the Medicare Advantage statutory non-drug monthly bid amount, adjusted under clause (iv), plus the amount of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year.

"(II) PLANS WITH BIDS AT OR ABOVE BENCHMARK.—In the case of a plan for which there are no average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the Medicare Advantage statutory non-drug monthly benchmark amount, adjusted under clause (iv).

(iv) PAYMENT FOR AREA-SPECIFIC NON-DRUG BENCHMARK.—In the case of a plan for which there are no average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the Medicare Advantage statutory non-drug monthly benchmark amount, adjusted under clause (iv).

(j) IN GENERAL.—Section 1853(a)(1)(A) (42 U.S.C. 1395w–23) is amended by striking "in an amount" and all that follows and inserting the following: "in an amount determined as follows:"

(ii) PAYMENT BEFORE 2006.—For years before 2006, the payment amount shall be equal to ½ of the annual Medicare Advantage plan capitation rate (as defined in subsection (c)(ii)) with respect to that individual for that area, reduced by the amount of any reduction elected under section 1854(f)(1)(E) and adjusted under clause (iv).

(iii) PAYMENT FOR STATUTORY NON-DRUG BENEFITS BEGINNING WITH 2006.—For years beginning with 2006—

"(I) PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the Medicare Advantage statutory non-drug monthly bid amount, adjusted under clause (iv), plus the amount of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year.

"(II) PLANS WITH BIDS AT OR ABOVE BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the Medicare Advantage statutory non-drug monthly benchmark amount, adjusted under clause (iv).

(v) PAYMENT FOR AREA-SPECIFIC NON-DRUG BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the Medicare Advantage statutory non-drug monthly benchmark amount, adjusted under clause (iv).

(j) IN GENERAL.—Section 1853(a)(1)(A) (42 U.S.C. 1395w–23) is amended by striking "in an amount" and all that follows and inserting the following: "in an amount determined as follows:"

(ii) PAYMENT BEFORE 2006.—For years before 2006, the payment amount shall be equal to ½ of the annual Medicare Advantage plan capitation rate (as defined in subsection (c)(ii)) with respect to that individual for that area, reduced by the amount of any reduction elected under section 1854(f)(1)(E) and adjusted under clause (iv).

(iii) PAYMENT FOR STATUTORY NON-DRUG BENEFITS BEGINNING WITH 2006.—For years beginning with 2006—

"(I) PLANS WITH BIDS BELOW BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the Medicare Advantage statutory non-drug monthly bid amount, adjusted under clause (iv), plus the amount of the monthly rebate computed under section 1854(b)(1)(C)(i) for that plan and year.

"(II) PLANS WITH BIDS AT OR ABOVE BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the Medicare Advantage statutory non-drug monthly benchmark amount, adjusted under clause (iv).

(v) PAYMENT FOR AREA-SPECIFIC NON-DRUG BENCHMARK.—In the case of a plan for which there are average per capita monthly savings described in section 1854(b)(3)(C), the payment amount under this subsection is equal to the Medicare Advantage statutory non-drug monthly benchmark amount, adjusted under clause (iv).
“(ii) described in section 1853(a)(1)(A)(ii), the amount (if any) by which the unadjusted Medicare Advantage statutory non-drug monthly bid amount exceeds the Medicare Advantage specific non-drug monthly benchmark amount.

“(B) MEDICAID ADVANTAGE MONTHLY PRESCRIPTION DRUG BENEFICIARY PREMIUM.—The term ‘Medicaid Advantage monthly prescription drug beneficiary premium’ means, with respect to a Medicare Advantage plan, that portion of the bid amount submitted under section (a)(6) for the year that is attributable under such section to the provision of statutory prescription drug benefits.

“(C) MEDICAID ADVANTAGE MONTHLY SUPPLEMENTAL BENEFICIARY PREMIUM.—The term ‘Medicare Advantage monthly supplemental beneficiary premium’ means, with respect to a Medicare Advantage plan, the portion of the aggregate monthly bid amount submitted under clause (i) of subsection (a)(6)(A) for the year that is attributable under such section to the provision of nonstatutory benefits.”

“(3) REQUIREMENT FOR UNIFORM PREMIUM AND BID AMOUNTS.—Section 1854(c) (42 U.S.C. 1395w–22(c)(2)) is amended to read as follows:

“(c) UNIFORM PREMIUM AND BID AMOUNTS.—The Medicare Advantage monthly bid amount submitted under subsection (a)(6), the Medicare Advantage monthly basic, prescription drug, and supplemental beneficiary premiums, and the Medicare Advantage monthly MSA premium charged under subsection (b) of a Medicare Advantage organization under this part may not vary among individuals enrolled in the plan.”

“(4) PERMITTING BENEFICIARY RETABULATIONS.—(A) Section 1855(h)(4)(A) (42 U.S.C. 1395w–21(h)(4)(A)) is amended by inserting ‘except as provided under section 1854(b)(1)(C)’ after ‘or otherwise’.

“(B) Section 1854(d) (42 U.S.C. 1395w–21(d)) is amended by inserting ‘, except as provided under subsection (b)(1)(C),’ after ‘and may not provide’.

“(5) OTHER CONFORMING AMENDMENTS RELATING TO BIDS.—Section 1854 (42 U.S.C. 1395w–21f) is amended—

“(A) in the heading of subsection (a), by inserting ‘AND BID AMOUNTS’ after ‘PREMIUM’; and

“(B) in subsection (a)(5)(A), by inserting ‘paragraphs (2), (3), and (4) of’ after ‘under file’.

“(e) ADDITIONAL CONFORMING AMENDMENTS.—

“(1) ANNUAL DETERMINATION AND ANNOUNCEMENT PERIOD.—Section 1851(e)(3)(B) (42 U.S.C. 1395w–21h(3)(B)) is amended by striking ‘including the respective calendar year’, and all that follows and inserting the following: ‘the calendar year concerned with respect to each Medicare Advantage payment area, the following:

“(A) PRE-COMPETITION INFORMATION.—For years from January 1, 2002, through 2005, the following:

“(i) MEDICARE ADVANTAGE CAPITATION RATES.—The annual Medicare Advantage capitation rate for each Medicare Advantage payment area for the year

“(ii) ADJUSTMENT FACTORS.—The risk and other factors to be used in adjusting such rates under subsection (a)(1)(A) for payments for months in that year, the following:

“(B) COMPETITION INFORMATION.—For years beginning with 2006, the following:

“(i) BENCHMARK.—The Medicare Advantage area-specific non-drug benchmark under section 1853(j).

“(ii) ADJUSTMENT FACTORS.—The adjustment factors applied under section 1853(a)(1)(B) (relating to demographic adjustment), section 1853(a)(1)(B) (relating to adjustment for end-stage renal disease), and section 1853(a)(3) (relating to health status adjustment).”

“(2) REPEAL OF PROVISIONS RELATING TO ADJUSTED COMMUNITY RATE.—(A) IN GENERAL.—Sections 1851(a)(3)(B) and 1852(a)(3)(B) of title XVIII (42 U.S.C. 1395w–21(a)(3)(B) and 1395w–22(a)(3)(B)) are repealed.

“(B) CONFORMING AMENDMENTS.—(i) Section 1859(b)(2) (42 U.S.C. 1395w–22(b)(2)) is amended by striking ‘and after 2007’ and inserting ‘and after 2005’ and ‘and after 2007’; and


“(2) by striking ‘and after 2005’; and

“(2) by striking ‘2003, and 2004 or July 1 of each other year’ and inserting ‘2002 and each subsequent year’;

“(2) by striking ‘2003, and 2004 or July 1 of each other year’ and inserting ‘2002 and each subsequent year’.


“(1) by striking ‘and after 2005’; and

“(2) by striking ‘, 2004, and 2005 and inserting ‘2002 and each subsequent year’.

“(c) ANNUAL ANNOUNCEMENT OF PAYMENT RATES.—Section 1853(b)(3)(A) (42 U.S.C. 1395w–21(b)(3)(A)), as amended by section 532(d)(1) of the Public Health Security and Bioterrorism Preparedness and Response Act of 2002, is amended—

“(1) by striking ‘and after 2005’; and

“(2) by striking ‘, 2004, and 2005 and inserting ‘and each subsequent year’.

“(d) REQUIRING PROVISION OF AVAILABLE INFORMATION COMPARING PLAN OPTIONS.—The first sentence of section 1851(d)(2)(A)(iii) (42 U.S.C. 1395w–21(d)(2)(A)(iii)) is amended by inserting ‘before the period the following: “to the extent such information is available at the time of preparation of materials for the mailing”.

“SEC. 232. AVOIDING DUPLICATE STATE REGULATION.

“(a) IN GENERAL.—Section 1856(b)(1)(3) (42 U.S.C. 1395w–21(b)(3)) is amended to read as follows:

“(3) RELATION TO STATE LAWS.—The standards established under this subsection shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to Medicare Advantage plans which are offered by Medicare Advantage organizations under this part.”

“(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on January 1, 2006.

“SEC. 233. SPECIALIZED MEDICAID ADVANTAGE PLANS FOR SPECIAL NEEDS BENEFICIARIES.

“(a) TREATMENT AS CoORDINATED CARE PLAN.—Section 1851(a)(2)(A) (42 U.S.C. 1395w–22(a)(2)(A)) is amended by adding at the end the following new sentence: ‘Specialized Medicare Advantage plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.’

“(b) SPECIAL NEEDS BENEFICIARY.—The term ‘special needs beneficiary’ means a Medicare Advantage eligible individual who

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

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

“(iii) meets such requirements as the Secretary shall determine would benefit from enrollment in a special needs Medicare Advantage plan described in subsection (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 MEDICAID ADVANTAGE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare Advantage plan described in subsection (A) for individuals with severe or disabling chronic conditions

“(d) AUTHORITY TO DESIGNATE OTHER PLANS AS SPECIALIZED MEDICAID ADVANTAGE PLANS.—In promulgating regulations to carry out the last sentence of section 1851(a)(2)(A) of the Social Security Act (as added by subsection (a)) and section 1859(b)(4) of such Act (as added by subsection (b)), the Secretary may, by regulation, designate section 1859(d)(A) of such Act for the offering of specialized Medicare Advantage plans by Medicare Advantage plans that disproportionately serve special needs beneficiaries who are frail, elderly Medicare beneficiaries.

“(e) REPORT TO CONGRESS.—Not later than December 31, 2005, the Medicare-Eisenhower Administration shall submit to Congress a report that assesses the impact of specialized Medicare Advantage plans for special needs beneficiaries on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the Medicare program as a result of the amendments made by subsections (a), (b), and (c).

“(f) EFFECTIVE DATES.—
required under such section''; and
(42 U.S.C. 1395w–22) is amended—
paragraph (C).
paragraph (A); and
1851(e)(5)(A) (42 U.S.C. 1395w–21(e)(5)(A)) is
(ii) and inserting a semicolon; and
22(k)(1)) is amended by inserting ''or with an
organization offering a MSA plan'' after
U.S. C. 1395w–22(b)(4) (42
(2) by striking the first sentence of sub-
paragraph (A); and
(3) by striking the second sentence of sub-
paragraph (C).
A. APPLICATION OF REASONABLE COST
CONTRACTS.
Subparagraph (C) of section 1876h(5)(G) (42
U.S. C. 1395mm(h)(5)) is amended to read as
follows:
''(C) Subject to clause (ii), may be ex-
tended or renewed under this subsection in-
definitely.
''(i) If any period beginning on or after
January 1, 2008, a reasonable cost reimburse-
ment contract under this subsection may not
be extended or renewed for a service area in-
solation from any other service area, during the entire previous
year, was within the service area of 2 or more plans which were coordinated care
Medicare Advantage plans under part C or 2 or more enhanced fee-for-service plans under
part E and each of which met the min-
imum requirement during the previous year for the area involved meets the
following requirement:
''(I) With respect to any portion of the area
involved that is within a Metropolitan Sta-
tistical Area with a population of more than
250,000 contiguous to such Met-
ropolitan Statistical Area, 5,000 individuals.
''(II) With respect to any other portion of
such area, 1,500 individuals.
B. EXTENSION OF MUNICIPAL HEALTH
SERVICE DEMONSTRATION PROJECTS.
Section 9215(a) of the Consolidated Omni-
bus Budget and Reconciliation Act of 1986 (42
U.S. C. 1395q–1 note), as amended by section
6135 of the Omnibus Budget Reconciliation Act of 1989, section 1357 of the Omnibus
Budget Reconciliation Act of 1993, section
401.7 of BBA, section 534 of BBA (113 Stat.
150A–390), and section 633 of BIPA, is amend-
ed by striking ''December 31, 2004'' and in-
serting ''December 31, 2009''.
ED. 227. STUDY OF PERFORMANCE-BASED PAY-
MENT SYSTEMS.
(a) In General.—The Secretary shall re-
spect the Institute of Medicine of the Na-
tional Academy of Sciences to—
(1) conduct a study that reviews and evalu-
ates the experiences in establishing performance measures and pay-
ment incentives under the medicare program and
linking performance to payment; and
(2) report recommendations to the Secre-
tary and Congress, not later than 18 months after the date of the enactment of this Act, regard-
ing such study.
(b) Study.—The study under subsection
(a) shall—
(1) include a review and evaluation of in-
centives that have been or could be used to
encourage quality performance, including those
aimed at health plans and their enrol-
lees, providers and their patients, and other
incentives that encourage quality-based health care purchasing and collaborative ef-
forts to improve performance; and
(2) examine how these measures and incen-
tives might be applied in the Medicare Ad-
mnistration's Enhanced and Medically In-
Stocking Service (EFS) program, and
traditional fee-
for-service programs.
(c) Report Recommendations.—The re-
port under subsection (a) shall—
(1) include recommendations regarding ap-
propriate performance measures for use in
assessing and paying for quality; and
(2) identify actions for updating perform-
ance measures.
Subtitle C—Application of FEHBP-Style
Competitive Reforms
SEC. 241. APPLICATION OF FEHBP-STYLE COM-
PETITIVE REFORM BEGINNING IN 2010.
(a) IDENTIFICATION OF COMPETITIVE EFFS
REGIONS FOR THE 2010 EFFS NON-DRUG BENCHMARKS UNDER EFFS PROGRAM.—
(1) IN GENERAL.—Section 1851(e)(3)(B) as added by section 201(a), is amended by adding at
the end the following new subsection:
''(e) APPLICATION OF COMPETITION.—
''(1) DETERMINATION OF COMPETITIVE EFFS REGIONS.
''(A) EFFS COMPONENT.—The product of
the following:
''(i) the percentage, as estimated by the
Institute of Medicine of the National
Academy of Sciences, in clause (I)
of section 1851(e)(5)(A) (42 U.S.C. 1395-
w–21(e)(5)(A)) of the Social Security Act,
subject to clause (ii), the percent-
age') of the EFFS eligible individuals
enrolled in Medicare Advantage plans during
March of the previous year.
''(II) the percentage, as estimated by the
Institute of Medicine of the National
Academy of Sciences, in any EFFS region
that was a competitive EFFS region
prior to the enactment of this Act, the
percentage') of the EFFS eligible individu-
als who reside in the region and who were
enrolled under such plan under this part during
March of the previous year.
''(3) 2 COMPONENTS.—For purposes of sub-
paragraph (A), the weighted average of EFFS plan bids for an EFFS region and a
year is the sum of the following products for EFFS plans described in subparagraph (C) in
the region and year:
''(I) UNADJUSTED EFFS STATUTORY NON-DRUG MONTHLY BID AMOUNT.—The unaccounted
EFFS statutory non-drug monthly bid amount (as defined in subsection (a)(3)(A)(i)) for the
region and year.
''(II) FEE-FOR-SERVICE MARKET SHARE.—
The fee-for-service market share percentage
determined under paragraph (5) for the region and the
year.
''(3) 2 COMPONENTS.—For purposes of para-
graph (2), the 2 components described in this paragraph for an EFFS region and a
year are the following:
''(A) EFFS COMPONENT.—The product of
the following:
''(I) WEIGHTED AVERAGE PLAN BIDS IN RE-
GION.—The weighted average of the EFFS plan bids for the region and year (as deter-
mined under paragraph (4))
''(II) NON-FFS MARKET SHARE.—1 minus the
fee-for-service market share percentage
determined under paragraph (5) for the region and
the year.
''(B) FEE-FOR-SERVICE COMPONENT.—The product of the following:
''(I) FEE-FOR-SERVICE REGION-SPECIFIC NON-
DRUG BID AMOUNT.—The region-specific non-drug amount (as defined in para-
graph (6)) for the region and year.
''(II) FEE-FOR-SERVICE MARKET SHARE.—
The fee-for-service market share percentage
determined under paragraph (5) for the region and
the year.
''(4) DETERMINATION OF WEIGHTED AVERAGE EFFS PLAN BIDS FOR A REGION.—
''(A) IN GENERAL.—For purposes of this par-
agraph (3)(A)(i), the weighted average of plan bids for a region and a
year is the sum of the following products for EFFS plans described in subparagraph (C) in
the region and year:
''(I) ADJUSTED EFFS STATUTORY NON-DRUG MONTHLY BID AMOUNT.—The unadjusted EFFS
statutory non-drug monthly bid amount (as defined in subsection (a)(3)(A)(iii)) for the
region and year.
''(II) PLAN'S SHARE OF EFFS ENROLLMENT IN REGION.—The number of individuals
described in subparagraph (B), divided by the total number of such individuals for all
EFFS plans described in subparagraph (C) for that
region and year.
''(B) COUNTING OF INDIVIDUALS.—The Ad-
mnistrator shall count each plan described in subparagraph (C) for an EFFS region and year, the number of individuals who reside in the region and who were
enrolled under such plan during this part during
March of the previous year.
''(C) EXCLUSION OF PLANS NOT OFFERED IN PREVIOUS YEAR.—For an EFFS region and
year, the EFFS plans described in this subparagraph are plans that are offered in the
region and year and were offered in the region in March of the previous year.
''(D) COMPUTATION OF FEHBP-FOR-SERVICE MAR-
KET SHARE PERCENTAGE.—The Administrator shall determine, for a year and an EFFS re-
gion, the proportion (in this subsection re-
defined as the 'fee-for-service market share percentage') of the EFFS eligible individuals
who are residents of the region during March
of the previous year, of such individuals who
were not enrolled in an EFFS plan or in a
Medicare Advantage plan (or, if greater, such proportion determined for individuals na-
tionally).

(6) FEE-FOR-SERVICE REGION-SPECIFIC NON-
DRUG AMOUNT.—

(A) IN GENERAL.—For purposes of para-
graph (3)(B) and section 1839h)(2)(A), sub-
ject to subparagraph (C), the term ‘fee-for-
service region-specific non-drug amount’ means, for a competitive EFFS region and a
year, the sum of the average per capita cost
for the area involved, determined under section
1986a(i) (4) for such region for services covered
under paragraph (3)(B) for the year, but adjusted
to exclude costs attributable to payments
under section 1986(h).

(B) USE OF FULL RISK ADJUSTMENT TO
STANDARDIZE FEE-FOR-SERVICE COSTS TO TYP-
ICAL BENEFICIARY.—In determining the ad-
justed average per capita cost for a region and
year under subparagraph (A), such costs shall
be adjusted to account for the demographic and health status risk fac-
tors established under subsection (c)(2) so that such per capita costs reflect the average
costs for a typical beneficiary residing in the
region.

(7) INCLUSION OF COSTS OF VA AND DOD
MILITARY SERVICES TO MILITARY ELIGI-
BLE BENEFICIARIES.—In determining the ad-
justed average per capita cost under subpara-
graph (A) for a year, such cost shall be ad-
justed to include the Administrator’s esti-
mate, on a per capita basis, of the amount of
additional payments that would have been
made in the region involved under this title if
individuals who received services under this
title had not received services from facilities
of the Department of Veterans Affairs or the
Department of Defense.

(8) APPLICATION OF COMPETITION.—In the
case of an EFFS region that is a competitive
EFFS region for a year, for purposes of ap-
plying subsections (b) and (c)(1) and section
1986e–4(a), any reference to an EFFS region-
specific non-drug monthly benchmark
amount shall be treated as a reference to the
competitive EFFS non-drug monthly bench-
mrk amount determined under paragraph (2) for the
region and year.

(9) PHASE-IN OF BENCHMARK FOR EACH RE-
GION.—

(A) USE OF BLENDED BENCHMARK.—In the
case of a region that has not been a compe-
titive EFFS region for each of the previous 4
years and which is a competitive EFFS region under
paragraph (2) for the region and year.

(B) PERCENTAGE SPECIFIED.—

(i) IN GENERAL.—For purposes of subpara-
graph (A), subject to clause (ii), the percent-
age specified in subparagraph (B) for a
year is equal to 1 minus the weighted average
phase-in proportion for that region and year.

(ii) OLD COMPETITIVE EFFS REGION NOT
COMPETITIVE REGION IN PREVIOUS YEAR.—If the
area was not a competitive EFFS region in the
previous year, the weighted average phase-in
proportion for the region for the year is equal to
0.

(iii) COMPETITIVE REGION IN PREVIOUS
YEAR if the region was a competitive EFFS
region in the previous year, the weighted av-
ge phase-in proportion for the region for the
year is equal to the weighted average phase-in
proportion for the region for the previous
year plus 1⁄5, but in no case more than 1.

(10) CONFORMING AMENDMENT.—

(A) Such section 1986e–3 is further amend-
ed—

(i) in subsection (b), by adding at the end
the following:

(ii) the competitive EFFS non-drug
monthly benchmark amount, with respect
to a competitive Medicare Advantage area for a
month, is the sum of the 2 components
described in paragraph (3) for the area and
year. The Administrator shall compute
such benchmark amounts for each competi-
tive Medicare Advantage area before the begin-
ing of each annual, coordinated election period under
section 1851(e)(3)(B) for each year (beginning with
2010) in which it is designated as such area.

(3) 2 COMPONENTS.—For purposes of para-
graph (2), the 2 components described in this
paragraph for a competitive Medicare Ad-
vantage area and a year are the following:

(A) MEDICARE ADVANTAGE COMPONENT.—

The product of the following:

(i) WEIGHTED AVERAGE OF MEDICARE ADV-
ANTAGE PLAN BIDS IN AREA.—The weighted
average of the plan bids for the area and year
(as determined under paragraph (4)(A)).

(ii) NON-FFS MARKET SHARE.—1 minus the
fee-for-service market share percentage, de-
termined under paragraph (5) for the area and
year.

(B) FEE-FOR-SERVICE COMPONENT.—The
product of the following:

(i) FEE-FOR-SERVICE AREA-SPECIFIC NON-
DRUG AMOUNT.—The fee-for-service area-specified
non-drug amount (as defined in para-
graph (6)) for the area and year.

(ii) FEE-FOR-SERVICE MARKET SHARE.—The
fee-for-service market share percentage, de-
termined under paragraph (5) for the area and
year.

(4) DETERMINATION OF WEIGHTED AVERAGE
MEDICARE ADVANTAGE BID FOR AN AREA.—

(A) IN GENERAL.—For purposes of this
paragraph (3)(A)(i), the weighted average of plan
bids for an area and a year is the sum of the fol-
lowing products for Medicare Advantage plans
described in subparagraph (C) in the area and
year:

(i) MONTHLY MEDICARE ADVANTAGE STATU-
TORY NON-DRUG BID AMOUNT.—The unadjusted
Medicare Advantage statutory non-drug monthly
bid amount.

(ii) PLAN’S SHARE OF MEDICARE ADVANTAGE
ENROLLMENT IN AREA.—The number of
individuals described in subparagraph (B), di-
vided by the total number of such individu-
als for all Medicare Advantage plans de-
scribed in subparagraph (C) for that area and
year.

(B) COUNCIL OF INDIVIDUALS.—The Ad-
mnistrator shall count, for each Medicare
Advantage plan described in subparagraph (B)
in an area and year, the number of indi-
viduals who reside in the area and who
were enrolled in March of the previous year.

(M) EXCLUSION OF THE NON OFFERED IN PREVIOUS
YEAR.—For an area and year, the Medicare
Advantage plans described in this
paragraph are plans described in the first
sentence of this paragraph (B), that were
not offered in the area and year for
March of the previous year.

(5) COMPUTATION OF FEE-FOR-SERVICE MARK-
ET SHARE.—The Administrator shall
determine, for a year and a competitive
Medicare Advantage area, the proportion (in
this subsection referred to as the ‘fee-for-
service market share percentage’), by a
competitive Medicare Advantage eligible
individuals residing in the area who were
enrolled in March of the previous year.

(M) COMPARISON OF FEE-FOR-SERVICE MARK-
ET SHARE.—The Administrator shall
}
"(6) Fee-for-service area-specific non-drug amount.—

"(A) In general.—For purposes of paragraph (3)(B)(i) and section 1839(i)(1)(A), subject to paragraph (C), the term "fee-for-service area-specific non-drug amount" means, for a competitive Medicare Advantage area and a year, the adjusted average per capita spend in each year involving the area for services covered under parts A and B for individuals entitled to benefits under part A and effective for that year under subparagraph (a)(1)(A)(iv) so that such per capita costs reflect the average costs for a typical beneficiary residing in the area.

"(B) Use of full risk adjustment to standardize fee-for-service costs to typical beneficiary.—In determining the adjusted average per capita cost for an area and year under subparagraph (A), such costs shall be adjusted to fully take into account the demographic and health status risk factors established under subsection (a)(1)(A)(iv) so that such per capita costs reflect the average costs for a typical beneficiary residing in the area.

"(C) Inclusion of costs of VA and DoD military facility services to Medicare-eligible beneficiaries.—In determining the adjusted average per capita cost under subparagraph (A), such costs shall be adjusted to include the Administrator's estimate, on a per capita basis, of the amount of additional payments that would have been made in the area involved under this title if individuals entitled to benefits under this title had not received services from facilities of the Department of Veterans Affairs or the Department of Defense.

"(7) Application of competition.—In the case of an area that is a Part D competitive Medicare Advantage area for a year, for purposes of subsections (a)(1)(A) and (2)(C) and sections 1854(b)(2)(A)(ii) and 1854(b)(3)(B)(i), any reference to a Medicare Advantage area-specific non-drug monthly benchmark amount shall be treated as a reference to the competitive Medicare Advantage non-drug monthly benchmark amount for that area and year.

"(8) Phase-in of benchmark for each area.—

"(A) Use of blended benchmark.—In the case of an area that has not been a competitive Medicare Advantage area for any of the previous 4 years, the competitive Medicare Advantage non-drug monthly benchmark amount shall be equal to the sum of the following:

"(i) New competitive component.—The product of—

"(II) the average weighted phase-in proportion for that area and year; and

"(ii) the competitive Medicare Advantage non-drug monthly benchmark amount for the area and year.

"(B) Computation of weighted average phase-in proportion.—For purposes of this paragraph, the weighted average phase-in proportion for a Part D competitive Medicare Advantage area for a year shall be determined as follows:

"(I) First year (and area that is a competitive Medicare Advantage area in the previous year).—If the area was not a Medicare Advantage competitive area in the previous year, the weighted average phase-in proportion for the area for the year is equal to 1.

"(II) Competitive area in previous year.—If the area was a competitive Medicare Advantage area and the average weighted phase-in proportion determined under this subparagraph for the area in the previous year plus 1/5, but in no case more than 1.

"(C) Medicare Advantage area-wide non-drug benchmark amount.—For purposes of subparagraph (A)(ii)(II), the term 'Medicare Advantage area-wide non-drug benchmark amount' means, for an area and year, the product of the amount described in section 1853(j) for Medicare Advantage payment area or areas included in the area (based on the number of traditional fee-for-service enrollees in such payment area or areas) and year.''

"(2) Application.—Section 1854 (42 U.S.C. 1395w–24) is amended—

"(A) in subsection (b)(3)(C)(ii), as added by section 221(b)(1)(A), by striking ''(i) REQUIREMENT.—The'' and inserting ''(i) REQUIREMENT FOR NON-COMPETITIVE AREAS.—In the case of Medicare Advantage payment area that is not a competitive Medicare Advantage area, the monthly premium factor under section 1853(k)(6) for the area.''

"(B) in subsection (b)(1)(C), as added by section 221(b)(1)(B) and 221(b)(2), the following new paragraph:

"(6) Computation of average per capita monthly savings for competitive Medicare Advantage areas.—For purposes of paragraph (1)(C)(ii), the average per capita monthly savings for a competitive Medicare Advantage plan and year shall be computed in the same manner as the average per capita monthly savings for a competitive Medicare plan (described in subparagraph (B), that—

"(I) is amended by inserting after clause (i) the following new clause:

"(II) REQUIREMENT FOR COMPETITIVE MEDICARE ADVANTAGE AREAS.—In the case of a competitive Medicare Advantage payment area that is designated as a competitive Medicare Advantage area under section 1853(k)(1), if there are average per capita monthly savings described in subparagraph (A)(ii)(II), the term 'Medicare Advantage area under section 1853(k)(1), the'.

"(C) in subsection (b)(1)(C), as added by section 221(d)(2), as amended by section 221(b)(1)(B) and 221(b)(2), the following new paragraph:

"(6) Computation of average per capita monthly savings for competitive Medicare Advantage areas.—For purposes of paragraph (1)(C)(ii), the average per capita monthly savings for a competitive Medicare Advantage plan and year shall be computed in the same manner as the average per capita monthly savings for a competitive Medicare plan that—

"(I) is amended by inserting after clause (i) the following new clause:

"(II) REQUIREMENT FOR COMPETITIVE MEDICARE ADVANTAGE AREAS.—In the case of a competitive Medicare Advantage plan and year, the Medicare Advantage plan shall provide to the enrollee a monthly rebate equal to 75 percent of such savings; and

"(D) by adding at the end of subsection (b), as amended by sections 221(b)(1)(B) and 221(b)(2), the following new paragraph:

"(6) Computation of average per capita monthly savings for competitive Medicare Advantage areas.—For purposes of paragraph (1)(C)(ii), the average per capita monthly savings for a competitive Medicare Advantage plan and year shall be computed in the same manner as the average per capita monthly savings for a competitive Medicare plan that—

"(I) is amended by inserting after clause (i) the following new clause:

"(II) REQUIREMENT FOR COMPETITIVE MEDICARE ADVANTAGE AREAS.—In the case of a competitive Medicare Advantage plan and year, the Medicare Advantage plan shall provide to the enrollee a monthly rebate equal to 75 percent of such savings; and

"(2) Additional conforming amendments.—Section 1839 (42 U.S.C. 1395w–24) is amended—

"(A) in subsection (a)(3)(B)(i), as added by section 221(c)(1), is amended—

"(I) in subclauses (I) and (II), by inserting ''(or, insofar as such payment area is a competitive Medicare Advantage area, described in section 1854(b)(6))'' after ''section 1854(b)(3)(C)(i)'' and

"(II) in subclause (II), by inserting ''(or, insofar as such payment area is a competitive Medicare Advantage area, described in section 1854(b)(6))'' after ''section 1854(b)(3)(C)(ii)'' and

"(B) Disclosure of information.—Section 1839(i)(1)(B), as amended by section 221(e)(1), is amended by inserting after subsection (a)(3)(B)(i) the following new subsection:

"(6) Computational information.—For years beginning after 2006, the following:
(c) The adjustment factor under this subsection (A)(iii) without regard to this subparagraph (A)(ii) shall be adjusted as changing the entitlement to defined benefits under parts A and B of title XVIII of the Social Security Act.

(2) Adjustment of premium for non-drug monthly benchmark amount, non-drug monthly benchmark amount for the region, or non-drug monthly benchmark amount for the region.

(a) Technical Amendment Concerning Secretary's Authority to Make Conditional Payment When Certain Primary Plans Do Not Pay Promptly.

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

(b) Clarifying Amendments to Conditional Payment Provisions.

(1) in paragraph (1)(A), by striking "promptly (as determined in accordance with regulations)");

(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 Act of 1994 (Public Law 98-369).

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

(3) NO CHANGE IN MEDICARE'S DEFINED BENEFIT PACKAGE.—Nothing in this part (or the amendments made by this part) shall be construed as changing the entitlement to defined benefits under parts A and B of title XVIII of the Social Security Act.

(2) No change in Medicare's defined benefit package—Nothing in this part (or the amendments made by this part) shall be construed as changing the entitlement to defined benefits under parts A and B of title XVIII of the Social Security Act.

(2) Effective Date—The amendments made by this section shall take effect on the first day of the first month following the date of the enactment of this title.

(a) Medicaid Secondary Payor (MSP) Premiums.

(3) in subparagraph (A)(iii), by striking "(i) the number of consecutive years (insofar as it is effected through the manner of collection of premiums under 1840(a)), the Medicare Benefits Administrator shall transmit to the Commissioner of Social Security—"

(4) To prevent the rebates and discounts from being lower than the required amount, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year.

(5) In order to carry out this subsection (insofar as it is effected through the manner of collection of premiums under 1840(a)), the Medicare Benefits Administrator shall transmit to the Commissioner of Social Security—

(A) at the beginning of each year, the number of individuals in the account, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year; and

(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

(2) No change in Medicare's defined benefit package—Nothing in this part (or the amendments made by this part) shall be construed as changing the entitlement to defined benefits under parts A and B of title XVIII of the Social Security Act.

(3) in subparagraph (A)(iii), by striking "the Medicare Benefits Administrator shall transmit to the Commissioner of Social Security—"

(4) To prevent the rebates and discounts from being lower than the required amount, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year.

(5) In order to carry out this subsection (insofar as it is effected through the manner of collection of premiums under 1840(a)), the Medicare Benefits Administrator shall transmit to the Commissioner of Social Security—

(A) at the beginning of each year, the number of individuals in the account, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year; and

(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

(2) No change in Medicare's defined benefit package—Nothing in this part (or the amendments made by this part) shall be construed as changing the entitlement to defined benefits under parts A and B of title XVIII of the Social Security Act.

(3) in subparagraph (A)(iii), by striking "the Medicare Benefits Administrator shall transmit to the Commissioner of Social Security—"

(4) To prevent the rebates and discounts from being lower than the required amount, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year.

(5) In order to carry out this subsection (insofar as it is effected through the manner of collection of premiums under 1840(a)), the Medicare Benefits Administrator shall transmit to the Commissioner of Social Security—

(A) at the beginning of each year, the number of individuals in the account, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year; and

(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

(2) No change in Medicare's defined benefit package—Nothing in this part (or the amendments made by this part) shall be construed as changing the entitlement to defined benefits under parts A and B of title XVIII of the Social Security Act.

(3) in subparagraph (A)(iii), by striking "the Medicare Benefits Administrator shall transmit to the Commissioner of Social Security—"

(4) To prevent the rebates and discounts from being lower than the required amount, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year.

(5) In order to carry out this subsection (insofar as it is effected through the manner of collection of premiums under 1840(a)), the Medicare Benefits Administrator shall transmit to the Commissioner of Social Security—

(A) at the beginning of each year, the number of individuals in the account, and the amount of the adjustment (if any) under this subsection for each individual enrolled under this part for each month during the year; and

(B) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.
subsection (a) with respect to such items and conduct a competition among entities supplying percent of the applicable contract award section (c).

Secretary finds all of the following: furnish such items or services unless the competition conducted in an competitive acquisition is not like- not competitive, unless there is a significant saving.

Secretary may exempt—

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

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

(4) SPECIAL RULE FOR CERTAIN RENTED ITEMS OF DURABLE MEDICAL EQUIPMENT.—In the case of a covered item for which payment is made on a rental basis under section 1834(a), the Secretary may specify.

(5) PHYSICIAN AUTHORIZATION.—The Secretary may authorize a physician to authorize the item or service involved is clinically more appropriate than other similar items or services.

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

(7) CONSIDERATION IN DETERMINING CATEGORY AUTHORITY.—In the case of covered items and services that are included in a competitive acquisition program to adjust the payment basis, the Secretary concerning) the quality standards specified under subparagraph (A)(i) shall not apply prospectively and shall be published in the Federal Register by the Department of Health and Human Services.

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 (ii).

(8) CONSTRUCTION.—Nothing in this subparagraph shall be construed as delaying the effective date of the implementation of the competitive acquisition program under this section.

(3) CONTENTS OF CONTRACT.—

(A) IN GENERAL.—A contract entered into under an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify.

(B) TERM OF CONTRACTS.—The Secretary shall recompete contracts under this section not less often than once every 3 years.

(4) LIMIT ON NUMBER OF CONTRACTORS.—

(A) IN GENERAL.—In general, the Secretary may limit the number of contractors in a competitive acquisition area to the number needed to meet projected demand for items and services under the contracts. In awarding contracts, the Secretary shall take into account the ability of bidding entities to furnish items or services in sufficient quantities to meet the anticipated needs of beneficiaries for such items or services in the geographic area covered under the contract on a timely basis.

(B) MULTIPLE OWNERS.—The Secretary shall award contracts to multiple entities submitting bids in each area for an item or service.

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

(6) PARTICIPATING CONTRACTORS.—Payment shall not be made for items and services described in subsection (a)(2) furnished for 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 contractor has awarded a contract to the contractor for such items and services under this section.

In this paragraph, 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 con- consider the cost, efficiency, and value of specific codes and products, including products that may provide a therapeu- tic advantage to beneficiaries, before de- lineating the categories and products that will be subject to bidding.

(8) AUTHORITY TO CONTRACT FOR EDUCATION, MONITORING, OUTREACH AND COM- munication.—The Secretary may enter into contracts with an appropriate entity to address complaints from beneficiaries who receive items and services from an entity and submit a report on the number of complaints to the Program Advisory and Oversight Committee concerning monitoring quality of services with respect to the program.

(9) RULES.—The Secretary shall prescribe such rules as the Secretary determines appropriate.

(10) ESTABLISHMENT.—There is established a Program Advisory and Oversight Com- mittee (hereinafter in this section referred to as the Committee).

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

(B) DUTIES.—

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

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

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

(iii) The development of proposals for effi- cient interaction among manufacturers and distributors of the items and services and providers and beneficiaries.

(B) ADDITIONAL DUTIES.—The Committee shall perform such additional functions as the Secretary may specify.

(11) PLANNING SERVICES.—The Secretary may enter into a contract with a provider of services for the purpose of planning the competitive acquisition under this section to the extent and in the manner provided.

(12) NON-APPLICABILITY OF FACA.—The provi- sions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to such contracts.

(13) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual management report on the competitive acquisition program under this section. Each such report shall include informa- tion on savings, reductions in beneficiary cost-sharing, access to and quality of items and services, and beneficiary satisfaction.

(14) DEMONSTRATION PROJECT FOR CLINICAL LABORATORY SERVICES.—

(A) IN GENERAL.—The Secretary shall conduct a demonstration project on the applica- tion of competitive acquisition under this section to clinical diagnostic laboratory tests.

(B) DELINEATION OF TESTS.—(1) The Secretary shall conduct the demonstration project—

(II) for which payment is otherwise made under section 1833(h) or 1834(d)(1) (relating to colorectal cancer screening tests); and

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

(C) REPORT.—The Secretary shall submit to Congress an initial report on the demonstration project.

(D) INAPPLICABILITY OF FACA.—The provi- sions of the Federal Advisory Committee Act (5 U.S.C. App.) shall not apply to such contracts.

(E) CONFORMING AMENDMENTS.—

(1) DURABLE MEDICAL EQUIPMENT; ELIMI- nation of inherent reasonableness au- thority.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended—

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

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

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

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

(i) the payment basis under this sub- section for such items and services furnished in such area shall be the payment basis de- termined under such competitive acquisition program; and

(ii) the Secretary may use information on the payment basis determined under such com- petitive acquisition programs to adjust the payment amount otherwise recognized under
subparagraph (B)(ii) for an area that is not a competitive acquisition area under section 1847 and in the case of such adjustment, paragraph (10)(B) shall not be applied.”; and (ii) the term "competitive acquisition area" includes areas not defined under such methodology and which are not affected relative to the practice expense relative value units of other services not determined under such non-physician work pool program.

Subparagraph (B)(ii) for an area that is not a competitive acquisition area under such section—

(1) STUDY.—The Secretary shall conduct a study to determine the extent to which (if any) suppliers of covered items of durable medical equipment that are subject to the competitive acquisition program under section 1847 of the Social Security Act, as amended by subsection (b), are soliciting physicians to purchase on a one-time basis or monthly delivery of covered items based on profitability.

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

(2) REPORT.—Not later than May 1, 2004, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1).

(3) USE OF FINDINGS IN DEVELOPING STANDARDS.—In promulgating regulations to carry out section 1847 of the Social Security Act, as amended by subsection (a), the Secretary shall ensure that quality standards developed under section 1842(a)(2)(B) of such section reflect the findings of the Comptroller General set forth in the report under paragraph (2).
appropriate subcategories of such drugs and biologicals, as identified by the Secretary:

(ii) Blood clotting factors.

(iii) Drugs and biologicals furnished to individuals in connection with the treatment of end stage renal disease.

(iv) Diagnostic and therapeutic substances.

(v) Vaccines.

(ii) Drugs and biologicals prescribed by a physician who has not elected section 1847B to apply—

(A) Blood clotting factors.

(B) A DDITIONAL CONSIDERATIONS.—The Secretary may not award a contract to any entity under the competition conducted pursuant to paragraph (1) with respect to the acquisition of covered outpatient drugs and biologicals in the area under the contract.

(i) the contractor shall comply with a code of conduct, specified or recognized by the Secretary, that includes standards relating to the establishment and maintenance of a system for the prevention of fraud and abuse, including compliance and ethics programs.

(ii) the contractor shall comply with applicable provisions relating to prevention of fraud and abuse, including provisions of the Inspector General of the Department of Health and Human Services.

(4) CONTRACT REQUIRED.—

(A) IN GENERAL.—Payment may not be made for covered outpatient drugs and biologicals prescribed by a physician who has not elected section 1847B to apply within a category and a competitive acquisition area with respect to which the program applies unless—

(i) the drugs or biologicals are supplied by a contractor with a contract under this section.

(ii) the physician has elected such contractor under paragraph (5) for such category and area.

(B) PHYSICIAN CHOICE.—Subparagraph (A) shall not apply for a category of drugs for an area if the physician prescribing the covered outpatient drug or biological under section (i) is a hospital outpatient drug or biological.

(C) APPLICATION OF MEDICARE PROVIDER OMBUDSMAN.—For provision providing for a program-wide Medicare Provider Ombudsman to review complaints, see section 923 of the Medicare Prescription Drug and Modernization Act of 2003.

"(3) AWARDING MULTIPLE CONTRACTS FOR A CATEGORY AND AREA.—In order to provide a choice of at least 2 contractors in each competitive acquisition area for the acquisition of drugs and biologicals, the Secretary may limit (but not below 2) the number of qualified entities that are awarded such contracts for any category and area. The Secretary shall select among qualified entities based on the following:

(A) the bid prices for covered outpatient drugs and biologicals within the category and area.

(B) Bid price for distribution of such drugs and biologicals.

(C) Ability to ensure product integrity.

(D) Customer service.

(E) Past experience in the distribution of drugs and biologicals, including controlled substances.

(F) Such other factors as the Secretary may specify.

(4) TERMS OF CONTRACTS.—

(A) IN GENERAL.—A contract entered into with an entity under the competition conducted pursuant to paragraph (1) is subject to terms and conditions that the Secretary may specify consistent with this section.

(B) PERIOD OF CONTRACTS.—A contract under this section shall be for a term of 2 years, but may be terminated by the Secretary or the entity with appropriate, advance notice.

(C) INTEGRITY OF DRUG AND BIOLOGICAL DISTRIBUTION SYSTEM.—The Secretary shall require that for all drug and biological products produced by a contractor under this section be acquired directly from the manufacturer or from a distributor that has acquired the products directly from the manufacturer; and

(ii) may require, in the case of such products that are particularly susceptible to counterfeit or diversion, that the contractor comply with such additional product integrity safeguards as may be determined to be necessary.
"(F) DIRECT DELIVERY OF DRUGS AND BIOLOGICALS TO PHYSICIANS.—Under the contract the contractor shall only supply covered outpatient drugs and biologicals directly to physicians and not directly to beneficiaries, except under circumstances and settings where a beneficiary currently receives a drug or biological in the beneficiary’s home or other non-physician office setting as the Secretary may provide. The contractor shall not deliver drugs and biologicals to a selecting physician except upon request of that physician for such drugs and biologicals, and such necessary data as may be required by the Secretary to carry out any of the provisions of the contract for the contract period for a single treatment or a course of treatment.

"(S) PERMITTING ACCESS TO DRUGS AND BIOLOGICALS.—The Secretary shall establish rules under this section for drugs and biologicals which are acquired through a contractor within a single source drug or biological or for which the Secretary determines that a single source drug or biological is the most cost-effective and consistent with safe drug practices and with adequate safeguards against fraud and abuse. The previous sentence shall apply if the physician reasonably determines that the contractor may provide the drugs or biologicals in a timely manner.

"(D) The drugs or biologicals were administered to the beneficiary in the physician's office

"(6) CONSTRUCTION.—Nothing in this section shall be construed as waiving applicable section 1847B).

"(7) AVERAGE COSTS.—The bid price submitted in a contract offer for a covered outpatient drug or biological shall:

"(A) include all costs related to the delivery of the drug to the selecting physician (or other point of delivery); and

"(B) include the costs of dispensing (including shipping) of such drug or biological, and management fees, and any costs related to the administration of the drug or biological, or wastage, spillage, or spoilage.

"(8) PRICE ADJUSTMENTS DURING CONTRACT PERIOD; DISCLOSURE OF COSTS.—Each contract awarded shall provide for:

"(A) disclosure to the contractor the average and contractual drug acquisition costs for periods specified by the Secretary, not more often than quarterly, of the contract; and

"(B) appropriate price adjustments over the period of the contract to reflect significant increases or decreases in a contractor’s reasonable, net acquisition costs, as so disclosed.

"(9) COMPUTATION OF AVERAGE BID PRICES FOR A CATEGORY AND AREA.

"(1) IN GENERAL.—For each year or other contract period for each covered outpatient drug or biological and area with respect to which a competition is conducted under the program, the Secretary shall compute an area average of the bid prices submitted, in contract offers accepted for the category and area, for that year or other contract period.

"(2) SPECIAL RULES.—The Secretary shall establish rules regarding the use under this section of the alternative payment amount provided under section 1847B to the use of a price for specific covered outpatient drugs and biologicals in the following cases:

"(A) NEW DRUGS AND BIOLOGICALS.—A covered outpatient drug or biological for which an average bid price has not been previously determined.

"(B) OTHER CASES.—Such other exceptional cases as the Secretary may specify in regulations, section 1861(i)(2)(Q) and immunosuppressives under section 1861(s)(2)(J).

"(10) COINSURANCE.—

"(1) IN GENERAL.—Coinsurance under this part with respect to a covered outpatient drug or biological for which payment is payable under this section shall be based on 20 percent of the payment basis under this section.

"(2) COLLECTION.—Such coinsurance shall be collected by the person that supplies the drug or biological involved and, subject to subsection (a)(3)(B), in the same manner as coinsurance is collected for durable medical equipment under this part.

"(f) SPECIAL PAYMENT RULES.—

"(1) IN GENERAL.—The Secretary may not provide for an adjustment to reimbursement for covered outpatient drugs and biologicals unless adjustments to the practice expense payment adjustment are made on the basis of supplemental surveys under section 1848(c)(2)(D) of the Social Security Act, as added by subsection (a)(1)(B).

"(2) USE IN EXCLUSION CASES.—If the Secretary excludes a drug or biological (or class or group thereof) under subsection (a)(1)(D) the Secretary may provide for reimbursement to be made under this part for such drugs and biologicals (or class) using the payment methodology under section 1847B.

"(3) COORDINATION RULES.—The provisions of section 1842(h)(3) shall apply to a contractor with respect to covered outpatient drugs and biologicals supplied by that contractor in the same manner as they apply to a participating supplier. In order to administer this section, the Secretary may condition payment under this part to a person for the administration of a drug or biological supplied under this subsection on the person’s provision of information on such administration.

"(4) APPLICATION OF REQUIREMENT FOR ASSIGNMENT.—For provision requiring assignment of claims for covered outpatient drugs and biologicals, see section 1842(o)(3).

"(5) PROTECTION FOR BENEFICIARY IN CASE OF MEDICAL NECTHITY DENIAL.—For protection of beneficiaries against liability in the case of medical necessity determinations, see section 1842(b)(3)(B)(ii)(I).

"(6) PHYSICIAN ROLE IN APPEALS PROCESS.—The Secretary shall establish a procedure under which a physician who prescribes a covered outpatient drug or biological for a beneficiary under this section has appeal rights that are similar to those provided to a physician who prescribes durable medical equipment or a laboratory test.

"(g) ADVISORY COMMITTEE.—The Secretary shall establish an advisory committee that is representative of the beneficiaries affected by the program under this section, including physicians, pharmacy benefit managers, distributors, manufacturers, and beneficiaries. The Secretary shall advise the Secretary on issues relating to the effective implementation of this section.

"(h) ANNUAL REPORTS.—The Secretary shall submit to Congress an annual report in each of 2005, 2006, and 2007, on the program. Each such report shall include information on the performance of the program, the availability of access to covered outpatient drugs and biologicals, the range of choices of contractors available to providers, the beneficiary and provider satisfaction.

"OPTIONAL USE OF AVERAGE SALES PRICE PAYMENT METHODOLOGY

"SEC. 1847B. (a) IN GENERAL.

"(1) ELECTRONIC DATA INTERCHANGE.—In connection with the annual election made by a physician under section 1847A(a)(5), the physician may elect to apply this section to the payment for covered outpatient drugs and biologicals instead of the payment methodology under section 1847A.

"(2) IMPLEMENTATION.—This section shall be implemented with respect to categories of covered outpatient drugs and biologicals described in section 1847A(a)(2)(B).

"(3) COVERED OUTPATIENT DRUGS AND BIOLOGICALS DEFINED.—For purposes of this section, the term 'covered outpatient drugs and biologicals' has the meaning given such term in section 1847A(a)(2)(A).

"(4) COMPUTATION OF PAYMENT AMOUNT.—

"(1) IN GENERAL.—If this section applies with respect to a covered outpatient drug or biological, the amount payable for the drug or biological (based on a minimum dosage unit) is, subject to applicable deductible and coinsurance—

"(A) in the case of a multiple source drug (as defined in subsection (c)(6)(C)), 100 percent (or in the case of covered outpatient drugs and biologicals furnished during 2005 and 2006, 112 percent) of the amount determined under paragraph (4).

"(B) in the case of a single source drug (as defined in subsection (c)(6)(D)), 100 percent (or in the case of covered outpatient drugs and biologicals furnished during 2005 and 2006, 112 percent) of the amount determined under paragraph (4).
(2) Specification of unit.—

The manufacturer of a covered outpatient drug shall specify the unit associated with each National Drug Code (NDC) that is a part of the submission of data under section 1927(b)(3)(A)(iii).

(B) UNIT DEFINED.—In this section, the term ‘unit’ means, with respect to a covered outpatient drug, the lowest identifiable quantity (such as a capsule or tablet, milligram of molecules, or grams) of the drug that is suitable for any discount without reference to volume measures pertaining to liquid.

(3) Multiple source drug.—For all drug products included within the same multiple source drug, the amount specified in this paragraph is the volume-weighted average of the average sales prices reported under section 1927(b)(3)(A)(iii) as computed follows:

(A) Compute the sum of the products (for each national drug code assigned to such drug products)

(i) the manufacturer’s average sales price (as defined in subsection (c)); and

(ii) the total number of units specified under paragraph (2) sold, as reported under section 1927(b)(3)(A)(iii).

(B) Divide the sum computed under subparagraph (A) by the sum of the National Drug Code (NDC) national drug codes assigned to such drug products.

(4) Single source drug.—The amount specified in this paragraph for a single source drug is the lesser of the following:

(A) Manufacturer’s Average Sales Price.—The manufacturer’s average sales price for a national drug code, as computed using the methodology applied under paragraph (3).

(B) Wholesale Acquisition Cost (WAC).—The wholesale acquisition cost (as defined in subsection (c)(6)(B)) reported for the single source drug.

(5) Basis for determination.—The payment amount shall be determined under this subsection based on information reported under subsection (e) and without regard to any special packaging, labeling, or identification on the dosage form or product packaging.

(6) Manufacturer’s Average Sales Price.—

(I) IN GENERAL.—For purposes of this subsection, subject to paragraphs (2) and (3), the manufacturer’s average sales price is defined as the cost (or other reasonable measure of drug cost) to the purchaser. A rebate to a payer or other entity that does not take title to a covered outpatient drug shall not be taken into account in determining the manufacturer’s average sales price under this subsection on a quarterly basis and shall be applied based upon the manufacturer to compute an average sales price for the drug, the Secretary may determine the amount payable under this section for the drug without considering the manufacturer’s average sales price of that manufacturer for that drug.

(II) Frequency of determinations.—

(A) IN GENERAL ON A QUARTERLY BASIS.—The manufacturer’s average sales price, for a covered outpatient drug, shall be determined by the Secretary on a quarterly basis and shall be applied based upon the manufacturer’s average sales price determined for the most recent quarter calendar.

(B) Updates in rates.—The payment rates under subsection (b)(1) and (b)(2)(A) shall be updated by the Secretary on a quarterly basis and shall be applied based upon the manufacturer’s average sales price determined for the most recent quarter calendar.

(7) Use of Contractors; Implementation.—The Secretary may use a contractor, financial intermediary, or other contractor to determine the payment amount under subsection (b). Notwithstanding any other provision of law, the Secretary may implement, by program memorandum or otherwise, any of the provisions of this section.

(8) Definitions and other rules.—In this section:

(A) Manufacturer.—The term ‘manufacturer’ means, with respect to a covered outpatient drug, the manufacturer (as defined in subsection 1927(b)(3)).

(B) Wholesale Acquisition Cost.—The term ‘wholesale acquisition cost’ means, with respect to a drug, the manufacturer’s list price for the drug to wholesalers or direct purchasers in the United States, not including prompt pay or other discounts, rebates or reductions in price, for the most recent month for which the information is available, as reported in wholesale price guides or other publications of drug prices, or, if no information is available, as determined by the Secretary.

(C) Multiple Source Drug.—The term ‘multiple source drug’ means, with respect to a drug, a drug product marketed by any cross-licensed manufacturers, and a concomitant increase in the price, of a drug or biological which is not reflected in the manufacturer’s average sales price for one or more quarters, the Secretary may use the wholesale acquisition cost (or other reasonable measure of drug price) instead of the manufacturer’s average sales price for such quarters and for subsequent quarters until the price and available information on the drug are stabilized and is substantially reflected in the applicable manufacturer’s average sales price.

(D) Reports.—

(I) Quarterly report on average sales price.—For requirements for reporting the manufacturer’s average sales price (and, if required to make payment, the manufacturer’s wholesale acquisition cost) for the covered outpatient drug or biological, see section 1927(b)(3).

(II) Annual report to congress.—The Secretary shall submit to the Committees on Energy and Commerce and Ways and Means of the House of Representatives and the Senate an annual report on the operation of this section. Such report shall include information on the following:

(a) Trends in average sales price under subsection (b).

(b) Administrative costs associated with compliance with this section.

(III) Total value of payments made under this section.

(D) Comparison of the average manufacturer price as applied under section 1927 for a single source drug and for multiple source drug or biological with the manufacturer’saverage sales price for the drug or biological under this section.
"(f) RESTRICTION ON ADMINISTRATIVE AND JUDICIAL REVIEW.—There shall be no administrative or judicial review under section 1869, section 1870, or otherwise, of determinations of the Secretary that any drug or biological is average sales price under subsection (c)."

(c) CONTINUATION OF PAYMENT METHODOLOGY FOR RADIOPHARMACEUTICALS.—Nothing in this section or in the amendments made by this section shall be construed as changing the payment methodology under part B of title XVIII of the Social Security Act for radiopharmaceuticals, including carriers of in-vivo pricing methodology.

(d) CONFORMING AMENDMENTS.—

(1) IN GENERAL.—Section 1842(o) (42 U.S.C. 1395w–4(o)) is amended—

(A) in paragraph (3), by inserting "subject to section 1847A and 1847B," before "the amount payable for the drug or biological"; and

(B) by adding at the end of paragraph (2) the following: "This paragraph shall not apply in the case of payment under section 1847A or 1847B."

(2) NO CHANGE IN COVERAGE BASIS.—Section 1861(s)(2)(A) (42 U.S.C. 1395(s)(2)(A)) is amended by inserting "(or would have been so included for the application of section 1847A or 1847B)" after "included in the physicians' bills".

(3) CONSOLIDATED REPORTING OF PRICING INFORMATION.—Section 1927 (42 U.S.C. 1395s–8) is amended—

(A) in subsection (a)(1), by inserting "or under part B of title XVIII" after "section 1833(a)";

(B) in subsection (b)(3)(A)—

(i) in clause (i), by striking "and" at the end;

(ii) in clause (ii), by striking the period and inserting ; and

(iii) by adding at the end of the following new clause: "(iii) for calendar quarters beginning on or after April 1, 2004, in conjunction with reporting required under clause (i) and by national drug code (NDC)."

(4) STUDY.—The Secretary shall conduct a study to determine the appropriateness of establishing and implementing separate codes for non-oncology infusions that are based on the level of complexity of the administration and resources required.

(5) RESTRICTION ON ADMINISTRATION FEE IN CERTAIN CASES.—In establishing the fee schedule under this section, the Secretary shall provide for a separate payment to physicians' services a demonstration of the unique administrative and management costs associated with covered drugs and biologicals, and shall establish a methodology for determining such costs for the purposes of section 1847A (compared with such costs if such drugs and biologicals were acquired directly by such physicians)."
to discharges occurring on or after October 1, 2003.

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

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

(1) by inserting ''(i)'' before paragraph (1); and

(2) by redesignating paragraphs (2) and (3) as paragraphs (3) and (4), respectively, and inserting after clause (ii) the following new clause:

''(i) The term 'essential rural hospital' means the hospital that provided''.
emergencies in accordance with local protocols (as determined by the Secretary)."

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

(3) DEVELOPMENT OF ALTERNATIVE METHODS OF PERIODIC INTERIM PAYMENTS.—With respect to periodic interim payments to critical access hospitals for inpatient critical access care, section 1813(e)(2)(E) of the Social Security Act, as added by paragraph (1), the Secretary shall develop alternative methods for such payments that are based on expenditures of the hospital.

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

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

(1) IN GENERAL.—Section 1813(e)(2)(E) of the Social Security Act, as added by paragraph (1), the Secretary shall develop alternative methods for such payments that are based on expenditures of the hospital.

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

(f) FLEXIBILITY IN BED LIMITATION FOR HOSPITALS WITH STRONG SEASONAL CENSUS.—

(1) IN GENERAL.—Section 1886(h)(4)(A) of title 42, United States Code, as added by paragraph (1), the Secretary shall first distribute the increase in the otherwise applicable resident limit (as defined in clause (ii)(I)) on a per capita basis to hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of clause (d) on a first-come-first-served basis (as determined by the Secretary) based on a hospital's request for an increase under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

(2) APPLICATION OF LOCALITY ADJUSTED NATIONAL AVERAGE PER RESIDENT AMOUNT.—With respect to additional residency positions in a hospital attributable to the increase provided under subparagraph (1), the Secretary shall first distribute the increase in the otherwise applicable resident limit (as defined in clause (ii)(I)) on a per capita basis to hospitals located in rural areas or in urban areas that are not large urban areas (as defined for purposes of clause (d) on a first-come-first-served basis (as determined by the Secretary) based on a hospital's request for an increase under this clause and not to exceed an increase of 25 full-time equivalent positions with respect to any hospital.

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

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

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

(5) REPORT ON EXTENSION OF APPLICATIONS UNDER REDISTRIBUTION PROGRAM.—Not later than July 1, 2004, the Secretary shall submit to Congress a report containing recommendations regarding whether to extend
the deadline for applications for an increase in resident limits under section 1888(h)(4)(I)(i) of the Social Security Act (as added by subsection (a)).

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

(a) HOLD HARMLESS PROVISIONS.—

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

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

(B) by striking the first sentence of such section and inserting the following:

"(I) a hospital that is located in a rural area'' after "100 beds’’; and

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

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

(b) STUDY; ADJUSTMENT.—

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

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

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

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

(1) in clause (ii), by striking “clauses (ii) and (iii)” and inserting “clauses (ii), (iii), (iv), and (v)”;

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

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

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

(II) federally qualified health center services (as defined in paragraph (3) of such section);”.

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

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

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

(a) IN GENERAL.—Section 1861(dd)(3)(B) (42 U.S.C. 1395ww(dd)(3)(B)) is amended by inserting “or nurse practitioner (as defined in section (aa)(3))” after “the physician (as defined in subsection (a)(3))”.

(b) CLARIFICATION OF HOSPICE ROLE OF NURSE PRACTITIONERS.—Section 1814(a)(7)(A)(I)(I) (42 U.S.C. 1395ww(a)(7)(A)(I)(I)) is amended by inserting “which for purposes of this subparagraph does not include a nurse practitioner” after “attending physician (as defined in section 1861(dd)(3)(B))”.

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

(a) I N GENERAL.—Section 1831(I) (42 U.S.C. 1395n(I)) is amended—

(1) by redesigning paragraph (8), as added by section 223(a) of BIPA (114 Stat. 2763A-486), as paragraph (9); and

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

"(10) ASSISTANCE FOR RURAL PROVIDERS FURNISHING SERVICES IN LOW MEDICARE POPULATION DENSITY AREAS.—(A) IN GENERAL.—In the case of ground ambulance services furnished on or after January 1, 2004, for which the transportation originates in a qualified rural area (as defined in subparagraph (B)), the Secretary shall provide for payment at a rate increased in the base rate of the fee schedule for a trip established under this subsection. In establishing such percent increase, the Secretary shall estimate the average cost per trip for the base rate in the lowest quartile as compared to the average cost for the base rate for such services in the highest quartile of all rural county populations.

(B) QUALIFIED RURAL AREA DEFINED.—For purposes of subparagraph (A), the term ‘‘qualified rural area’’ (as defined in section 1866(d)(2)(D)) with a population density of medicare beneficiaries residing in the area that is in the lowest quartile of all rural county populations.”.

SEC. 411. WAIVING BUDGET NEUTRALITY 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 1861(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D)) during 2004 and 2005, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395ff) for such services by 5 percent.

(b) WAIVING BUDGET NEUTRALITY.—The Secretary shall not reduce the standard prospective payment amount (or amounts) under section 1895 of the Social Security Act (42 U.S.C. 1395fff) for such services by 5 percent.

SEC. 412. PROVIDING SAFE HARBOR FOR CERTAIN COLLABORATIVE EFFORTS THAT BENEFIT MEDICALLY UNDER-SERVED POPULATIONS.

(a) IN GENERAL.—Section 1128B(b)(3) (42 U.S.C. 1320a-7(b)(3)), as amended by section 102(b)(2), is amended—

(1) by striking (F), by striking “and” after the semicolon at the end; and

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

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

"(H) any remuneration between a public or nonprofit private health center entity described under section (ii) of section 1907(a)(2)(B) and any individual or entity providing goods, items, services, donations or loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other arrangement, if such arrangement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.”.

(b) PROVIDING SAFE HARBOR FOR HEALTH CENTER ENTITY ARRANGEMENTS.—

(1) ESTABLISHMENT.—

(A) IN GENERAL.—The Secretary of Health and Human Services shall establish, in consultation with the Secretary of Labor, regulations that refer to the Secretary shall establish, on an expedited basis, standards relating to

the exception described in section 1128B(b)(3)(H) of the Social Security Act, as added by subsection (a), for health center entity arrangements to the antikickback penalties.

(B) FACTORS TO CONSIDER.—The Secretary shall consider the following factors, among others, in establishing standards relating to certifications 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 results in savings of Federal grant funds or increased revenues to the health center entity.

(iii) Whether the arrangement between the health center entity and the other party protects a health care professional’s independent medical judgment regarding medically appropriate treatment.

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

(2) INTERIM FINAL EFFECT.—No later than 180 days after the date of enactment of this Act, the Comptroller General of the United States shall conduct a study of differences in payment amounts under the prospective payment system for hospital outpatient departments services furnished on or after the date of the enactment of this Act, the Federal Register consistent with the factors under paragraph (1)(B). Such rule shall be effective and final immediately, subject to such change and revision, after public notice and opportunity (for a period of not more than 60 days) for public comment, as is consistent with this subsection.

SEC. 413. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIAN SERVICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the prospective payment system for hospital outpatient services furnished on or after the date the geographic cost of practice index was established under this title.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding the use of more current data to compute such cost of practice indices as well as the use of data directly representative of physicians’ costs (rather than proxy measures of such costs).

SEC. 414. PROHIBITION OF HOLD HARMLESS FOR PROFESSIONAL LIABILITY INSURANCE PROFESSIONAL LIABILITY INSURANCE COSTS.

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

"(I) Any remuneration between a public or nonprofit private health center entity described under section (ii) of section 1907(a)(2)(B) and any individual or entity providing goods, items, services, donations or loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other arrangement, if such arrangement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.”.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding the use of more current data in computing such cost of practice indices as well as the use of data directly representative of physicians’ costs.

SEC. 415. TREATMENT OF MISSING COST REPORTING PERIODS FOR SINGLE COMMUNITY HOSPITALS.

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

"(I) Any remuneration between a public or nonprofit private health center entity described under section (ii) of section 1907(a)(2)(B) and any individual or entity providing goods, items, services, donations or loans, or a combination thereof, to such health center entity pursuant to a contract, lease, grant, loan, or other arrangement, if such arrangement contributes to the ability of the health center entity to maintain or increase the availability, or enhance the quality, of services provided to a medically underserved population served by the health center entity.”.

(b) REPORT.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding the use of more current data in computing such cost of practice indices as well as the use of data directly representative of physicians’ costs.
applicable base cost reporting period is available.”

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

SEC. 415. EXTENSION OF TELEMEDEICINE DEMONSTRATION PROJECT.

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

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

(2) by striking “$30,000,000” and inserting “$60,000,000.”

SEC. 416. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REFLECT THE LABOR-RELATED SHARE OF SUCH INDEX.

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

(1) by striking “WAGE LEVELS.—The Secretary” and inserting “WAGE LEVELS.—(i) In general.—Except as provided in clause (ii), the Secretary; and

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

“(ii) ALTERNATIVE PROPORTION TO BE APPLIED.—If the application of clause (i) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this clause had not been enacted.”

(b) Waiving Budget Neutrality.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence:

“The Secretary shall apply the proportion set forth under clause (i) for any period as if the amendments made by section 402(a) of the Medicare Prescription Drug and Modernization Act of 2003 had not been enacted.”

SEC. 417. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS FOR PHYSICIAN SCARCITY.

(a) Additional Bonus Payment for Certain Physician Scarcity Areas.—

(1) In general.—Section 1833(m) (42 U.S.C. 1395x(dd)).

(b) In general.—In the case of physicians’ services furnished in a year—

“(A) by a primary care physician in a primary care scarcity county (identified under paragraph (4)); or

“(B) by a physician who is not a primary care physician in a specialist care scarcity county (as so identified),

in addition to the amount of payment that would otherwise be made for such services under this part, there shall also be paid an amount equal to 5 percent of the payment amount for the service under this part.

“(2) DETERMINATION OF RATIOS OF PHYSICIANS TO MEDICARE BENEFICIARIES RESIDENT IN AREA.—The number of individuals who are residing in the county and are entitled to benefits under part A or enrolled under part B, and

“(C) DETERMINATION OF—

“(i) PRIMARY CARE RATIO.—The ratio (in this paragraph referred to as the ‘primary care ratio’) of the number of primary care physicians (A)(i), to the number of Medicare beneficiaries determined under subparagraph (B).

“(ii) SPECIALIST CARE RATIO.—The ratio (in this paragraph referred to as the ‘specialist care ratio’) of the number of other physicians (determined under subparagraph (A)(ii)), to the number of Medicare beneficiaries determined under subparagraph (B).

“(3) RANKING OF COUNTIES.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

“(4) IDENTIFICATION OF COUNTIES.—The Secretary shall identify—

“(A) those counties and areas (in this paragraph referred to as ‘primary care scarcity counties’) with the lowest primary care ratios that represent, if each such county or area were weighted by the number of Medicare beneficiaries determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the Medicare beneficiaries determined under such paragraph; and

“(B) those counties and areas (in this subsection referred to as ‘specialist care scarcity counties’) with the lowest specialist care ratios that represent, if each such county or area were weighted by the number of Medicare beneficiaries determined under paragraph (2)(B), an aggregate total of 20 percent of the total of the Medicare beneficiaries determined under such paragraph.

“(5) RURAL CENSUS TRACKS.—To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area as a primary care scarcity county; and

“(6) IDENTIFICATION OF COUNTIES.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

“(7) PROVISIONS RELATING TO PRIMARY AND SPECIALIST CARE RATIO.—The Secretary shall consider any primary or specialist care ratio in ranking counties or areas for purposes of applying bonus payments under this subsection.

“(8) IDENTIFICATION OF PRIMARY AND SPECIALIST CARE RATIO.—The Secretary shall consider any primary or specialist care ratio in ranking counties or areas for purposes of applying bonus payments under this subsection.

“(9) LIMITATION ON BONUS PAYMENTS.—The Secretary shall consider any primary or specialist care ratio in ranking counties or areas for purposes of applying bonus payments under this subsection.

“(10) REPORT.—The Secretary shall submit a report to Congress on the project and shall include in the report recommendations regarding extension of such project to hospice programs serving rural areas.

(b) RURAL HOSPICE DEMONSTRATION PROJECT.

(a) In general.—The Secretary shall conduct a demonstration project for the delivery of hospice care to Medicare beneficiaries in rural areas. Under the project Medicare beneficiary populations shall be selected to serve in rural areas in the home for less than 5 years.

(b) Scope of project.—The Secretary shall conduct the project under this section with respect to no more than 3 hospice programs over a period of not less than 5 years each.

(c) Compliance with Conditions.—Under the demonstration project—

“(1) The hospice program shall comply with otherwise applicable requirements, except that it shall not be required to offer services outside of the home or to provide level of care outside of the home that would otherwise be required, provided that such care is furnished to Medicare beneficiaries in rural areas. Under the project Medicare beneficiary populations shall be selected to serve in rural areas in the home for less than 5 years.

“(3) The Secretary shall consider any primary or specialist care ratio in ranking counties or areas for purposes of applying bonus payments under this subsection.

“(5) RURAL CENSUS TRACKS.—To the extent feasible, the Secretary shall treat a rural census tract of a metropolitan statistical area as a primary care scarcity county; and

“(6) IDENTIFICATION OF COUNTIES.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

“(7) PROVISIONS RELATING TO PRIMARY AND SPECIALIST CARE RATIO.—The Secretary shall consider any primary or specialist care ratio in ranking counties or areas for purposes of applying bonus payments under this subsection.

“(8) IDENTIFICATION OF COUNTIES.—The Secretary shall rank each such county or area based separately on its primary care ratio and its specialist care ratio.

“(9) LIMITATION ON BONUS PAYMENTS.—The Secretary shall consider any primary or specialist care ratio in ranking counties or areas for purposes of applying bonus payments under this subsection.

“(10) REPORT.—The Secretary shall submit a report to Congress on the project and shall include in the report recommendations regarding extension of such project to hospice programs serving rural areas.

TITLE V—PROVISIONS RELATING TO PART A

Subtitle A—Inpatient Hospital Services

SEC. 501. REVISION OF INPATIENT HOSPITAL PAYMENT UPDATES.


“(1) STRIKING ‘and’ at the end of subclause (XVIII);

“(2) by striking subclause (XIX); and

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

“‘(XIX) for each of fiscal years 2004 through 2006, the market basket percentage increase minus 0.4 percentage points for hospitals in all areas; and

“(XX) for fiscal year 2007 and each subsequent fiscal year, the market basket percentage increase for hospitals in all areas.”

SEC. 592. RECOGNITION OF NEW MEDICAL TECHNOLOGIES UNDER INPATIENT HOSPITAL PPS.

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

“(vii) Under the mechanism under this subpart, the Secretary shall provide for the addition of new diagnosis and procedure codes provided by CMS on or after April 1, 2004. The addition of such codes shall not require the Secretary to adjust the payment (or diagnosis-
related group classification) under this subsection until the fiscal year that begins after such date.

(b) ELIGIBILITY STANDARD FOR TECHNOLOGY OUTLINES

(1) MINIMUM PERIOD FOR RECOGNITION OF NEW TECHNOLOGIES.—Section 1886(d)(5)(K)(i)(vi) (42 U.S.C. 1395ww(d)(5)(K)(i)(vi)) is amended—

(A) by inserting "(ii)" after "(i)"; and

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

"(ii) The Secretary shall accept comments, recommendations, and data from the public regarding whether the service or technology represents a substantial improvement. The Secretary shall provide for a meeting at which organizations representing hospitals, physicians, Medicare beneficiaries, manufacturers, and any other interested parties make such recommendations, and data to the clinical staff of the Centers for Medicare & Medicaid Services before publication of a notice of proposed rulemaking under this subparagraph with respect to a new service or technology represents a substantial improvement.

(c) PREFERENCE FOR USE OF DRG ADJUSTMENT.—Section 1886(d)(5)(K) (42 U.S.C. 1395ww(d)(5)(K)) is further amended by adding at the end the following new clause:

"(x) Before any add-on payment under this subparagraph with respect to a new technology, the Secretary shall seek to identify one or more diagnosis-related groups associated with such technology, based on similar clinical or anatomical characteristics and the cost of the technology, and the Secretary shall adjust the amount provided under subsection (d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by inserting at the end the following:

"(C) For purposes of subparagraph (A), for discharges occurring on or after October 1, 1997, and before October 1, 2017, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent; and

"(E) For purposes of subparagraph (A), for discharges occurring on or after October 1, 1997, and before October 1, 2017, and after October 1, 2017, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent.

(d) IMPROVEMENT IN PAYMENT FOR NEW TECHNOLOGY.—Section 1886(d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is amended by inserting at the end "and that substantially improves the diagnosis or treatment of beneficiaries, the Secretary shall adjust the amount provided under subsection (d)(5)(K)(ii)(III) (42 U.S.C. 1395ww(d)(5)(K)(ii)(III)) is further amended by adding at the end the following:

"(v) on or after October 1, 2005, the applicable Puerto Rico percentage is 33 percent and the applicable Federal percentage is 67 percent; and

"(v) on or after October 1, 2005, the applicable Puerto Rico percentage is 33 percent and the applicable Federal percentage is 67 percent.

SEC. 504. WAGE INDEX RECLASSIFICATION REFORM.

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

"(III) on or after October 1, 2005, the term 'higher wage index area' means, with respect to a hospital, an area with a wage index that exceeds that of the area in which the hospital is located.

"(D) The increase in the wage index under subparagraph (A) for a hospital shall be based on the percentage increase in the wage index for the hospital that resides in any higher wage index area multiplied by the sum of the products, for each higher wage index area of the hospital, of the difference between (I) the wage index for such area, and (II) the wage index of the area in which the hospital is located (before the application of this paragraph); and

"(E) The process under this paragraph shall be based upon the process used by the Medicare Geographic Classification Review Board under paragraph (10) with respect to data submitted by hospitals to the Board on the location of residence of hospital employees.

"(F) A reclassification under this paragraph shall be effective for a period of 3 fiscal years, except that the Secretary shall establish procedures under which a subsection (d) hospital may elect to terminate such reclassification before the end of such period.

"(G) A hospital that is reclassified under this paragraph for a period is not eligible for
SEC. 505. MEDPAC REPORT ON SPECIALTY HOSPITALS.

(a) MedPAC Study.—The Medicare Payment Advisory Commission shall conduct a study of specialty hospitals compared with other similar general acute care hospitals under the medicare program. Such study shall examine—

(1) whether there are excessive self-referrals;

(2) quality of care furnished;

(3) the impact of specialty hospitals on such general acute care hospitals; and

(4) differences in the scope of services, medicaid utilization, and uncompensated care furnished.

(b) Effective Date.—Not later than 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under subsection (a), and shall include any recommendations for legislation or administrative change as the Secretary determines appropriate.

Subtitle B—Other Provisions

SEC. 511. PAYMENT FOR COVERED SKILLED NURSING FACILITY SERVICES.

(a) Adjustment to RUGs for AIDS Residents.—Paragraph (12) of section 1888(e) (42 U.S.C. 1395yy(e)) is amended to read as follows:

"(12) Adjustment for residents with AIDS.—

"(A) In general.—Subject to subparagraph (B), in the case of a resident of a skilled nursing facility who is afflicted with acquired immune deficiency syndrome (AIDS), the per diem amount of payment otherwise required shall be increased by 128 percent to reflect increased costs associated with such residents.

"(B) Sunset.—Subparagraph (A) shall not apply to a resident as of the date on which the Secretary certifies that there is an appropriate adjustment in the case mix under paragraph (4)(G)(i) to compensate for the increased costs associated with residents described in such subparagraph.";

(b) Effective Date.—The amendment made by paragraph (1) shall apply to services furnished on or after October 1, 2003.

SEC. 512. COVERAGE OF HOSPICE CONSULTATION SERVICES.

(a) Coverage of Hospice Consultation Services.—Section 1821a (42 U.S.C. 1395dd) is amended—

(1) by striking "and" at the end of paragraph (3);

(2) by striking the period at the end of paragraph (4) and inserting "; and"; and

(3) by inserting after paragraph (4) the following new paragraph:

"(5) for individuals who are terminally ill, have not made an election under subsection (d)(1), and have not previously received services under this paragraph, services that are furnished by a physician who is either the medical director or an employee of a hospice program and that consist of—

(A) an evaluation of the individual's need for palliative care management; and

(B) counseling the individual with respect to end-of-life issues and care options; and

"(6) in general.—Section 1814(d) (42 U.S.C. 1395f(d)) is amended by adding at the end the following new paragraph:

"(7) the amount paid to a hospice program with respect to the services under section 1832(a)(5) for which payment may be made under subpart D of such 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 preventive medicine and health supervision and management for a method of practice that is on the fee schedule established under section 1848(b), other than the portion of such amount attributable to the practice expense component;"

(b) Conforming Amendment.—Paragraph (4)(B) of such section is amended, in the matter before clause (i), by inserting "and paragraph (5) after "subparagraph (D)".

(c) Effective Date.—The amendments made by this subsection shall be treated as a change in law for purposes of applying section 1848(f)(2)(D) of the Social Security Act (42 U.S.C. 1395w-4(f)(2)(D)).

(b) Use of 10-Year Rolling Average in Computing Gross Domestic Product.—

(1) In general.—Section 1848(f)(2)(C) (42 U.S.C. 1395w-4(f)(2)(C)) is amended—

(A) by striking "projected" and inserting "annual average"; and

(B) by striking "from the previous applicable period to the applicable period involved" and inserting "during the 10-year period ending with the applicable period involved".

(2) Effective Date.—The amendment made by paragraph (1) shall apply to computations of the sustainable growth rate for years beginning with 2003.

SEC. 602. STUDIES ON ACCESS TO PHYSICIANS' SERVICES.

(a) GAO Study on Beneficiary Access to Physicians' Services.—

The Comptroller General of the United States shall conduct a study on access of medicare beneficiaries to physicians' services under the medicare program.

(1) Study.—Not later than 18 months after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the results of the study described in this section.

(A) an examination of the extent to which physicians are not accepting new medicare beneficiaries as patients;

(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 enactment of this Act, the Comptroller General shall submit to Congress a report on the results of the study described in this section.

(a) In General.—Within 120 days after the effective date of this subsection, the Secretary of Health and Human Services shall conduct a study to examine—

(1) whether there are excessive self-referrals;

(2) differences in the scope of services, Medicare utilization, and uncompensated care furnished;

(3) the impact of specialty hospitals on such general acute care hospitals; and

(4) differences in the scope of services, medicaid utilization, and uncompensated care furnished.

(b) Effective Date.—The amendment made by this section shall apply to services furnished on or after January 1, 2004.

SEC. 513. CORRECTION OF TRUST FUND HOLDING ERROR.

(a) In General.—Within 120 days after the effective date of this section, the Secretary of Health and Human Services, to be equal to the interest income lost by the trust fund for a period of 20 years after the date of enactment of this section referred to as the "Trust Fund") shall replicate, to the extent practicable in the judgment of the Secretary of the Treasury, in consultation with the Secretary, the obligations that would have been held by the Trust Fund if the clerical error had not occurred.

(b) Obligations Issued and Redeemed.—The Secretary of the Treasury shall—

(1) issue to the Trust Fund obligations under chapter 31 of title 31, United States Code, that bear issue dates, interest rates, and maturity dates as the obligations that—

(A) would have been issued to the Trust Fund if the clerical error had not occurred; or

(B) were issued to the Trust Fund and were redeemed by reason of the clerical error; and

(2) redeem from the Trust Fund obligations that would have been redeemed from the Trust Fund if the clerical error had not occurred.

(c) Appropriation to Trust Fund.—Within 120 days after the effective date of this section, there is hereby appropriated to the Trust Fund, out of any money in the Treasury not otherwise appropriated, an amount determined by the Secretary of the Treasury, consult with the Secretary of Health and Human Services, to be equal to the interest income lost by the trust fund through the date of credit by reason of the clerical error.

(d) Clerical Error Defined.—For purposes of this section, the term "clerical error" means an error that—

(1) transferred the correct amount from the general fund to the Trust Fund, which failure occurred on January 1, 2004.

(e) Effective Date.—The amendment made by this section shall apply to services furnished on or after October 1, 2004.
SEC. 602. MEDPAC REPORT ON PAYMENT FOR PHYSICIANS’ SERVICES.

(a) PRACTICE EXPENSE COMPONENT.—Not later than the date of the enactment of this Act, the Medicare Payment Advisory Commission shall submit to Congress a report on the effect of refinements to the practice expense component of payment for physicians’ services, after the transition to a full resource-based payment system in 2002, under section 1848 of the Social Security Act (42 U.S.C. 1395w–4). Such report shall examine the following matters by physician specialty:

(1) the effect of such refinements on payment for physicians’ services;

(2) the interaction of the practice expense component with other components of and adjustments to payment for physicians’ services under such section;

(3) the appropriateness of the amount of compensation by reason of such refinements;

(4) the effect of such refinements on access to care by Medicare beneficiaries to physicians’ services;

(5) the effect of such refinements on physician participation under the Medicare program.

(b) VOLUME OF PHYSICIAN SERVICES.—The Medicare Payment Advisory Commission shall submit to Congress a report on the extent to which increases in the volume of physicians’ services under part B of the Medicare program are a result of care that improves the health and well-being of Medicare beneficiaries. The study shall include the following:

(1) an analysis of recent and historic growth in the components that the Secretary includes under the sustainable growth rate (under section 1840(f) of the Social Security Act);

(2) an examination of the relative growth of volume in physician services between Medicare beneficiaries and other populations;

(3) an analysis of the degree to which new technology, including coverage determinations of the Centers for Medicare & Medicaid Services, has affected the volume of physicians’ services;

(4) an examination of the impact on volume of demographic changes;

(5) an examination of shifts in the site of services and the influence the change in the intensity of services furnished in physicians’ offices and the extent to which changes in reimbursement rates to other providers have contributed to such changes;

(6) an evaluation of the extent to which the Centers for Medicare & Medicaid Services takes into account the impact of law and regulations on the sustainable growth rate.

SEC. 604. INCLUSION OF PODIATRISTS AND DENTISTS UNDER PRIVATE CONTRACTING AUTHORITY.

Section 1822(b)(5)(B) (42 U.S.C. 1395a(b)(5)(B)) is amended by striking "section 1831(i)(1)", and inserting paragraphs (1), (2), and (3) of section 1831(e)".

SEC. 605. ESTABLISHMENT OF FLOOR ON WORK GEOGRAPHIC ADJUSTMENT.

(a) MINIMUM INDEX.—Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)) is amended by adding at the end the following new subparagraph:

"(E) FLOOR AT 1.0 ON WORK GEOGRAPHIC INDEX.

(i) IN GENERAL.—Subject to clause (ii), after calculating the work geographic index in subparagraph (A)(iii), for purposes of payment for services furnished under part B after January 1, 2004, and before January 1, 2006, the Secretary shall increase the work geographic index to 1.00 for any locality for which such work geographic index is less than 1.00.

(ii) SECRETARIAL DISCRETION.—Clause (i) shall have no force or effect in law if the Secretary determines, taking into account the report of the Comptroller General under section 605(b)(2) of the Medicare Prescription Drug and Modernization Act of 2003, that there is no sound economic rationale for the implementation of that clause.".

(b) GAO REPORT.—

(1) EVALUATION.—As part of the study on geographic physician payment, for physicians’ services conducted under section 413, the Comptroller General of the United States shall evaluate the following:

(A) whether there is a sound economic basis for the implementation of the adjustment of the work geographic index under section 1848(e)(1) of the Social Security Act under subsection (a) in those areas in which the adjustment applies;

(B) the effect of such adjustment on physician location and retention in areas affected by such adjustment, taking into account—

(i) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

(ii) the mobility of physicians, including specialists, over the last decade;

(C) the appropriateness of establishing a floor of 1.0 for the work geographic index.

(2) REPORT.—By not later than September 1, 2004, the Comptroller General shall submit to Congress and the Secretary a report on the evaluation conducted under paragraph (1).

Subtitle B—Preventive Services

SEC. 611. COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)) is amended—

(1) in subparagraph (U), by striking "and" at the end; and

(2) in subparagraph (V), by inserting "and" at the end; and

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

"(W) an initial preventive physical examination (as defined in subsection (ww))."

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 611(b), is amended by adding at the end the following new subsection:

"Cholesterol and Other Blood Lipid Screening Test".

SEC. 612. COVERAGE OF CHOLESTEROL AND OTHER BLOOD LIPID SCREENING TESTS.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2), as amended by section 611(a), is amended—

(1) by requiring "and" at the end of paragraph (H); and

(2) by striking the semicolon at the end of subparagraph (I) and inserting ";", and;

(b) SERVICES DESCRIBED.—Section 1861 (42 U.S.C. 1395x), as amended by section 611(b), is amended by adding at the end the following new subsection:

"Cholesterol and Other Blood Lipid Screening Test".

"(xx)(1) The term 'cholesterol and other blood lipid screening test' means diagnostic testing of cholesterol and other lipid levels of the blood for the purpose of early detection of abnormal cholesterol and other lipid levels.

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

(c) FREQUENCY.—Section 1861(ww) (42 U.S.C. 1395x), as amended by section 611(e), is amended—

(1) by striking "and" at the end of subparagraph (I) and inserting ";";

(2) by striking the semicolon at the end of subparagraph (J) and inserting ";"; and

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

"(K) in the case of a cholesterol and other blood lipid screening test (as defined in section 1861(ww)(1)), which is performed more frequently than is covered under section 1861(ww)(2)."

(d) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished after January 1, 2005.

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

(a) IN GENERAL.—The first sentence of section 1833(b) (42 U.S.C. 1395l(a)(1)), as amended by section 611(c), is amended—

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

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

"(7) such deductible shall not apply with respect to an initial preventive examination (as defined in section 1833(b)(1)) whose cost is not in excess of the deductible amount for such examination specified under section 1833(b)(1)(B)."

(b) CONSIDERATION.—

(1) IN GENERAL.—The first sentence of section 1833(b) (42 U.S.C. 1395l(a)(1)), as amended by section 611(c), is amended—

(2) by striking "and" before "(7)"; and

(3) by inserting before the period at the end the following:

"(7) such deductible shall not apply with respect to a colorectal cancer screening test (as defined in section 1833(b)(1)), which is performed more frequently than is covered under section 1833(b)(1))."

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished after January 1, 2005.
and services furnished on or after January 1, 2004.

SEC. 614. IMPROVED PAYMENT FOR CERTAIN MAMMOGRAPHY SERVICES.

(a) EXCLUSION FROM OPD FEE SCHEDULE.—Section 1833(t)(1)(B)(i)(iv) (42 U.S.C. 1395t(1)(B)(i)(iv)) is amended by inserting before the period at the end the following: ‘‘(B) Whether the study produced useful data on hospital acquisition cost.’’

(b) REQUIREMENT OF HOSPITAL ACQUISITION COST.—(1) IN GENERAL.—The amendment made by paragraph (1) shall apply to the acquisition cost of drugs for which payment is made under section 1833(t) of the Social Security Act (42 U.S.C. 1395t) (as defined in section 1927(k)(7)(A)(ii)).

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to drugs acquired on or after January 1, 2006.

(c) REPRESENTATIVE SAMPLE OF HOSPITALS.—In conducting the study under paragraph (1), the Secretary shall collect data from a statistically valid sample of hospitals with an urban/rural stratification.

(4) REPORT.—Not later than January 1, 2006, the Secretary shall submit to Congress a report on the study conducted under paragraph (1), and shall include recommendations with respect to the following:

(1) Whether the study should be repeated, and if so how frequently.

(2) Whether the study produced useful data on hospital acquisition cost.

(3) Whether data produced in the study is appropriate for use in determining payments to hospitals for drugs and biologicals under section 1847a of the Social Security Act.

(4) Whether separate estimates can be made of overhead costs, including handling and administering costs for drugs.

SEC. 622. PAYMENT FOR AMBULATORY SERVICES.

(a) PHASE-IN OF ADDITIONAL GROUPS FOR AMBULATORY SERVICES.—Section 1833(t)(2) (42 U.S.C. 1395t(2)) is amended—

(1) by redesignating paragraph (4) as paragraph (5); and

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

‘‘(6) IN EFFECTIVE DATE.—The amendment made by this amendment shall apply to the payment of drug services on or after January 1, 2004.’’

(b) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the payment of drug services on or after January 1, 2004.

(c) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the payment of drug services on or after January 1, 2004.

(d) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the payment of drug services on or after January 1, 2004.

(e) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the payment of drug services on or after January 1, 2004.

(f) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to the payment of drug services on or after January 1, 2004.
(1) in paragraph (2)(E), by inserting "consistent with paragraph (11)" after "in an efficient and fair manner"; and

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

"(11) Phase-in Providing Floor Using Blend of Fee Schedule and Regional Fee Schedules.—In carrying out the phase-in under subparagraphs (B) and (C) of section 1834(h) for each level of service furnished in a year, the portion of the payment amount that is based on the fee schedule shall be the greater of the amount determined under the fee schedule (without regard to this paragraph) or the following blended rate of the fee schedule under paragraph (1) and of a regional fee schedule for the region involved:

(A) For 2005, the blended rate shall be based 20 percent on the fee schedule under paragraph (1) and 80 percent on the regional fee schedule.

(B) For 2006, the blended rate shall be based 40 percent on the fee schedule under paragraph (1) and 60 percent on the regional fee schedule.

(C) For 2007, the blended rate shall be based 60 percent on the fee schedule under paragraph (1) and 40 percent on the regional fee schedule.

(D) For 2007, 2008, and 2009, the blended rate shall be based 80 percent on the fee schedule under paragraph (1) and 20 percent on the regional fee schedule.

(E) For 2010 and each succeeding year, the blended rate shall be based 100 percent on the fee schedule under paragraph (1).

For purposes of this paragraph, the Secretary shall establish a regional fee schedule for each of the 9 Census divisions using the methodology (used in establishing the fee schedule under paragraph (11) to calculate a regional conversion factor and a regional mileage payment rate and using the same payment adjustments and the same relative value units as used in the fee schedule under such paragraph.

(2) Adjustment in Payment for Certain Long Trips.—Section 1834(h), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

"(12) Adjustment in Payment for Certain Long Trips.—In the case of ground ambulance services furnished on or after January 1, 2004, and before January 1, 2009, regardless of where the transportation originates, the fee schedule established under this section shall provide that, with respect to the payment rate for mileage for a trip above 50 miles the per mile rate otherwise established shall be increased by 25 percent of the payment per mile otherwise applicable to such miles.

(g) GAO Report on Costs and Access.—Not later than December 31, 2005, the Comptroller General of the United States shall submit to Congress an initial report on how costs differ among the types of ambulance services provided by Medicare, Medicaid, and SCHIP beneficiaries and how the availability of ambulance services in those regions and States that have a reduction in payment under the medicare ambulance fee schedule (under recommendations with respect to the establishment and operation of such demonstration project).

(2) Representatives.—Representatives referred to in paragraph (1) include representatives of the following:

(A) Patient organizations.

(B) Clinicians.

(C) The Medicare payment advisory commission, established under section 1806 of the Social Security Act (42 U.S.C. 1395bb-6).

(D) The National Kidney Foundation.

(E) The National Institutes of Health and National Institutes of Health.

(F) End-stage renal disease networks.

(G) Medicare contractors to monitor quality of care.

(1) providers of services and renal dialysis facilities furnishing end-stage renal disease services.

(J) Economists.

(K) Researchers.

(D) REIMBURSEMENT RATE EXCEPTIONS FOR PEDIATRIC FACILITIES.—

(1) In General.—Section 422(a)(2) of BIPA is amended—

(A) in subparagraph (A), by striking "and" and inserting "and"

(B) in subparagraph (B), by striking "in the case" and inserting "subject to subparagraphs (A), (B), and (C)";

(2) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)), as amended by subsection (b), is further amended by striking "Until" and inserting "until July 1, 2007, and after July 1, 2007, as determined based on the cost of care for each of the fiscal years 2004 through 2008".

(3) INCREASE IN RENAL DIALYSIS COMPOSITE RATE FOR SERVICES FURNISHED IN 2004.—Notwithstanding any other provision of law, with respect to payment under part B of title XVIII of such Act for renal dialysis services furnished in 2004, the composite payment rate otherwise established under section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)) shall be increased by 1.6 percent.

(h) ONE-YEAR MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO RECAPS; PROVISIONS RELATING TO RECAPS; PROVISIONS RELATING TO CAPS.—Section 1833(g)(4)(C) of BIPA is amended—

(B) The Secretary or a carrier may establish an advisory board comprised of representatives referred to in subparagraph (A) and representatives with respect to the establishment and operation of demonstration projects.

(2) REPRESENTATIVES.—Representatives referred to in paragraph (1) include representatives of the following:

(A) Patient organizations.

(B) Clinicians.

(C) The Medicare payment advisory commission, established under section 1806 of the Social Security Act (42 U.S.C. 1395bb-6).

(D) The National Kidney Foundation.

(E) The National Institutes of Health and National Institutes of Health.

(F) End-stage renal disease networks.

(G) Medicare contractors to monitor quality of care.

(1) providers of services and renal dialysis facilities furnishing end-stage renal disease services.

(J) Economists.

(K) Researchers.

(D) REIMBURSEMENT RATE EXCEPTIONS FOR PEDIATRIC FACILITIES.—

(1) In General.—Section 422(a)(2) of BIPA is amended—

(A) in subparagraph (A), by striking "and" and inserting "and"

(B) in subparagraph (B), by striking "in the case" and inserting "subject to subparagraphs (A), (B), and (C)";

(2) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)), as amended by subsection (b), is further amended by striking "Until" and inserting "until July 1, 2007, and after July 1, 2007, as determined based on the cost of care for each of the fiscal years 2004 through 2008".

(i) ONE-YEAR MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO RECAPS; PROVISIONS RELATING TO CAPS.—Section 1833(g)(4)(C) of BIPA is amended—

(B) The Secretary or a carrier may establish an advisory board comprised of representatives referred to in subparagraph (A) and representatives with respect to the establishment and operation of demonstration projects.

(2) REPRESENTATIVES.—Representatives referred to in paragraph (1) include representatives of the following:

(A) Patient organizations.

(B) Clinicians.

(C) The Medicare payment advisory commission, established under section 1806 of the Social Security Act (42 U.S.C. 1395bb-6).

(D) The National Kidney Foundation.

(E) The National Institutes of Health and National Institutes of Health.

(F) End-stage renal disease networks.

(G) Medicare contractors to monitor quality of care.

(1) providers of services and renal dialysis facilities furnishing end-stage renal disease services.

(J) Economists.

(K) Researchers.

(D) REIMBURSEMENT RATE EXCEPTIONS FOR PEDIATRIC FACILITIES.—

(1) In General.—Section 422(a)(2) of BIPA is amended—

(A) in subparagraph (A), by striking "and" and inserting "and"

(B) in subparagraph (B), by striking "in the case" and inserting "subject to subparagraphs (A), (B), and (C)";

(2) CONFORMING AMENDMENT.—The fourth sentence of section 1881(b)(7) of such Act (42 U.S.C. 1395rr(b)(7)), as amended by subsection (b), is further amended by striking "Until" and inserting "until July 1, 2007, and after July 1, 2007, as determined based on the cost of care for each of the fiscal years 2004 through 2008".

(i) ONE-YEAR MORATORIUM ON THERAPY CAPS; PROVISIONS RELATING TO RECAPS; PROVISIONS RELATING TO CAPS.—Section 1833(g)(4)(C) of BIPA is amended—

(B) The Secretary or a carrier may establish an advisory board comprised of representatives referred to in subparagraph (A) and representatives with respect to the establishment and operation of demonstration projects.

(2) REPRESENTATIVES.—Representatives referred to in paragraph (1) include representatives of the following:

(A) Patient organizations.

(B) Clinicians.

(C) The Medicare payment advisory commission, established under section 1806 of the Social Security Act (42 U.S.C. 1395bb-6).

(D) The National Kidney Foundation.

(E) The National Institutes of Health and National Institutes of Health.

(F) End-stage renal disease networks.

(G) Medicare contractors to monitor quality of care.

(1) providers of services and renal dialysis facilities furnishing end-stage renal disease services.

(J) Economists.

(K) Researchers.
"(C) In accordance with procedures established by the Secretary, an individual entitled to benefits with respect to shoes described in section 1861(s)(12) may substitute modified form of shoes instead of obtaining one (or more, as specified by the Secretary) pair of inserts (other than the original pair of inserts with respect to such shoes). In such case, the Secretary shall, for the payment amount established under section 1834(h), a payment amount that the Secretary estimates will assure that there are no net economic benefits to the Secretary under this subsection as a result of this subparagraph.

(C) CONFORMING AMENDMENTS.—(1) Section 1834(h)(4)(C) (42 U.S.C. 1395n(h)(4)(C)) is amended by inserting ``(and includes shoes described in section 1861(s)(12))'' after ``in'' in section 1861(s)(12).

(2) Section 1842(s)(2) (42 U.S.C. 1395u(s)(2)) is amended by striking subparagraph (C).

(C) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished on or after January 1, 2004.

SEC. 627. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) WAIVER OF PENALTY.—

(i) IN GENERAL.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: ``(i) No increase in the premium shall be effected for a month in the case of an individual who is 65 years of age or older, who enrolls under this part during 201, 2002, 2003, or 2004 and who demonstrates to the Secretary before December 31, 2004, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary of Health and Human Services shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.

(ii) EFFECTIVE DATE.—The amendment made by paragraph (i) shall apply to premiums for months beginning with January 1, 2004.

(b) MEDICAID COVERAGE OF DIABETES LABORATORY DIAGNOSTIC TESTS.

(a) COVERAGE.—Section 1861(s)(2) (42 U.S.C. 1395x(s)(2)), as amended by sections 611 and 612, is amended—

(1) in subparagraph (W), by striking ``and'' and inserting ``(including intravenous immune globulin for the treatment of primary immune deficiency diseases in the home (as defined in subsection (yy)));''

(2) in subparagraph (Y), by striking ``(X)'' and inserting ``(X)''

(b) SERVICES DESCRIBED.—Section 1861(s)(2), as amended by sections 611 and 612, as added by subsection (a), is further amended by adding at the end the following new subparagraph:

``(yy) The term ‘intravenous immune globulin’ means an approved pooled plasma derivative for the treatment of the patient’s home of a patient with a diagnosed primary immune deficiency disease (as defined in subsection (yy));''

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished administered on or after January 1, 2004.

SEC. 630. DETERMINATION OF COVERAGE OF INTRAVENOUS IMMUNE GLOBULIN FOR CERTAIN IMMUNE DEFICIENCY DISEASES IN THE HOME.

(a) COVERAGE.—Section 1861(s)(12) (42 U.S.C. 1395x(s)(12)), as amended by sections 611 and 612, is amended—

(1) in subparagraph (A), by striking ``(and includes shoes described in section 1861(s)(12))'' after ``(and includes shoes described in section 1861(s)(12))'';

(2) in subparagraph (B), by striking ``(and includes shoes described in section 1861(s)(12))'' after ``(and includes shoes described in section 1861(s)(12))''

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to items furnished administered on or after January 1, 2004.
SEC. 702. ESTABLISHMENT OF REDUCED COPAYMENTS.

(a) by striking "or coinurance and insertion in the manner of subsection (a)(4)" and inserting "(a)(4)" and inserting "(a)(4), or (a)(5)"

SEC. 703. MEDPAC STUDY ON MEDICARE BENEFICIARIES.

(a) by striking "or coinurance, or copayment; and" and inserting "(a)(4), or (a)(5)"

SEC. 704. DEMONSTRATION PROJECT TO CLARIFY THE DEFINITION OF HOMEBOUND.

(a) DEMONSTRATION PROJECT.—Not later than 180 days after the date of the enactment of this Act, the Secretary shall conduct a two-year demonstration project under part B of title XVIII of the Social Security Act under which medicare beneficiaries with chronic conditions in subpart (b) of section 1861(k) of the Social Security Act (42 U.S.C. 1395fff) are deemed to be homebound for purposes of receiving home health services under the medicare program.

(b) MEDICARE BENEFICIARY DESCRIBED.—For purposes of subsection (a), a medicare beneficiary is eligible to be deemed to be homebound, without regard to the purpose, frequency, or duration of absences from the home, if—

(1) the beneficiary has been certified by one physician as an individual who has a permanent and severe condition that will not improve;

(2) the beneficiary requires the individual to receive assistance from another individual with at least 3 out of the 5 activities of daily living for the rest of the individual's life;

(3) the beneficiary requires skilled nursing services on a permanent basis and the skilled nursing is more than medication management;

(4) either (A) an attendant is needed during the day to monitor and treat the beneficiary's medical condition, or (B) the beneficiary needs daily skilled nursing on a permanent basis and the skilled nursing is more than medication management;

(5) the beneficiary requires technological assistance or the assistance of another person to leave the home.

(c) DEMONSTRATION PROJECT SITES.—The demonstration project established under this section shall be conducted in 3 States selected by the Secretary to represent the Northeast, Midwest, and Western regions of the United States.

(d) LIMITATION ON NUMBER OF PARTICIPANTS.—The aggregate number of such beneficiaries that shall participate in the project may not exceed 15,000.

(e) DATA.—The Secretary shall collect such data on the demonstration project with respect to the provision of home health services to medicare beneficiaries that relates to quality of care, patient outcomes, and additional costs, if any, to the medicare program.

(f) REPORT TO CONGRESS.—Not later than 1 year after the date of the completion of the demonstration project under this subsection, 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; or

(B) directly causes an unreasonable increase of expenditures under the medicare program for the provision of such services that is directly attributable to such clarification;

(2) the specific data evidencing the amount of any increase in expenditures that is a directly attributable to the demonstration project (expressed both in absolute dollars and as a percent of 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 home-bound beneficiaries from restrictions on the length, frequency, and receipt of their absences from the home to qualify for home health services without incurring additional unreasonable costs to the medicare program.

(g) WAIVER AUTHORITY.—The Secretary shall waive compliance with the requirements of title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.) to such extent and for such period as the Secretary determines is necessary to conduct demonstration projects.

(h) CONSTRUCTION.—Nothing in this section shall be construed as waiving any applicable civil monetary penalty, criminal penalty, or other remedy available under title XI or title XVIII of the Social Security Act for acts prohibited under such titles, including penalties for false certifications for purposes of Medicare or donations to or services under the medicare program.

(i) AUTHORIZATION OF APPROPRIATIONS.—Payments for the costs of carrying out the demonstration project under this section shall be made from the Federal Supplementary Medical Care Trust Fund under section 1841 of such Act and shall be made pursuant to section 18002 of such Act.

(j) DEFINITIONS.—In this section:

(1) MEDICARE BENEFICIARY.—The term "medicare beneficiary" means an individual who is enrolled under part B of title XVIII of the Social Security Act.

(2) HOME HEALTH SERVICES.—The term "home health services" has the meaning given such term in section 1861 of such Act (42 U.S.C. 1395bb).

(3) ACTIVITIES OF DAILY LIVING DEFINED.—The term "activities of daily living" means eating, toileting, transferring, bathing, and dressing.

(4) SECRETARY.—The term "Secretary" means the Secretary of Health and Human Services.

Subtitle B—Directorate Medical Education

SEC. 711. EXTENSION OF UPDATE LIMITATION ON TITLES V, V-A, AND V-B.

SEC. 712. VOLUNTARY CHRONIC CARE IMPROVEMENT PROJECTS.—This Act shall be implemented during fiscal years 2004 through 2013 as a pilot project known as a "chronic care improvement for service project".

Title XVIII, as amended by section 108(a), is amended by inserting, after section 1887, the following new section:

"CHRONIC CARE IMPROVEMENT PROJECT.

SEC. 1898. (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 in Medicare C or D or who have certain chronic conditions, such as congestive heart failure, diabetes, chronic obstructive pulmonary disease (COPD), stroke, prostate and other cancers, or are at high risk for such conditions as identified by the Secretary as appropriate for chronic care improvement. Such a process shall begin to be implemented no later than 2 years 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) INDIVIDUAL PLAN.—The term ‘individual plan’ means an entity with a contract to provide a chronic care improvement program in a CCIA region under this section.

"(C) CONTRACTOR.—The term ‘contractor’ means an entity with a contract to provide a chronic care improvement program under this section.

"(D) INDIVIDUAL PLAN.—The term ‘individual plan’ means a chronic care improvement plan established under subsection (c)(5) for and individual.

"(3) CONSTRUCTION.—Nothing in this section shall be construed as expanding the amount, duration, or scope of benefits under this title.

"(4) COMPETITIVE BIDDING PROCESS.—

"(1) IN GENERAL.—Under this section the Secretary shall award contracts to qualified entities to provide 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 determine the United States into multiple chronic care improvement administrative regions; and

"(B) the Secretary shall select at least 2 winning bidders in each CCIA region on the basis of the ability of each bidder to carry out a chronic care improvement program in accordance with this section, in order to achieve improved health and financial outcomes.

"(3) ELIGIBLE CONTRACTOR.—A contractor may be a disease improvement organization, health care provider, or any other legal entity that the Secretary determines appropriate.

"(4) CHRONIC CARE IMPROVEMENT PROGRAMS.—

"(1) IN GENERAL.—Each contract under this section shall provide for the operation of a chronic care improvement program by a contractor in a CCIA region consistent with this subsection.

"(2) IDENTIFICATION OF PROSPECTIVE PROGRAM.—Each contract shall have a method for identifying Medicare beneficiaries in the region to whom it will offer services under its program. The contractor shall identify such beneficiaries through claims or other data and other means permitted consistent with applicable disclosure provisions.

"(3) INITIAL CONTACT BY SECRETARY.—The Secretary shall communicate with each beneficiary identified under paragraph (2) as a prospective participant in one or more programs a participation in a program. Such communication may be made by the Secretary (or on behalf of the Secretary) and shall include information on the following:

"(A) A description of the advantages to the beneficiary in participating in a program.

"(B) Notification that the contractor offering a program may contact the beneficiary directly concerning such participation.

"(C) Notification that participation in a program is voluntary.

"(D) A description of the method for the beneficiary to select the single program in which the beneficiary wishes to participate and a method to meet such requirements.

"(E) Identification of the benefits offered by each program.

"(F) Other information that the Secretary deems appropriate.

"(4) PROGRAM DESIGN.—A Medicare beneficiary may participate in only one program under this section and may terminate participation at any time in a manner specified by the Secretary.

"(5) INDIVIDUAL CHRONIC CARE IMPROVEMENT PLANS.—

"(1) IN GENERAL.—For each beneficiary participating in a program under this section, the contractor shall develop with the beneficiary an individualized, goal-oriented chronic care improvement plan.

"(2) ELEMENTS OF INDIVIDUAL PLAN.—Each individual plan developed under subparagraph (A) shall include a single point of contact to coordinate care and the following, as appropriate:

"(i) Self-improvement education for the beneficiary (such as education for disease management through medical nutrition therapy, medication therapy, and education for health care providers, primary caregivers, and family members).

"(ii) Coordination of health care services, such as application of a prescription drug regimen and home health services.

"(iii) Collaboration with physicians and other providers to enhance communication of relevant clinical information.

"(iv) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as vital signs, symptomatic information, and health self-assessment.

"(v) The provision of information about hospice care, pain and palliative care, and end-of-life care.

"(C) CONTRACTOR RESPONSIBILITIES.—In establishing and carrying out individual plans under a program, a contractor shall, directly or through subcontractors—

"(i) guide participants in managing their health, including all their co-morbidities, and in performing activities as specified under the elements of the plan;

"(ii) use decision support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

"(iii) develop a clinical information database to track and monitor each participant across settings and to evaluate outcomes.

"(6) ADDITIONAL REQUIREMENTS.—The Secretary may establish additional requirements for programs and contractors under this section.

"(7) ACCREDITATION.—The Secretary may provide that programs that are accredited by qualified organizations may be deemed to meet such requirements under this section as the Secretary may specify.

"(C) CONTRACT TERMS.—

"(1) IN GENERAL.—A contract under this section shall contain such terms and conditions as the Secretary may specify with respect to each program under this section. The Secretary may not enter into a contract with an entity under this section unless the entity meets such such clinical, quality improvement, financial, and other requirements as the Secretary deems to be appropriate for the population to be served.

"(2) USE OF SUBCONTRACTORS PERMITTED.—A contractor may carry out a program directly or through contracts with subcontractors.

"(3) BUDGET NeUTRAL PAYMENT CONDITION.—In entering into a contract with an entity under this subsection, the Secretary shall establish payment rates that assure such contractors a payment equal to the increase in payments under this title over any period of 3 years or longer, as agreed to by the Secretary. Under this section, the Secretary shall assume any increased program outlays plus administrative expenses (that would not have been paid under this title without implementation of this section), including contractor fees, that are not otherwise reimbursable under this title to the extent of the program for obtaining additional information concerning such participation.

"(4) PARTICIPATION.—A Medicare beneficiary may participate in only one program under this section and may terminate participation at any time in a manner specified by the Secretary.

"(5) PERFORMANCE STANDARDS.—Payment to contractors under this section shall be subject to the contractor’s meeting of clinical and financial performance standards set by the Secretary.

"(6) CONTRACTOR OUTCOMES REPORT.—Each contractor offering a program shall monitor and report to the Secretary, in a manner specified by the Secretary, the quality of care and efficacy of such program in terms of—

"(A) process measures, such as reductions in errors of treatment and rehospitalization rates;

"(B) beneficiary and provider satisfaction;

"(C) health outcomes; and

"(D) financial outcomes.

"(7) PHASED IN IMPLEMENTATION.—Nothing in this section shall be construed as preventing the Secretary from phasing in the implementation of programs.

"(8) ANNUAL OUTCOMES REPORT.—The Secretary shall submit to the Congress annual reports on the implementation of this section. Each such report shall include information on—

"(1) the scope of implementation (in terms of both regions and chronic conditions); (2) program design; and (3) improvements in health outcomes and financial efficiencies that result from such implementation.

"(9) CLINICAL TRIALS.—The Secretary shall conduct randomized clinical trials, that compare program participants with Medicare beneficiaries who are offered, but decline, to participate, in order to assess the potential of programs to—

"(1) reduce costs under this title; and

"(2) improve health outcomes under this title.

"(10) 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.

"(11) LIMITATION ON FUNDING.—In no case shall the funding under this section exceed $100,000,000 over a period of 3 years.

SEC. 722. CHRONIC CARE IMPROVEMENT UNDER MEDICARE ADVANTAGE AND ENHANCED FEE-FOR-SERVICE PROGRAMS.

"(a) UNDER MEDICARE ADVANTAGE PROGRAMS.—Section 1852 (42 U.S.C. 1395w–22) is amended—

"(1) by amending subsection (e) to read as follows:

"(B) IMPLEMENTATION OF CHRONIC CARE IMPROVEMENT PROGRAMS FOR BENEFICIARIES WITH MULTIPLE OR SUFFICIENTLY SEVERE CHRONIC CONDITIONS.—

"(C) CONTRACT TERMS.—A contract shall include a program designed to improve the health and health care of Medicare beneficiaries with multiple or sufficiently severe chronic conditions. The contract shall include a program designed to improve the health and health care of Medicare beneficiaries with multiple or sufficiently severe chronic conditions.
effect, for enrollees with multiple or sufficiently severe chronic conditions, a chronic care improvement program that is designed to manage the needs of such enrollees and that meets the requirements of this subsection.

(2) ENROLLEE WITH MULTIPLE OR SUFFICIENTLY SEVERE CHRONIC CONDITIONS.—For purposes of paragraph (1), the term "enrollee with multiple or sufficiently severe chronic conditions" means an enrollee in a Medicare Advantage plan of a Medicare Advantage organization, an enrollee in the plan who has one or more chronic conditions, such as congestive heart failure, diabetes, COPD, stroke, prostate and colon cancer, hypertension, or other disease as identified by the organization as appropriate for chronic care improvement.

(3) GENERAL REQUIREMENTS.—

(A) IN GENERAL.—Each chronic care improvement program under this subsection shall be conducted consistent with this subsection.

(B) IDENTIFICATION OF ENROLLEES.—Each such program shall have a method for monitoring enrollees with multiple or sufficiently severe chronic conditions that meet the organization’s criteria for participation under the program.

(D) ELEMENTS OF PLANS.—Each chronic care improvement plan developed under subparagraph (C) shall include a single point of contact to coordinate care and the following, as appropriate:

(i) Coordination of health care services, such as application of a prescription drug regimen and home health services.

(ii) Collaboration with physicians and other providers to enhance communication of relevant clinical information.

(iv) The use of monitoring technologies that enable patient guidance through the exchange of pertinent clinical information, such as symptomatic information, and health self-assessment.

(v) The provision of information about hospice care, pain and palliative care, and end-of-life care.

(E) ORGANIZATION RESPONSIBILITIES.—In establishing and carrying out chronic care improvement plans for participants under this paragraph, a Medicare Advantage organization shall, directly or through sub-contractors—

(i) Guide participants in managing their health care and their co-morbidities, and in performing the activities as specified under the elements of the plan;

(ii) Use decision support tools such as evidence-based practice guidelines or other criteria as determined by the Secretary; and

(iii) Develop a clinical information database to track and monitor each participant across the facility and home care settings.

(3) ADDITIONAL REQUIREMENTS.—The Secretary may establish additional requirements for chronic care improvement programs.

(4) ACCREDITATION.—The Secretary may provide that chronic care improvement programs that are accredited by qualified organizations shall meet such requirements under this subsection as the Secretary may specify.

(5) OUTCOMES REPORT.—Each Medicare Advantage organization with respect to its chronic care improvement program under this subsection shall monitor and report to the Secretary information on the quality of care and efficacy of such program as the Secretary may require.

(1) my subparagraph (i) of subsection (c) of this section shall be conducted consistent with this subsection.

(ii) by amending subparagraph (I) of subsection (c) of this section to read as follows:

(II) CHRONIC CARE IMPROVEMENT PROGRAM.—A description of the organization's chronic care improvement program under subsection (b).

(2) by amending subparagraph (i) of subsection (c) of this section to read as follows:

(II) CHRONIC CARE IMPROVEMENT PROGRAM.—A description of the organization's chronic care improvement program under subsection (b).

(B) APPLICATION UNDER ENHANCED FEE-FOR-SERVICE PROGRAM.—Section 1800E–2(c)(3), as inserted by section 203(a), is amended by inserting "and (e) (relating to implementation of chronic care improvement programs)" after "The provisions of section 1852.".

(3) EFFECTIVE DATE.—The amendments made by this section shall apply for contract years beginning on or after 1 year after the date of enactment of this Act.

SEC. 725. INSTITUTE OF MEDICINE REPORT.

(a) STUDY.—

(1) IN GENERAL.—The Secretary of Health and Human Services shall contract with the Institute of Medicine of the National Academy of Sciences to conduct a study of the barriers to effective integrated care improvement for Medicare beneficiaries with multiple or severe chronic conditions across settings and over time and to submit a report under subsection (b).

(2) SPECIALITY.—The study shall examine the statutory and regulatory barriers to coordinating care across settings for Medicare beneficiaries in transition from one setting to another (such as between hospital, nursing facility, home health, hospice, and home). The study shall specifically identify the following:

(A) Clinical, financial, or administrative requirements in the Medicare program that present barriers to effective, seamless transitions across care settings.

(B) Policies that impede the establishment of administrative and clinical information systems to track health status, utilization, cost, and quality data across settings.

(C) State-level requirements that may present barriers to better care for Medicare beneficiaries.

(3) CONSULTATION.—The study under this subsection shall consult with experts in the field of chronic care, consumers, and family caregivers, working to integrate care delivery and create more seamless transitions across settings and over time.

(b) REPORT.—The report under this subsection shall be submitted to the Secretary and Congress not later than 18 months after the date of enactment of this Act.

SEC. 726. MEDPAC REPORT.

(a) EVALUATION.—shall conduct an evaluation that includes a description of the status of the demonstration projects and of the effects of the demonstration projects under section 1808 of the Social Security Act, the quality of health care services provided to individuals in such demonstration projects, and the cost savings attributed to implementation of such projects.

(b) REPORT.—Not later than 2 years after the date of implementation of such chronic care improvement programs, the Commission shall submit a report on such evaluation.

Subtitle D—Other Provisions

SEC. 731. MODIFICATIONS TO MEDICARE PAYMENT ADVISORY COMMISSION PAYMENT INTEGRATION CAPACITIES.

(a) EXAMINATION OF BUDGET CONSEQUENCES.—Section 1805(b)(2) (42 U.S.C. 1395b–6(b)) is amended by adding at the end the following new paragraph:

(8) EXAMINATION OF BUDGET CONSEQUENCES.—Before making any recommendations, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.

(b) CONSIDERATION OF DISCLOSURE REQUIREMENTS.—Section 1805(c)(2)(B) (42 U.S.C. 1395b–6(c)(2)(B)) is amended by adding at the end the following:

(5) DISCLOSURE REQUIREMENTS.—The Secretary shall require that Medicare cost reports and cost report data submitted under this section be made available for public disclosure.

(c) A PPLICATION OF DISCLOSURE REQUIREMENTS.—Section 1805(c)(2)(C) (42 U.S.C. 1395b–6(c)(2)(C)) is amended by adding at the end the following:

(5) DISCLOSURE REQUIREMENTS.—The Secretary shall require that Medicare cost reports and cost report data submitted under this section be made available for public disclosure.

(d) ADDITIONAL REPORTS.—

(1) DATA NEEDS AND SOURCES.—The Medicare Payment Advisory Commission shall conduct a study and, submit a report to Congress by not later than June 1, 2004, on the need for current data, and sources of current data, to conduct studies to identify and evaluate the effects, impacts, and financial circumstances of hospitals and chronic care providers of services. The study shall specifically identify data on uncompensated care, as well as the share of uncompensated care accounted for by the expenses for treating illegal aliens.

(1) DATA NEEDS AND SOURCES.—The Medicare Payment Advisory Commission shall conduct a study and, submit a report to Congress by not later than June 1, 2004, on the need for current data, and sources of current data, to conduct studies to identify and evaluate the effects, impacts, and financial circumstances of hospitals and chronic care providers of services. The study shall specifically identify data on uncompensated care, as well as the share of uncompensated care accounted for by the expenses for treating illegal aliens.

(2) USE OF TAX-RELATED RETURNS.—Using return information provided under Form 990 of the Internal Revenue Service, the Commission shall submit to Congress, by not later than June 1, 2004, a report on the following:

(A) Investments, endowments, and fund-raising of hospitals participating under the Medicare program and related foundations.

(B) Access to capital financing for private and for not-for-profit hospitals.

SEC. 732. DEMONSTRATION PROJECT FOR MEDICAL ADULT DAY CARE SERVICES.

(a) ESTABLISHMENT.—Subject to the succeeding provisions of this section, the Secretary of Health and Human Services shall, to the extent funds are available, to establish a demonstration project under which the Secretary shall, as the Secretary may require, directly or through consultation with appropriate expert entities, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.

(b) BUDGET NEUTRALITY FOR DEMONSTRATION PROJECT.—In no case may the Secretary of Health and Human Services authorize a demonstration project which consists of substituting medical adult day care services, under the demonstration project shall be made at a rate equal to 95 percent of the amount that would otherwise apply for such home health services under section 1895 of the Social Security Act (42 U.S.C. 1395ff). In no case may a home health agency, or a medical adult day care facility, permit a home health agency, directly or under arrangements with a medical adult day care facility, to provide medical adult day care services as a substitute for a portion of home health services that would otherwise be provided in the beneficiary’s home.

(c) CONSIDERATION OF DISCLOSURE REQUIREMENTS.—The Secretary of Health and Human Services shall, to the extent funds are available, to establish a demonstration project under which the Secretary shall, as the Secretary may require, directly or through consultation with appropriate expert entities, the Commission shall examine the budget consequences of such recommendations, directly or through consultation with appropriate expert entities.

(d) ADDITIONAL REPORTS.—

(1) DATA NEEDS AND SOURCES.—The Medicare Payment Advisory Commission shall conduct a study and, submit a report to Congress by not later than June 1, 2004, on the need for current data, and sources of current data, to conduct studies to identify and evaluate the effects, impacts, and financial circumstances of hospitals and chronic care providers of services. The study shall specifically identify data on uncompensated care, as well as the share of uncompensated care accounted for by the expenses for treating illegal aliens.

(2) USE OF TAX-RELATED RETURNS.—Using return information provided under Form 990 of the Internal Revenue Service, the Commission shall submit to Congress, by not later than June 1, 2004, a report on the following:

(A) Investments, endowments, and fund-raising of hospitals participating under the Medicare program and related foundations.

(B) Access to capital financing for private and for not-for-profit hospitals.
finds necessary in the interest of the health of the individuals; and

(ii) is designed to promote physical and mental health of the individuals; and

(iii) such other services as the Secretary may specify.

(a) MEDICARE BENEFICIARY.—The term "medicare beneficiary" means an individual entitled to benefits under part A of this title, enrolled under part B of this title, or both.

SEC. 733. IMPROVEMENTS IN NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS TO RESPOND TO CHANGES IN TECHNOLOGY.

(a) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

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

(A) in the title VIII of subsection (a) by inserting "consistent with subsection (k)" after "the Secretary shall ensure"; and

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

(k) NATIONAL AND LOCAL COVERAGE DETERMINATION PROCESS.—

(1) FACTORS AND EVIDENCE USED IN MAKING NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall make available to the public the factors considered in making national coverage determinations of whether an item or service is reasonable and necessary. The Secretary shall publish documents to carry out this paragraph in a manner similar to the development of guidance documents under section 702(h) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 371(h)).

(2) TIMEFRAME FOR DECISIONS ON REQUESTS FOR NATIONAL COVERAGE DETERMINATIONS.—In the case of a request for a national coverage determination that—

(A) does not require a technology assessment, or the delivery of items or services from the Medicare Coverage Advisory Committee, the decision on the request shall be made not later than 6 months after the date of the request; or

(B) requires such an assessment or deliberation and in which a clinical trial is not requested, the decision on the request shall be made not later than 9 months after the date of the request.

(3) PROCESS FOR PUBLIC COMMENT IN NATIONAL COVERAGE DETERMINATIONS.—At the end of the 30-day public comment period for requests described in paragraph (2)(B) that begins on the date a request for a national coverage determination is made, the Secretary shall—

(A) make a draft of proposed decision on the request available to the public through the Medicare Internet site of the Department of Health and Human Services or other appropriate means;

(B) provide a 30-day period for public comment on such draft;

(C) make a final decision on the request within 60 days of the conclusion of the 30-day period referred to under subparagraph (B); and

(D) include in such final decision summary responses thereto;

(E) make available to the public the clinical evidence and other data used in making such a decision when the decision differs from the recommendations of the Medicare Coverage Advisory Committee; and

(F) in the case of a decision to grant the coverage of an item or service, assign a temporary or permanent code and implement the coding change.

(4) CONSULTATION WITH CLINICAL/EXPERTS.—With respect to a national coverage determination for which there is not a review by the Medicare Coverage Advisory Committee, the Secretary shall consult with appropriate clinical experts.

(b) MEDICARE COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS.—

(1) IN GENERAL.—With respect to the coverage of routine costs of care for beneficiaries participating in a qualifying clinical trial, as set forth on the date of the enactment of this Act in National Coverage Determination 30-1 of the Medicare Coverage Issues Manual, the Secretary shall eliminate the requirements of paragraph (1) and to items and services furnished on or after such date.

(c) ISSUANCE OF TEMPORARY NATIONAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection, the term "national coverage determination" and "local coverage determination" have the meaning given such terms in paragraphs (1)(B) and (2)(B), respectively, of section 1861(s).

SEC. 734. TRANSITIONlug Rulemaking and Coverage Determination Processes.

(a) NATIONAL AND LOCAL COVERAGE DETERMINATION DEFINED.—For purposes of this subsection, the terms "national coverage determination" and "local coverage determination" have the meaning given such terms in paragraphs (1)(B) and (2)(B), respectively, of section 1861(s).

(b) NATIONAL COVERAGE DETERMINATIONS TO BE AUTOMATICALLY QUALIFIED.—The Secretary shall, with respect to a request for a national coverage determination made on or after January 1, 2004, make a final decision on such request not later than 6 months after the date of the request.

(c) PROVISIONAL COVERAGE DETERMINATIONS TO BE AUTOMATICALLY QUALIFIED.—The Secretary shall, with respect to a request for a provisional coverage determination made on or after January 1, 2004, make a final decision on such request not later than 9 months after the date of the request.

(d) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to national and local coverage determinations made on or after January 1, 2004.

(e) IN GENERAL.—Section 1880(b) (42 U.S.C. 1395w-41) is amended by adding at the end the following new paragraph:

(4) TREATMENT OF CERTAIN INPATIENT PHYSICIAN PATHOLOGY SERVICES.—

(A) IN GENERAL.—With respect to services furnished on or after January 1, 2004, and before January 1, 2009, if an independent laboratory furnishes the testing component of a physician pathology service to a fee-for-service Medicare beneficiary who is an inpatient or outpatient of a covered hospital, the Secretary shall treat such service for which payment shall be made to the laboratory under this section and not as...
an inpatient hospital service for which payment is made to the hospital under section 1886(d) or as a hospital outpatient service for which payment is made to the hospital under section 1862, but is not enrolled under part C of such title who is diagnosed as having one or more chronic conditions (as defined in subsection (b)(2)), as diabetes.

(b) Design of Projects.—

(1) In general.—In establishing the demonstration projects under this section, the Secretary shall direct that projects be employed by group health plans and practices under State plans for medical assistance under the medicaid program under title XIX of the Social Security Act and the Secretary shall self-direct the provision of personal care services.

(2) Scope of Services.—The Secretary shall determine the appropriate scope of personal care services that would apply under the demonstration projects.

(c) Voluntary Participation.—Participation of Medicare beneficiaries in the demonstration projects shall be voluntary. Demonstration Projects Sites.—Not later than 2 years after the date of the enactment of this Act, the Secretary shall conduct no fewer than 3 demonstration projects established under this section. Of those demonstration projects, the Secretary shall conduct at least one in each of the following areas:

(1) An urban area.

(2) A rural area.

(3) An area that the Secretary determines has a Medicare population with a rate of incidence of diabetes that significantly exceeds the national average rate of all areas.

(d) Evaluation and Report.—

(1) Evaluations.—The Secretary shall conduct evaluations of the clinical and cost effectiveness of the demonstration projects.

(2) Reports.—Not later than 2 years after the commencement of the demonstration projects, and annually thereafter, the Secretary shall submit a report on the evaluation, and shall include in the report the following:

(A) An analysis of the patient outcomes and costs of furnishing care to the Medicare beneficiaries participating in the projects as compared to such outcomes and costs to other beneficiaries for the same health conditions.

(B) Evaluation of patient satisfaction under the demonstration projects.

(C) Such recommendations regarding the extension, expansion, or termination of the projects as the Secretary determines appropriate.

(e) Rulemaking Authority.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administrator. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code. The Administrator shall provide for the issuance of new regulations to carry out parts C, D, and E.

(f) Authority to Establish Organizational Units.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administrator as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all officers and employees of the Administration who shall have the same force and effect as though performed or rendered by the Administrator.

(g) Term of Office.—The Administrator shall be appointed for a term of 4 years. In any case in which a successor does not take office at the end of the Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of a successor's term of office shall have authority and control over all personnel and activities thereunder.

(h) Rulemaking Authority.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administrator. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code. The Administrator shall provide for the issuance of new regulations to carry out parts C, D, and E.

(i) Authority to Establish Organizational Units.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administrator as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all officers and employees of the Administration who shall have the same force and effect as though performed or rendered by the Administrator.

(j) Term of Office.—The Administrator shall be appointed for a term of 4 years. In any case in which a successor does not take office at the end of the Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of a successor's term of office shall have authority and control over all personnel and activities thereunder.

(k) Rulemaking Authority.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administrator. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code. The Administrator shall provide for the issuance of new regulations to carry out parts C, D, and E.

(l) Authority to Establish Organizational Units.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administrator as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all officers and employees of the Administration who shall have the same force and effect as though performed or rendered by the Administrator.

(m) Term of Office.—The Administrator shall be appointed for a term of 4 years. In any case in which a successor does not take office at the end of the Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of a successor's term of office shall have authority and control over all personnel and activities thereunder.

(n) Rulemaking Authority.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Administrator. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code. The Administrator shall provide for the issuance of new regulations to carry out parts C, D, and E.

(o) Authority to Establish Organizational Units.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Administrator as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all officers and employees of the Administration who shall have the same force and effect as though performed or rendered by the Administrator.
expertise in the actuarial sciences. The Chief Actuary may be removed only for cause.

(B) COMPENSATION.—The Chief Actuary shall be compensated at the highest rate of basic pay payable to an employee of the Executive Service under section 3302 of title 5, United States Code.

(C) DUTIES.—The Chief Actuary shall exercise such duties as are appropriate for the office of the Chief Actuary and in accordance with professional standards of actuarial independence.

(4) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—(A) In general.—The Secretary shall ensure appropriate coordination between the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

(B) General.—(i) The Secretary, the Administrator, and the Administrator of the Centers for Medicare & Medicaid Services shall coordinate the administration of parts C, D, and E of title XVIII, the Medicare Advantage program under part C, the Voluntary Prescription Drug Benefit Program under part D, and the Enhanced Fee-for-Service program under part E.

(ii) The Secretary shall establish an appropriate transition of functions, authorities, and responsibilities among the Centers for Medicare & Medicaid Services and the Medicare Benefits Administration for the administration of parts C, D, and E.

(iii) In carrying out the duties referred to in paragraph (i), the Secretary shall ensure appropriate coordination between the Centers for Medicare & Medicaid Services and the Medicare Benefits Administration with respect to the administration of parts C, D, and E.

(C) LIMITATION ON Full -TIME EQUIVALENT EMPLOYMENT.—(i) In general.—The Secretary may not employ under this paragraph a number of full-time equivalent employees that exceeds the number of such full-time equivalent employees authorized to be employed by the Centers for Medicare & Medicaid Services.

(ii) Time frame.—The Secretary shall make an appropriate transition under this subparagraph of the number of full-time equivalent employees to the Centers for Medicare & Medicaid Services, that exceeds the number of such full-time equivalent employees authorized to be employed by the Centers for Medicare & Medicaid Services, to the Medicare Benefits Administration.

(D) NONINTERFERENCE.—The Centers for Medicare & Medicaid Services shall not interfere in any way with the provision of primary care services to such beneficiaries through the use of a managed care organization or through the provision of primary care services by any other entity with appropriate such care coordination projects carried out in part or in whole under such title, the programs of all-inclusive care for the elderly (PACE program) under section 1894 of the Social Security Act.

(E) INTERVENTION.—Nothing in this title shall be construed to prohibit the Medicare Benefits Administration from notifying the Secretary that the Medicare Benefits Administration has determined appropriate transition of functions, authorities, and responsibilities among the Centers for Medicare & Medicaid Services and the Medicare Benefits Administration with respect to the administration of parts C, D, and E.

(F) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Centers for Medicare & Medicaid Services transfers to the Medicare Benefits Administration such reports as the Board deems appropriate before the Medicare Benefits Administration with respect to the administration of parts C, D, and E.

(G) LIMITATION ON FULL -TIME EQUIVALENT EMPLOYMENT.—The Secretary may not employ under this paragraph a number of full-time equivalent employees that exceeds the number of such full-time equivalent employees authorized to be employed by the Centers for Medicare & Medicaid Services.

(H) NONINTERFERENCE.—Nothing in this title shall be construed to prohibit the Medicare Benefits Administration from notifying the Secretary that the Medicare Benefits Administration has determined appropriate transition of functions, authorities, and responsibilities among the Centers for Medicare & Medicaid Services and the Medicare Benefits Administration with respect to the administration of parts C, D, and E.

(I) IMPLEMENTATION OF RISK -ADJUSTED PAYMENT METHODS.—The Secretary shall establish an appropriate transition of functions, authorities, and responsibilities among the Centers for Medicare & Medicaid Services and the Medicare Benefits Administration with respect to the administration of parts C, D, and E.

(J) IMPLEMENTATION OF RISK -ADJUSTED PAYMENT METHODS.—The Secretary shall establish an appropriate transition of functions, authorities, and responsibilities among the Centers for Medicare & Medicaid Services and the Medicare Benefits Administration with respect to the administration of parts C, D, and E.

(K) IMPLEMENTATION OF RISK -ADJUSTED PAYMENT METHODS.—The Secretary shall establish an appropriate transition of functions, authorities, and responsibilities among the Centers for Medicare & Medicaid Services and the Medicare Benefits Administration with respect to the administration of parts C, D, and E.

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(N) IMPLEMENTATION OF RISK -ADJUSTED PAYMENT METHODS.—The Secretary shall establish an appropriate transition of functions, authorities, and responsibilities among the Centers for Medicare & Medicaid Services and the Medicare Benefits Administration with respect to the administration of parts C, D, and E.
(d) The term 'supplier' means, unless the context otherwise requires, a physician or other practitioner, a facility, or other entity (other than a provider of services) that furnishes items or services under this title.

(2) EFFECTIVE DATE.—The amendment made by this paragraph take effect on January 1, 2004.
(b) LIMITATIONS ON NEW MATTER IN FINAL REGULATIONS.—

(1) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)), as amended by section (a), is amended by adding at the end the following new paragraph:

"(4) If the Secretary publishes a final regulation that includes a provision that is not a logical or necessary outgrowth of a previously published notice of proposed rulemaking or interim final rule, such provision shall be treated as a proposed regulation and shall not take effect until the further opportunity for public comment and a publication of the provision again as a final regulation."

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to final regulations published on or after the date of the enactment of this Act.

SEC. 903. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh), as amended by section 902(a), is amended by adding at the end the following new subsection:

"(e) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be made (by way of re-interpretation or otherwise) retroactively to items and services furnished prior to the effective date of the change, unless the Secretary determines that—

"(i) such retroactive application is necessary to comply with statutory requirements; or

"(ii) failure to apply the change retroactively would be contrary to the public interest.

"(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes made by subsection (a), is amended by adding after such subsection the following:

"(1) IN GENERAL.—Section 1871(e)(1), as amended by subsection (a), is further amended by adding at the end the following new paragraph:

"(i) a provider of services or supplier follows the written guidance (which may be transmitted electronically) provided by the Secretary or by a Medicare contractor (as defined in section 1889(g)) acting within the scope of the contractor's authority, and otherwise in accordance with the furnishing of items or services and submission of a claim for benefits for such items or services with respect to such provider or supplier;

"(ii) the Secretary determines that the provider of services or supplier has accurately presented the circumstances relating to such items, services, and claim to the contractor in question;

"(iii) the guidance was in error; the provider of services or supplier shall not be subject to any penalty or requirement for repayment of any amount if the provider of services or supplier reasonably relied on such guidance.

"(2) Subparagraph (A) shall be construed as preventing the recoupment or repayment (without any additional penalty) relating to an overpayment as follows: the overpayment was solely the result of a clerical or technical operational error.

"(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act but shall not apply to any sanction for which notice was provided on or before the date of the enactment of this Act.

SEC. 904. REPORTS AND STUDIES RELATING TO REGULATORY REFORM.

(a) GAO STUDY ON ADVISORY OPINION AUTHORITY.—

"(1) STUDY.—The Comptroller General of the United States shall conduct a study to determine to what extent the necessity of establishing in the Secretary authority to provide legally binding advisory opinions on appropriate interpretation and application of regulations to carry out the Medicare program under title XVIII of the Social Security Act. Such study shall examine the appropriate timeframe for issuing such advisory opinions to provide the Secretary with the necessary additional staff and funding to provide such opinions.

"(2) REPORT.—The Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) by not later than one year after the date of the enactment of this Act.

(b) REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.—Section 1871 (42 U.S.C. 1395hh), as amended by section 2(a), is amended by adding at the end the following new subsection:

"(f)(1) Not later than 2 years after the date of enactment of this Act, the Secretary shall submit to Congress a report with respect to the performance of any or all of the following functions:

"(1) Collecting—

"(A) information from individuals entitled to benefits under part A or enrolled under part B, or both, that is necessary to determine the coverage of such benefits; and

"(B) information from Medicare contractors that tracks the nature of written and telephone inquiries.

"(2) A report under paragraph (1) shall include a description by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines as necessary for the title and otherwise to qualify as providers of services or suppliers.

"(2) DETERMINATION OF PAYMENT AMOUNTS.—(A) BENEFICIARY EDUCATION AND ASSISTANCE.—Section 1871(e), as amended by section 902(a), is amended by adding at the end the following:

"(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal necessity for the title and otherwise to qualify as providers of services or suppliers.

"(E) COMMUNICATION WITH PROVIDERS.—Publishing conveying to providers of services and suppliers any information or instructions furnished to the Medicare administrative..."
contractor by the Secretary, and facilitating communication between such providers and suppliers and the Secretary.

(3) PERFORMANCE REQUIREMENTS.—

(1) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—In developing contract performance requirements, the Secretary shall develop performance requirements applicable to functions described in subsection (a)(4).

(2) CONSULTATION.—In developing such requirements, the Secretary may consult with—

(A) the providers of services and suppliers of services; and

(B) certain contractors; and

(3) CERTIFYING OFFICER.—

(A) IN GENERAL.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payment by such officer under this section if—

(i) the officer acts in good faith; or

(ii) the officer's approval of a claim for payment was made in the absence of the reckless disregard of the officer's obligations or the intent by such officer to defraud the United States.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed—

(A) to require the Secretary to accept a claim for payment before a determination that the claim is entitled to payment; or

(B) to preclude the Secretary from denying a claim for payment where the Secretary determines that the claim is not entitled to payment.

(5) RELATIONSHIP TO MIP CONTRACTS.—

(A) NONREPLACEMENT OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of Medicare administrative contractors in carrying out activities under parts A and B and under title XIX of the Social Security Act under the Medicare Integrity Program under section 1893 (under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payment by such officer under this section if—

(i) the officer acts in good faith; or

(ii) the officer's approval of a claim for payment was made in the absence of the reckless disregard of the officer's obligations or the intent by such officer to defraud the United States.

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(i) the officer acts in good faith; or

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(i) the officer acts in good faith; or

(ii) the officer's approval of a claim for payment was made in the absence of the reckless disregard of the officer's obligations or the intent by such officer to defraud the United States.

(4) CONSTRUCTION.—Nothing in this subsection shall be construed—

(A) to require the Secretary to accept a claim for payment before a determination that the claim is entitled to payment; or

(B) to preclude the Secretary from denying a claim for payment where the Secretary determines that the claim is not entitled to payment.

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(A) NONREPLACEMENT OF DUTIES.—In entering into contracts under this section, the Secretary shall assure that functions of Medicare administrative contractors in carrying out activities under parts A and B and under title XIX of the Social Security Act under the Medicare Integrity Program under section 1893 (under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payment by such officer under this section if—

(i) the officer acts in good faith; or

(ii) the officer's approval of a claim for payment was made in the absence of the reckless disregard of the officer's obligations or the intent by such officer to defraud the United States.
standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of the enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES.—Section 1816 (42 U.S.C. 1395n) is amended as follows:

(1) The heading is amended to read as follows:

"PROVISIONS RELATING TO THE ADMINISTRATION OF PART A":

(2) Subsection (a) is amended to read as follows:

"(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.

(b) Subsection (b) is repealed.

(c) Subsection (c) is amended—

(i) by striking paragraph (1); and

(ii) by striking subparagraphs (A), (B), (F), and (G) in paragraph (2), by striking "such agency or organization" and inserting "medicare administrative contractor" each place it appears.

(d) Subsection (d) is repealed.

(e) Subsections (j) and (k) are each amended—

(i) by striking "agreement under this part"; and

(ii) by striking "carrier" and inserting "medicare administrative contractor" each place it appears.

(f) Subsection (e) is amended—

(i) by striking subparagraphs (A) and (B); and

(ii) by striking subparagraphs (C) in paragraph (2)—

(1) by striking "agreement with the Secretary under subsection (a)(1)(B)," and inserting "contract under this section which provides for making payments under this part"; and

(2) by striking "carrier or carriers" and inserting "medicare administrative contractor or contractors".

(g) Subsection (f) is amended—

(i) by striking subparagraphs (A) and (B); and

(ii) by striking subparagraph (C), by striking "the contractor" and inserting "the Secretary".

(h) Subsection (g) is amended—

(i) by striking "the contractor" and inserting "the Secretary"; and

(ii) by striking "carrier" and inserting "medicare administrative contractor".

(i) Subsection (h) is amended—

(i) by striking subparagraph (I); and

(ii) by striking subparagraph (J).

(j) Subsection (i) is amended—

(i) by striking subparagraph (A); and

(ii) by striking subparagraph (B).

(k) Subsection (j) is amended—

(i) by striking subparagraph (A); and

(ii) by striking subparagraph (B).

(l) Subsection (k) is amended—

(i) by striking subparagraph (A); and

(ii) by striking subparagraph (B).

(m) Subsection (l) is amended—

(i) by striking subparagraph (A); and

(ii) by striking subparagraph (B).

(n) Subsection (m) is amended—

(i) by striking subparagraph (A); and

(ii) by striking subparagraph (B).

(o) Subsection (n) is amended—

(i) by striking subparagraph (A); and

(ii) by striking subparagraph (B).

(p) Subsection (o) is amended—

(i) by striking subparagraph (A); and

(ii) by striking subparagraph (B).

(q) Subsection (q) is amended—

(i) by striking subparagraph (A); and

(ii) by striking subparagraph (B).
SEC. 912. REQUIREMENTS FOR INFORMATION SECURITY FOR MEDICARE ADMINISTRATIVE CONTRACTORS.

(a) In General.—Section 1874A, as added by section 1811(a)(2) of the Social Security Act, is amended by adding at the end the following new subsection:

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(e) REQUIREMENTS FOR INFORMATION SECURITY.—
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(1) DEVELOPMENT OF INFORMATION SECURITY PROGRAM.—A medicare administrative contractor that performs the functions referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) shall implement an contractor-wide information security program to provide information security for the operation and assessment of the contractor's information systems of contractors and rules of the Department of Health and Human Services shall submit to Congress annual reports on the results of such evaluations, including assessments of the scope and sufficiency of such evaluations.
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(2) INDEPENDENT AUDITS.—
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(A) PERFORMANCE OF ANNUAL EVALUATIONS.—Each year a medicare administrative contractor covered by this subsection that has not previously been referred to in subparagraphs (A) and (B) of subsection (a)(4) (relating to determining and making payments) as a fiscal intermediary or carrier under section 1842 of such Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395h) in the same manner as they apply to medicare administrative contractors under such provisions.
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(B) DEADLINE FOR INITIAL EVALUATION.—In the case of such a fiscal intermediary or carrier with respect to such functions under this title that is not described in paragraph (1) pursuant to paragraph (1), shall be completed (and on the report submitted to the Secretary) by not later than 1 year after such such provision.
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(3) REPORT.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that describes how the Secretary intends to use the information referred to in this subsection (g) for claims processing and for those individuals entitled under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.
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(4) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that each medicare administrative contractor shall provide, for those providers of services and suppliers which submit claims for claims processing and for those individuals entitled under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries.
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(f) COMMUNICATIONS WITH BENEFICIARIES, PROVIDERS OF SERVICES AND SUPPLIERS.—
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(A) COMMUNICATIONS.—The Secretary shall establish a system for identifying who provides the information referred to in paragraph (1) or (2) in a clear, concise, and accurate manner to inquiries of providers of services, suppliers and individuals entitled to benefits under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such such provision.
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(B) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—
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SEC. 913. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.
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(f) MONITORING OF CONTRACTOR PERFORMANCE.—
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(1) IN GENERAL.—Section 1874A, as added by section 1811(a)(1) and as amended by section 1812(a) and subsection (b), is further amended by adding at the end the following new subsection:
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(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.
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(3) REPORT.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of program under section 1889(a) of the Social Security Act, as added by paragraph (1).
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(1) PROVIDER EDUCATION ASSISTANCE.—
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(2) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(f) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and each carrier under section 1842 of such Act (42 U.S.C. 1395h) in the same manner as they apply to medicare administrative contractors under such such provision.
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(3) APPOINTMENT OF REVIEW.—The Secretary shall, in conducting reviews of the activities of such providers of services and suppliers which submit claims for claims processing and for those individuals entitled under part A or enrolled under part B, or both, concerning the programs under this title within 45 business days of the date of receipt of such inquiries, monitor the accuracy, consistency, and timeliness of the information so provided.
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(B) DEVELOPMENT OF STANDARDS.—
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(1) IN GENERAL.—The Secretary shall establish and make public standards to monitor the accuracy, consistency, and timeliness of the information provided in response to written and telephone inquiries under this section. Such standards shall be consistent with the performance requirements established under subsection (b).
(ii) EVALUATION.—In conducting evaluations of individual Medicare administrative contractors, the Secretary shall take into account the results of the monitoring conducted under subparagraph (A) (taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services or suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(3) APPLICATION TO FISCAL INTERMEDIARIES AND CARRIERS.—The provisions of section 1874A(g) of the Social Security Act, as added by paragraph (1), shall apply to each fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395f) and each Medicare contractor under section 1874 of such Act (42 U.S.C. 1395cc) in the same manner as they apply to Medicare administrative contractors under such provisions.

(D) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(I) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (d) and (e), is further amended by adding at the end the following new subsections:

(b) ENHANCED EDUCATION AND TRAINING.—

(1) ADDITIONAL RESOURCES.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) $25,000,000 for each of fiscal years 2005 and 2006 and such sums as may be necessary for succeeding fiscal years.

(2) USE.—The funds made available under paragraph (1) shall be used to increase the conduct by Medicare contractors of education and training of providers of services and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses.

(c) DESCRIPTION OF TECHNICAL ASSISTANCE ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

(I) IN GENERAL.—Insofar as a Medicare contractor conducts education and training activities, it shall tailor such activities to meet the special needs of small providers of services or suppliers (as defined in paragraph (2)).

(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this section, the term ‘small provider of services or supplier’ means—

(A) a provider of services with fewer than 25 full-time-equivalent employees;

(B) a supplier with fewer than 10 full-time-equivalent employees.

(D) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(E) REQUIREMENT TO MAINTAIN INTERNET SITES.—

(I) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (d), is further amended by adding at the end the following new subsection:

(d) INTERNET SITES; FAQ S.—The Secretary, and each Medicare contractor, shall maintain an Internet site which—

(A) provides answers in an easily accessible format to frequently asked questions, and

(B) includes other published materials of the contractor, that relate to providers of services and suppliers under the programs under this title (including title XI if insofar as it relates to such programs)."

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(F) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(I) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsections (d) and (e), is further amended by adding at the end the following new subsections:

(e) ENCOURAGEMENT OF EDUCATION PROGRAM ACTIVITIES.—A Medicare contractor may not use a record of attendance at (or failure to attend) education and training programs for a small provider of services or supplier that was gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of services or suppliers for the purpose of conducting any type of audit or prepayment review.

(F) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a Medicare contractor of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

(1) DEFINITIONS.—For purposes of this section, the term ‘Medicare contractor’ includes the following:

(I) A Medicare administrative contractor with a contract under section 1874A, including a fiscal intermediary with a contract under section 1816 and a carrier with a contract under section 1842.

(2) An eligible entity with a contract under section 1874A.

Such term does not include, with respect to activities of a specific provider of services or supplier an entity that has no authority under this title or title XI with respect to such activities and such provider of services or supplier.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of the enactment of this Act.

SEC. 922. SMALL PROVIDER TECHNICAL ASSISTANCE PROGRAM.

(a) ESTABLISHMENT.—

(I) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the demonstration program’) under which technical assistance described in paragraph (2) is made available, upon request and on a voluntary basis, to small providers of services or suppliers in order to improve compliance with the applicable requirements of the programs under Medicare program under title XVIII of the Social Security Act (including provisions of title XI of such Act insofar as they relate to such title and are not administered by the Office of the Inspector General of the Department of Health and Human Services).

(2) FORMS OF TECHNICAL ASSISTANCE.—The technical assistance described in this paragraph is—

(A) evaluation and recommendations regarding billing and related systems; and

(B) information and assistance regarding policies and procedures under the Medicare program, including coding and reimbursements.

(3) SMALL PROVIDERS OF SERVICES OR SUPPLIERS.—In this section, 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.

(I) QUALIFICATION OF CONTRACTORS.—In conducting the demonstration program, the Secretary shall enter into contracts with qualified organizations (such as peer review organizations or entities described in section 1889(g)(2) of the Social Security Act, as in effect on the date of enactment of this Act) that have expertise with billing systems of the full range of providers of services and suppliers to provide the technical assistance. In awarding such contracts, the Secretary shall consider any prior investigations of the entity’s work by the Inspector General of the Department of Health and Human Services or the Comptroller General of the United States.

(C) DESCRIPTION OF TECHNICAL ASSISTANCE.—The technical assistance provided under the demonstration program shall include a determination of the operation of billing systems and internal controls of small providers of services or suppliers to determine program compliance and to suggest more effective or efficient means of achieving such compliance.

(D) AVOIDANCE OF RECOVERY ACTIONS FOR PROBLEMS IDENTIFIED AS CORRECTED.—The Secretary shall provide that, absent evidence of fraud and notwithstanding any other provision of law, any errors found in a compliance review for a small provider of services or supplier that participates in the demonstration program shall not be subject to recovery action if the technical assistance personnel under the program determine that—

(I) the problem that is the subject of the compliance review has been corrected to the satisfaction of the technical assistance personnel, or

(2) such problem remains corrected for such period as the Secretary determines is appropriate.

The previous sentence applies only to claims filed as part of the demonstration program and lasts only for the duration of such program. Only one small provider of services or supplier is a participant in such program.

(4) EFFECTIVE DATE.—Not later than 2 years after the date of the date the demonstration program is first implemented, the Comptroller General, in consultation with the Inspector General of the Department of Health and Human Services, shall conduct an evaluation of the demonstration program. The evaluation shall include a determination of whether such assistance and contracts are appropriately designed for small providers of services or suppliers who participated in the program and the extent of improper payments made as a result of the demonstration program. The Comptroller General shall submit a report to the Secretary and the Congress on such evaluation and shall include in such report recommendations regarding the continuation or extension of the demonstration program.

(f) FINANCIAL PARTICIPATION BY PROVIDERS.—The provision of technical assistance under this section for 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 assessed in a manner consistent with the provider’s participation in the program) to be equal to 25 percent of the cost of the technical assistance.

(g) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to carry out the demonstration program—

(I) for fiscal year 2005, $1,000,000; and

(II) for fiscal year 2006, $6,000,000.

SEC. 923. MEDICARE PROVIDER OMBUDSMAN; MEDICARE BENEFICIARY OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1889 (42 U.S.C. 1395ee) is amended—
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(1) by adding at the end of the heading the following: "MEDICARE PROVIDER OMBUDSMAN;"

(2) by inserting "PRACTICING PHYSICIAN ADVISOR OR CONCILIATOR."—"(1)" after "(a);"

(3) in paragraph (1), as so redesignated under paragraph (2), by striking "in this section" and inserting "in this subsection;"

(4) subject to subsection (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 questions, complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medical 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)

recommending to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration),
\]

and

\[(b)

regarding to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.
\]

The Ombudsman shall not serve as an advocate for any increases in payments or new coverage of services, but may identify issues and problems in payment or coverage policies.

(c) WORKING WITH HEALTH INSURANCE COUNSELING PROGRAMS.—To the extent possible, the Ombudsman shall work with health insurance counseling programs (receiving funds under section 436 of Omnibus Budget Reconciliation Act of 1990) to facilitate the provision of information to individuals entitled to benefits under part A or enrolled under part B, or both regarding Medicare-Choice plans and changes to those plans. Nothing in this subsection shall preclude further collaboration between the Ombudsman and such programs.

(d) DEADLINE FOR APPOINTMENT.—The Secretary shall appoint the Medicare Provider Ombudsman and the Medicare Beneficiary Ombudsman, under the amendments made by subsections (a) and (b), respectively, not later than 1 year after the date of the enactment of this Act.

(e) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund, the Federal Supplementary Medical Insurance Trust Fund) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5) and section 1807 of such Act (relating to the Medicare Beneficiary Ombudsman), as added by subsection (a)(6), such sums as may be necessary for the fiscal year 2004 and each succeeding fiscal year.

(f) USE OF CENTRAL TOLL-FREE NUMBER (1-800-MEDICARE).—

(1) PHONE TRIAGE SYSTEM; LISTING IN MEDICARE HANDBOOK INSTEAD OF OTHER TOLL-FREE NUMBERS.—Section 1807(b)(4)(D)(v) of title XVIII of the Social Security Act is amended by inserting after "toll-free number" the following: "and covered under part B, or both regarding Medicare-Choice plans and changes to those plans."

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under this Act, or enrolled under part B, or both regarding Medicare-Choice plans and changes to those plans. Nothing in this subsection shall preclude further collaboration between the Ombudsman and such programs.

(3) ENSURE THAT MEDICARE BENEFICIARIES HAVE THE RIGHT TO SEEK AN INDEPENDENT DEGREE OF INVESTIGATION OF FRAUD AND ABUSE.—The Ombudsman shall publically provide information that enables hospital discharge planners, medicare beneficiaries, and the public to identify skilled nursing facilities that are participating in the medicare program.

(g) INCLUSION OF INFORMATION IN CERTAIN NOTICES TO BENEFICIARIES.—(1) GENERAL.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395d–2(e), as added by this Act) with respect to the provision of post-hospital extended care services under part A of title XVIII of the Social Security Act, there shall be included information that the number of days of coverage of such services remaining under such part for the medicare beneficiary at the spell of illness involved.

(h) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 925. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN THE HOSPITAL DISCHARGE PLANS.

(a) AVAILABILITY OF DATA.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395d–2(e), as added by this Act) with respect to the provision of post-hospital extended care services under part A of title XVIII of the Social Security Act, there shall be included information that the number of days of coverage of such services remaining under such part for the medicare beneficiary at the spell of illness involved.

(b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL DISCHARGE PLANS.—

(a) IN GENERAL.—Section 1812(a)(2)(D) of title XVIII of the Social Security Act (42 U.S.C. 1395x–1(a)(2)(D)) is amended by inserting before "services", as added by this Act, such services, and the public to identify skilled nursing facilities that are participating in the medicare program.

(b) INCLUSION OF INFORMATION IN CERTAIN HOSPITAL DISCHARGE PLANS.—

(a) IN GENERAL.—Section 1812(a)(2)(D) of title XVIII of the Social Security Act (42 U.S.C. 1395x–1(a)(2)(D)) is amended by inserting before "services", as added by this Act, such services, and the public to identify skilled nursing facilities that are participating in the medicare program.

SEC. 924. BENEFICIARY OUTREACH DEMONSTRATION PROGRAM.

(a) IN GENERAL.—The Secretary shall establish a demonstration program (in this section referred to as the “demonstration program”) under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to individuals entitled to benefits under part A or enrolled under part B, or both, regarding the medicare program at the location of existing local offices of the Social Security Administration.

(b) LOCATIONS.—

(1) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to paragraph (2), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by individuals referred to the Secretary.

(2) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(c) DURATION.—The demonstration program shall be conducted over a 3-year period.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

\[(A)

utilization of, and satisfaction of those individuals referred to in subsection (a) with, the assistance provided under the program; and
\]

\[(B)

the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local offices of the Social Security Administration.
\]

SEC. 923. INCLUSION OF ADDITIONAL INFORMATION IN NOTICES TO BENEFICIARIES ABOUT SKILLED NURSING FACILITY INSPECTIONS.

(a) IN GENERAL.—The Secretary shall provide that in medicare beneficiary notices provided (under section 1806(a) of the Social Security Act, 42 U.S.C. 1395d–2(e), as added by this Act) with respect to the provision of post-hospital extended care services under part A of title XVIII of the Social Security Act, there shall be included information that the number of days of coverage of such services remaining under such part for the medicare beneficiary at the spell of illness involved.

(b) EFFECTIVE DATE.—Subsection (a) shall apply to notices provided during calendar quarters beginning more than 6 months after the date of the enactment of this Act.

SEC. 926. INFORMATION ON MEDICARE-CERTIFIED SKILLED NURSING FACILITIES IN THE HOSPITAL DISCHARGE PLANS.
(2) Effective date.—The amendments made by paragraph (1) shall apply to discharge plans made on or after such date as the Secretary shall specify, but not later than December 17, 2004. In making such determination by such review panel shall be considered a final decision and not subject to review by the Secretary.

(3) Increased financial support.—In addition to any amounts otherwise appropriated, there may be authorized before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (as amended by section 521 of BIPA, 114 Stat. 2763-534), 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—

(a) increase the number of administrative law judges (and their staffs) under subsection (b)(4); and

(b) improve education and training opportunities for administrative law judges (and their staffs); and

(c) increase the staff of the Departmental Appeals Board.


(1) in paragraph (3)(A), by inserting '', subject to paragraph (2),'' before ''to judicial review under the process established by the Secretary of Health and Human Services;''

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

(3) Increased financial support.—In addition to any amounts otherwise appropriated, there may be appropriated before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (as amended by section 523 of BIPA, 114 Stat. 2763-534), 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—

(a) increase the number of administrative law judges (and their staffs) under subsection (b)(4); and

(b) improve education and training opportunities for administrative law judges (and their staffs); and

(c) increase the staff of the Departmental Appeals Board.


(1) in paragraph (3)(A), by inserting '', subject to paragraph (2),'' before ''to judicial review under the process established by the Secretary of Health and Human Services;''

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

(3) Increased financial support.—In addition to any amounts otherwise appropriated, there may be appropriated before administrative law judges and the Departmental Appeals Board consistent with section 1869 of the Social Security Act (as amended by section 523 of BIPA, 114 Stat. 2763-534), 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—

(a) increase the number of administrative law judges (and their staffs) under subsection (b)(4); and

(b) improve education and training opportunities for administrative law judges (and their staffs); and

(c) increase the staff of the Departmental Appeals Board.
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proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which the remedy of termination of participation, or a remedy described in clause (i) or (ii) of section 1869(f)(2)(B) of the Act (42 U.S.C. 1395f(f)(2)(B)) which is applied on an immediate basis, has been imposed. Under such process priority shall be provided in cases so determined.

(2) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated part from the Federal Hospital Insurance Trust Fund (42 U.S.C. 1395f(f)(2)(B)).

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 health care professionals in Medicare and Medicaid appeals.

(3) PROCESS FOR REINSTATEMENT OF APPROVAL OF CERTAIN SNF TRAINING PROGRAMS.—

(a) IN GENERAL.—In the case of a termination of approval of a nurse aide training program described in paragraph (2) of a skill nursing facility, the Secretary shall develop and implement a process for the reinstatement of approval of such program before the end of the 2 year disapproval period if the facility and program is certified by the Secretary, in coordination with the applicable State survey and certification agencies and after public notice, as being in substantial compliance with applicable rules and as having remedied any deficiencies in the facility or program that resulted in noncompliance.

(b) TERMINATION OF APPROVAL DESCRIBED.—

A termination of approval of a training program described in this paragraph is a mandatory 2 year disapproval provided for under section 1869(f)(2)(B) if the only basis for the mandatory disapproval was the assessment of a civil money penalty (relating to qualifications of reviewing professional) imposed.

SEC. 933. REVISIONS TO MEDICAID APPEALS PROCESS.

(a) REQUIRING FULL AND EARLY PRESENTATION OF EVIDENCE.—

(1) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by BIPA and as amended by section 932(a), is further amended by adding at the end the following new paragraph:

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on October 1, 2004.

(b) USE OF PATIENTS' MEDICAL RECORDS.—

Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)), as amended by BIPA, is amended by inserting ''(including the medical records of the individual involved)'' after ''clinical experience''.

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDECISIONS.—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) SUBMISSION OF RECORD FOR APPEAL.—

Section 1869(c)(3)(J)(i) (42 U.S.C. 1395ff(c)(3)(J)(i)) by striking ''prepare'' and inserting ''submit'' and by striking ''with reviewing professional'' and all that follows through ''and relevant policies''.

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS FOR QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(3)(C) (42 U.S.C. 1395ff(c)(3)), as amended by BIPA, is amended—

(A) in subparagraph (A), by striking ''sufficient medical, legal, and other expertise'' and inserting ''sufficient medical and legal expertise''; and

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

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"(K) INDEPENDENCE REQUIREMENTS.—

(i) IN GENERAL.—Subject to clause (ii), a qualified independent contractor shall not conduct any activities in a case unless the entity—

(II) is not a related party (as defined in subsection (g)(5));

(III) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

(iv) does not otherwise have a conflict of interest with such a party.

(ii) EXCEPTION FOR REASONABLE COMPENSATION.—Nothing in clause (i) shall be construed to prohibit a reviewing professional from rendering services to a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor under a contract with respect to an action 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. 1395f), as amended by BIPA, is amended—

(A) by amending subsection c(3)(D) to read as follows:

(1) REQUIREMENTS OF REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals); and

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

(3) 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); and

(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') in which an individual qualified independent contractor is a related party (as defined in subsection (g)(5)) of a reviewer, the reviewing professional meets the qualifications described in paragraphs (4) and (8) and, where a claim is regarding the furnishing of treatment by a physician (allopathic or osteopathic) or the provision of items or services by a physician (allopathic or osteopathic), a reviewing professional shall be a physician (allopathic or osteopathic).

(2) INDEPENDENCE.—

(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review shall—

(i) not be a related party (as defined in paragraph (5))

(ii) have no other conflict of interest with such a party.

(iii) prior to rendering any services, disclose to the contractor and to the individual or entity being reviewed any undisclosed conflict of interest known to the individual at the time of the disclosure.

(iv) comply with the requirements of this section and any standards established by the Secretary.

(B) REQUIREMENTS OF REVIEWERS.—

(1) IN GENERAL.—A reviewing professional shall—

(A) have no conflict of interest with such a party.

(B) have no material familial, financial, or professional relationship with such a party in relation to such case;

(C) have no other conflict of interest known to the reviewing professional at the time of the disclosure; and

(D) disclose any undisclosed conflict of interest known to the reviewing professional at the time of the disclosure.

(2) REQUIREMENTS OF REVIEWERS.—A reviewing professional shall—

(A) have no conflict of interest with such a party;

(B) have no material familial, financial, or professional relationship with such a party in relation to such case;

(C) have no other conflict of interest known to the reviewing professional at the time of the disclosure; and

(D) disclose any undisclosed conflict of interest known to the reviewing professional at the time of the disclosure.

(3) REQUIREMENTS OF REVIEWERS.—A reviewing professional shall—

(A) have no conflict of interest with such a party;

(B) have no material familial, financial, or professional relationship with such a party in relation to such case;

(C) have no other conflict of interest known to the reviewing professional at the time of the disclosure; and

(D) disclose any undisclosed conflict of interest known to the reviewing professional at the time of the disclosure.

(4) REQUIREMENTS OF REVIEWERS.—A reviewing professional shall—

(A) have no conflict of interest with such a party;

(B) have no material familial, financial, or professional relationship with such a party in relation to such case;

(C) have no other conflict of interest known to the reviewing professional at the time of the disclosure; and

(D) disclose any undisclosed conflict of interest known to the reviewing professional at the time of the disclosure.

(5) REQUIREMENTS OF REVIEWERS.—A reviewing professional shall—

(A) have no conflict of interest with such a party;

(B) have no material familial, financial, or professional relationship with such a party in relation to such case;

(C) have no other conflict of interest known to the reviewing professional at the time of the disclosure; and

(D) disclose any undisclosed conflict of interest known to the reviewing professional at the time of the disclosure.
(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

(iii) not otherwise have a conflict of interest, as defined by State law.

(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

(i) prohibit an individual, solely on the basis of the provision of services, from participating in a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional, or from being entitled to benefits under part A enrolled under part B, or both, (or authorized representative) and neither party objects; and

(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewing professional based 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 and has medical expertise in the field of practice that is appropriate for such items or services involved in the case.

(3) LIMITATIONS ON REVIEWER COMPENSATION.—The Secretary shall first conduct a random prepayment review of a provider of services or supplier for the previous cost reporting period. In the case of a provider of services or supplier for the cost reporting period, the Secretary shall conduct a random prepayment review of such provider or supplier any of the following:

(A) shall be construed to—

(i) the Secretary has reason to suspect that services or items or services or benefits under a provider of services or supplier for the previous cost reporting period.

(ii) review the identification by that provider of services or supplier for the previous cost reporting period for the overpayments exceeds 10 percent of the amount paid under this title to the provider of services or supplier for the repayment period, computed in accordance with regulations issued by the Secretary.

(iii) TREATMENT OF PREVIOUS OVERPAYMENT.—For purposes of this paragraph, the term 'overpayment' means the denial of payments for claims actually reviewed under a random prepayment review.
"(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

(E) NOTICE TO PROVIDER OF SERVICES OR SUPPLIER.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

(2) LIMITATION ON RECoupMENT.—(A) IN GENERAL.—In the case of a provider of services or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration by a qualified independent contractor on such determination and after the date of the original notice of overpayment, interest on the overpayment shall accrue on the provider of services or supplier, including any interest on 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) does not waive any appeal rights with respect to the alleged overpayment involved.

(2) LIMITATION ON RECoupMENT.—For purposes of subsection (a), in determining whether the term ‘‘consent settlement’’ means an agreement between the Secretary and a provider of services or supplier whereby both parties agree to a settlement based on less than a statistically valid sample of claims and the provider of services or supplier agrees not to appeal the claims involved.

(3) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services and suppliers, a process under which the Secretary provides for notice to classes of providers of services and suppliers, for selection of sample claims for abnormal billing codes and patterns. The Secretary may furnish additional information concerning the medical records for the claims that are at the discretion of the Secretary.

(4) STANDARD FOR ABNORMAL BILLING PATTERNS.—Not later than 1 year after the date of the enactment of this Act, the Secretary shall first establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1893(f)(8) of the Social Security Act, as added by subsection (a).

SEC. 936. PROVIDER ENROLLMENT PROCESS; RIGHT OF APPEAL.

(a) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended—

(1) by adding at the end the heading following: ‘‘ENROLLMENT PROCESSES’’;

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

(1) ENROLLMENT PROCESS FOR PROVIDERS OF SERVICES AND SUPPLIERS.—

(A) IN GENERAL.—The Secretary shall establish by regulation a process for the enrollment of providers of services and suppliers under this title.

(2) DEADLINES.—The Secretary shall establish by regulation procedures under which there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment) and the Secretary shall monitor the performance of Medicare administrative contractors in meeting the deadlines established under such subparagraph.

(3) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—The Secretary shall consult with providers of services and suppliers before making changes in the processes for enrollment of providers and suppliers to be eligible to submit claims for which payment may be made under this title.

(4) RIGHT OF REVIEW IN CASES OF DENIAL OR NON-RENEWAL.—A provider of services or supplier whose application to enroll (or, if applicable, to renew enrollment) under this title is denied may have a final review of such denial under the procedures that apply under subsection (h)(1)(A) to 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), applies to requests for repayment plans made after the date of the enactment of this Act.

(2) LIMITATION ON RECoupMENT.—Section 1893(f)(2) of the Social Security Act, as added by subsection (a), applies to statistically valid random samples initiated after the date of the enactment of this Act.
provider of services that is dissatisfied with a determination by the Secretary.".

**2. EFFECTIVE DATES.**

(1) ENROLLMENT PROCESS.—The Secretary shall establish and implement the enrollment process under section 1866(i)(1) of the Social Security Act, as added by subsection (a) and amended by subsection (c) of this section, not later than 18 months after the date of the enactment of this Act.

(2) CONSULTATION.—Section 1866(i)(1)(C) of the Social Security Act, as added by subsection (a) of this section and as amended by subsection (c) of this section, shall apply to any enrollment process that has been settled.''.

(42 U.S.C. 1395ww(d)(10)(D)(vi)) is amended by adding after subclause (II) at the end the following new matter:

(2) TRANSITION.—During the period in which this subsection is in effect, any changes in provider enrollment forms made by the Secretary shall apply to fiscal years beginning with fiscal year 2004.

(b) EFFECTIVE DATES.—The amendment made by paragraph (2) shall apply to fiscal years beginning with fiscal year 2004.

(3) SUBMITTAL AND RESUBMITTAL OF APPLICATIONS FOR PAYMENT WITHOUT PROOF OF ELIGIBILITY.—

(a) IN GENERAL.—Section 1866(d)(10)(D)(vi) (42 U.S.C. 1395ww(d)(10)(D)(vi)) is amended by adding after subclause (II) at the end the following

''(2) T RANSITION.—During the period in which this subsection is in effect, any changes in provider enrollment forms made by the Secretary shall apply to fiscal years beginning with fiscal year 2004.''

(b) EFFECTIVE DATES.—The amendment made by paragraph (2) shall apply to fiscal years beginning with fiscal year 2004.

(3) SUBMITTAL AND RESUBMITTAL OF APPLICATIONS FOR PAYMENT WITHOUT PROOF OF ELIGIBILITY.—

(a) IN GENERAL.—Section 1866(d)(10)(D)(vi) (42 U.S.C. 1395ww(d)(10)(D)(vi)) is amended by adding after subclause (II) at the end the following:

''(2) T RANSITION.—During the period in which this subsection is in effect, any changes in provider enrollment forms made by the Secretary shall apply to fiscal years beginning with fiscal year 2004.''

(b) EFFECTIVE DATES.—The amendment made by paragraph (2) shall apply to fiscal years beginning with fiscal year 2004.

(4) EFFECTIVE DATES.—

(1) EFFECTIVE DATE; TRANSITION.—During the period in which the amendment made by subsection (c) of this section is in effect, any changes in provider enrollment forms made by the Secretary shall apply to fiscal years beginning with fiscal year 2004.''

**3. SEC. 938. PRIOR DETERMINATION PROCESS FOR CERTAIN ITEMS AND SERVICES.**

(a) IN GENERAL.—Section 1866(d)(10)(D)(vi) (42 U.S.C. 1395ww(d)(10)(D)(vi)) is amended by adding after subclause (II) at the end the following:

''(4) EFFECTIVE DATES.—

(1) EFFECTIVE DATE; TRANSITION.—During the period in which the amendment made by subsection (c) of this section is in effect, any changes in provider enrollment forms made by the Secretary shall apply to fiscal years beginning with fiscal year 2004.''

(b) EFFECTIVE DATES.—The amendment made by paragraph (2) shall apply to fiscal years beginning with fiscal year 2004.

(3) EFFECTIVE DATES.—

(1) EFFECTIVE DATE; TRANSITION.—During the period in which the amendment made by subsection (c) of this section is in effect, any changes in provider enrollment forms made by the Secretary shall apply to fiscal years beginning with fiscal year 2004.''

(b) EFFECTIVE DATES.—The amendment made by paragraph (2) shall apply to fiscal years beginning with fiscal year 2004.

(4) EFFECTIVE DATES.—

(1) EFFECTIVE DATE; TRANSITION.—During the period in which the amendment made by subsection (c) of this section is in effect, any changes in provider enrollment forms made by the Secretary shall apply to fiscal years beginning with fiscal year 2004.''

(b) EFFECTIVE DATES.—The amendment made by paragraph (2) shall apply to fiscal years beginning with fiscal year 2004.
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(a) has become effective but contracts are not provided under section 1874A of the Social Security Act with Medicare administrative contractors, any reference in section 1886(d) of the Social Security Act (as added by such amendment) to such a contractor is deemed a reference to a fiscal intermediary or carrier with an agreement under section 1860 or contract under section 1882, respectively, of such Act.

(3) LIMITATION ON APPLICATION TO SGR.—For purposes of applying section 1887(f)(2)(D) of the Social Security Act (as added by such amendment), the amendment by subsection (a) shall not be considered to be a change in simplification.

(b) PROVISIONS RELATING TO ADVANCE BENEFICIARY NOTICES; REPORT ON PRIOR DETERMINATION PROCESS.—

(1) IN GENERAL.—The Secretary shall establish a process for the collection of information on the instances in which an advance beneficiary notice (as defined in paragraph (2)) is required and the manner 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 regarding the coverage policies under the Medicare program and reporting of overpayment demands or post-payment audits. Such program shall include notice and the response of beneficiaries to such notices.

(3) GAO REPORT REPORT ON USE OF ADVANCE BENEFICIARY NOTICES.—Not later than 18 months after the date on which section 1890(g) of the Social Security Act (as added by such amendment) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of advance beneficiary notices under title XVIII of such Act. Such report shall include information concerning the provisions of services and other persons on the appropriate use of advance beneficiary notices and coverage policies under the Medicare program.

(4) GAO REPORT REPORT ON USE OF PRIOR DETERMINATION PROCESS.—Not later than 18 months after the date on which section 1890(g) of the Social Security Act (as added by such amendment) takes effect, the Comptroller General of the United States shall submit to Congress a report on the use of the prior determination process under such section. Such report shall include—

(A) information concerning the types of procedures for which a prior determination has been sought, determinations made under the process, and changes in receipt of services resulting from the application of such process; and

(B) an evaluation of whether the process was useful for physicians (and other suppliers), beneficiaries, or both beneficiaries and beneficiaries.

(5) ADVANCE BENEFICIARY NOTICE DEFINED.—In this subsection, the term ‘advance beneficiary notice’ means a written notice provided under section 1874A(g) of the Social Security Act (as added by such amendment) to an individual entitled to benefits under part A or B of title XVIII of such Act before items or services are furnished under such part in cases where a beneficiary indicates on such notice that the item or service will not be furnished for such person.

Subtitle V—Miscellaneous Provisions

SEC. 941. POLICY DEVELOPMENT REGARDING EVALUATION AND MANAGEMENT OF 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 such guidelines are developed by the Secretary in consultation with, and approved by, the Medicare Payment Advisory Commission.

(b) DEVELOPMENT OF GUIDELINES.—(1) The Secretary shall develop guidelines for evaluation and management physician services under title XVIII of the Social Security Act.

(2) The Secretary shall ensure that such guidelines reflect the appropriate level of care for such services as determined by the Medicare Payment Advisory Commission.

(3) The Secretary shall ensure that the guidelines are developed in accordance with the provisions of section 1874(a) of the Social Security Act.

(c) IMPLEMENTATION.—The Secretary shall establish a program of outreach and education for beneficiaries and providers regarding the coverage policies under the Medicare program and the implementation of such guidelines.

(c) LIMITATION ON APPLICATION TO SGR.—For purposes of applying section 1887(f)(2)(D) of the Social Security Act (as added by such amendment), the amendment by subsection (a) shall not be considered to be a change in simplification.
Title II: Payment Systems

SEC. 917. TREATMENT OF HOSPITALS FOR CERTAIN MEDICAL SCREENING SERVICES.

(a) In General.—The Secretary shall not request a hospital (including a critical access hospital) to perform a medical screening examination for any item or service that is not furnished to the hospital in accordance with subdivision (c) of such item or service. The Secretary shall not impose on the hospital any requirement that the hospital furnish such item or service that is not furnished to the hospital in accordance with subdivision (c).

(b) Notification of Providers When EMTALA Investigation Closed.—Section 1862(o)(2)(A) of title 42, United States Code (amended by section 1890 of the Affordable Care Act), is amended by adding at the end the following paragraph:

"(2) REFERENCE LABORATORY SERVICES DEFINITION.—The term "reference laboratory services" means diagnosis and treatment of illnesses and injuries, and the provision of laboratory services in connection with such care and treatment."

SEC. 918. TREATMENT OF HOSPITALS FOR CERTAIN MEDICAL SCREENING SERVICES.

(a) In General.—Except in the case of any item or service that is furnished to the hospital in accordance with subdivision (c) of such item or service, the Secretary shall not request a hospital to furnish such item or service, and shall not impose any requirement that the hospital furnish such item or service, to the extent that the hospital has reason to believe that such item or service is not furnished to the hospital in accordance with subdivision (c).

(b) Notification of Providers When EMTALA Investigation Closed.—Section 1862(o)(2)(A) of title 42, United States Code (amended by section 1890 of the Affordable Care Act), is amended by adding at the end the following paragraph:

"(2) REFERENCE LABORATORY SERVICES DEFINITION.—The term "reference laboratory services" means diagnosis and treatment of illnesses and injuries, and the provision of laboratory services in connection with such care and treatment."

SEC. 919. TREATMENT OF HOSPITALS FOR CERTAIN MEDICAL SCREENING SERVICES.

(a) In General.—Except in the case of any item or service that is furnished to the hospital in accordance with subdivision (c) of such item or service, the Secretary shall not request a hospital to furnish such item or service, and shall not impose any requirement that the hospital furnish such item or service, to the extent that the hospital has reason to believe that such item or service is not furnished to the hospital in accordance with subdivision (c).

(b) Notification of Providers When EMTALA Investigation Closed.—Section 1862(o)(2)(A) of title 42, United States Code (amended by section 1890 of the Affordable Care Act), is amended by adding at the end the following paragraph:

"(2) REFERENCE LABORATORY SERVICES DEFINITION.—The term "reference laboratory services" means diagnosis and treatment of illnesses and injuries, and the provision of laboratory services in connection with such care and treatment."

SEC. 920. TREATMENT OF HOSPITALS FOR CERTAIN MEDICAL SCREENING SERVICES.

(a) In General.—Except in the case of any item or service that is furnished to the hospital in accordance with subdivision (c) of such item or service, the Secretary shall not request a hospital to furnish such item or service, and shall not impose any requirement that the hospital furnish such item or service, to the extent that the hospital has reason to believe that such item or service is not furnished to the hospital in accordance with subdivision (c).

(b) Notification of Providers When EMTALA Investigation Closed.—Section 1862(o)(2)(A) of title 42, United States Code (amended by section 1890 of the Affordable Care Act), is amended by adding at the end the following paragraph:

"(2) REFERENCE LABORATORY SERVICES DEFINITION.—The term "reference laboratory services" means diagnosis and treatment of illnesses and injuries, and the provision of laboratory services in connection with such care and treatment."
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 EMTALA and its implementing regulations.

(b) MEMBERSHIP.—The Advisory Group shall be composed of representatives of hospitals, including at least one hospital that has been identified for violation of EMTALA regulations.

(c) GENERAL RESPONSIBILITIES.—The Advisory Group shall: (1) review EMTALA regulations and the Public Health Service Act; (2) be representatives of hospitals, including one hospital that has been identified for violation of EMTALA regulations; (3) be staffed in EMTALA investigations conducted by CMS; and (4) be staffed in EMTALA investigations conducted by CMS.

(d) ADMINISTRATIVE MATTERS.—

(1) CHAIRPERSON.—The members of the Advisory Group shall elect a chairperson as the 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 Advisory Group shall meet twice per year and at such other times as the Advisory Group may provide.

(e) TERMINATION.—The Advisory Group shall terminate 30 months after the date of its first meeting.

(f) WAIVER OF ADMINISTRATIVE LIMITATION.—The Secretary shall establish the Advisory Group notwithstanding any limitation that may apply to the number of advisory committees that may be established (within the Department of Health and Human Services or otherwise).

SEC. 946. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE MEDICAL SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end of the section the following new paragraph:

"(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of natural disasters, 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)(I). The provisions of paragraph (2)(A)(iii)(I) shall apply with respect to the services provided under such arrangements."

(b) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice programs 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. 1395x(dd)) is amended by adding after subsection (b) the following new subsection:

"(c) IN GENERAL.—Section 1866 (42 U.S.C. 1395x(dd)) is amended by adding at the end of the section the following new paragraph:

"(d) In the case of hospitals that are not otherwise subject to the Occupational Safety and Health Act of 1970, to comply with the Bloodborne Pathogens standards under section 1910.1030 of title 29 of the Code of Federal Regulations (or as subsequently redesignated), and by adding at the end of subsection (b) the following new paragraph:

"(4)(A) A hospital that fails to comply with the requirement of subsection (a)(3)(B) (relating to the Bloodborne Pathogens standard) is subject to a civil money penalty in an amount described in subparagraph (B), but is not subject to notification of an agreement under this section.

"(B) The amount referred to in subparagraph (A) is an amount that is similar to the amount of civil penalties that may be imposed under the Occupational Safety and Health Act of 1970 for a violation of the Bloodborne Pathogens standard referred to in subsection (a)(3)(B) by a hospital that is subject to the provisions of such Act."
(h)(1) Subject to paragraph (2), a group health plan (as defined in subsection (a)(1)(A)(iv)) providing supplemental or secondary coverage to individuals also entitled to, or enrolled under, such title shall not require an individual to undergo a medicare claims determination under this title for dental benefits specifically excluded under subsection (a)(12) as a condition of making, or continuing, the election to receive such benefits under the group health plan.

(2) A group health plan may require that a medicare claims determination under this title be made on or after the date of the enactment of this Act, the Comptroller General shall submit to Congress a report on the implications if there were flexibility in the application of the medicare conditions of participation requirements for home health agencies with respect to groups or types of patients who are not medicare beneficiaries. The report shall include an analysis of the potential impact of such flexible application on clinical operations and the recipients of such services and an analysis of methods for monitoring the quality of care and outcomes.

(b) ANNUAL PUBLICATION OF LIST OF NATIONAL COVERAGE DETERMINATIONS.—The Secretary shall, in an appropriate manner, make available to the public a list of national coverage determinations made under title XVIII of the Social Security Act in the previous year and information on how to get more information with respect to such determinations.

(g) GA Report on Flexibility in Applying Use of Hospital Condition of Participation to Patients Who Are Not Medicare Beneficiaries.—No later than 6 months after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the implications if there were flexibility in the application of the medicare conditions of participation for home health agencies with respect to groups or types of patients who are not medicare beneficiaries. The report shall include an analysis of methods for monitoring the quality of care and outcomes.

(h) OIG Report on Notices Relating to Use of Hospital Lifetime Reserve Days.—No later than 1 year after the date of the enactment of this Act, the Inspector General shall submit to Congress a report on the implications if there were flexibility in the application of the medicare conditions of participation for home health agencies with respect to groups or types of patients who are not medicare beneficiaries. The report shall include an analysis of methods for monitoring the quality of care and outcomes.

(i) OIG Report on Notice Relating to Application of the Medicare Conditions of Participation to Non-Medicare/Non-Medicaid Beneficiaries.—No later than 1 year after the date of the enactment of this Act, the Inspector General shall submit to Congress a report on the implications if there were flexibility in the application of the medicare conditions of participation for home health agencies with respect to groups or types of patients who are not medicare beneficiaries. The report shall include an analysis of methods for monitoring the quality of care and outcomes.

SEC. 1101. 30-MONTH STAY-OF-EFFECTIVENESS ORDERKEEPING REQUIREMENTS.—With respect to actions taken by the Secretary.

SEC. 1102. CLARIFICATION OF INCLUSION OF INPATIENT PAYMENTS CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.—

(a) In General.—Section 1927(c)(1)(C)(i)(I) (42 U.S.C. 1396r–8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following:

"(including inpatient payments charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)"

(b) PERIOD OF SUSPENSION.—The period described in this subsection—

(1) begins on the date of the enactment of this Act; and

(2) ends on the last day of the 2nd month beginning after the date as of which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare and Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c).

(2) Study.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies to improve their performance.

(b) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.

TITLE XI—ACCESS TO AFFORDABLE PHARMACEUTICALS

Subtitle A—Access to Affordable Pharmaceuticals

SEC. 1101. 30-MONTH STAY-OF-EFFECTIVENESS ORDERKEEPING REQUIREMENTS.

(a) ABBREVIATED NEW DRUG APPLICATIONS.—Section 505(j) of the Federal Food,
(A) by striking subparagraph (B) and inserting the following:

"(B) by adding at the end the following sub-
paragraph:

"(I) if the certification is in the applica-
tion, that the applicant will give notice as re-
quired by this paragraph.

(ii) TIMING OF NOTICE.—An applicant that
makes a certification described in subpara-
graph (A)(vii)(IV) shall include in the applica-
tion a statement that the applicant will
give notice as required by this paragraph.

(iii) RECIPROCAL NOTICE.—An applicant
required under this subparagraph to give no-
tice shall give notice to—

(I) if the certification is in the applica-
tion, not later than 20 days after the date of
the postmark on the notice with which the
Secretary informs the applicant that the ap-
plication has been filed; or

(ii) if the certification is in an amend-
ment or supplement to the application,
at the time at which the applicant submits
the amendment or supplement, regardless of
whether the applicant has already given no-
tice to another such certifi-
cation contained in the application or in an
amendment or supplement to the applica-
tion.

(iv) CONTENTS OF NOTICE.—A notice re-
quired under this subparagraph shall—

(I) state that an application that contains
data from bioavailability or bioequivalence
studies has been submitted under this sub-
section 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 certifi-
cation; and

(II) include a detailed statement of the
factual and legal basis of the opinion that
the patent is invalid or will not be infringed;

(B) by redesignating subparagraphs (C) and
(D) as subparagraphs (E) and (F), respec-
tively; and

(C) by inserting after subparagraph (B) the
following:

"(C) CIVIL ACTION TO OBTAIN PATENT CER-
TIFICATION.—

(I) AGREEMENT TO GIVE NOTICE.—An appli-
cant may not amend or
supplement an application to seek approval
of a drug referring to a different listed drug
without giving notice as required by subsidi-
ary paragraph (B) of the application a statement that the applicant will
be entitled to damages in a civil action
pursuant to any issue of patent infringement.

(II) COUNTERCLAIM TO INFRINGEMENT AC-
TION.—

(i) IN GENERAL.—If an owner of the patent
or the holder of the approved application
under subsection (b) or (c) on the date that
is claimed by the patent or a use of which
is claimed by the patent brings a patent in-
fringement action against the applicant, the
applicant may assert a counterclaim seeking
an order requiring the holder to correct or
delete the patent information submitted by
the holder under subsection (b) or (c) on the
ground that the patent does not claim ei-
ther—

(aa) the drug for which the application was
approved; or

(bb) an approved method of using the

(ii) NO INDEPENDENT CAUSE OF ACTION.—

Subclause (I) does not authorize the asser-
tion of a claim described in subclause (I) in
any civil action or proceeding other than a

(iii) DAMAGES.—An applicant shall not be
entitled to damages in a civil action
under subparagraph (i) or a counterclaim
under subparagraph (ii)."

(b) APPLICATIONS GENERALLY.—Section 505
of the Federal Food, Drug, and Cosmetic Act
(21 U.S.C. 355) is amended—

(1) in subsection (b)(1)—

(A) by striking paragraph (3) and inserting
the following:

"(3) NOTICE OF OPINION THAT PATENT IS IN-
VAILD OR WILL NOT BE INFRINGED.—

(A) AGREEMENT TO GIVE NOTICE.—An appli-
cant that makes a certification described in
paragraph (2)(A)(iv) shall include in the appli-
cation a statement that the applicant will
be entitled to damages in a civil action
pursuant to any issue of patent infringement.

(B) TIMING OF NOTICE.—An applicant that
makes a certification described in paragraph
(2)(A)(iv) shall give notice as required under
this paragraph—

(i) if the certification is in the applica-
tion, not later than 20 days after the date of
the postmark on the notice with which the
Secretary informs the applicant that the ap-
plication has been filed; or

(ii) if the certification is in an amend-
ment or supplement to the application, at
the time at which the applicant submits
the amendment or supplement, regardless of
whether the applicant has already given no-
tice with respect to another such certifi-
cation contained in the application or in an
amendment or supplement to the applica-

(C) RECIPIENTS OF NOTICE.—An applicant required under this paragraph to give notice shall give notice to—

(i) each owner of the patent that is the subject of the certification (or a representative of the owner designated to receive such a notice); and

(ii) the holder of the approved application under subsection (b)(2)(A)(vii) for the drug that is claimed by the patent or a use of which is claimed by the patent (or a representative of the holder designated to receive such a notice).

(D) CONTENTS OF NOTICE.—A notice required under this paragraph shall—

(i) state that an application that contains data from bioavailability or bioequivalence studies has been submitted under this subsection for the drug with respect to which the certification is made to obtain approval to engage in the commercial manufacture, use, or sale of the drug before the expiration of the patent referred to in the certification; and

(ii) include a detailed statement of the factual and legal basis of the opinion of the applicant that the patent is invalid or will not be infringed; and

(B) in subparagraph (C) should be brought. The amendments made by subsections (a) and (b) apply with respect to any civil action or proceeding other than a counterclaim described in subclause (I).

(3) EFFECTIVE DATE OF APPROVAL.—The amendments made by subsections (a) and (b)(2)(B)(i) apply with respect to any civil action or proceeding other than a counterclaim described in subclause (I).

(4) IVORY TRADE.—Except as provided in paragraphs (2) and (3), the amendments made by sections 2201 of title 28, United States Code, and as amended by section 1101, are amended—

(I) DEFINITIONS.—In this paragraph:

(1) IN GENERAL.—Except as provided in paragraph (i), the amendments made by subsections (b)(2)(A)(vii) or (j) and (s) of this Act regarding the drug, Food, and Drug, and Cosmetic Act (2 U.S.C. 355) that is pending on or after the date of enactment of this Act regardless of the date on which the proceeding was commenced or is commenced.

(2) NOTICE OF OPINION THAT PATENT IS INVALID OR WILL NOT BE INFRINGED.—The amendments made by subsections (a) and (b) apply with respect to any certification under subsection (b)(2)(A)(iv) or (j) of this Act regarding the drug, Food, and Drug, and Cosmetic Act (2 U.S.C. 355) that is pending on or after the date of enactment of this Act regardless of the date on which the proceeding was commenced or is commenced.

SEC. 1102. FORFEITURE OF 180-DAY EXCLUSIVITY PERIOD.

(a) IN GENERAL.—Section 585(c)(15) of the Federal Food, Drug, and Cosmetic Act (2 U.S.C. 355(c)(15) as amended by section 1101) is amended—

(I) by striking “paragraph (3)(B)” and inserting “subsection (b)(3)”; and

(ii) by striking clause (i) and inserting the following:

(II) NO INDEPENDENT CAUSE OF ACTION.—

(1) I N GENERAL.—No action may be brought under section 232 of title 28, United States Code, by an applicant referred to in subparagraph (A)(vii) for a declaratory judgment with respect to a patent which is the subject of the certification under subsection (b)(2)(A)(vii) if in subparagraph (C) unless the forty-five day period referred to in such subparagraph has expired, and unless, if the notice the applicant provided to the holder of the approved application under section (b)(2)(A)(vii) was approved, the notice was accompanied by a document described in subclause (II). Any such action shall be brought in the judicial district in which the defendant has its principal place of business or a regular and established place of business.

(III) RIGHT OF CONFIDENTIAL ACCESS TO APPLICATION.—For purposes of subclause (I), the document described in this subclause is a document providing a right of confidential access to the application of the applicant referred to in subparagraph (C) for the purpose of determining whether an action referred to in subparagraph (C) should be brought. The document providing the right of confidential access shall contain such restrictions as to access shall contain such restrictions as to

persons entitled to access, and on the use and disposition of any information accessed, as would apply had a protective order been entered for the purpose of protecting trade secrets and other confidential business information. Any person provided a right of confidential access shall review the application in order to evaluate possible infringement of the patent that is the subject of the certification under subsection (b)(2)(A)(iv) and for no other purpose.

(IV) 180-DAY EXCLUSIVITY PERIOD.—

(I) DEFINITIONS.—In this paragraph:

(aa) 180-DAY EXCLUSIVITY PERIOD.—The term ‘180-day exclusivity period’ means the 180-day period ending on the day before the date on which an application submitted by an applicant other than a first applicant could become effective under this clause.

(bb) FIRST APPLICANT.—As used in this subsection, the term ‘first applicant’ means an applicant that, on the first day on which a substantially complete application containing a certification described in paragraph (2)(A)(ii)(IV) is submitted for approval of a drug, submits a substantially complete application containing a certification described in paragraph (2)(A)(ii)(IV) for the drug.
(cc) Substantially complete application.—As used in this subsection, the term `substantially complete application' means an application under this subsection that on its face contains information to permit substantive review and contains all the information required by paragraph (2)(A).

(dd) Tentative approval.—(A) In general.—The term `tentative approval' means notification to an applicant by the Secretary that an application under this subsection meets the requirements of paragraph (2)(A), but cannot receive effective approval because the application does not meet the requirements of this subparagraph, there is no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the patent or in a declaratory judgment action described in section 505A, or there is a 7-year period of exclusivity for the listed drug under subparagraph (E) or section 505A, or there has been withdrawn as a result of a determination under paragraph (2)(A)(vi) of this section.

(EE) 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 no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the patent or in a declaratory judgment action described in section 505A, or there is a 7-year period of exclusivity for the listed drug under section 527.

(B) Limitation.—A drug that is granted tentative approval by the Secretary is not an approved drug and shall not have an effective approval until the Secretary issues an approval after any necessary additional review of the application.

(II) Effectiveness of application.—Subject to subparagraph (D), if the application contains the information described in subparagraph (A)(vi)(IV) and for a drug for which a first applicant has submitted an application containing such a certification, the application shall be made effective on the date that is 180 days after the date on which the first commercial marketing of the drug (including the commercial marketing by the first applicant) is initiated.

(i) Definition of forfeiture event.—In this subparagraph, the term `forfeiture event' means the occurrence of any of the following:

(aa) the earlier of the date that is—

(AA) 75 days after the date on which the approval of the application of the first applicant is made effective under subparagraph (B)(iii); or

(BB) 30 months after the date of submission of the application of the first applicant; or

(bb) with respect to the first applicant or any other applicant to which subparagraph (A)(vi)(IV) of section 505A applies, the date that is 75 days after the date as of which, as to each of the patents with respect to which the first applicant submitted a certification qualifying the first applicant for the 180-day exclusivity period under subparagraph (B)(ii), at least 1 of the following has occurred:

(A) In an infringement action brought against that applicant with respect to the patent or in a declaratory judgment action brought against that applicant with respect to the patent, a court enters a final decision from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the patent is invalid or not infringed.

(B) In an infringement action or a declaratory judgment action described in subparagraph (A), a court has issued an order or decree that enters a final judgment that includes a finding that the patent is invalid or not infringed.


(ii) Failure to obtain tentative approval.—The first applicant amends or withdraws the certification for all of the patents with respect to which that applicant submitted a certification qualifying the applicant for the 180-day exclusivity period.

(III) Failure to obtain tentative approval.—The first applicant fails to obtain tentative approval and the application is filed within 30 months after the date on which the application is filed, unless the failure is caused by a change in the requirements for approval of the application imposed after the date on which the application is filed.

(iv) Agreement with another applicant, the listed drug application holder, or a patent owner.—The first applicant enters into an agreement with another applicant under this subsection for the drug, the holder of the application for the listed drug, or an owner of the patent that is the subject of the certification under paragraph (2)(A)(vi)(IV), the Federal Trade Commission or the court with regard to the complaint from which no appeal (other than a petition to the Supreme Court for a writ of certiorari) has been or can be taken that the agreement has violated the Federal Trade Commission Act (15 U.S.C. 41 et seq.) or section 5 of the Clayton Act (15 U.S.C. 12), except that the term includes section 5 of the Federal Trade Commission Act (15 U.S.C. 45) to the extent that section applies to unfair methods of competition.

(i) Expiration of all patents.—All of the patents as to which the applicant submitted a certification qualifying the first applicant for the 180-day exclusivity period have expired.

(ii) Forfeiture.—The 180-day exclusivity period described in subparagraph (B)(iv) shall be forfeited by a first applicant if a forfeiture event occurs with respect to that first applicant.

(iii) Subsequent applicant.—If all first applicants forfeit the 180-day exclusivity period under clause (ii),

(1) approval of any application containing a certification qualifying the first applicant for the 180-day exclusivity period under subparagraph (B)(ii), and

(2) no applicant shall be eligible for a 180-day exclusivity period.

(B) Effective date.—(1) In general.—Except as provided in this paragraph, the amendment made by this section applies to an application filed under section 505(j)(5)(F) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)(5)(F)) after the date of enactment of this Act.

(C) For a drug that is not intended to be absorbed into the bloodstream, the Secretary may establish scientifically valid methods to show bioequivalence if the alternative methods are expected to detect a significant difference between the drug and the reference drug in safety and therapeutic effect.

(B) Effect of amendment.—The amendment made by subsection (a) does not alter the standards for approval of drugs under section 505(j) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 355(j)).

81104. 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)(i) and (c)(1)(A)(i), by striking ``(j)(5)(D)(ii)'' each place it appears and inserting ``(j)(5)(F)(ii)'';

(2) in subsections (b)(2)(A)(i) and (c)(1)(A)(i), by striking ``(j)(5)(F)(ii)'' each place it appears and inserting ``(j)(5)(F)(i)'';

(3) in subsections (e) and (l), by striking ``(5)(5)(I)(D)'' each place it appears and inserting ``(5)(5)(I)(D)''.

Subtitle B—Federal Trade Commission Review

SEC. 1111. DEFINITIONS.

In this subtitle:

(1) ANDA.—The term `ANDA' means an abbreviated drug application, as defined under section 201(aa) of the Federal Food, Drug, and Cosmetic Act.

(2) BRAND NAME DRUG.—The term `brand name drug' means a drug for which an application is approved under section 505(j)(5) of the Federal Food, Drug, and Cosmetic Act, including an application referred to in section 505(b)(2) of such Act.

(3) BRAND NAME DRUG COMPANY.—The term `brand name drug company' means the party that holds the approved application referred to in paragraph (2) for a brand name drug that is a listed drug in an ANDA, or a party that is the owner of a patent for which information is submitted for such drug under subsection (b) or (c) of section 505 of the Federal Food, Drug, and Cosmetic Act.

(4) COMMISSION.—The term `Commission' means the Federal Trade Commission.

(5) GENERIC DRUG.—The term `generic drug' means a drug for which an application has been submitted under section 505(j) of the Federal Food, Drug, and Cosmetic Act.

(6) GENERIC DRUG COMPANY.—The term `generic drug company' means a person who has filed or is included in an ANDA under section 505(j) of the Federal Food, Drug, and Cosmetic Act.
(7) **Listed Drug.—** The term ‘listed drug’ means a brand name drug that is listed under section 505(j)(7) of the Federal Food, Drug, and Cosmetic Act.

**SEC. 1101. NOTIFICATION OF AGREEMENTS.**

**(a) Agreement With Brand Name Drug Company.—**

(1) **Requirement.**—A generic drug applicant that has submitted an ANDA containing a certification under subsection (505)(j)(7)(A)(ii)(V) of the Federal Food, Drug, and Cosmetic Act and a brand name drug company that enters into an agreement described in this paragraph shall each file the agreement in accordance with subsection (c). The agreement shall be filed prior to the date of the first commercial marketing of the generic drug that is the subject of the ANDA.

(2) **Subject Matter of Agreement.—** An agreement described in this paragraph between a generic drug applicant and a brand name drug company is an agreement regarding—

(A) the manufacture, marketing or sale of the brand name drug that is the listed drug in the ANDA involved;

(B) the manufacture, marketing, or sale of the generic drug for which the ANDA was submitted;

—or (C) the 180-day period referred to in section 505(j)(8)(B)(iv) of the Federal Food, Drug, and Cosmetic Act as it applies to such ANDA or any other ANDA based on the same brand name drug.

**(b) Agreement With Another Generic Drug Applicant.—**

(1) **Requirement.**—A generic drug applicant that has submitted an ANDA containing a certification under section 505(j)(2)(A)(vii)(IV) of the Federal Food, Drug, and Cosmetic Act with respect to a listed drug and another generic drug applicant that has submitted an ANDA containing such a certification for the same listed drug shall each file the agreement in accordance with subsection (c). The agreement shall be filed prior to the date of the first commercial marketing of either of the generic drugs for which such ANDAs were submitted.

(2) **Subject Matter of Agreement.—** An agreement described in this paragraph between two generic drug applicants is an agreement regarding the 180-day period referred to in section 505(j)(8)(B)(iv) of the Federal Food, Drug, and Cosmetic Act as it applies to the ANDAs with which the agreement is concerned.

**(c) Filing.**

(1) **Agreement.—** The parties that are required in subsection (a) or (b) to file an agreement in accordance with this subsection shall file with the Commission the text of any such agreement, except that the parties involved shall file written descriptions of such agreement that are sufficient to disclose all the terms and conditions of the agreement.

**(d) Filing Deadlines.** Any filing required under section 1112 shall be filed with the Commission not later than 10 business days after the agreements are executed.

**SEC. 1114. DISCLOSURE EXEMPTION.**

Any information or documentary material filed with the Commission pursuant to this section that is subject to section 552 of the United States Code, and no such information or documentary material may be made public, except as provided in section 552a of that title; or

(2) may exempt classes of persons or agreements from the requirements of this Act.

**(3) Description.—** Any agreement that is required to be filed under this section shall—

(A) define the terms used in this subsection;

(B) exempt classes of persons or agreements from the requirements of this Act; and

(C) terminate in violation of this Act.

**(4) Civil Penalty.—** Any person who violates this section shall be subject to a civil penalty.

**(5) Injunction.—** The Commission, by rule in accordance with the purposes of this Act may prescribe such other rules as may be necessary to carry out the purposes of this Act.

**SEC. 1115. ENFORCEMENT.**

**(a) Civil Penalty.—** Any person who violates this section shall be subject to a fine in accordance with the purposes of this Act.

**(b) Injunction.—** The Commission, by rule in accordance with the purposes of this Act may promulgate regulations permitting pharmacists and wholesalers to import prescription drugs from Canada into the United States.

**(c) Limitation.—** The regulations under subsection (b) shall—

(1) require that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug) with sections 501 and 502, and with all other applicable requirements of this Act;

(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e);

(3) require that any prescription drug from Canada imported by a domestic pharmacist or a wholesaler who shall be subject to the provisions of this Act.

**(d) Enumerations.—** The Secretary may prescribe such other rules as may be necessary to carry out the purposes of this Act.

(1) require that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug) with sections 501 and 502, and with all other applicable requirements of this Act;

(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e);

(3) require that any prescription drug from Canada imported by a domestic pharmacist or a wholesaler who shall be subject to the provisions of this Act.

**(e) Limitation.—** The regulations under subsection (d) shall—

(1) require that each prescription drug imported under the regulations complies with section 505 (including with respect to being safe and effective for the intended use of the prescription drug) with sections 501 and 502, and with all other applicable requirements of this Act;

(2) require that an importer of a prescription drug under the regulations comply with subsections (d)(1) and (e);

(3) require that any prescription drug from Canada imported by a domestic pharmacist or a wholesaler who shall be subject to the provisions of this Act.

(4) require that all prescription drugs from Canada imported by a domestic pharmacist or a wholesaler who shall be subject to the provisions of this Act.

(5) require that only prescription drugs which have not left the possession of the first Canadian recipient of such prescription drugs after receipt from the manufacturer of such prescription drugs be eligible for importation into the United States under this section;

(6) require, if determined appropriate by the Secretary, that all prescription drugs imported from Canada under this section by domestic pharmacists and wholesalers enter the United States through ports of entry designated by the Secretary for purposes of this section;

(7) contain any additional provisions determined by the Secretary to be appropriate to such public health; and

(8) contain any additional provisions determined by the Secretary to be appropriate.
to facilitate the importation of prescription drugs that do not jeopardize the public health.

(d) INFORMATION AND RECORDS.—

(1) IN GENERAL.—The regulations under subsection (b) shall require the importer or the manufacturer of the prescription drug to submit to the Secretary the following information and documentation:

(A) The name and quantity of the active ingredient of the prescription drug.

(B) A description of the dosage form of the prescription drug.

(C) The date on which the prescription drug was shipped.

(D) The quantity of the prescription drug that is shipped.

(E) The point of origin and destination of the prescription drug.

(F) The price paid and the price charged by the importer for the prescription drug.

(G) Documentation from the foreign seller, specifying—

(i) the original source of the prescription drug; and

(ii) the quantity of each lot of the prescription drug originally received by the seller from that source.

(H) The lot or control number assigned to the prescription drug by the manufacturer of the prescription drug.

(1) The name, telephone number, and professional license number (if any) of the importer.

(i) Documentation demonstrating that the prescription drug was received by the recipient from the manufacturer and subsequently shipped by the first foreign recipient to the importer.

(ii) Documentation of the quantity of each lot of the prescription drug received by the first foreign recipient demonstrating that the quantity received was 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 for authenticity and degradation.

(K) Certification from the importer or manufacturer of the prescription drug that the prescription drug—

(1) is approved for marketing in the United States and is not adulterated or misbranded;

(2) meets all labeling requirements under this Act; and

(3) authenticate the prescription drug by the manufacturer of the prescription drug at a qualified laboratory.

(L) Laboratory records, including complete data derived from all tests necessary to ensure that the prescription drug is in compliance with established specifications and standards.

(M) Documentation demonstrating that the testing required by subparagraphs (j) and (L) was conducted at a qualified laboratory.

(N) Any other information that the Secretary determines is necessary to ensure the protection of the public health.

(2) MAINTENANCE BY THE SECRETARY.—The Secretary shall maintain information and documentation submitted under paragraph (1) for such period of time as the Secretary determines to be necessary.

(e) TESTING.—The regulations under subsection (b) shall require that—

(1) that testing described in subparagraphs (j) and (L) of subsection (d) be conducted by the importer or by the manufacturer of the prescription drug at a qualified laboratory;

(2) if the tests are conducted by the importer—

(i) that information needed to—

(A) authenticate the prescription drug being tested; and

(B) confirm that the labeling of the prescription drug complies with labeling requirements under this Act;

(ii) be supplied by the manufacturer of the prescription drug to the pharmacist or wholesaler; and

(3) that the information supplied under subparagraph (A) be kept in strict confidence and used only for purposes of testing under this section; and

(4) may include such additional provisions as the Secretary determines to be appropriate for providing for the protection of trade secrets and commercial or financial information that is privileged or confidential.

(f) REGISTRATION OF FOREIGN SELLERS.—Any establishment in Canada engaged in the distribution of a prescription drug that is imported or offered for importation into the United States shall register with the Secretary the name and place of business of the establishment and the name of the United States agent for the establishment.

(g) SUSPENSION OF IMPORTATION.—The Secretary shall require that importations of a specific prescription drug or importations by a specific importer under subsection (b) be immediately suspended on discovery of a pattern of importation of that specific prescription drug by the specific importer of drugs that are counterfeit or in violation of any requirements under this section, until an investigation by the Secretary determines that the public is adequately protected from counterfeit and substitute prescription drugs being imported under subsection (b).

(h) APPROVED LABELING.—The manufacturer of a prescription drug shall provide an importer with a written authorization for the importer to use the approved labeling for the prescription drug.

(i) CHARITABLE CONTRIBUTIONS.—Notwithstanding any other provision of this section, section 803(l)(1) continues to apply to a prescription drug that is donated or otherwise supplied at no charge by the manufacturer of the drug to a charitable or humanitarian organization (including the United Nations and affiliates) or to a government of a foreign country.

(j) WAIVER AUTHORITY FOR IMPORTATION BY INDIVIDUALS.—(1) The Secretary may, for drugs being imported from a licensed Canadian pharmacy, grant to individuals, by regulation or on a case-by-case basis, a waiver of the requirement of importation of a prescription drug or device of class prescription drugs or devices, under such conditions as the Secretary determines to be appropriate. Such conditions shall include conditions that such drug or device be—

(I) in the possession of an individual when the individual enters the United States;

(2) imported directly from a licensed pharmacy for personal use by the individual, not for resale, in quantities that do not exceed a 90-day supply, which individual will use during the trip (or for a family member of such individual);

(3) accompanied by a copy of a valid prescription;

(4) imported from Canada, from a seller registered with the Secretary;

(5) a prescription drug approved by the Secretary under chapter V that is not adulterated or misbranded; and

(6) in the form of a final finished dosage that was manufactured in an establishment registered under section 510 and

(7) importation of other conditions as the Secretary determines to be necessary to ensure public safety.

(k) STUDIES; REPORTS.—

(1) BY THE NATIONAL ACADEMY OF SCIENCES.—

(A) STUDY.—

(i) IN GENERAL.—The Secretary shall request that the Institute of Medicine of the National Academy of Sciences conduct a study of—

(A) the importations of prescription drugs made under the regulations under subsection (b); and

(B) information and documentation submitted under subsection (b).

(ii) REQUIREMENTS.—In conducting the study, the Institute of Medicine shall—

(A) evaluate the compliance of importers with the regulations under subsection (b); and

(B) compare the number of shipments under the regulations under subsection (b) during the study period that are determined to be counterfeit, misbranded, or adulterated, and compare that number with the number of shipments made during the study period within the United States that are determined to be counterfeit, misbranded, or adulterated; and

(iii) consult with the Secretary to evaluate the effect of importations under the regulations under subsection (b) on trade and patent rights under Federal law.

(B) REPORT.—Not later than 2 years after the effective date of the regulations under subsection (b), the Comptroller General of the United States shall submit to Congress a report describing the findings of the study under subparagraph (A).

(l) CONSTRUCTION.—Nothing in this section limits the authority of the Secretary relating to the importation of prescription drugs, other than with respect to section 801(d)(1) as provided in this section.

(m) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

(n) CONDITIONS.—This section shall become effective only if the Secretary determines that the implementation of this section will—

(1) pose no additional risk to the public's health and safety; and

(2) result in a significant reduction in the cost of prescription drugs to the American consumer.

(2) CONFORMING AMENDMENTS.—The Federal Food, Drug, and Cosmetic Act is amended—

(1) in section 301(aa) (21 U.S.C. 331(aa)), by striking "covered product pursuant to section 804(a)" and inserting "prescription drug in violation of section 804"; and

(2) in section 303(a)(6) (21 U.S.C. 333(a)(6)), by striking "agreement to section 804(a)" and inserting "prescription drug under section 804(b)".

The SPEAKER pro tempore. After 3
from Louisiana (Mr. TAUZIN), and the gentleman from Michigan (Mr. Dingell) each will control 45 minutes of debate on the bill.

The Chair recognizes the gentleman from California (Mr. THOMAS).

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

As we begin the 3 hours of debate on the primary bill and an additional hour on the substitute, I do want to indicate that this day, in my opinion, has been too long in coming.

I worked with the President Bush for his position during the campaign that Medicare needed to be modernized and we were overdue for putting prescription drugs in Medicare.

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

I believe he has continued to be firm in his resolve that both the House, and the Senate now for the first time, pass legislation so that we can conference a common bill and send it to him for his signature.

I also want to thank the Speaker of the House. The gentleman from Illinois (Mr. HASTERT) was involved in these discussions with us in becoming the majority and, of course, prior to becoming Speaker. If you examine H.R. 1, you will find that the Speaker has been willing to be the lead author. I think it is entirely proper and appropriate that the Speaker of the House lead the House in this, in the most fundamental and important change in Medicare since its inception.

I especially want to thank my colleague and friend and chairman of the Committee on Energy and Commerce, the gentleman from Louisiana (Mr. TAUZIN). In this institution, where jurisdictions are guarded with a pretty vicious willingness to have turf wars whenever necessary to hang on to your jurisdiction, the working relationship with both committees and back together again in the Committee on Rules to produce a complex and difficult piece of legislation as you have in front of you without the dedicated staff. And I mean not just on the committees, but the Congressional Budget Office, and I will mention from Leg Counsel Ed Counsel and I want to personally thank him once again for the hours of commitment that he has put in to produce this piece of legislation.

I want to thank, and I do not want to go through every staff member, but I do want to thank the chair of our Subcommittee on Health staff John McManus for the enormous number of hours he and the staff have put in. You cannot produce and difficult a piece of legislation as you have in front of you without the dedicated staff. And I mean not just on the committees, but the Congressional Budget Office, and I will mention from Leg Counsel Ed Counsel and I want to personally thank him once again for the hours of commitment that he has put in to produce this piece of legislation.

There are organizations and associations who have very strong feelings about the direction of Medicare and the changes that might be made, and I want to thank all of them for their openness and willingness to present comments upon which we reacted. Most recently, I think of one of the more prominent organizations, formerly known as the American Association of Retired Persons, now AARP, and I am indebted to my colleague, the gentlewoman from California (Mrs. CAPPS), for circulating the letter from AARP, because I think it is very instructive. It provides us with an example of how these organizations point with pride and view with alarm some of the changes that are being made.

For another paragraph in the letter addressed to me, says, and I quote, “AARP is encouraged by the advancement in the House of legislation to add prescription drug coverage to Medicare. Relief from the high cost of drugs is long overdue. Our members and all older Americans and their families expect and need legislation this year. We appreciate your efforts and leadership toward this end.”

But they go on to say in the letter, in terms of a number of additional points that they think certain areas need to be strengthened and perhaps some changes need to be made. For example, under low-income protections, they say, “We are encouraged by the bill’s inclusion of all Medicare beneficiaries, including dual eligibles.” We spend $43 billion over the next decade picking up these low-income seniors. We believe they should be classified as seniors first in the Federal Medicare program and not low-income first, as they currently are today.

But they go on to say that they are concerned because eligibility is limited by a restrictive assets test. And we took that letter to heart and we have fixed that. But more importantly, understanding the fact that the original bill doubled the assets provision under the SSI, Social Security provisions for low-income eligibility. The bill had doubled it. We examined it, we determined that perhaps we should go that extra mile. Under the bill before you today we have tripled it. We have tripled the SSI standards in terms of low-income protection. These are the kinds of exchanges that improved this legislation as we move forward.

And let me say lastly that I am very pleased that the Senate, I believe, will pass legislation and join the House finally in conference to craft a piece of legislation that will become law. Mr. Speaker, I understand the rules of the House in terms of the very narrow line we must tread, and I am not allowed to mention a Senator, but just let me say that a senior Senator, who has been a leader in health care debate for a number of years, frankly needs to be commended, because without his courageous step forward I do not believe the Senate would have moved as quickly or as rapidly as they have to a conclusion on their legislation.

I have enjoyed my conversations that I have had with him over the years, obviously more frequently as I have moved into a position of effect adding prescription drugs to Medicare. Although we have profound differences in terms of our view ofentimes of the role of the Federal Government and assistance, we have never ever left the focus of policy, and although we may differ, the differences have always been over policy.

Never, ever has he mentioned Jim Jones, Kool-aid, mass suicide. Never, ever in our discussions has he mentioned the Holocaust. Never, ever has he mentioned black’s or slavery. He has always carried on the discussion on the basis of substance and the differences that we have on substance and the fact that in this society, in this civil society, the debate ought to be over choices of a legislative nature rather than trying to create an atmosphere of fear. For that I am grateful for his friendship and the fact that we will meet in conference and, finally, seniors, who are the last bastion of paying the price of retail for drugs, that will be the case, all of us will be grateful. Policy will have triumphed over politics.

Mr. Speaker, I reserve the balance of my time.
June 26, 2003

CONGRESSIONAL RECORD — HOUSE

H6079

ANNOUNCEMENT BY THE SPEAKER PRO TEMPORE

The SPEAKER pro tempore (Mr. LAHood). Although it is permissible to refer to a Senator as the sponsor of legislation, other personal references are not permitted.

Mr. RANGEL. Mr. Speaker, I yield such time as he may consume to the distinguished gentleman from Rhode Island (Mr. KENNEDY).

(Mr. KENNEDY of Rhode Island) asked and was given permission to re-state and re-phrase his remarks.)

Mr. KENNEDY of Rhode Island. Mr. Speaker, I would just like to state for the record that the Senator from Massachusetts referred to is my father, and I rise in opposition to H.R. 1.

Mr. Speaker, I rise in opposition to the Republican prescription drug bill.

Our seniors know that Democrats have worked to provide them with universal, affordable, and reliable drug coverage.

And they know that this bill is just another Republican attempt to dismantle Medicare.

This bill won’t help seniors... in fact, there is no guaranteed backstop to insure that there will be drug coverage in their area. Indeed, seniors may end up without any drug coverage.... or forced into an HMO that they do not want to be in.

And the problems with the bill today will only increase in 2010, when premium support and competitive bidding kicks in.

Republicans divide this issue between helping our Nation’s elderly now or helping our young in the future, but we can help both.

James, a Boy Scout from Lincoln, Rhode Island, wrote to me because he is worried about his two grandmothers who cannot afford their medications.

I hope he doesn’t grow up only to realize that we passed a bill in Congress that actually made it worse for his loved ones.

We should not disappoint James, his family, or the forty million Medicare beneficiaries in this Nation.

Vote “no” on H.R. 1.

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

Mr. Speaker, I think this is one of those days that we will never forget as legislators. This is one of those days that I think as legislators we will never forget. And even though we have some people who have not studied the bill that are so anxious to believe that they are going to get prescription drug relief, I think at the end of the day that they might be able to see that this is the first step that has been specifically designed not to reform the Medicare system as we know it but to dissolve it.

There are some people who are honest enough, at least outside of this hallway, to admit that that is exactly what they would want to do, to dissolve the Medicare. Many of the people on the other side of the aisle, and perhaps a handful on our side, believe that health care should not be an entitlement, Social Security should not be an entitlement; that the free marketplace should be able to work its will; that government should not be involved in providing these type of services.

Ultimately, I do believe that when the bill is studied and they see that the transfer of the ability to determine how much prescription drugs will cost, which prescriptions would be filled, what is the recipient entitled to, when does the bill lock into place, and at the year 2010 what do they do with the vouchers under Medicare, all of these things, I think, will be answered at some time, but I really hope that they are answered today.

We have many people that have worked hard on this bill; certainly the gentleman from Michigan (Mr. Dingell) been working for health care for decades; the gentleman from California (Mr. Stark), who will be handling the remainder of this bill, the gentleman from New Jersey (Mr. Pallone), the gentleman from Ohio (Mr. Brown), and so many others. But as I have said so many times publicly, at some point in time people will be asking, when they were moving to dissolve Medicare, where were you and what were you doing?

I think, as in the votes in the past, that people will remember this vote. And those of us who oppose this piece of legislation will be giving our colleagues an opportunity on voting for legislation that provides all of the coverage that they have requested from AARP, and while parts of the letter was read, I think it is safe to say that the objections that were raised to the bill or the questions that they had hoped that would be changed, that that is handled in this bill.

Mr. Speaker, I ask unanimous consent to allocate the remainder of my time to the gentleman from California (Mr. Stark), with the understanding that he be permitted to allocate the rest of the remaining time.

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

There was no objection.

Mr. THOMAS. Mr. Speaker, I yield 2 minutes to the gentleman from Florida (Mr. Foley), a member of the Committee on Ways and Means.

Mr. FOLEY. Mr. Speaker, I thank the chairman for yielding me this time, and to both chairmen who have brought this bill to the floor, I congratulate them for this landmark legislation.

During the rule debate, it was a little depressing to me to hear so many people refer to the fact that our seniors wouldn’t be able to figure these programs out. These people we are talking about survived the Depression, they fought in World War II and Korea, they taught us how to read and write, they taught us how to ride our bikes and drive our cars. They are our parents. They are smart enough to figure this out.

I come from a district in Florida, the fifth largest population of Medicare recipients in the Nation, the fifth largest Medicare spending champion in the Nation. When I go to town hall meetings, they do not ask for anything free. They want a break. They want a discount. They want an opportunity to shop. They want freedom in the marketplace. But they want security to know they will not go broke. This bill provides that.

The bill provides for a discount card that I helped author, along with Senator Kennedy, so people may get immediate access to discount pharmaceutical prices. Real reforms in Medicare allowing generics, something I have heard about on this floor repeatedly from the other side of the aisle. We have to get generics to the marketplace sooner, faster, quicker, cheaper. That is in this bill.

This bill provides for increased rural funding for hospitals, which is an incredibly important thing for people in my community and rural communities like Glades, Okeechobee, Hendry, and Highlands County. These are Medicare reforms that will save billions of dollars.

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

Mr. Speaker, it is difficult to know where to begin to warn the seniors in this country about this sham of a bill at the beginning of the destruction of Medicare, as the Republicans have wanted to do for a number of years. There is no question that this is a major move toward privatizing Medicare. By the calculations that we have from the last feeble attempt to do this, of course Health and Human Services refuses to give us the most recent actuarial computations, but using the last ones, the Medicare premium for B in this drug benefit would rise to $342 a month if the premium could hold at $32.
to turn this over to private companies to operate it, and it is very interesting that one of the largest and best known private companies, Medco, a subsidiary of Merck was just indicted, or as they say, essentially indicted, by the U.S. Attorney's Office for a series of crimes committed under our Federal employees' health insurance benefits. This company that the Republicans would turn the management of this drug benefit over to was indicted for canceling, deleting and destroying patients mail orders. To avoid penalties for late filing and mailing; short-charging patients on the number of pills paid for; making false statements to the insurance plan they were contracted with about compliance with mailing timelines; calling and inducing physicians to authorize switching to higher cost medications while representing that this would save money for the insurance company, which was untrue; fabricating records of calls by pharmacists to physicians; and the list goes on.

This is the type of company who supports the Republicans, and they are in turn paying back that favor by offering Medco and Merck and their ilk the opportunity to provide a so-called benefit to seniors. I say so-called benefit because the next cruel hoax in this bill is there is no benefit defined in the bill. Nowhere in the bill does it define a premium, nowhere in the bill does it define a copay, and nowhere in the bill does it define a benefit. Now, we can all do some math and the CBO actuaries tell us that the actuarial value of a suggested benefit might be $1,360. It is important to add that our actuarial benefit for our health employees' benefit plan is probably closer to $3,000, but there is nothing that states in this law that the U.S. Government shall create, provide, or require a benefit of any type. In other words, if the insurance companies cannot be induced or bribed to offer a benefit, there will not be any. This is a nothing bill. It does not provide a benefit.

Now, I guess perhaps Members may not want to just take my word for it, so I think it is important to note what many others might say about the bill. Mr. Speaker, the Arizona Daily Star says that "the Democratic bill is better in every respect," and that the House drug bill is "awful" and "repulsive."

The Chicago Tribune says the Medicare debate "has more to do with campaign 2004 than providing a prescription drug benefit." The Long Island Newsday said that "the proposal's complex Medicare reform now being considered by Congress may be one of the more irresponsible measures in the long history of cradle-to-grave legislation."

The Akron Beacon Journal says that while the Medicare reform bills would address the lack of drug coverage in Medicare, beneficiaries might be "no better off with the benefit than they are at present because "on the key issues of affordability, the structure of premiums, and copayments, both versions fail to an elabo rate path to disappointment."
The list goes on.

In North Carolina, the Raleigh News Observer says the bill's actual benefit does not come off to outweigh the drawbacks of its so-called reforms.

The Roanoke Times and World News says even if the drug bill passes, seniors still will have to fear the possibility they will face crushing drug bills.

In Kansas, the Windfield Courier says the doughnut hole "hurts many seniors when they need the help the most."

"The majority Republicans are at risk of passing a Medicare bill that looks, walks and talks like a political campaign creature."

Washington State, the Seattle Post-Intelligencer says what Congress finally sends to the White House will surely be a disappointment.

The Oregonian says it is difficult to see the congressional proposals for Medicare drug coverage as much more than a big letdown. They are thin in coverage and convoluted in delivery.

Mr. Speaker, I think we can sum this all up, people will say this is drug coverage for seniors. The truth is this bill is nothing but political coverage for the Republicans.

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

Mr. THOMAS. Mr. Speaker, I yield myself 15 seconds.

Mr. Speaker, Members will find periodical during this 3-hour debate that we will take a very short segment of time to make sure that when an outlandish, outrageous, untrue statement has been made, we will correct the record immediately.

Mr. Speaker, I yield 1 minute to the gentlewoman from Connecticut (Mrs. Johnson), the chairman of the Subcommittee on Health for the Committee on Ways and Means.

Mrs. JOHNSON of Connecticut. Mr. Speaker, this bill does not allow the IRS to share your income information with insurance companies. The bill will very clearly protect the confidentiality of your information, and there are criminal and civil penalties for violating those provisions. Violators can go to jail.

It is true that for 5 percent of the seniors, they will have a higher threshold for catastrophic coverage. I personally do not believe that someone with a $200,000 income living in a gated community should have exactly the same subsidy as someone struggling along on $25,000 or $30,000 of income. I think that is a strength of this bill. But if some one does not want the government to tell you what your catastrophic threshold is, you can opt out and just take the highest threshold. That is your right. But only 5 percent will fall above the threshold, and we think that is progressive. We think we need to target this benefit at those who need it the most, and that is what we do.

Mr. THOMAS. Mr. Speaker, I yield 2 minutes to the gentleman from Illinois (Mr. CRANE), chairman of the Subcommittee on Trade, a long time member of the Committee on Ways and Means.

Mr. CRANE. Mr. Speaker, I rise in support of H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003. As a member of the Committee on Ways and Means' Subcommittee on Health, I can say with confidence that this bill is a fair and balanced approach towards providing millions of America's seniors with prescription drug coverage.

Congress is long overdue in helping our seniors with the skyrocketing costs of their prescription medication. Seniors are struggling and we need to help them. But we cannot ignore that the current program without an expensive drug benefit is financially unstable. The Medicare program is already struggling to provide a finite number of health services to nearly 41 million elderly and disabled. It is imperative that this House takes action before the retirement of the baby boom generation, which will add another 36 million beneficiaries to the Medicare roll. Simply adding a new drug benefit is not the answer.

I support H.R. 1 because it includes a number of reforms that will ensure the long-term fiscal integrity of Medicare through modernization. This legislation gives seniors the same range of private health insurance plans available to Members of Congress and other Federal employees. If seniors do not want to enroll in a private plan, they have the option of staying in traditional fee-for-service.

The time has come for Congress to work together to move past political rhetoric and provide prescription drug coverage for seniors. More importantly, it is time to institute reforms to ensure that future generations will have the security of knowing that Medicare will be there when they need it. I urge my colleagues on both sides of the aisle to support H.R. 1.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from California (Mr. Matsui), a member of the Committee on Ways and Means.

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

I have to first of all say that I am extremely disappointed that my colleagues on the other side of the aisle have gotten this bill before us. It is a shame because if they would have thought through the matter better and instead of bringing up those tax cuts, particularly the dividend tax cut and...
the capital gains tax cut, we could have gotten a bill on the floor that all Americans could be proud of, and every senior citizen in this country would not only be proud of, but would have an adequate benefit.

I think this bill is a sham and I think instead of covering senior citizens, what we are doing is giving my Republican colleagues cover, political cover that eventually the senior citizens will lift and begin to understand what this bill is really all about. I guarantee Members of this House, senior citizens in America will understand this bill and they will be very, very unhappy with a vote in favor of this legislation.

When we think about it for a minute, this bill does not do much at all. If a senior citizen has $5,000 worth of prescription drug coverage in any given year, the senior citizen will have to pay $4,000 immediately, $4,000 of the first $5,000 of coverage before they can even consider federal government benefit. They have to have $670 that they have to pay out in the form of monthly premiums, in the form of copayments.

Mr. THOMAS. I yield 3 minutes to the gentleman from Pennsylvania (Mr. GERLACH) to enter into a colloquy.

Mr. GERLACH. Mr. Speaker, I thank the gentleman from California (Mr. THOMAS) just the other day say on national television, "Those who say that the bill would end Medicare as we know it, our answer is, 'We certainly hope so.' \" Because what they really want to do is privatize Medicare, make it so that insurance companies could increase premiums to whatever they want to do and douse the health care bill which is so important to senior citizens so that the chronically ill will ultimately wither on the vine.

This system that is being put forward today is one that will in fact do major damage to the Medicare system in America. Why did we have Medicare in 1964 in the first place? Because we knew senior citizens could not get coverage because seniors by their very nature are the ones that get ill and the ones that ultimately go into very, very difficult physical situations. And so ultimately what we are going to have is going back to 1964 with this legislation. That is their intent, because they want to see Medicare wither on the vine.

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

Mr. GERLACH. Mr. Speaker, it is my pleasure to yield to the gentleman from Pennsylvania (Mr. ENGLISH), a member of the Committee on Ways and Means.

Mr. ENGLISH. Mr. Speaker, I rise in strong support of the bill before the House today. This bill is the most historic and significant addition to Medicare in the program’s history. This Medicare bill offers enormous benefits to all seniors. As we do this, while saving the Commonwealth hundreds of millions of dollars. The Medicare Prescription Drug and Modernization Act provides all seniors with a thorough, flexible, and voluntary prescription drug plan while at the same time augmenting Pennsylvania’s PACE plan. Importantly, for the nearly 2 million seniors in Pennsylvania, this bill would allow PACE to wrap around the Federal plan. Those who contribute, get supplementary and build on PACE’s current benefits. And to ensure that Pennsylvania’s seniors get maximum drug coverage, this Medicare bill would allow PACE to pay for beneficiaries’ copays under Medicare while at the same time protecting those copay contributions toward out-of-pocket expenditures to more rapidly trigger catastrophic coverage.

Our seniors have waited too long to receive the benefits that they deserve. This flexible, voluntary, and affordable plan would provide seniors with dependable benefits. This is a huge benefit for seniors in the roughly 10 States that have a significant State plan already in place.

Mr. Speaker, this bill also provides resources to America’s rural health providers to allow them to deliver the highest quality care to seniors and meet the demanding fiscal challenges that they currently face. In many rural areas like my own district of western Pennsylvania, inequities in Medicare’s wage reimbursements and payments for hospitals often drive workers, especially skilled nurses, to look for jobs in higher-paying metropolitan hospitals and contribute to staffing shortages in my rural communities.

Several provisions in this bill mirror legislation I introduced earlier this year to help alleviate those high costs by increasing Medicare’s salary reimbursements to our hospitals. These two provisions would pump $13.3 billion into the struggling rural health systems, and I am pleased to note that hospitals in my district alone would receive approximately $65 million as part of this fix. I ask for support for the bill.

Mr. STARK. Mr. Speaker, I am pleased to yield 3 minutes to the gentleman from Michigan (Mr. LEVIN).

Mr. LEWIN. Mr. Speaker, the Republican bill contains a ticking time bomb, a ticking time bomb of Medicare privatization set to go off in 2010. Under this bill, starting in 2010, seniors, in essence, would receive a voucher from Medicare’s guaranteed benefits, instead of open access to doctors and hospitals and predictable costs.

Seniors who cannot afford to pay more than they do right now would have to leave Medicare and join HMOs. This so-called benefit for prescription drugs in the Republican bill serves as a decoy, but it is not a very good one.

The Republican drug plan is insurance without assurance. No assured plan from one year to the next, no assured coverage and stop-loss, no assured list of drugs, no assured list of pharmacies, no assured plan from one year to the next.
next. It could change from year to year.

From the very beginning, Republicans have wanted to use prescription drugs as leverage to end Medicare. The President said earlier to seniors, we will reduce prescription drug costs. The chairman of a drug company that will help depending on whether you leave Medicare and join an HMO. And now what this Republican bill is doing is using a very inferior drug insurance plan in 2006, not until then, to make everything except HMOs unaffordable for seniors. The chairman of a drug company will say just a few days ago, "Old-fashioned Medicare isn't very good," and I quote his quote. What Republicans call old-fashioned Medicare is the system of guaranteed benefits, set premiums and deductibles and access to doctors and hospitals that have served seniors so well since 1965. Republicans want to end all that, but current and future Medicare beneficiaries do not. And we Democrats intend to keep fighting for those good aspects of old-fashioned Medicare. Indeed, it has been very, very, very good.

Mr. THOMAS. Mr. Speaker, I yield myself such time as I may consume. If it has been very, very, very good, why did the Democrats fight for a substitute, which will change the structure significantly?

Mr. Speaker, I yield 1 minute to the gentleman from Washington (Ms. JOHNSON), a very valued member of the Committee on Ways and Means. Ms. JOHNSON of Connecticut. Mr. Speaker, scare tactics have no place in this debate. There are no vouchers in this bill. In 2010, a senior that wants to be in the Medicare program will be in the Medicare program exactly as they are now. They will be in that Medicare program and have that choice of the Medicare program in 2010, in 2011, in 2012, in 2013. They will never receive a voucher. That is not in this legislation. It is used rhetorically to scare seniors. I want to assure the seniors listening that this bill represents the most dramatic expansion of benefits under Medicare since the program was founded, not only prescription drugs but additional preventive benefits and a whole system to support seniors with chronic illness.

Mr. STARK. Mr. Speaker, I am happy to yield 3 minutes to the gentleman from Maryland (Mr. CARDIN). The gentleman from Maryland understands that with proponents like THOMAS and JOHNSON, the seniors do not need any scare from us.

Mr. CARDIN. Mr. Speaker, I oppose the passage of this bill. The passage will make it much more difficult for Congress to enact a meaningful prescription drug benefit for our Nation's seniors. Let me give you five reasons why.

Reason number one. There is no guaranteed benefit in this bill. Unlike seeing a doctor or going to a hospital, we cannot tell our seniors that their prescription drugs will be covered. It will be different in different parts of the country. Mr. Speaker, I tried to correct that by offering an amendment in the Committee on Ways and Means, and it was rejected by the Republicans. I tried to give this body an opportunity to vote on it, but the Committee on Rules would not make that amendment in order.

Reason number two. We are set on a course to privatize Medicare. Only private insurance can participate in the prescription drug coverage. Private insurance companies, causes harm to the Medicare beneficiaries to lower drug prices just like the Canadians do.

Reason number five. The benefits are inadequate. The Republicans project that this bill will provide for a $35 a month premium, $250 deductible, then some help up to $2,000, but then our seniors are on their own for the next $2,900. Our seniors are expected to pay a $35-a-month premium when they are not entitled to any benefit for a good part of the year. I think that is unrealistic.

My Republican friends say, well, you only have $400 billion. We offered alternatives within $400 billion that would provide real benefits. I offered a substitute that said, look, if you cannot afford all drugs, let us at least cover drugs for those illnesses such as high blood pressure and coronary artery disease and diabetes and severe depression. But, no, the Committee on Rules would not allow this body to decide whether that would be a better package than the one that Mr. Speaker, I cannot support a bill that provides no guaranteed benefit, relies solely on the whim of private insurance companies, causes harm to seniors who currently have adequate prescription drug coverage, will not do enough to bring down the cost of prescription drugs, and provides inadequate benefits. Therefore, I will vote "no" on the Republican bill.

Mr. THOMAS. Mr. Speaker, I yield myself 1 minute.

You know, it just kind of makes you wonder what the Democrats did for 30 years when they were the majority, because, you know, when Republicans became the majority in 1995, there was literally no prevention and wellness in Medicare. We are the ones that are supposed to be destroying Medicare? We are the ones that added diabetes. We are the ones that added prostate and colorectal screening. We are the ones that added the mammography. In fact, in this bill that they continue to speak against, we provide for the first time every new beneficiary should have a physical.

I want to underscore that. Every new beneficiary should have a physical. In addition to that, we believe that cholesterol screening has now been advanced, and it should be provided as well.

I find it amazing that they go back to the same old scare statements. Read the bill. It is an enhanced and an improved Medicare. What in the world were you doing for 30 years? The fact of the matter is you did not have a competent challenge.

What we have done is provide real change, and they are afraid those old frayed bumper stickers will not work anymore.

Mr. Speaker, I yield 3 minutes to the gentlewoman from Washington (Ms. DUNN), a very valued member of the Committee on Ways and Means.

Ms. DUNN. Mr. Speaker, for one am very proud that the President and the majority in the House of Representatives, the majority in the House of Representatives, the majority in the State of the Union address directed the Congress to put together a program that will cost about $400 billion to provide prescription drugs for seniors because I think it is time to keep our promise to the people we represent and provide a comprehensive and voluntary prescription drug benefit for all seniors.

We have all heard stories of seniors paying too much for prescription drugs. This problem is acute among low-income seniors, especially for women who comprise half of Medicare beneficiaries with annual incomes below 150 percent of the poverty level. In this bill to help seniors on fixed incomes and those with high drug costs. A woman, for example, with an income of less than $14,400 today, which is 150 percent of poverty, will receive assistance from the Federal Government for prescription drugs. While all seniors will benefit, nearly 11 million or 34 percent of Medicare beneficiaries will qualify for additional assistance when this bill is fully implemented.

Improving Medicare is not only about providing a drug benefit, but it is also about giving seniors access to doctors, hospitals, Medicare HMOs, and other services they need. To ensure access to doctors, we address the low reimbursements that are receiving. We also increase funding for rural hospitals so that seniors can get the health care service they need right in their community.

For Medicare HMOs, this bill requires Medicare to accurately account for
military retirees in the formula and that means higher Medicare-Choice reimbursements in areas with military facilities. Strengthening Medicare also means improving the quality of life for every senior. For this reason I am very happy that we are able to deal with rheumatoid arthritis and other chronic diseases. This bill provides seniors immediate access to self-injectable biologics. Besides providing the choice of which drug works best for rheumatoid arthritis, these self-injectable treatments will allow seniors to receive treatments right in their homes instead of going to the hospital or to a physician's office and will take the burden off those hospitals, clinics and doctors. This is a real prescription drug plan, Mr. Speaker. It is one that provides seniors with very high drug discounts for drugs. It strengthening Medicare's future without changing the benefits that seniors enjoy today. I ask my colleagues to support a real prescription drug plan by passing this legislation.

Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Washington (Mr. McDERMOTT), a member of the Committee on Ways and Means, who understands that seniors are going to have to pay $4,000 bucks for the first $5,000 of drugs regardless. Mr. Speaker, well the rubber stamp Congress is ready tonight. The drug companies, after they contributed and got the President elected, gave him this bill, and they said this is what we want. The President brought it up here. We are rubber stamping it. Can we believe that the Senate, excuse me, in another part of this building they are considering something like 400 amendments, but we cannot have one because when you are using a rubber stamp, you cannot have one amendment in here. Nothing can be improved in this bill. Can you believe it? It is like the Ten Commandments. It is perfect. It came down from God or somewhere, the Ten Commandments. It is perfect. We have heard a lot of argument about Medicare since its inception. I compliment the chairman and all of those who did this very complex bill and put it together. It is a good bill and it is one this Congress should pass.

Mr. KLECZKA. Mr. Speaker, I yield 3 minutes to the gentleman from Wisconsin (Mr. KLECZKA), a member of the Committee on Ways and Means, who, unlike the authors of this bill, did not spend his entire life in the public trough but actually worked in private enterprise; so he understands what privatization is.

Mr. KLECZKA. Mr. Speaker, I worked for an insurance company before I was elected to the legislature. So with that as an opening, Mr. Speaker, let me say to the body that in my view this is the beginning of the end of the Medicare program. For 38 years Medicare has provided seniors with quality health care, a defined benefit, and whether one lived in California or Alaska, that premium was the same, they knew what the benefit was, and they knew what the services were, and it has worked.

So there are those in this House who say there has been a change in the way we deliver medicine today, and that is called drug therapy. Let us add that coverage to the Medicare program and we can use the purchasing power of the Federal Government to get the best deal on drugs for all 40 million seniors and 25 percent in drug discounts for manufacturers. It covers seniors to participate in the drug program, and it protects those with very high drug costs. It strengthens Medicare's future without changing the benefits that seniors enjoy today. I ask my colleagues to support a real prescription drug plan by passing this legislation.
drug profits of their friends, the drug companies. But know full well, Mr. Speaker, we do it for the VA and it works and it works well.

So instead of doing a benefit connected to the Medicare program, what we are doing is going to send our seniors out to the private insurance market, we are going to tell them go shop for a drug-only policy. The policy that is being offered in this bill has one big problem, and that is once one spends $2,000 on drugs in any one year covered stops until their expenditures total $4,900. Know full well during that period they are paying 100 percent of their drug cost. Their premiums go on. They are paying premiums and getting no benefit. There is something wrong with that system, and that is why this bill is very bad in that respect.

The other problem with the bill is we had this program for a couple years now called Medicare+Choice, and we are going to show those seniors that the people who did not want them 35 years ago wants them now. They are holding their arms open. We want the seniors because we know they have a lot of drug costs and a lot of health care costs. So the Committee on Ways and Means and this Congress go along with this Medicare+Choice. What it is, is a private insurance company selling policies to seniors. Milwaukee, where I come from, has four of these companies and they were peddling those policies and offering the sun and the moon. A sudden binge, three of them go belly up, the seniors have to scurry to get back into some type of Medicare program, and today we have one left. One left.

And the reimbursement for that 110 percent of the Medicare rate. So clearly, we are not saving a heck of a lot of money to get private insurance companies.

Well, it is a failed experiment, Mr. Speaker. So what are we doing in this bill? We are changing the name. We are modernizing Medicare+Choice, and it is supposed to look and smell like Medicare+Choice. But know full well, Mr. Speaker, tonight we hear some partisan political rhetoric, particularly from the other side of the aisle, who began this process by announcing they were going to oppose the bill. It does not matter what is in it; they are going to oppose it.

So I think the important question that we really should ask is: What does this mean, this modernization of Medicare? What does it mean that we are modernizing Medicare for the 21st century? What does it mean that we are investing $400 billion in modernizing Medicare with prescription drugs?

When I think of prescription drug coverage, I think of the seniors who I have met over the 9 years I have had the privilege of serving in this body. They are men and women who I have talked with in their homes who sit there and they sit in that easy chair and right next to their chair, they have that tray, a tray full of pill bottles, and they talked and shared with me the choices they have had to make, whether or not they go to the drugstore, the grocery store that particular week because of the expenses they are facing because of rising prescription drug costs.

Well, those are the people that are the primary beneficiaries of this legislation. Because we have a plan before us that helps those who are truly needy, low-income, by ensuring they pay no premiums; and for others, they pay a pretty affordable premium. This plan would cost a senior about $35 a month, $1 a day. Think about that. A dollar a day for a senior participating in this plan. And if you qualify for Medicaid today and you are going to be eligible tomorrow, you qualify now and are able to take advantage of this new prescription drug plan. But for a dollar a day, it is projected you could save anywhere from 30 to 70 percent of your prescription drug costs.

Think about that. When you think of that elderly man or woman who you have had the opportunity to talk with in their home and sit there while they talk with you, perhaps they are home-bound, they have that tray of pill bottles, and they are, frankly, very concerned because they cannot do much else, other than buy their drugs and hopefully get to the grocery store, they are going to really benefit from this plan. It is affordable. It is available for all seniors.

We also give seniors choices. It is affordable, a dollar a day, $33 a month; it provides real savings, 30 to 70 percent that is projected by nonpartisan analysts who look at this and say, what does it really mean, is the question they ask. To qualify for Medicare, you qualify for this program, and you are going to have choice. You do not have to pick the one-size-fits-all that some seniors are on the other side of the aisle want to have and say, seniors, you only get one choice, and we are going to tell you what it is.

Mr. Speaker, we are going to give seniors more than one choice so they can find a plan that fits them. Think about that. That is what this really means. We are helping seniors who need help with their prescription drug costs. We are modernizing Medicare for the 21st century. We have a plan that is almost 50 years old that has not changed. We are going to modernize it. The most important choice that seniors face today is, of course, the availability and affordability of prescription drug costs.

Mr. Speaker, this is a commonsense plan. It deserves bipartisan support. I hope my friends on the other side of the aisle will do the right thing. I recognize that they set out today with a decision to oppose the bill, regardless of what is in it. We are going to work together. Let us provide a bipartisan vote to provide prescription drug coverage that will help every senior in America.

Mr. STARK. Mr. Speaker, I yield myself such time as I may consume, because I do not intend to let unsubstantiated remarks go unchallenged either. We do not oppose this bill because of what is in it, because there is nothing in it. There are no benefits in it. There is nothing in the bill except to spend money to get private insurance companies, if they decide to do it, on the other side of the aisle.

Mr. Speaker, I yield 3 minutes to the gentleman from Georgia (Mr. LEWIS), who recognizes that.

Mr. LEWIS of Georgia. Mr. Speaker, here we are once again debating Medicare. Thirty-eight years ago, the Republicans did not like Medicare, and they do not like it now. In 1965, 88 percent of Republicans voted against Medicare. And here they are, once again, trying to privatize prescription drug coverage for seniors just like they tried to privatize Medicare.

This is just another scheme by the Republicans to entice older voters.
last week, not last year, but just yes- 
terday, the gentleman from California 
(Mr. THOMAS), the Republican chair-
man of the Committee on Ways and 
Means, made it crystal clear when he 
said, "To those who say that the bill 
would not save money, we know the 
answer is: We hope so." He went on to 
say, "Old-fashioned Medicare is not 
very good." Tell my mother. Tell your 
mother that old-fashioned Medicare is 
not good. Tell your grandmother, tell 
your daughters, that old-fashioned 
Medicare was not good. It was good in 
1965. It was good yesterday. It was good 
then, and it is still good right now. We 
do not need to destroy Medicare. We 
need to save and strengthen Medicare.

Mr. Speaker, this bill is just another 
Republican scheme to deceive our 
seniors, to deceive our elderly. That is 
not right. That is not fair. I want my Re-
publican colleagues to tell the Amer-
ican people the truth. We must tell our 
seniors the truth. We must not offer our 
seniors the basic right to affordable 
medication. We must and we will tell the 
American people that the Republicans want to privatize 
Medicare.

We must tell the American people 
the truth. This is no time to play part-
isan politics with the lives of our sen-
iors.

The clock is running. Time is run-
ning out. My Republican colleagues, 
you still have time to do the right 
things. Do not turn your back on our 
seniors, on the elderly. This is a matter 
of life and death.

I beg my colleagues to vote against the Republican bill, not 
just for our parents, our grandparents, 
our children, but also for generations 
yet unborn. Old-fashioned Medicare 
was like a bridge over troubled waters. 
It was reliable. It was dependable then, 
and it is still dependable.

Ask the seniors, ask the old people 
who live on fixed incomes in our cities 
and rural areas. I say to my Republican 
colleagues, follow the dictates of your 
conscience. You have a moral obliga-
tion. Do not throw away $400 billion, if 
all else is going to be paying for it.

But at some point in this debate, we 
ought to realize that we are in the mid-
dle of the greatest intergenerational 
transfer of wealth in the history of the 
world. Because while we strive to pro-
vide a decent and appropriate health 
program for seniors, we all know some-
thing is pie in the sky, and then there is 
for it. And so we really ought to focus on 
what we are trying to do to make sure 
that the young people who are going to 
be carrying this bill understand that 
while we are providing additional bene-
fits to seniors, we must make sure 
that the program stays within the rea-
sonable bounds of the $400 billion that 
we are proposing to add to Medicare.

Mr. Speaker, to insist on focusing 
on that, it is my real pleasure to yield 
4 minutes to the gentleman from Lou-
isiana (Mr. MCCRERY), the chairman of 
the Subcommittee on Select Revenue 
of the Committee on Ways and Means. 
Mr. MCCRERY. Mr. Speaker, I rise in 
support of this legislation. I recognize 
forms Medicare and adds prescription 
drugs to the program; but I arrived at 
this position of support haltingly, 
grudgingly, reluctantly. I will tell my 
colleagues why.

I was reluctant to support this bill 
because I believe the current Medicare 
program as it is structured is finan-
cially unsustainable. I believe it is 
only a matter of time before, as the fi-
ancial experts tell us, Medicare, one 
of the greatest programs in the his-
tory of our Federal Government, consumes an 
ever-larger and larger share of our na-
ton. But I have realized that Medicare 
was not good. It was good in 1965. It was 
good yesterday. It was good then, and it 
is still good right now. We do not need to 
destroy Medicare. We need to save and 
strength...
standard benefit, the traditional Medicare program, has to be phased out. And they say, but trust us on Medicare. Do not be skeptical of our intentions. We have come to love Medicare. There is not anybody on that side of the aisle that does not care, and there certainly is not anybody on this side of the aisle that believes that tonight as well. And then they argue, well, we have improved Medicare. Think of what we might have done without those tax cuts over the last 2 years.

A predictable, carefully defined benefit would have been in place for Medicare recipients. It is the closest thing, Medicare, that this Nation has ever had to universal health care. It is an extraordinary achievement for those who turn 65 years old, and they refer to it as old-fashioned Medicare and we are to trust them. But let us talk about Medicare+Choice where I live in Massachusetts, the private sector’s answer to the public care. Well, they are all gone and the ones that are not gone have jacked premiums through the roof. They do not want to take care of the most vulnerable and whether we have a debate about government tonight and its role or not, that in the end is what government does. It takes care of those who are outside the mainstream of this economic life. Not the top 1 percent of the wage earners in this country, not those who benefit from the repeal of an estate tax. It is government that does that.

Medicare is a legacy and an amendment to the Social Security program, the greatest achievement domestically in this Nation’s history. And that amendment in Medicare is a great child and a success of a determined Congress and an enlightened President, Lyndon Johnson. Tonight let us stand with history, stand with Roosevelt and stand with Johnson on what Medicare has done to make us a much more equitable society. What a great achievement it is.

Reject the notion tonight of where they are going to take us, and that is down the road to privatization of Medicare.

Mr. STARK. Mr. Speaker, may I inquire of the time remaining?

The SPEAKER pro tempore. Is there objection to the request of the gentleman from Texas (Mr. DOGGETT), a member of the Committee on Ways and Means to the gentleman from California (Mr. THOMAS) joined him yesterday by declaring, “To those who say that [the bill] would end Medicare as we know it, our answer is: We certainly hope so.” “Old fashioned Medicare isn’t very good,” he added.

The gentleman may not like reporters, especially if they report, but really there is nothing new or inconsistent in this statement and many that he has made for years. He just reffered a few moments ago to Medicare as “yesterday’s Medicare,” denigrating and deriding it. “Yesterday’s Medicare,” “old fashioned Medicare” has served millions of Americans pretty well.

The one problem we have with it is not the result of a defective Medicare. Rather the failure with the outrageous, predatory pricing of prescription drugs has resulted from the sustained collusion of House Republicans and pharmaceutical manufacturers. We can do something meaningful about that, but this is not it.

What of this plan that seniors are finally offered tonight? It is basically a “pay a lot and get a little” plan. If you are a senior and you have been hoping and praying we would finally be able to overcome the Republican resistance and deal with prescription drugs, what do you get from this bill according to its own clear language? Well, this year you get nothing. Next year you get nothing. The year after that you get something. Oh, yes, you are entitled to a discount card. It is as valuable as one of those cards you pull out of a cereal box. With it and a dollar or two you can get a cup of coffee, but it does not guarantee you a cent of reduction in the cost of your medications.

Finally, in 2006 you get all their much ballyhooed help. If you have $4,900 in drug bills, and that is mighty easy to get at today’s outrageous prices, you pay $350, and you get $1,400 paid for you, and that is only if you also pay an unknown premium, already estimated at least $35 per month. And such incomplete coverage at such a cost tells us what this initiative is really all about. This is a plan to eliminate Medicare and force seniors out of what they have known and what they have been promised, into a private system with no guarantee of coverage. This is not a prescription drug. This is a prescription for disaster.

I hope that our Republican colleagues continue holding up this poster about “strengthening Medicare” that they have been showing here because it looks like the type of solicitation scams that so many seniors receive weekly. Their poster shows seniors out frickling on the beach because of all the benefits they will get, when in fact seniors will watch their prescription costs soar. And they will watch their protection then be so desperately need on their prescription drugs. That is because those who are proposing this bill are the same folks, who tried to undermine Medicare from the time Democrats and Lyndon Johnson got it passed through Congress in 1965, and they have not reunted until this very moment.

The SPEAKER pro tempore. Is there objection to the request of the gentleman from California (Mr. THOMAS), former House Speaker Newt Gingrich, who insisted that Medicare should be allowed “to wither on the vine.” He has been chattering again this month, that Medicare is an “obsolete government monopony.”

The gentleman from California (Mr. THOMAS) joined him yesterday by declaring, “To those who say that [the bill] would end Medicare as we know it, our answer is: We certainly hope so.” “Old fashioned Medicare isn’t very good,” he added.

The gentleman may not like reporters, especially if they report, but really there is nothing new or inconsistent in this statement and many that he has made for years. He just referred a few moments ago to Medicare as “yesterday’s Medicare,” denigrating and deriding it. “Yesterday’s Medicare,” “old fashioned Medicare” has served millions of Americans pretty well.

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Mr. STARK. Mr. Speaker, I yield 3 minutes to the gentleman from Texas (Mr. DOGGETT), a member of the Committee on Ways and Means.

Mr. DOGGETT. Mr. Speaker, since President Lyndon B. Johnson signed Medicare into law over massive Republican resistance, Republicans have never ceased their determination to end Medicare. We all remember the partner of the gentleman from California (Mr. THOMAS), former House Speaker Newt Gingrich, who insisted...
prejudice the Committee on Government Reform's jurisdictional interest and preroga-
tives on these provisions or any other simi-
lar legislation and will not be considered as
prejudicing consideration of matters of ju-
risdictional interest to my Committee in the
future. Moreover, should these provisions or
similar provisions be considered in a con-
ference with the Senate, I would expect
Members of the Committee on Government
Reform be appointed as outside conferees on
those provisions.

Find someone who would ask that you include a
copy of our exchange of letters on this mat-
ter in the Congressional Record during
House debate of the bill. If you have ques-
tions with the Senate, we will do our best to
tell you and we won't hesitate to call me. I thank you for your
consideration.

Sincerely,

TOM DAVIS,
Chairman.

I also include for the RECORD a quote:

Some of our friends on the other side of the
aisle are saying that if this bill becomes law, it
will be the end of Medicare as we know it. Our
answer to that is, we certainly hope so. Why
should seniors be the last group that pays
to save money for drugs? Old-fashioned Med-
icare is fine. It's working very, very well. You're
going to hear scare tactics . . . but seniors with ex-
tremely high drug costs, when this becomes
law, will save more than 60 percent of cur-
rent out-of-pocket costs, real change, real
making Medicare a real day-to-day benefit.—
Bill Thomas, Chairman, Committee on Ways
and Means.

MR. DOGGETT. Mr. Speaker, I ask
unanimous consent to place in the
RECORD the report from NBC news corres-
dent Norah O'Donnell entitled
"Prescription Drug Benefit Imminent"
from yesterday's MSNBC.

THE SPEAKER pro tempore. Is there objection to the request of the gen-
tleman from California?

There was no objection.

PRESCRIPTION DRUG BENEFIT IMMINENT
(By Norah O'Donnell)

After years of promising a prescription drug benefit for seniors, Congress is on the verge of passing such a bill. This week, the House and Senate are expected to pass bills that for the first time will allow seniors to sign up for a prescription drug plan in which the government helps pay their drug bills.

Passions surrounding the Medicare reform bill are reaching a crescendo heading into votes in both the House and the Senate by the end of this week, perhaps as early as Thursday.

"To those who say that (the bill) would end Medicare as we know it, our answer is: We certainly have always heard Ways and Means Chairman Bill Thomas, R-Calif., Wednesday morning. "Old-fashioned Medicare isn't very
good," he added.

House Speaker Dennis Hastert, R-Ill., echoed the sense around Capitol Hill that this is indeed the year that it gets done. "We are at the point now where politics and policy have married up," he said.

Health and Human Services Secretary Tommy Thompson appeared with Thomas
and other GOP leaders Wednesday morning to release figures that purport to show what seniors would save on some popular drugs. For example, Thompson said that seniors are now paying $108.65 for 30 pills of Lipitor, a drug that in the future, he projects that the cost would come down to $96.92. Seniors would have to pay only 20% as co-pay ($17.38), according to his figures.

But House Minority Leader Nancy Pelosi and other House Democrats fought back, saying that it has forbidden the Health and Human Services actuary Rick Foster from releasing his analysis of how much Part B premiums would go up under the plan. Foster has said that an existing program that insures seniors for medical services other than prescriptions.

They suspect the figures would show that the premium would rise substantially. A similar bill in 2000 would have resulted in a rise in Part B premiums of 47 percent. Pelosi and Rep. Pete Stark, D-Calif., said that Foster is being threatened with termination if he reveals the figures this time.

Once the measure passes, congressional Re-
publlicans and President George W. Bush will
dlclare victory, while Democrats, who have
traditionally championed. "This could be trasformational in terms of the image of
the Republicans among seniors," Bill McInturff, a Republican pollster, said.

Seniors or older voters have historically favored Democrats when it comes to the issue of prescription drugs. In a recent survey by the Kaiser Family Foun-
dation found older voters now trust Republic-
ans and Democrats equally.

Older Americans are the nation's most re-
liable voters. Two-thirds of them go to the polls.

As a quick example, George W. Bush lost the state of Pennsylvania to Al Gore by five points in the year 2000. He lost among older voters by a whopping 17 points. If the presi-
dent improves his standing among older vot-
ers, he could close the margin of victory in such a state.

But the potential political windfall could be stymied once seniors get a closer look at the details of the plan. After conducting polls and focus groups, strat-
gists are warning fellow party members that seniors who've done the kitchen-table test are not happy.

In fact, according to an internal Republic-
ian memo by McInturff, obtained by NBC News, the pollster warns that, in focus
groups, seniors are very disappointed: 'The
current drug coverage plan is not gentle
ous as the private coverage two-thirds of seniors already enjoy. It's clear most seniors are first evaluating this plan in comparison to their current, private coverage, then de-
ciding it's not as generous and certainly not
a replacement for that coverage, so some are
reacting unfavorably.

McInturff is advising Republican law-
makers and the president that they can over-
come deficiencies with the bill, stressing
rhetorically that the plan provides seniors with additional choices.

GAPS IN COVERAGE

The nation's largest lobby for seniors, the
American Association of Retired Persons, or
AARP, has warned Congress that it is deeply
concerned about gaps in the plan. "People are disappointed that there isn't more of a benefit here," said John Rother, policy director for the AARP. "And sometimes they think, 'Well, at least it's a first step.' But every-
one is disappointed."

That's especially true for seniors like 77-
year-old Pat Roussous of Madison, Conn. She
suffers from arthritis, diabetes and high
blood pressure. Her out-of-pocket drug costs were
$4,500 a year. "It's only a start. And I'm not convinced it's going to get very far," she said.

Roussous is one of an estimated 10 million seniors who will fall into a benefit gap, be-
cause, under the Senate plan, the govern-
ment will pay for half of drug costs up to
$4,500. But, there's a huge gap for the next
$1,500 where the beneficiary must pay for all of their drug costs.

Catastrophic coverage does not kick in
until one's drug costs exceed $5,500. Then the government will pay 90 percent of drug cost over that amount.

"I think, the gap—where people are required to pay for the drug themselves—I can't imagine that working," said Roussous. "Because those are the people who actually need to have the help."

Still, the AARP will not use its political
might to block the plan. "This year, 'some-
thing' in prescription drugs is better than
'nothing,'" said Rother.

The bulk of the proposed assistance in the prescription drug plan is set to be enacted until 2006. Until then, seniors will receive a discount card that will provide them with 10 to 15 percent off their drug costs. Low-in-
come seniors will get extra help.

Mr. THOMAS. Mr. Speaker, I yield myself 15 seconds.

I see the gentleman from Texas (Mr. DOGGETT) had two quotes connected
with a description of myself, rather than the continuation of the real
game, and I can understand why he
would fabricate the quote in that way.

Because what I said was, why should seniors be the last group that pays re-
tail prices for drugs? That really did not fit the intention of the gentleman's
thesis, but that is simply the truth.

Mr. Speaker, I yield 2 minutes to the gentleman from Iowa (Mr. NUSSELLE), the
chairman of the Committee on Budget, but I proudly say also a member of
Committee on Ways and Means.

Mr. NUSSELLE. Mr. Speaker, I thank the gentleman for yielding me time and
for his partnership and hard work on this bill.

The Democrats are living in 1965. Boy, we have heard a lot about that
time. We have heard about Bob Dole and Lyndon Baines Johnson. Well, that
is great but it is not 1965. Medicare is going bankrupt. Tax cuts did not cause
that. Health care costs are out of con-
trol. The reimbursement system under Medicare is broken and it is not paying
the bills. Hospitals are closing. Doctors are leaving rural areas or not taking
Medicare patients at all. Cost shifting is running rampant onto the private
pay side, and as a result, problems are running rampant within our health care
system.

Benefits have not improved. We do not have drugs. We do not have preven-
tion. We do not have disease manage-
ment. We have a sick care system, and
the Democrats have done nothing about it for the past 30 years since they
did pass Medicare in 1965.

Doing nothing tonight is not an op-
tion, and that is why in the budget we put $400 billion to improve Medicare,
increasing Medicare by $400 billion, hardly withering on anybody’s vine, because doing nothing is not an option. Tonight, H.R. 1 is the choice. It modernizes Medicare, saves it from bankruptcy, controls costs, modernizes benefits. It fixes the Iowa and other rural reimbursement problems, keeps these hospitals open and viable so that they can pay the bills as a result of amendments that have been passed in both the Committee on Ways and Means and the Committee on Energy and Commerce.

Quality health care will be available in rural areas on into the future as a result of what we have done tonight. Inaction is not an option.

But there is one other choice. The Democrats will offer a $1 trillion Medicare drug benefit tonight; one that CBO says costs $1 trillion. Guess what? That not only busts the Republican budget, but it busts the Democratic budget and it busts both of our budgets combined. It makes Medicare bankrupt Medicare.

Save it by passing H.R. 1.

Mr. STARK. Mr. Speaker, I yield 2 1/4 minutes to the gentlewoman from Ohio (Mrs. JONES), a member of the Committee on Ways and Means who understands that the Republican bill does not extend the life of the Medicare Trust Fund at all. In fact, it probably reduces it some.

Mrs. JONES of Ohio. Mr. Speaker, I will begin with a quote. “Seniors face a confusing hodgepodge of co-payments and deductibles in Medicare. The system is irrational and difficult to navigate. Simplifying and modernizing cost sharing will make coverage easier to understand and will strengthen the Medicare program over the long term. I believe we can better design both Medicare and Medigap so that seniors and people with disabilities get the most of the health care dollars they spend.”

That is a quote from a Republican colleague. But let me report from Howard Brown, 77 years old, from Cleveland, Ohio. He complained about the complexity of the program that will involve choosing a plan, tracking out-of-pocket expenses, and knowing when the coverage kicks in, lapses and then resumes in severe cases, all according to a sliding scale of benefit.

Mr. BROWN said, “I am too old to try to figure all this out. Make it simple. Make it plain so I can understand it.”

The people in the United States, the seniors are on Medicare, they want a defined benefit giving them an entitlement and a guarantee. They want it to be affordable with reasonable premiums and deductibles. They want it to be designed to significantly reduce the price of their prescriptions, and they believe in meaningful Medicare prescription drug bill that provides absolutely no gaps and no separate privatized ambulance.

□ 2030

But we have not heard any Republican get up tonight and define what the gap is. They have not explained to seniors across this country that there will be a gap in coverage, and it will not be Medicare improved for prescription drugs.

Truly, 35 years ago we did not think about prescriptions as being part of Medicare. In fact, a part of Medicare today, and our seniors do not want to wait till 2006 and then find out that after paying premiums all year that they do not get any coverage in this gap of coverage. Explain the gap. Mr. and Mrs. Republican on the Republican side.

What about the new preventive? Every new beneficiary gets an opportunity, but what about the old folks? It is like Mrs. Ruby Bogus from Cleveland, Ohio, said. She was annoyed that the program would not begin until 2006, and do my colleagues know what she told her friends. Well, girls, I guess we will just have to live a little bit longer to get a prescription drug benefit.

Mr. THOMAS. Mr. Speaker, I yield myself 15 seconds.

If the gentlewoman would go to page 260, line 19, from the legislation before us now, I quote, “Nothing in this part or the amendments made by this part shall be construed as changing the entitlement to benefits under parts A and B of title XVIII of the Social Security Act.”

Mr. STARK. Mr. Speaker, if the Chairman could explain the gap, but obviously he cannot. So I am happy to yield to the gentlewoman from Texas (Mr. SANDLIN), a member of the Committee on Ways and Means.

Mr. SANDLIN. Mr. Speaker, it is the old bait and switch. The Republican leadership has used smoke and mirrors to trick seniors into thinking they are getting a Medicare prescription drug plan when in reality they are forcing them to seek medication from private insurance companies, not Medicare.

Mr. Speaker, this is not an entitlement Medicare for seniors. All this is is an entitlement to ask to be able to make an offer, to make a purchase from a reluctant, profit-seeking insurance company who may or may not accept that offer. Importantly, not a single insurance company in the United States of America has volunteered or agreed to take part in this program, not one, nada, zip, zilch. This plan is nothing more than a mere vapor.

What has history shown us about what happens when private insurance companies get involved in Medicare? Medicare+Choice, the great managed care experiment on our Nation’s seniors, should have been named Medicare Minus Choice. After all, it has been a total disaster for seniors. Between 1998 and 2003, the number of Medicare+Choice plans dropped by more than half. In my home State of Texas, 313,000 Medicare+Choice seniors have been dropped by insurance companies just since 1999.

Question: Who sets the price of the drugs in the Republican insurance company plan? The Republican insurance company plan allows HMOs and pharmaceutical companies to determine how much to charge and what coverage to offer.

Mr. Speaker, I would like to take a vote, what do my colleagues think the insurance companies will charge, more coverage or less coverage? What will the pharmaceutical companies charge, more money or less money? The answer is clear.

The other day the President said, “When the government determines what drugs are covered and which illnesses are treated, patients face delays and inflexible limits on coverage.” And yet the Republican private insurance company bill wants to turn over these decisions to an insurance company who has financial interest in denying coverage. The more insurance companies deny, the more money they keep.

Now, is that not special?

Mr. THOMAS. Mr. Speaker, I have one speaker to close.

Mr. STARK. Mr. Speaker, I am delighted to yield 1 minute to the gentleman from Georgia (Mr. SCOTT). Mr. SCOTT of Georgia. Mr. Speaker, this bill is the Republican side.

Mr. Speaker, let me just say this about what course of action Congress is presenting to the American people. To help the least of us, to help those who cannot afford the medicine. Government is there for those who cannot afford the medicine. Government is there for something. They do not want it privatized.

Mr. Speaker, let me just say this from one of my constituents, and I would read this note. He said, “I am a 74-year-old retired senior on Medicare and this Medicare drug prescription plan is just a stone’s throw away from privatization of Medicare. That should not be allowed to happen.” Let us not let it happen.


Representative DAVID SCOTT, (dubbed, GA)

DEAR REPRESENTATIVE SCOTT: I am a 74-year-old retired senior that’s on Medicare at home recovering from a massive heart attack and bladder infection so I am very concerned about the course of action Congress is presently taking on the Medicare Drug Prescription Plan.
When the news first came out that Congress was finally going to add prescription drugs to Medicare in order to provide financial relief for seniors that are paying way to much for their prescription versus their meaner yearly income from Social Security and if they have one, their pension fund and any life savings they may have. At that time I heard the Republicans say that doing this was absolutely ruining Medicare. How such a plan Medicare beneficiaries would be given a choice if they needed and wanted their prescription drugs covered by Medicare. They had to do this plan for it and pay whatever the cost of the plan covers. For the rest of us who are happy staying with Medicare and our present secondary insurance coverage that provides better prescription drug coverage at a lower cost would not have to participate in any Medicare prescription drug plan.

Seniors that don’t have prescription drug coverage should be covered by this plan as a matter of choice, however; I feel it is unfair for Congress to make it a mandatory requirement for all seniors to pay for this plan which would override their own secondary insurance plan for their prescription drug plan. It just isn’t fair, they should have the right to make up our plan and end up paying far more than what we are presently paying! I’m sure if all seniors were aware of what really is going on they would want to make it a matter of choice also.

Representative Scott please give us Medicare beneficiaries a choice to join or not to join the prescription drug coverage.

Even though I’m not in your district I’m asking you to support us many seniors by making sure this choice provision will go into the final bill that is sent to President Bush. If this choice does not become part of this Medicare Drug Prescription plan it is just a stone’s throw away from the privatization of Medicare and that should not be allowed to happen. Please remember when you vote whatever the outcome is on this plan it will affect all Americans nation wide and in some way or other I’m sure it will have some sort of a bearing on the outcome of the 2004 elections.

May God Bless you and may God Bless America.

Sincerely yours,

RICHARD MCGRAW.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Florida (Mr. WEEXLER).

Mr. WEEXLER. Mr. Speaker, I am privileged to represent the oldest district in this country, and I thought it was important to hear from some of those seniors who fought in World War II and Korea and who rebuilt this country after the depression.

Mr. and Mrs. Robert Moore of Lantana, Florida: "Why do we worry about tax cuts for the rich while so many other folks have to choose between Social Security and Medicare and working or whatever?"

Speaking directly to the Republican plan, Mr. Arthur Taubman of Delray Beach, Florida: "I prefer nothing instead of a botched up Republican plan."

Mrs. Elaine Schwartz from Baynton Beach: "It is very disappointing to me that I live in this wonderful country and senior citizens who have contributed for so many years supporting this country have been forgotten."

Mrs. Hegel has got it right, forgotten benefits. Drug benefit for seniors, forgotten; lower drug costs for seniors, forgotten by the Republican plan. American seniors by the Republican plan, forgotten.

Mr. STARK. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. BELL).

Mr. BELL. Mr. Speaker, the gentleman from Texas (Mr. DELAY), the majority leader, has stated that the Democratic strategy on his Medicare bill is obstruction, obstruction, obstruction; but when the best that the GOP can do is create a plan that destroys Medicare, we should all rise in opposition.

I want to point out that the Republicans blocked every attempt at a Democratic substitute, sound proposals that would protect Medicare and provide comprehensive coverage for all seniors, regardless of the size of their bank accounts. The AARP, a trusted voice on this subject, says the Republican plan is not good public policy because it has too many coverage gaps.

Why do the Rethuglicans oppose better plans without gaps for seniors? Well, the gentleman from Iowa says one of the plans is too expensive. It was not too expensive for them to pass the largest tax cut in American history, only to create the largest deficit this country has ever seen. Just when it comes to providing our seniors with the most basic ability to protect their health the cost is too high.

It does seem to me to be a simple matter of priorities. So do I insist to obstruct the gentleman from Texas (Mr. DELAY) and the Republican’s plan to destroy Medicare? Absolutely.

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

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

Ms. JACKSON-LEE of Texas. Mr. Speaker, I yield 1 minute to the gentleman from Texas (Mr. BELL).

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

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

Ms. JACKSON-LEE of Texas. Mr. Speaker, I did not want this historic debate to leave without my words in opposition to a plan that does nothing to serve the needs of seniors in America. The reason? Because I am proud that President Lyndon Baines Johnson in 1965 extended the lives of American senior citizens, but today we have a plan that will be shoved through on this floor that denies the preservation of Medicare, denies the real Medicare benefit. Lower prices are denied. Full coverage is denied. Choice of drugs is denied because when a sick senior citizen gets ready to pay for their prescription drug benefit, then they drop through the doughnut hole; and if they survive, if they live through the gap between when they start paying for it, then they may be able to hit again when the amount of the prescriptions go up to $5,000.

The doughnut and privatization are two items in this particular legislation that I will stand against, and again, Medicare denied, real Medicare benefits denied; full coverage denied, choice of drugs denied. This is a historic debate. Vote "no" and stand on the side of saving lives of America’s senior citizens.

Mr. Speaker, when we look at the health care system for our seniors in the United States today, we see good news and bad news. The bad news is that drug costs are outrageously high. The good news is that Medicare is an effective and efficient program that is working well for our seniors, and that seniors who disagree with these two facts: that drug costs are too high and need to be brought down, and that Medicare is a good program that needs to be protected.

That means to me that the Prescription Drugs Bill that the Republicans are showing through Congress today without opportunity for amendment or time for debate, is preserving the bad—the high cost of drugs—and is dismantling the good—Medicare.

We Democrats have been fighting for years for a Medicare prescription drug program that is (1) affordable; (2) available to all seniors and Medicare beneficiaries with disabilities; (3) offers meaningful benefits; and (4) is available in the Medicare program—the tried and true program that seniors trust.

And now it seems that we have the political momentum to make a good prescription drug benefit a reality. The President says he wants it. Both parties, both sides of Capitol—everyone has declared their commitment to getting affordable prescription drugs to our nation. So why is it that the only Medicare prescription drug plan that the Republicans have to offer is a terrible bill with full of holes, and gifts to the HMOs, and protections for pharmaceutical companies. Every time we get a chance to take a closer look at the Republican drug plan, it becomes obvious that it is just another piece of the Republican machine that is trying to dismantle Medicare and turn our federal commitment to our nation's seniors, over to HMOs and the private insurance industry.

The Republican plan would be run by HMOs, not Medicare, HMOs would design the new prescription drug plans, decide what to charge, and even decide which drugs seniors would get. Plus, HMOs would only have to promise to stay in the program for one year. This means that seniors might have to change plans, change doctors, change pharmacies, and even change the drugs they take every twelve months.

Medicare expert Marilyn Moon told the Senate Finance Committee on Friday that "There will be a lot of confused and angry consumers in line at their local pharmacies in the fall," if the Republican approach is not changed. She's right.

The Republican plan provides poor benefits, and has a giant gap in coverage. Under the House Republican plan, many seniors would have to pay high copays if they don’t receive benefits. Reportedly, under the House GOP plan, Medicare beneficiaries have a high $250 deductible. After they reach that deductible, they would then be required to pay a portion of their first $2,000 in drug costs—that is a fairly normal system. But, after a senior’s costs hit $2000 for a year—that is when it becomes obvious just how bad this plan is. Once a senior’s drug costs hit $2000, the Republican plan cuts them off. Even though they must continue to pay premiums, they get no assistance in paying their drug costs until then. Let me give you an example. Let’s say that you make $15,000. Let me say that you gain a serious illness and your prescription drug costs hit $2000. Let me say that you have Medicare. Under the Republican plan, you would have to pay $15,000 and then $2000, which is $17,000. This is outrageous. The drug plan is not the answer. The answer is Medicare.
costs reach the $2000 mark—they fall into the Republican gap. They are left to pay the next $3000 out of their own pockets, while continuing to pay premiums. Almost half of seniors would be affected by this gap in coverage. They will be outraged, and our offices will be hearing about it. So today we are hearing that 4 out of 5 seniors, those people we are trying to help, are against this plan.

I have attended hundreds of health care briefings, and have read everything I can get my hands on, on the subject of improving Medicare and health insurance to the American people. And I have never heard anyone say that a hallmark of a smart health insurance program is to have a giant gap in coverage for those who need help the most. Why would our Republican colleagues put in this ditch in the road to health for seniors? Because they wasted all of our nation's hard-earned money, on massive tax breaks for the rich, and an unnecessary war.

So now they have placed an arbitrary budget cap on vital programs, pushed by President Bush, in order to compensate for the irresponsible health care they jammed through this Congress and last Congress. The way they are dealing with the mess that they have made is by throwing bad policy after bad policy. To remain within their own arbitrary budget cap, they are pitching a bill that will provide a confusing, insubstantial benefit to the majority of seniors.

If the Republicans wanted to save money, they could have put in a provision that I and many Democrats have pushed for—and that is to allow the Secretary of the HHS to negotiate with the pharmaceutical companies to get fairer prices for the American people. I believe that the American pharmaceuticals industry is the best in the world. They make good products that benefit the world. But Americans are now paying double the cost for drugs than their counterparts in other rich nations such as Germany, Canada, Great Britain, or Japan. I am glad our companies are making money. But as we enact a prescription drug benefit under Medicare, access to drugs will rise—and drug company profits will rise as well. It is only fair that the Secretary have the power to negotiate a good price for American consumers to make sure we get the best returns possible on our federal investment.

Not only did the Republicans not put in a provision to allow such negotiations, they went out of their way to forbid the Secretary from trying to get better prices for Americans. Why? Because they value the profits of their corporate sponsors at Pharma, more than they care about the well-being of our nation's seniors. It is fair because it helps the low-income. It is simple because it pays 80 percent with catastrophic coverage. It is right because it pays 80 percent with catastrophic insurance. It is practical because it would save $3,700 catastrophic cap, over which Medicare would pay 100 percent. The practical effect of this is that employers will stop offering retiree coverage. That is a step in the wrong direction.

We can do better. The House Democrats' legislation, that I and other new benefactors of, is designed to help seniors and people with disabilities, not HMOs and the pharmaceutical industry. Under the Democratic proposal, the new Medicare prescription drug program would be affordable for seniors and Americans with disabilities and available to all no matter where they lived. It offers a meaningful benefit with a guaranteed low premium; and would be available as a new "Medicare Part D" within the traditional Medicare program that seniors know and trust.

I am committed to getting seniors the prescription medications that their doctors deem they need. I want to work with our Colleagues on the other side of the aisle, and the Administration to make that happen. But unless I see a plan without a consistent benefit—with some smart cost-controls—and some protections for Medicare, an excellent plan for Americans, I cannot support this Republican drug scheme.

This bill is a sham. Our seniors have been looking forward to getting relief from the high cost of drugs. They will be waiting with anticipation until after the next elections, when this bill conveniently kicks in. When it does, they will be furious. Let's do better.

The SPEAKER pro tempore (Mr. STARK), to close for our side, to continue to talk about the bill that for the first time in the history of Medicare provides low-income help, and she is the chairwoman of the Subcommittee on Health of the Committee on Ways and Means.

Mrs. JOHNSON of Connecticut. Mr. Speaker, I thank the gentleman for yielding me the time.

Today, is an historic day for America's seniors. Congress is about to fulfill the promise and the potential of Medicare, which has been one of our greatest success stories in our history; but when Medicare was created in 1965, prescription drugs were few and far between. Instead, painful and invasive surgeries were standard treatment; but now, with the health security of our seniors tied directly to medicines, medicines that extend life and restore hope, we must add prescription drugs to Medicare for all our seniors. A Medicare program without a drug benefit is a false promise in the 21st century. I am proud to stand here on this House floor and bring prescription drugs to Medicare for all of our seniors and a benefit that is simple, generous, and fair.

It is simple because it pays 80 percent of the first $2,000 of drug costs; and it guarantees the peace of mind of our seniors, protecting them against catastrophic drug costs, covering all costs above $3,500.

It is generous because the average senior spends $1,200 on prescription drugs every year. Yet in this bill we cover 80 percent of the cost up to $2,000.

It is fair because it helps the low-income seniors more than any other group. It not only helps the very poor, below 150 percent of poverty, but for the first time, by allowing State subsidies to help seniors toward that threshold of catastrophic coverage, we help the next income group to have the security that seniors depend on in their retirement.

In addition, there is fairness at both ends of this bill. Should someone with a $200,000 income have the same level of catastrophic protection as a low-income senior? Of course not.

But modernizing Medicare cannot be just about prescription drugs, as important as prescription drugs are. It
must also be about addressing the most crippling threat to our seniors' well-being and their retirement. It must address chronic illness.

Current Medicare is an old-fashioned illness treatment program. This bill will provide seniors with chronic illnesses a chance to have truly progressive care, whose goal is to prevent the progression of chronic illness. Our goal must be to be sure that if you have diabetes, you do not end up on dialysis.

Disease management is the new frontier in medicine. It will slow, interrupt or reverse disease. It requires more sophisticated technology. It requires greater patient involvement in their own care. But it results in higher quality health care and much improved quality of life and lower costs for hospital care, emergency room care, and doctors' visits.

Mr. Speaker, this bill will bring the cutting edge of medical science and modern technology to the service of our seniors and disabled veterans. With over half of our seniors suffering from five or more illnesses and using 80 percent of Medicare's resources, we must bring chronic disease management to the service of our seniors. And no bill to this point has ever done that.

So I am proud to say that this bill brings both prescription drugs and preventive health care programs to Medicare and will provide unprecedented vitality to our Medicare program.

In conclusion, let me remind us all that this bill will revitalize our Medicare Choice plans and provide that reliable high-quality care year after year that seniors depend on, a more holistic integrated care than fee-for-service can provide. So I ask my colleagues tonight to support wholeheartedly and enthusiastically H.R. 1.

Mr. Speaker, this bill is so thoroughly and methodically, the extraordinary cooperation in the work has personally given to this effort and the way in which she has worked with members of the Committee on Energy and Commerce, so many long hours, to accomplish this bill.

It is important also that I highlight, while not acknowledging all the staff who contributed so many hours, the head of our health care staff of the Committee on Energy and Commerce, Mr. Pat Morrissey, who has done Herculean work once again on behalf of this effort. I also acknowledge and thank, again, Mr. Ed Grossman, who is a legend in the Legislative Counsel's office, in terms of his contribution to this entire body and the work we do in preparing legislation for the floor.

In my effort 2 1⁄2 years ago to create once again an opportunity for this House to pass a prescription drug benefit for Medicare, and at the same time, to modernize a system that is in deep trouble, we announced that the entire effort in health care would be dedicated to a theme of patients first; the idea that everything we did should be designed to make sure that patients in America continue to have the best health care delivery system in our country and, importantly in this area, that seniors get something they desperately need; and that is that every senior get access to prescription drug coverage and that the Medicare system itself, which has long been abhorrent to the Congress and the public, be reformed and modernized so adequately described, a much better bill, a bill richer in benefits, more secure in the texture of its structure, to make sure that seniors would, in fact, have more choices. Those like my mother, who want to stay in Medicare, can only stay in Medicare but enjoy a prescription drug benefit now; and those who might enter their senior years knowing about choice, liking choice, preferring choice, having the availability of different plans offered in the private sector that they could choose their prescription drug benefit.

In this bill this year, we do a number of other things. We address the concerns of many of our health care providers in terms of their lack of proper reimbursement. We deal with the insolvency. And Medicare, a system by which so many citizens have depended on for years for their health care, is absent this vital asset of prescription drug coverage. So we began our efforts to make sure we could add that coverage to the bill. We have been doing this in several Congresses every year we battle over what is the right number to fund this program and how best to fund it.

I want to point out that we owe a great debt of gratitude to the chairman of the Committee on Energy and Commerce, the gentleman from Iowa (Mr. Nussle), for including this year $40 billion for us to fund this effort. In last year's budget, we dealt with considerably less. In fact, in the Democratic budget that was prepared for the year 2002, our friends on the other side allocated only $330 billion to their effort to fund prescription drugs. This year, our Committee on the Budget provided us with $70 billion more than even the Democrats did when they prepared their budget for the year 2002. And I want to thank the Committee on the Budget and Chairman Nussle for that great effort.

With that amount of money available, we have been able to construct this year, as the gentleman from California (Mr. Thomas) and his team so adequately described, a much better bill, a bill richer in benefits, more secure in the texture of its structure, to make sure that seniors would, in fact, have more choices. Those like my mother, who want to stay in Medicare, can only stay in Medicare but enjoy a prescription drug benefit now; and those who might enter their senior years knowing about choice, liking choice, preferring choice, having the availability of different plans offered in the private sector that they could choose their prescription drug benefit.

That is the kind of world we hope to create when we pass this bill tonight, a world where we can bring prescription drugs into Medicare. We can bring new stores to town and make sure that every store, the government store and the private store, all have the products that seniors need so desperately, and that is prescription drugs.

In this bill this year, we do a number of other things. We address the concerns of many of our health care providers in terms of their lack of proper reimbursement. We give hospitals in New York and across America the money to do what they need to do. We add reimbursements to hospitals and physicians and caregivers and diabetes centers and doctors and patients. We provide $27.2 billion of assistance to rural health care givers and hospitals to beef up care in America where care is desperately short and, unfortunately, hospitals are closing and doctors are leaving their practices.

Indeed, because they add to the mix of choices that seniors will have in the future, there are predictions from CBO that Medicare will get back on its
feet, will not necessarily have to go insolvent. It will have a chance to be one of the options that seniors wish to choose for a long time in the future. These benefits are going to benefit all Americans. I know there is some talk out there that this plan has coverage and then there is a donut hole and there is coverage again for catastrophic coverage. The discounts provided to seniors in this bill will be available at all stages of prescription drug use. There will be a stage of prescription drug use and purchase throughout the bill. Seniors will see lower drug expenses in this bill. CBO estimates, in many cases, by as much as 50 to 70 percent. All seniors will benefit.

And for the seniors who live below 135 percent of poverty, and there are thousands and millions of those seniors living across America, this bill provides a 100 percent subsidy, 100 percent coverage for the drugs they are going to need under this prescription drug plan. And that is a pretty good effort and that is a pretty good reform of our system.

Indeed, we are also going to do some interesting things. We are concerned about the high prices of drugs. And like the Senate, we include reforms in the Hatch-Waxman laws that will speed the approval of generic drugs into the marketplace. And we reformed that awful, that phony wholesale prices that force seniors to pay 20 percent of phony prices whenever they suffer cancer and have to endure cancer therapies and urinary tract infections and strokes and other therapies. In short, we are going to lower the cost of drugs to America across the board, and we are going to increase the availability of drug coverage for every senior in this country and build new options for seniors to choose from. That is a pretty good package.

I want to again congratulate all who worked on it and all in the two committees who contributed so much to it. In the Energy and Commerce we had 65 amendments, I think 29 recorded votes, over 22½ hours of debate again this year. Are we ready for this vote tonight? You bet we are. Are seniors ready for the debate to end? You bet they are. Are seniors ready for us to really do this tonight? You know it. Are seniors ready for this House, the Senate, and the President to come together and actually sign a law that gives them these benefits, instead of constantly just debating the issue? You know that is true.

This is a historic moment, and this is our time to get it done.

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

The SPEAKER pro tempore. The gentleman from Michigan (Mr. DINGELL) is recognized for 45 minutes.

Mr. DINGELL. Mr. Speaker, I yield myself 3 minutes.

Mr. Speaker, three things: One, this is a bad bill. Two, it is not the Senate bill. And, three, it destroys Medicare as we now know it.

And if you do not believe it, take the words of my good friend, the chairman of the Committee on Ways and Means, who says, "To those who say this bill would end Medicare as we know it. Our answer is, we certainly hope so. Old-fashioned Medicare is a good program." Well, it is a safety net that has preserved and protected the health and the well-being of Americans for 38 years. It has been a fabulous system for the protection of the health and the welfare of the people.

This thought echoes the words of Speaker Gingrich, who wanted Medicare to wither on the vine.

Well, it is a fraud upon the American people. It provides very little for most people who are looking for the benefit of receiving prescription pharmaceuticals. What it does is it subsidizes the insurance companies. It does not control prices. It does not stimulate competition. So they offer the senior citizens a situation where they wait 2 years. And after they wait 2 years, what do they get? An enormous donut hole into which they fall after they have spent $2,000, during which period, for a period of about 1 year, they get no additional help from their government, but during which time they have to pay more money, more money, to not draw any benefits.

And it should be noted there is no requirement whatsoever, none in this legislation, that requires the insurance companies who will begin getting subsidized enormously in just 2 years after the enactment, to do a single thing to provide them with pharmaceuticals for the benefit of their subscribers. Indeed, most insurance companies have said they do not want to participate in the pharmaceutical-only care benefit that would be offered by this legislation. So they set up this wonderful situation where there will be enormous boundless subsidies to try to induce somebody to come in and set up HMOs which will serve the people in the area or provide pharmaceutical only care. And it should be noted there is no requirement that they will serve the people or provide pharmaceutical only care.

The Democrats have a simple, easy-to-understand piece of legislation, one which builds upon the practices which we have used in Medicare with such great success and so efficiently for so long to see it to that the people get the benefit on the payments of a modest sum and a modest deductible and then they get their benefits. No donut hole during which they do not gain benefits. And I would note that, by an interesting circumstance, while people under this wonderful Republican bill will pay a lot more than they will get out of this legislation. It is a piece of legislation which can best and most kindly be defined as a fraud upon a group of people who have high hopes that their Congress is going to take care of them.

Well, this Congress is going to take care of them; it is going to give them a deceitful piece of legislation which benefits them very little, if at all.

Mr. Speaker, less than 2 weeks ago, the House Republicans divorced themselves from the Senate bipartisan legislation and unveiled their lengthy and complicated proposal to make sweeping changes in Medicare. After taking months to develop more than 300 pages of fine print in secret consultation with corporate executives, the Senate brought this bill through committees last week and is ramming it through the House today under a rule developed in the wee hours this morning. No hearings, no significant opportunity for public comment, no concessions—just the way the House Republican leadership likes it.

But the Republican leadership is playing with fire. Not content merely to privatize a watered-down drug benefit, this bill, H.R. 1 privatizes the entire program in 7 years. As Chairman Thomas said yesterday, "[t]o those who say that [the bill] would end Medicare as we know it, our answer is: We certainly hope so. * * * Old fashioned Medicare isn’t very good." And a Republican Senator said quoted last month as saying that "I believe the standard benefit, the traditional Medicare program, has to be phased out," Speaker Gingrich’s 1995 prediction that traditional Medicare would “wither on the vine.” The list goes on. Former Majority Leader Dick Armey said, also in 1995, that Medicare was a "program I would have no part of in a free world."

Most recently, the Bush administration official in charge of Medicare, Tom Scully, 2 months ago called Medicare an "unbelievable disaster" and a "dumb system." And, of course, I was here in 1995 to witness the overwhelming majority of Republicans vote for the motion to recommit the legislation that created Medicare.

How will seniors react when told they will be forced to pay more to see their family doctor, or accept whatever doctors and benefits a private plan chooses to give them? How will seniors react when traditional fee-for-service Medicare is no longer a trusted safety net? How will seniors react when given a voucher and told to fend for themselves in the insurance marketplace—the same marketplace that failed them before Medicare? They should, and will, be outraged.

Seniors will also be angry when they learn that the Republican drug benefit helps insurance companies more than them. Democrats propose a true benefit provided under Medicare, with set premiums and benefits. Republicans propose payments to insurers to offer uncertain benefits, with uncertain premiums. The only certainty in the Republican plan is a huge coverage gap, when seniors will continue to pay premiums after substantial out-of-pocket expenses, and yet receive no benefit. And drug costs will continue to rise, because the Republicans prevent bargaining by Medicare to make prescription drugs more affordable to seniors.

Other nasty surprises will hurt seniors as well. Cuts in payments to hospital, when many are closing down. Inadequate payments to doctors, when seniors’ access already is jeopardized. Increasing seniors’ costs by $8.3 billion for their Part B coverage. These are shortsighted acts of extraordinary callousness.

I urge my colleagues to reject this dangerous Republican plan. Our senior citizens deserve better than to be guinea pigs for risky ideological experimentation.

Mr. Speaker, I reserve the balance of my time.
Mr. TAUZIN. Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. BILIRAKIS), the chairman of the Subcommittee on Health.

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

Mr. Speaker, I rise in support of H.R. 1, and I urge my colleagues to lend their support to this very important bill. We have before us a historic opportunity to provide our constituents with a meaningful prescription drug benefit that our Nation can afford. While the bill before us certainly is not perfect, it targets the $400 billion available under our budget resolution towards areas where it can do the most good.

Our bill provides a great deal of assistance to our lower-income seniors for whom we waive a deductible and co-insurance requirements. These seniors, those with incomes below 150 percent of the poverty level, which in 2002 was $13,290 for an individual and $17,910 for a married couple, will only be responsible for a small copayment per prescription.

In addition, the bill targets the prescription drug benefit towards those who need it the most. Beneficiaries are only responsible for 20 percent of their drug costs between a $250 deductible and a $2,000 initial coverage limit. When we consider that the 2003 median drug costs for Medicare beneficiaries are estimated to be $1,350, it is clear that our bill provides a very good, upfront benefit.

Finally, the bill ensures that seniors will have the peace of mind of knowing that their annual drug costs will be capped at no more than $3,500 out of pocket. While that number does rise for some wealthier seniors, I would note that 95 percent of seniors will qualify for the $3,500 figure. Our bill makes other improvements to the Medicare program, and includes some Medicare payment modifications to ensure that beneficiaries will still have access to high-quality health care.

I would like to close by noting my great disappointment with my colleagues on the other side of the aisle, who for 30 years when they controlled this House did not do a thing for Medicare. I had to sit through a 3-day markup where my intentions and those of my colleagues were constantly questioned. Republicans were often accused of not being willing to commit adequate resources to a Medicare prescription drug benefit. I find that odd since in 2001, 2 years ago, the Democratic substitute to the budget resolution included only $330 billion for a new drug benefit. Republicans added $70 billion to that number only 2 years later, and still our colleagues accuse us of underfunding that benefit.

Mr. Speaker, all this tells me is that most Democrats only care about engaging in a reckless bidding war with Republicans about developing a reasonable, affordable benefit. H.R. 1 is a good bill, and its passage today will move us one step closer to a law which will provide real help to tens of millions of Medicare beneficiaries.

Mr. DINGELL. Mr. Speaker, I yield 3 minutes to the gentleman from Ohio (Mr. BROWN), the ranking member of the Subcommittee on Health.

Mr. BROWN. Mr. Speaker, for years Republicans have tried to frighten seniors by telling them that Medicare was going broke. The media in this country scolded the Republicans for their Mediscare tactics. Well tonight, Republicans have graduated from using Medicare tactics to a new level, and that is scam.

Mediscare number one: my Republican colleagues tout H.R. 1 as the largest expansion of Medicare since the program's inception calling their plan generous. But under H.R. 1, seniors will be required to pay $4,000 out of pocket to receive $5,000 in benefits. That is not generous; that is not even insurance.

Mediscare number two: my Republican colleagues say H.R. 1 gives seniors coverage they trust. It is an expansion of the old, failed Medicare+Choice program which has dropped coverage for 2 million seniors outright. H.R. 1 is not coverage you can trust; H.R. 1 is coverage that cashes the check, then leaves seniors hanging.

Mediscare number three: my Republican colleagues say H.R. 1 gives seniors coverage they can trust. It is an expansion of the old, failed Medicare+Choice program which has dropped coverage for 2 million seniors outright. H.R. 1 is not coverage you can trust; H.R. 1 is coverage that cashes the check, then leaves seniors hanging.

Mediscare number four: my Republican colleagues say H.R. 1 will enhance the security of America's retirees, but the nonpartisan Congressional Budget Office says about one-third of the beneficiaries won't have adequate premium options if H.R. 1 becomes law. In other words, H.R. 1 will force seniors out of the drug coverage they now have. It will force seniors out of the drug coverage they now have.

Mediscare number five: my Republican colleagues say H.R. 1 will bring prices down through the magic of competition. How could that be? The drug industry wrote this legislation; the insurance industry wrote this legislation. They are the folks that want higher prices, and that is why my Republican colleagues took out any ability for the Secretary of Health and Human Services to lower drug prices. In fact, the drug companies gave $85 million to my Republican friends for their reelection in 2002 and tens of millions of dollars to President Bush.

Mediscare number six: my Republican colleagues say forcing seniors into private health insurance will reduce Medicare drug costs. Mr. President, while private plans are not efficient, my Republican friends know that private insurance plans actually operate less efficiently than Medicare with administration costs five times higher than Medicare.

Mr. Speaker, it is irresponsible to spend tax dollars bribing HMOs. It is irresponsible to provoke employers into dropping retiree health coverage. Vote "no" on H.R. 1.

Mr. TAUZIN. Mr. Speaker, I yield myself 30 seconds.

Mr. Speaker, the Mediscare bill that the gentleman just described is patterned after H.R. 1495, authored by the gentleman from California (Mr. STARK), the gentleman from Michigan (Mr. DINGELL), the gentleman from California (Mr. WAXMAN), and the gentleman from Ohio (Mr. BROWN) just a few sessions ago in the 106th Congress. It provided a $220 deductible, 20 percent cost share up to $1,700, a doughnut hole with a $3,000 catastrophic coverage, and no defined premiums. Does that sound familiar? The bill we wrote today is patterned after a bill written by my Republican friends on the other side of the aisle back then, and they complain today that it is Mediscare.

Mr. Speaker, I yield 3 minutes to the gentleman from Florida (Mr. STEARNS), the chairman of the Subcommittee on Commerce, Trade and Consumer Protection.

Mr. STEARNS. Mr. Speaker, we have heard from the Democrats that this is a plan that will not work and is a fraud. We had 2 days of hearing, and I never heard a plan from the gentleman from Michigan (Mr. DINGELL) or the gentleman from Ohio (Mr. BROWN). We had 64 amendments.

Mr. Speaker, H.R. 1 because seniors deserve better coverage options like those available to Members of Congress, yet this bill's drug coverage is less generous than the least generous coverage available to Members of Congress. That is not treatment for Members of Congress; that is treating seniors for suckers.

Mediscare number three: my Republican colleagues say H.R. 1 gives seniors coverage they trust. It is an expansion of the old, failed Medicare+Choice program which has dropped coverage for 2 million seniors outright. H.R. 1 is not coverage you can trust; H.R. 1 is coverage that cashes the check, then leaves seniors hanging.

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This bill contains the long-overdue addition of a prescription drug benefit. Our seniors and disabled beneficiaries have waited many years, particularly true in Florida; and I am pleased to be part of the solution and part of that mark for 9 days.

Now the folks on this side of the aisle say they have a bill. Their bill is for $1 trillion. Ours meets the budget demands of $400 billion. If we could spend all we want in the world, that would be the Democrat's plan.

But at long last Medicare beneficiaries will have available the same options that the President of the United States has, the Senate and the House and the President in Congress, have a choice to choose the plan that best meets their needs.

Mr. Speaker, I am very happy that part of this plan that we have here has a demonstration project in consumer directed care. It is a start. It is not perfect.

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But at long last Medicare beneficiaries will have available the same options that the President of the United States has, the Senate and the House and the President in Congress, have a choice to choose the plan that best meets their needs.
What it does is even worse, though. In a Congress, in a country, in a society that is facing the largest budget deficits in the history of the world, we take $400 billion out of working Americans, give it to seniors, but effectively take $200 billion out of the American middle income family and put it down the toilet and we get absolutely nothing from my Republican colleagues' proposal.

Mr. TAUZIN. Mr. Speaker, I first want to take 15 seconds, if I may, to point out that the bill that does now contain the drug reimportation provisions similar to the Senate provisions and adds language directing the FDA to conduct rulemaking to make sure that there is safe packaging, to make sure when we do get drugs under and through this program, that they are safe and effective.

Mr. Speaker, I yield 4 minutes to the gentleman from Pennsylvania (Mr. GREENWOOD), distinguished chairman of the Subcommittee on Oversight and Investigations of the Committee on Energy and Commerce, our grand inquisitor.

Mr. GREENWOOD asked and was given permission to revise and extend his remarks.

Mr. GREENWOOD. I thank the gentleman for yielding me this time.

Mr. Speaker, my parents, my mother and father, are 81 years of age, alive and well and I would like to dedicate all the work that I have put into this bill to them and I know it will benefit them immensely. My father used to say when I was a young lad, "I'm, there are three kinds of people in this world. There are shirkers, there are workers and then there are jerkers. The shirkers are the people who just don't do anything. They don't contribute. They don't help. The workers are the people who roll up their sleeves and get the job done. The jerkers are the ones that all the time the workers are working they keep tugging at them, pulling at them, jerking them around trying to interfere with the work."

I would submit that the Democratic Party, in all due respect, between 1965 and 1994, when they lost control of the House, were shirkers when it came to the issue of a prescription drug benefit, for they did nothing. They did not provide a big plan, a little plan, a medium-sized plan, they did not provide a plan for anything. They did not provide a plan of any kind. They did nothing. We have been the worker party. We have passed a prescription drug bill in this House year after year since we have had control. That is hard to do. That is hard to do because mature legislators have to figure out how to strike a balance.

We have people in this House who do not want to vote for this bill. They do not want to vote for this bill because they think it is too liberal. They think it is too big. This entitlement program that will bankrupt the country. They are against it because it is too liberal. There are a whole lot of people in this House who cannot vote for this and will not vote for it because it is too conservative; it does not spend enough money; it is not big government enough; it uses private sector factors, influences to curb prices. If you want to get to the appropriate prescription drug benefit for the elderly and the disabled in this country, you have to work very hard with very complex issues and strike a political balance down the center through the eye of the needle to get the job done, and that is what the House of Representatives stands for.

Now we have got the jerkers. We are trying to get this carefully balanced, incredibly complicated piece of work that our staff on both sides of the aisle have labored over for years to get done, want to try to move it through the House today, get it over to Senate, we have got some bipartisan support here, we have got some bipartisan support in the Senate, and we are going to get it done. And at the end of the day when the little old ladies and the little old men in my district and your districts who have been writing us letters and saying, with tears rolling down their cheeks, and we are going to get those letters for years and years. And when this year is over and when we stand with the President of the United States and he signs these bills, we will say to the little old men and the little old ladies and the disabled people of all ages in our district, we got the job done, when nobody else could or nobody else would. Whether the shirkers did not do their job or the jerkers tried to get in the way, the workers will get the job done and this will be an historic year for the Medicare program of this United States.

I am proud of everyone on either side of the aisle who actually rolled up their sleeves and contributed to the product.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from California (Ms. ESHOO).

Ms. ESHOO. I thank the distinguished ranking member of the committee for yielding me this time.

Mr. Speaker, for those that are listening in this evening, besides the vote that some Members of Congress have had to take on going to war, I consider this the most important vote in the House of Representatives. Tonight we debate a bill where there is only one thing that the two parties agree on, and that is that our seniors deserve prescription drug coverage.

For 38 years, there has been a gold standard for those that are 65 years and older and it was named Medicare. How dare my colleagues on this side of the aisle say that the Democrats have not done a damn thing. I regret those words in the Record. We love Medicare. We put it on the books, and we have defended it ever since then. And we want a policy in Medicare that is ennobling and recognizes what senior citizens are.

The advertisers are very busy, but beware. Beware of the advertising. Read the bill. If your insurance salesman comes to you, the first thing you say is, how much is this going to cost a month? Read the bill. There is no premium cost in the bill. It says that there will be choice of insurance companies but not choices of doctors.

By 2010, every senior citizen that is listening in, you will be forced, you will be mandated to go into a private insurance program. That is what our friends have written.

Mr. TAUZIN. Mr. Speaker, I am pleased to yield 2 minutes to the distinguished gentleman from the great State of Nebraska (Mr. OSBORNE).

Mr. OSBORNE. Mr. Speaker, rural health care is struggling. The hospitals are closing and many doctors are leaving. If you are in a small community and the doctor leaves or the hospital closes, the whole community begins to unravel. H.R. 1 addresses the troubles that we see currently in rural health care. Number one, it lowers the labor share of the wage index for rural hospitals. This allows them to be more competitive with urban areas in terms of their scale.

Number two, H.R. 1 increases Medicare reimbursement for rural doctors. Sixty percent of the patient load in my district and many other rural districts are Medicare patients. Doctors simply cannot afford to treat Medicare patient loads of this size because on many Medicare patients they lose money. As a result, they cut back Medicare patients or sometimes leave the area.

Thirdly, H.R. 1 provides a full and permanent equalization of Medicare payments to rural hospitals. An appendectomy is not cheaper in a small hospital than in a large urban hospital. In some cases it is actually more expensive. Also, H.R. 1 provides additional home health care payments and provides provision for rural ambulance.

Mr. Speaker, the reason I want to come to the floor tonight is simply to thank the gentleman from Louisiana for all that he has done for rural health care. This is probably, I am concerned, the most important part of the bill. I would also like to say I represent a rural area. Many retirees in my area live on fixed incomes. Most of these people are making $15, $20,000 a year. Most of them are spending 30, 40, 50 percent of their income on prescription drugs. And so the number one concern that I see in rural America is the prescription drug bill. This bill offers considerable help to these people.

Again, I would like to thank the gentleman from Louisiana, the gentleman from California (Mr. THOMAS) and also the gentleman from Iowa (Mr. NUSSLE). I urge the passage of H.R. 1.
Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New York (Mr. ENGEL).

Mr. ENGEL. I thank my friend for yielding me this time.

Mr. Speaker, I rise in strong opposition to this bill. This bill is a cruel hoax perpetrated on America's seniors. This bill is not about helping seniors. It is all about privatizing Medicare. This is not the Senate bill. This bill is a wolf in sheep's clothing. It purports to help seniors. All it does is create a goal that many people on the other side of the aisle have wanted for years, the privatization of Medicare. This bill drains the lifeblood out of the Medicare program and breaks the promise we made to seniors 38 years ago when Medicare was created.

I wish this Congress could have come together for an historic moment that would finally provide seniors with the type of prescription drug coverage they need and deserve. Unfortunately, we are doing a disservice to our seniors by shortchanging them with a woefully inadequate drug benefit. Why is it inadequate? Let us face it, there is not enough money in this bill because my friends on the other side of the aisle have shortchanged them with huge tax cuts, huge tax cuts to benefit the rich, huge tax cuts which make it impossible to help entitlement programs like Medicare. When the leaders over there said they wanted Medicare to wither on the vine, they were speaking the truth and that is what is happening today. With the enactment of this bill, Medicare is withering on the vine.

When I came to Congress 15 years ago, my goal was to provide meaningful prescription drug benefits. My bill and others, 1045, would keep the promise of Medicare, which was created to prevent seniors from having their life savings ravaged by health care costs. Today, considering no such thing. The legislation before us is not a promise kept to seniors, it is a promise kept to HMOs and insurance companies. This is not the Senate bill. The Senate bill was a starting point to improve upon. This bill bankrupts Medicare, privatizes it by the year 2010, American seniors will not have Medicare as they know it by 2010. Again, when you have tax cuts for the rich and you do it to help your rich friends and you want to strangle social programs and entitlement programs, you do not have an adequate bill.

This bill should be rejected.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Maryland (Mr. WYNN).

Mr. WYNN. Mr. Speaker, I thank the gentleman for yielding me this time. I rise in strong opposition to the Republican plan. This Medicare reform plan is woefully inadequate. Everyone agrees that a real prescription drug plan would cost between $500 and $800 billion. This plan only provides $400 billion. Why? My Republican colleagues will say, well, this is because that's all we can afford. The truth of the matter is that is all we can afford because of their big tax cuts. But keep in mind, you did not get a big tax cut. The wealthy got a big tax cut. Mr. and Mrs. Average American got cuts in service, cuts in benefits and cuts in quality. What we have is an attempt by the Republicans to do prescription drug coverage on the cheap.

There are three problems with this. First, in their plan, there are no guaranteed drug benefits. The private insurers may choose to exclude drugs that are going to be available to you, not your needs. So that if your drugs are not covered, then you have to pay the full price. This is no prescription drug benefit. Second, there are no fixed premiums. You hear the Republicans tell you, well, it's going to be $35 a month. Wait a minute. $35 a month is nowhere in their bill. These premiums could rise to as much as $85 a month. You will drive seniors into bankruptcy with that.

The third problem with this plan is the hole in the doughnut, the gap. Under the Republican plan, this plan they are talking about tonight, after the first $2,000 of prescription drug costs, you have to pay the rest up to $5,000. That is a gap of $3,000. Again, that would drive seniors into bankruptcy. The neediest, sickest seniors do not get the benefits when they need it, the consequence of doing prescription drug coverage on the cheap. Forty-eight percent of Medicare beneficiaries will fall into this gap. This is not a true prescription drug plan.

Second, this bill contains something called Medicare reform. That is another name for privatizing and destroying Medicare as we know it. Plans will have to compete. Medicare will compete against private plans and our seniors will be forced out of a plan that they have to trust. This plan will not work in a plan that will not provide the benefits as a safety net for our seniors. I urge its rejection.

Mr. TAUZIN. Mr. Speaker, I yield myself 10 seconds to ask a question. If this plan funded at $400 billion is prescription drugs on the cheap, what do you call the $330 billion that was allotted by the Democratic budget for the year 2002?

Mr. Speaker, I yield 3 minutes to the gentleman from North Carolina (Mr. BURR), the distinguished vice chairman of the Committee on Energy and Commerce.

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

Mr. GREEN of Texas. Mr. Speaker, following the gentleman from North Carolina, my good friend, it is frustrating because I feel the same thing, that we were given a plan and even though we spent 3 days and a long night debating it in a committee we did not really get to testify about the plan. Then we really had a plan given to us and it was either take it or leave it. But this is the most important issue that we will consider this year not only for our seniors but for each other. I have talked to a lot of my colleagues feel that we should support any legislation because it is a step in the right direction or maybe it is like the Senate bill.
June 26, 2003

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Ms. McCARTHY of Missouri asked and was given permission to revise and extend her remarks.)

Ms. McCARTHY of Missouri. Mr. Speaker, the Republican Medicare bill fails to provide seniors with meaningful prescription drug coverage and is an attempt to end Medicare as we know it. With their plan seniors will have no assurance from 1 year to the next on what plan will be available to them, what drugs will cost them nor what doctors will serve them. Under their plan many of us will pay a premium without receiving any assistance with their drug costs.

Seniors deserve affordable prescription drugs without gaps in coverage. Our seniors should not be forced to pay more to keep their choice of doctors. Not only would the plan before us limit or charge extra for choice, it would force seniors to go to a primary care physician before seeing a specialist.

The Republicans have produced a plan that makes prescription drugs more affordable and, disturbingly, ends the Medicare system that has been an irreplaceable safety net to millions of people for the past four decades. Instead they are creating a plan that costs seniors a lot and gives them very little.

Mr. Speaker, I urge my colleagues to oppose H.R. 1, the so-called Medicare Prescription Drug and Modernization Act of 2003, and to support the Democratic initiative which will preserve Medicare and provide our seniors with the affordable prescription drugs they need.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from New Jersey (Mr. Ferguson), one of our newer members on the Committee on Energy and Commerce.

Mr. FERGUSON. Mr. Speaker, I thank the chairman and ranking member and my colleagues who have worked so hard on this bill.

I rise in strong support of H.R. 1. It includes an amendment that I offered in the Committee on Energy and Commerce which will assist our most vulnerable seniors by allowing State drug spending to count towards a senior's catastrophic limit. Especially in States like New Jersey, this provision is going to dramatically reduce seniors' out-of-pocket spending while saving our States $5 billion.

About a year ago I stood in the well of this House when we debated the drug bill last year and I told the Members about my mom who has been battling cancer and who is only alive today by the grace of God and because she has had access to great medical care and the prescription drugs which have quite literally saved her life. I am proud that my State of New Jersey is home to thousands of researchers and scientists and companies which have spent the billions of dollars on research to find the cures of tomorrow. This very day, today, they are working on finding the cures to cancer and diabetes and AIDS and Alzheimer's.

What are we here to do tonight? We are here to make these great products more affordable and more available to more people.

Mr. Speaker, as I love my mom, her situation is not unique. She is like millions of other Americans who depend on prescription drugs for their quality of life. Our responsibility today is to pass this generous and responsible bill, to provide the miracle cure of tomorrow available to people like my mom. I just as importantly, though, we have to do so in a way which values and encourages the incredible research and innovation which will create the cures of tomorrow because I do not only love my mom, but my wife and I love and treasure our three young children and it is they who will benefit as well because the lives of our children and our children's children will be better and stronger and more fulfilling because of the cures that we create and the fact that they will be affordable because of this plan. That is our charge. That is our responsibility. Let us pass this plan tonight.

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Maryland (Mr. HOYER), the very able and respected minority whip.

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

Mr. Speaker, if truth in advertising applies to legislation, we would have a duty to warn America's seniors, beware, the Republicans' prescription drug bill could be hazardous to your health. This bill is nothing less than an historic betrayal of America's seniors. The GOP pretends that it is merely extending Medicare, but in fact the bill is the most dangerous attempt yet to dismantle the most popular health care program in history.

The Republicans fought the adoption of Medicare in 1965. Their majority leader said that Medicare should not exist in a free society. Yesterday the chairman of the Committee on Ways and Means, the architect of this bill, said on television, and the Members can read it here, "To those who say that [the bill] would end Medicare as we know it, our answer is we certainly hope so."

This bill would drive seniors out of Medicare and into the arms of private insurers. There is no guaranteed monthly premium. There is no defined benefit for seniors. There is no guaranteed access to drugs seniors must have. The only guarantee in this bill is that it would leave a huge gap in coverage. Seniors would pay a $250 deductible, $420 a year in premiums, and all costs between $2,000 and $5,100 in drug expenses. That is $3,100 left to seniors to pay. This bill even prohibits the government to negotiate lower drug prices for seniors.

In contrast, the Democratic substitute offered by the gentleman from
Michigan (Mr. DINGELL) and the gentleman from New York (Mr. RANGEL) would provide a prescription drug benefit that guarantees affordable, universal and voluntary Medicare coverage for prescription drugs. There are no gaps in coverage. Senior citizens do not have to give the Secretary of Health and Human Services the authority to negotiate prices. Our bill does. I would ask the Members to vote for this substitute which guarantees prescription drug coverage for seniors.

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

Mr. DINGELL. Mr. Speaker, I am always happy to accommodate the gentleman from Ohio (Mr. STRICKLAND), my dear friend, even when he is pushing an outrageous piece of legislation under an appallingly constrictive rule. Mr. Speaker, I yield 2 1/2 minutes to the distinguished gentleman from Massachusetts (Mr. MARKEY), and I ask the chairman from the Committee on Energy and Commerce to listen closely.

Mr. MARKEY. Watch out, Grandma. Watch out, Grandpa. The GOP is selling snake oil off the back of a wagon, and, boy, do they have a prescription for you.

Mr. Speaker, every senior citizen gets a bottle with three bitter pills. Bitter pill number one is a lethal dose of price fixation poison. The Republicans are diverting Medicare funds into private drug plans with no maximum premiums, no guaranteed coverage, and a cynical drive to destroy the Medicare program.

Bitter pill number two is a dose of crushing costs. Incr...
the best of both bills for the best people of this country.

Almost 40 years ago when I was in the Texas senate, Members of this Congress came to Texas, came to the Texas house and the senate, touring two great hospitals. When they were going to introduce and pass. They named them Medicare and Medicaid. And they said by 1990, Medicare could cost $9 billion a year. And as I remember, they said Medicaid could cost almost $1 billion a year. I don’t think we really need to monitor the program closely or the costs could double.

Well, my colleagues know what has happened to the cost, what has happened to Medicare and Medicaid. There is an awful lot to do, and we need to be doing it.

There is no doubt that Medicare has helped millions of seniors escape dire poverty and live fuller lives. There is also no doubt that medical costs have far outstripped inflation due to a number of factors, including expansion of benefits, increased use, and coverage of the disabled population. Our seniors are staring into their pocketbooks to find what they need for their care. We desperately need to do something to save a great program for people in their golden years.

Mr. Speaker, Medicare needs to be modernized to include a meaningful provision for drug coverage. In my lifetime, we have seen how prescription drugs have greatly improved and extended the lives of Americans. We have been able to see the good that these drugs have done for nonpractice expenses, twice as much as any other specialist.

It is true that Medicare beneficiaries continue to be pleased with them. The system and the safety net that it provides nationwide, including our rural providers, have been diminishing in the face of increasing costs and decreasing reimbursement. We simply must confront this issue because without access, the rest of the program is meaningless.

Like many people, I am not completely satisfied with this bill, but I am very hopeful that we can pass a bill.

I am particularly pleased that we are introducing long-overdue Medicare reforms that will bring health care into the 21st century; name- ly—regulatory reforms and provider reimbursement issues. We are all aware that providers nationwide, including our rural providers, have been diminishing in the face of increasing costs and decreasing reimbursement. We simply must confront this issue because without access, the rest of the program is meaningless.

Like many people, I am not completely satisfied with this bill, but I am also not satisfied to see this program collapse. We are closer than we have ever been to making some meaningful reforms and providing a prescription drug benefit to seniors. I am hopeful that we will improve this bill in the conference committee as we seek to find a bipartisan solution to our common problem. This is just a first step in an ongoing process of reform to ensure that our seniors get the care that they deserve. Congress, through the yearly appropriations process, will continue to monitor the program—making necessary changes and improvements to guarantee healthy years for our Medicare population.

Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from California (Mrs. CAPPS). Mrs. CAPPS. Mr. Speaker, I thank my distinguished ranking member for yielding me this time.

Mr. Speaker, the Medicare bill before us is not a good bill. The coverage it provides is unreliable and insufficient. After a senior has used $2,000 in medications, they get no more help until they have spent another $9,000 out of pocket without help and while continuing to pay premiums. And that is only if a private plan chooses to come into their area. This bill turns Medicare into a voucher, handing it over to the insurance companies and forcing seniors to pay more. It reneges on a promise made to America’s seniors by ending Medicare as we know it.

In addition, the bill before us cuts cancer care by hundreds of millions of dollars, jeopardizing access to cancer care for seniors who face this dreaded diagnosis. If this bill passes, many cancer centers will close. Others will curtail their services, admit fewer patients, and lay off oncology nurses and critical support staff. This bill is supposed to make it easier for patients to get health care, but it will actually make it harder for cancer patients to get the care they need.

It is true that Medicare beneficiaries are paying too much for their oncology medications. We all agree we must fix this. But Medicare also pays way too little for essential oncology services, and so the overpayment for oncology drugs has been used to pay for treatments oncologists provide to cancer patients. We must fix both parts of this problem, but this bill will cut hundreds of millions of dollars from cancer care. And it still risks the lives of cancer patients.

We will all go home after passing a Medicare bill, and we will face our constituents. I, for one, do not want to tell the cancer patients in my district that Congress has decided to curtail their treatment and endanger their care.

We can do better. We must. I urge my colleagues to vote against this bill.

Mr. TAUZIN. Mr. Speaker, I yield myself 10 seconds. I want to point out our bill provides 430 million new dollars to oncologists in America that provided to any other specialist for nonpractice expenses, twice as much as any other specialist.

Mr. Speaker, I am pleased to yield 3 minutes to the gentleman from Texas (Mr. BARTON), the chairman of the Subcommittee on Energy of the Committee on Energy and Commerce.

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

Mr. Speaker, first, I want to commend my chairman, the gentleman from Louisiana (Mr. Tauzin), for his work in this noble effort, and I want to thank him for allowing the reform group that I have been a part of in his committee the opportunity to present an alternative and to try to make that a part of the package I really appreciate that.

I would say to my friends on the Democratic side of the aisle, as they have talked about privatizing Medicare, that the first thing that we need to do is preserve what we have. I would point out that if we do nothing to the existing Medicare program, the projections are that within the next 5 to 10 years, there will be no Medicare, because doctors and hospitals will opt out of the system because they are not able to be reimbursed adequately for the services they are providing.

So the first thing that we need to do is to preserve the current Medicare system. In the bill before us, we have talked about things such as competitive bidding for durable medical equipment and other reforms.

The second thing I would like to point out is that we understand that seniors need a prescription drug benefit.

And my reform group was able to get into this bill a transition program that if this bill becomes law within 90 days of enactment, 17 million seniors in this country will begin to get a prescription drug benefit immediately. They will get a prescription drug card, and if they are low income those drug cards will have $800 of benefits on them; and if they are moderate income, they will have $500 and if they are upper income, they will have $100. Their families and employers can add money to those cards, up to $5,000, and within 90 days of enactment there will be a prescription drug benefit. Not 3 years from now, not 4 years from now, within 90 days. And this drug benefit will not require a deductible, and it will not require any paperwork. It will not have any doughnuts.
It will require a modest co-pay, but then you get your prescription drugs plus any discounts that the prescription drug benefit card allows. And I think that is important that we as a country say to our senior citizens, not that we want to get old people but that we want to give our parents and grandparents a break. We want to give them a benefit and we want to do it sooner rather than later.

I think the most important thing about this bill is that there is an acknowledgment that those who are real savings and real choices. We are providing them with a benefit and we want to do it sooner rather than later.

Now, the Republicans are here tonight saying choices, choices, choices. We are giving America's seniors choice. Well, what kind of choice are they giving America's seniors? Well, not a choice of doctors and not a choice of hospitals. What they are saying is we are going to give you a choice of insurance plans. Well, no one in my state of Maine has ever come up to me and said, You know what I really want is not a choice of doctors or hospitals, I want to see different brochures, different insurance brochures. Please have some insurance agents call me and talk about their different plans.

What is happening in Maine, in the private sector with this wonderful competition for the employed market is every year 20 percent increases, 30 percent increases, higher payments, lower benefits. That is not competition and what the Republicans are saying is that is what America's seniors need. It is unbelievable. Every senior I talk to says we want lower prices. Please give us lower prices. We are being squeezed from Canada, we are taking buses to Canada, and this bill prevents the administrator from negotiating lower prices for America's seniors.

This bill is never likely to work in my opinion, but if it did, you ought to forget the money. This is not from this bill? The insurance companies will make millions, hundreds of millions of dollars. The pharmaceutical industry will be able to keep charging the highest prices in the world. America's seniors? Well, not a choice of benefits. That is competition and what the Republicans are saying is that is what America's seniors need. It is unbelievable. Every senior I talk to says we want lower prices. Please give us lower prices. We are being squeezed from Canada. It is unbelievable. Every senior I talk to says we want lower prices.

Mr. TAUZIN. Mr. Speaker, how much time remains on each side? The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Louisiana (Mr. TAUZIN) has 8 minutes remaining. The gentleman from Michigan (Mr. DINGELL) has 14½ minutes remaining.

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

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Louisiana (Mr. JOHn).

Mr. JOHn asked and was given permission to revise and extend his remarks. The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Louisiana (Mr. TAUZIN) has 8 minutes remaining. The gentleman from Michigan (Mr. DINGELL) has 14½ minutes remaining.

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

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Louisiana (Mr. JOHn).

Mr. JOHn asked and was given permission to revise and extend his remarks. The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Louisiana (Mr. TAUZIN) has 8 minutes remaining. The gentleman from Michigan (Mr. DINGELL) has 14½ minutes remaining.

Mr. TAUZIN. Mr. Speaker, I reserve the balance of my time.
now all of the debate is about it being a part of Medicare. So in that aspect, I think that we have won as Democrats. But I do believe that what they have done with this bill is continue to try to privatize Medicare and the benefits that that will use.

An entire generation of baby boomers are upon us, Mr. Speaker, and in just a few years away we are going to have to deal with this. Unfortunately, this bill fails short of what our seniors deserve as it has holes in it that the Republican bill does not.

Perhaps the $174 billion bill that we passed just previous to this debate could have been used for the doughnut to be plugged. Efforts to fix this problem were denied us through the amendment process in this body on this debate. I offered amendments to try to bring some certainty with 2 years for our seniors to try to provide our rural ambulance services, our rural home health care and our rural doctors a fair reimbursement. In particular, I believe this bill fails short in addressing the needs of rural seniors and rural Americans. In fact, our previous experience should tell us that it has not worked. It is not profitable to offer plans to seniors in rural areas. In southwest Louisiana we have no Medicare+Choice plans.

I urge Members to vote against this, and I urge the other side to work, as the Senate did, in a bipartisan fashion to fashion a bill that our seniors can use.

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

Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentleman from Florida (Mr. Davis).

Mr. DAVIS of Florida. Mr. Speaker, one of the things that Democrats and Republicans ought to be able to agree upon tonight is that we owe our seniors truthfulness. We should be very clear and honest with them and ourselves as to exactly what is happening. Our failure to do so is a cardinal sin because it is ultimately to disrespect our seniors.

This bill offered by the House Republicans is based on a remarkable fixation with private insurance companies. Private insurance companies throughout the country in Washington have said once again do they do not want the money that is being offered under this bill to write these private insurance plans.

The distinguished chairman of the committee’s response to that is we will subsidize 99 percent of this cost as necessary to get private insurance companies to sell this benefit. How often in Washington, D.C. do you hear somebody turn down that type of money the government is offering them? Something is wrong with this plan.

I salute the Republicans on the committee who acknowledge they were concerned whether or not private insurance companies would offer this benefit to seniors. Some of them are going to vote against the bill tonight based on that concern. A number of Democrats have said to those Republicans and others, we will work with you on a bill that fits within our budget constraints but let us have a traditional Medicare benefit that provides drug coverage.

What does this bill do? It does not set any maximum premium. It does not set any maximum deductible. It has a doughnut that almost 50 percent of seniors will experience after they have spent $2,000 on drug costs. During that time period they will be forced to pay a premium for basically nothing. I would like to bring a chart up here to also show you just how complicated this plan will be that is being foisted on seniors. This represents a relatively detailed description of what this bill attempts to do.

Would somebody on the majority please explain to me how this bill works and how any senior at home, Democrat, Republican or Independent, is expected to understand how to use this drug benefit? Mr. Speaker, I ask unanimous consent for 2 additional hours to explain the chart.

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

Mr. TAUZIN. Mr. Speaker, I object.

The SPEAKER pro tempore. Objection is heard.

Mr. TAUZIN. Mr. Speaker, I yield 2 minutes to the gentleman from Kentucky (Mr. Whitfield), a distinguished member of the Committee on Energy and Commerce.

Mr. WHITFIELD. Mr. Speaker, I thank the gentleman for yielding me time.

Mr. Speaker, tonight is the culmination of 4 or 5 years of debate of a prescription drug benefit for our senior citizens here in America. I hear a lot of the criticism and I have heard it all day today about private insurance companies being involved in this program that we are submitting tonight. Yet, I would remind those on the other side of the aisle that private insurance companies and Medicare as it exists today and has been for some time because it is the private companies that are responsible for the reimbursement of our health care.

So private companies are already very much involved in our Medicare system today.

I would also say, what benefit are seniors going to get from this program? First of all, if they are 135 percent of the poverty level and below, and I can tell my colleagues, in my district that is about 60 percent of them, they are not going to have to pay anything. The government would pay their premium for them. The only thing that they will have to pay is a $2 small copay for a generic drug and a $5 copay for a name-brand drug. What is wrong with a program that provides free medicines for seniors who today cannot get them? I would also say that in addition to that tremendous benefit, and we provide catastrophic coverage for them as well, but in addition to that tremendous benefit, we have a rural health package in this bill that is going to help rural America, rural health providers. It is going to provide $27 billion for that purpose over 10 years and not transfer the disproportionate share payment for our rural hospitals, children’s hospitals around the country, urban hospitals that treat our citizens on Medicaid, our hospitals over the next 10 years are going to get $3.8 billion for those who treat the neediest.

This is a program that we should all be supporting, and certainly we should not support the Democratic substitute. Mr. DINGELL. Mr. Speaker, I yield 2 minutes to the distinguished gentlewoman from California (Ms. Solis).

Ms. SOLIS. Mr. Speaker, I thank our ranking member for yielding me the time.

I rise tonight in opposition to this bill. We have heard a lot tonight about how this bill is going to help our seniors from the other side of the aisle. Well, I want to talk about the seniors that I represent in my hometown in the San Gabriel Valley in East Los Angeles, California.

In my congressional district, I represent nearly 6,000, 6,000 seniors in poverty, making less than $11,000 a year. For them the cost of prescription drugs is so overwhelming that they often have to forgo between paying their medicine or having a meal or paying a phone bill. That is what it means to seniors in my district.

This is a choice that no senior citizen should have to make. Yet the Republican bill does nothing to reduce the cost of prescription drugs. It does not allow us to use the purchasing power of Medicare beneficiaries to negotiate lower drug prices, just like we do for the Veterans Administration.

So what do we tell Grandma, living alone on a fixed income who cannot afford her medicine? Sorry, but Medicare has a new drug benefit, but it is not for you. Sorry, but Medicare is raising Part B deductibles by eight times as much as our Social Security cost-of-living increase.

The only Democratic alternative that we will debate later on tonight will do exactly what I think my seniors want to hear, and it will provide them with the guaranteed, affordable, easy-to-use drug benefit that is part of Medicare.

Let us be clear tonight. For our seniors, for our grandparents, our uncles, our fathers and our mothers, there is only one thing to talk about tonight and it is about medicine. This should not be about privatization or insurance companies or anything else. Let us give our senior citizens the help they need to pay for the medications they need. Let us oppose this proposal being put forward tonight by the Republicans and support the Democratic prescription drug bill.
Mr. TAUZIN. Mr. Speaker, how much time remains on each side?

The SPEAKER pro tempore (Mr. HASTINGS of Washington). The gentleman from Louisiana (Mr. TAUZIN) has 6 minutes remaining. The gentleman from Michigan (Mr. DINGELL) has 8½ minutes remaining.

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

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

Mr. BERRY. Mr. Speaker, I thank the distinguished gentleman from Michigan for yielding me the time, and I appreciate his leadership on this and all other matters before this House.

Mr. Speaker, one thing we understand is the Republicans are in the majority. They are in charge. You can do whatever you want to do. You have got the Senate over there, and you have the House. Now, you may talk more trash than a $3 radio, but you are in charge.

The difference in these two plans is very simple. The Democrats would offer you the best plan, the best price, and you would pay 20 percent and let the patient, the Medicare beneficiary, pay 20 percent. The Republicans only, on the other hand, will allow the pharmaceutical companies, by law, statutorily, to continue to rob our senior citizen of everything from the highest price and let them pay 80 percent; and they will pay 20 percent of the bill, if you are lucky enough to live long enough.

They come to the floor repeatedly this evening and ask about this bill. It is not perfect. Boy, you have got that right. I will agree with you on that one.

They say it is historic, and they are right. Never before in the history of this country has there been such an outrageous attempt to provide the ability to insurance companies, as if they needed any help, to rob and deceive and cheat our senior citizens. Never before have they been presented with an opportunity, the pharmaceutical companies, to cheat and continue to rob our senior citizens.

It is indeed historic by their own admission. The chairman of the Committee on Ways and Means says we want to end Medicare as you know it. I suggest you all get you a buckeye; it will bring you good luck and keep you honest. There is no doubt that Americans have benefited from the development of new and innovative medicines. New drugs can improve and extend lives.

New drugs exist that can dramatically reduce cholesterol, fight cancer, alleviate debilitating arthritis.

An entirely new class of medicines, collectively known as selective estrogen receptor modulators, are available for reducing breast cancer mortality. New horrified therapies, such as anti-angiogenic agents, are in expanded role in preventing this disease.

Unfortunately, Medicare has been deeply rooted in the medicine of 1965, not the medicine of today; and this has negatively impacted the health of our senior citizens.

Tonight, the House of Representatives will take a bold step to improve the lives of senior citizens. Not only will seniors have greater access to prescription drugs, but built-in reforms will hold down the cost of these medications.

In a report released today by Secretary Tommy Thompson, seniors will save substantially through upfront drug discounts under the House plan. The Medicare actuary estimates seniors will see an immediate savings of 25 percent off their current prescription drug costs.

On the other side of the aisle, those who were wearing the arm bands earlier today, where were those arm bands in 1998 and 1999? Where were those arm bands when that administration refused to even open the book and look at the Medicare commission, bipartisan commission.

Mr. DINGELL. Mr. Speaker, I yield 1 minute to the distinguished gentleman from Michigan (Ms. KILPATRICK).

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

Ms. KILPATRICK. Mr. Speaker, I thank the ranking member for yielding me the time, and certainly I want to acknowledge the great leadership of our chairman and the gentleman from Texas (Mr. BARTON), as well, who proposed the prescription drug bill.

I rise tonight to support H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003.

Mr. Speaker, this debate is about taking care of America. This debate is about making a guarantee to senior citizens that they will have access to quality medical care which includes prescription drugs. This debate is about ensuring the future of Medicare.

This debate is about delivering better outcomes at lower cost.

H.R. 1 is a strong solution to these serious problems. Providing prescription drugs for America's seniors is the right thing to do. I cannot picture what America would already look like today if pharmaceuticals were not an available treatment option. Physicians and other providers would have no option but to resort to seriously invasive treatments when confronted with acute medical conditions.

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I rise tonight to support H.R. 1, the Medicare Prescription Drug and Modernization Act of 2003.

What most people want in America, including seniors, is to contain the high costs of prescription drugs. This bill prohibits the Secretary of Health and Human Services from negotiating lower prices for prescription drugs. None of that is contained in this bill. The only thing that is contained in this bill is for you to vote "no" on this bill.

Mr. Speaker, I rise today to express my disappointment and opposition to H.R. 1. We, in Congress, over the last few years, have repeatedly pledged to provide seniors with the prescription drug coverage they so desperately need—and deserve. My Republican colleagues have touted this day as a "historical day." Unfortunately, for Democrats, who support a meaningful, comprehensive drug plan under Medicare, this day is not a "historical day" in the positive sense but a day when we failed on our promise to come through for our seniors. What this bill does do is afford the Republicans the ability to say, "We kept our pledge." Unfortunately, their rhetoric does not match up with the emptiness that will be felt in our seniors' pocketbooks. Nor does it match up in providing seniors with real choice and a meaningful, comprehensive prescription drug program.

The GOP Prescription Drug Plan is a flawed plan, period. It would put the power in the hands of private insurers—those same insurers who have abandoned seniors in providing essential health care services in the past. Why, our Republican colleagues want to give even more power to HMOs and private insurers is a question I cannot answer. However, the consequences of such actions will be felt by the most vulnerable in our society.

The majority of seniors across our nation live on fixed monthly incomes. With so many seniors today living longer, this also means that they need to save as much money as they can to ensure their survival over the years. They cannot afford to pay exorbitant costs for their drugs. Moreover, seniors need security. What they do not need is to be forced into private managed care plans that are able to opt-out of coverage for seniors at their free will. Seniors deserve better—they deserve a universal, comprehensive, affordable, and meaningful drug plan under Medicare.

The House Republican prescription drug bill is even worse than the one considered by Congress last year and goes much further in privatizing Medicare. Seniors would need to use private insurance companies for drug coverage and these private insurance companies and managed care plans would design the new prescription drug plans. These insurance plans would also need to commit to the program for only one year. What does this mean? It means that seniors can be dropped from their plan year-to-year. They would have to pay out of pocket for their drugs. They are forced to pay for their drugs they take every 12 months. This puts seniors at the mercy of private insurance companies, rather than giving them an option that provides...
them with the security and stability they need. Seniors do not want to be forced into an HMO. In fact, 72 percent of seniors polled say they do not want to be forced into getting coverage through an HMO. We need to listen to those we are trying to serve.

The GOP plan receives an “F” on the affordability scale. Under their plan, seniors would be required to pay high premiums even if they are not receiving coverage. The Republican plan would deny assistance to those seniors with drug costs between $2,000 and $4,900. Nearly half of Medicare beneficiaries would fall into the “coverage gap” every year; however, they would still be expected to pay the monthly premium. Seniors would be asked to continue paying for a service they are not receiving—a service that does not honor seniors with meaningful support in the first place.

Another glitch in the Republican bill is its inability to deal with the underlying problem—the rising costs of prescription drugs. Seniors want help in curtailing the increasing costs of prescription drugs. In fact, seniors prefer cost control measures by a vote of two to one. While they would like to keep purchasing their medicines, they also want solutions in curbing the rising costs. The Republican bill does not do this. It neglects to include an important provision supported by Democrats to provide the Secretary of Health and Human Services with the authority to negotiate for lower prices like the Veterans’ Administration has done. Including cost-control provisions is the right and responsible thing to do; however, our Republican friends do not see the benefit of this. How unfortunate.

The Democratic Substitute, which I proudly support, is the coverage that will fulfill our pledge to seniors. It provides them with real assistance within Medicare and includes provisions to curb the high cost of prescription drugs. Seniors do not need to worry about paying more in the future if they decide to stay in the traditional Medicare program. They do need to worry about this with the Republican bill, since the “competitive bidding” provision would force seniors to pay more for their prescription drugs than they do now. Seniors want a plan that is straight up, no-nonsense, and shows what Democrats have provided in the substitute measure.

I want to do right by the seniors in my district and for seniors all across the nation who are struggling to pay for the prescription drugs they need to live fulfilling and healthy lives. H.R. 1 was constructed with the interests of insurance companies and private insurance companies at heart. The voice of seniors was nothing but a faint echo in the rooms where this bill was constructed and their best interests have been left in the dust. For these reasons, I vote against passage of H.R. 1. We need to safeguard our nation’s seniors, not have enough money to fund credible prescription drug coverage for our seniors.

This bill provides no coverage when a senior’s prescription drug costs are between $2,000 and $4,900 a year. This huge coverage gap affects 47 percent of Medicare beneficiaries. This bill is also a giveaway to pharmaceutical companies, as it prohibits the Secretary of Health and Human Services from negotiating lower drug prices. The primary beneficiaries of this bill are not the beneficiaries of Medicare. They are the wealthy special interests and the pharmaceutical industry that give huge campaign contributions to the Republicans.

Mr. Speaker, the Republicans have given huge tax cuts to the wealthy, promised the Iraqis a universal health care plan. They are spending millions attempting to buy the loyalty of war-lords in Afghanistan, and the President just gave Musharraf $3 billion. Seniors, call your Republican Members and ask them why they do not take care of the seniors of this country.

Mr. Speaker, I yield 1 minute to the distinguished gentleman from Arkansas (Mr. Ross).

Mr. Ross. Mr. Speaker, I thank the gentleman from Michigan (Mr. Dingell), the ranking member, for yielding me the time.

As the owner of a small-town family pharmacy, I got sick and tired of seeing seniors who could not afford their medicines or could not afford to take it properly. That is why back in 2000 I decided to run for the United States House of Representatives.
deed. In doing so, the Republicans insinu-
the intelligence, they insult the intel-
ligence of America’s seniors. Many of
you are blessed to still have your par-
teys with you, and some of us are
even bordering on being seniors our-
selves, but any of you who have your parents
or dear relatives who are older
know that they are into stats. They
know their statistics. They know their
blood count, they know their blood
pressure, they know their bank ac-
count balance, they know the cost of
everything, many of them, because
many of them are on fixed incomes and
the slightest change has an impact on
their economic security.

So I want those seniors who are so
sensitive to changes in cost to take
a look at this chart, which was in the
New York Times this morning, and it
says, “Under House GOP Bill Seniors’
Out-of-pocket Drug Costs Remain
Staggering.” Remain staggering. The
average cost that seniors will pay in
drug costs in 2006 is reported to be
$3,155. So let us take the $3,000 line for
the Republican hoax on seniors. If the
beneficiary’s annual drug costs are
$3,000, seniors out there, if you are pay-
ning about $3,000, under the House bill
your deductible will be $250. Your pre-
mium will be $420. The share of initial
coverage is $350. Gap in coverage, here
is where you fall into the gap, $1,000.

So of that $3,000 worth of drug cost,
you, America’s seniors, will be paying
$2,020 out-of-pocket. Where is the ben-
efit? And this is the best case scenario.
These prices that you see here are sug-
gestions to the HMOs. The prices could
be much more, and your out-of-pocket
cost could be much more.

I do not know how many of you think
the hole is the most delicious part of
the donut, but seniors, when they fall
into this donut hole where they get no
coverage, they still pay the premium.
They are paying a premium for some-
thing that is not there. It is not there.
And of course, if they pay $4,500 in drug
benefits, they have no protection in
their pocket. A cruel hoax on America’s
seniors. And they call that modernization.
I call it humiliation. I call that insult-
ing the intelligence of America’s sen-
iors.

It was interesting, in this same arti-
cle today one senior who was quoted on
these numbers said, “If you think any-
body in Washington, D.C. has any idea
what people on a limited income have
to do to live?” Clearly, the Republicans
do not. They are just too busy giving
the biggest tax breaks to the highest-
end people in our country. They are
just too busy giving those tax breaks
that they cannot write a decent pre-
scription drug benefit for seniors.

In fact, I might add seniors and chil-
dren. Where, oh where did the child tax
credit go in all of this, as we adjourn
tomorrow? Tax cuts instead of child
tax credits. Tax cuts instead of pre-
scription drug benefits. At the begin-
ning of life; toward the end of life. It is
a cruel hoax.

And so, my colleagues, no matter
what the Republicans tell you about
their bill, the euphemism that it is a
modernization of Medicare is really a
laugh. It is an elimination of Medicare.
Because no matter what they tell you,
the facts are these: The Republicans do
not provide a guaranteed defined ben-
efit for seniors. The Republican bill
does not reduce the high cost of pre-
scription drugs.

Indeed, the hardest to explain to any-
one is that the bill prohibits the Sec-
retary of Health and Human Services
from negotiating for best prices. I re-
peat: Not only does the bill not bring
down the cost of drugs, it prohibits the
Secretary of HHS from negotiating for
the best prices. Every business in
America, indeed the VA, does that.
Volume gives you leverage; gives you
opportunity. Except in this bill it is
prohibited.

And at this point I want to say that
the proposal put forth by the gen-
tleman from Michigan (Mr. DINGELL)
and the gentleman from New York (Mr.
RANGEL), the cost of it would be cut in
half, cut in half, if the Secretary had
the authority, which our bill calls for,
and indeed took that responsibility to
negotiate for best prices.

What the bill does also, instead of
modernizing Medicare, is to unravel
not only Medicare, and I hope seniors
are listening, not only the prescription
drug benefit, but part A and part B
along with the prescription drug ben-
efit, forcing seniors to compete and pay
more to stay in Medicare, the Medicare
they know and trust. I repeat: When
this bill, in 2010, comes to fruition, sen-
niors will have to pay more to stay in
Medicare for part A, part B, and pre-
scription drug benefits.

And this is really a sad one in their
bill. The employer piece. The employer
piece. There are many businesses in
America who honor their responsibility
to their retirees. The CBO, the Con-
gressional Budget Office, estimates
that under the Republican bill one-
third of all retirees who get their bene-
fits from their employers will lose their
coverage. Millions of seniors will
be worse off.
So that is why I say this is really a tragedy. It is a missed opportunity. It could be so good. It could be bipartisan. It could be what seniors expect and deserve. Democrats have a better idea. The Rangel-Dingell/Dingell-Rangel proposal, the two distinguished gentlemen who have spent a lifetime in public policy promoting access to quality health care, whose credentials are impeccable in this regard, they support Medicare. They have promoted a bill that is worthy of the seniors whom we respect. It is a guaranteed defined benefit under Medicare. It does give the authority to the Secretary to negotiate for best prices. It protects seniors’ options in terms of their employers giving them benefits; not making millions of seniors be worse off.

America’s seniors deserve a benefit that is affordable, with reasonable premiums and deductibles. America’s seniors deserve a benefit that is available to all seniors and disabled Americans, including Americans in rural areas.
The Senate met at 9:15 a.m. and was called to order by the President pro tempore (Mr. STEVENS).

The PRESIDENT pro tempore. Today's prayer will be offered by our guest Chaplain, Rev. Richard A. Laphehn of Milton Presbyterian Church, Rittman, OH.

PLEDGE OF ALLEGIANCE

The PRESIDENT pro tempore led the Pledge of Allegiance, as follows:

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

RECOGNITION OF THE MAJORITY LEADER

The PRESIDENT pro tempore. The majority leader is recognized.

SCHEDULE

Mr. FRIST. Mr. President, this morning the Senate will immediately resume consideration of S. 1, the prescription drug benefit/Medicare bill. Under the previous agreement, the Senate will begin two back-to-back rollcall votes shortly. We were in late last night, and we set those votes to occur the first thing this morning.

The voting schedule will be as follows: The first vote will be in relation to the Harkin amendment No. 991 dealing with demonstration programs. The second vote will be in relation to the Edwards amendment No. 1052 dealing with drug advertising. For the remainder of the day, we will continue to debate and vote on amendments to S. 1.

We have made very good progress over the last 2 weeks on this bill. The Democratic leader and I were just talking, and we still have 50 amendments pending. It is my hope a number of these amendments will be disposed of by voice vote. I know the managers are working along that line. Inevitably, though, we are going to have a very heavy voting schedule today and into this evening. Members should expect rollcall votes throughout the day and, if necessary, into the wee hours of the morning on Friday. We will know a little bit later today the pace of these amendments and how they can best be handled.

My intention was to finish this bill before the July 4 recess. I think everybody is working in good faith to do just that. With the cooperation of all Members, and if we are able to continue voting throughout the day and the debate-and-amendment process, we may be able to pass this legislation this evening.

RECOGNITION OF THE MINORITY LEADER

The PRESIDENT pro tempore. The Democratic leader is recognized.

Mr. DASCHLE. Mr. President, I have indicated to the majority leader that I intend to work with him today to schedule as many of these votes and to work through the pending amendments.

As he noted, there are approximately 50 pending amendments. It is my hope that our managers might look carefully at many of them and perhaps accept them on voice votes, but those requiring rollcalls I hope can be scheduled earlier rather than later throughout the day.

We will work on our side to perhaps offer them en bloc, where we could have a sequence of rollcall votes throughout the day, but we certainly will work with the majority leader to see if we can accomplish as much as he has laid out for the schedule, with an expectation that perhaps by the end of this evening we will have completed our work on the bill.

I yield the floor.

RESERVATION OF LEADER TIME

The PRESIDENT pro tempore. Under the previous order, the leadership time is reserved.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Resumed

The PRESIDENT pro tempore. Under the previous order, the hour of 9:15 a.m. having arrived, the Senate will proceed to the consideration of S. 1, which the clerk will report.

The legislative clerk read as follows: A bill (S. 1) to amend title XVIII of the Social Security Act to make improvements in the Medicare Program, to provide prescription drug coverage under the Medicare Program, and for other purposes.

Pending:

This “bullet” symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.
The President pro tempore. There will be 2 minutes equally divided on the amendment.

The Senate modified amendment No. 991 to provide for the treatment of payments to certain comprehensive care organizations.

The amendment before us is the one where the money follows the purse. It is $350 million a year for States whereby States can use this money to get out of institutions, out of nursing homes, people with disabilities and get them into community, home-based living.

Mr. HARKIN. The amendment before us is the one where the money follows the purse. It is $350 million a year for States whereby States can use this money to get out of institutions, out of nursing homes, people with disabilities and get them into community, home-based living.

Thirteen years ago, this Congress and the President signed a bill called the Americans With Disabilities Act. One of the premises of that was we no longer wanted to segregate people with disabilities in our society. We wanted to integrate people with disabilities in education, work, travel, jobs, everything. However, under the Medicaid system, it is still segregation.

Seventy percent of our Medicaid money goes to institutional care, only 30 percent to community-based care. What this amendment says is that for the first time, the administration will pick up the full share of the State so the State can take people out of institutions and put them into community-based living.
This was proposed by President Bush in his budget proposal for next year. It is exactly what the President proposed.

The President pro tempore. The Senator’s time has expired.

Mr. HARKIN. I ask unanimous consent that a letter I received from United Cerebral Palsy and The Arc of the United States in support of this amendment be printed in the Record.

I likewise ask unanimous consent that a letter I received from United Cerebral Palsy and The Arc of the United States in support of this amendment be printed in the Record.

Finally, this amendment would help States comply with the Americans with Disabilities Act. As my colleagues in the Senate are well aware, we are nearing the 13th anniversary of the Americans with Disabilities Act and of the Supreme Court’s decision.

That decision ruled that needless institutionalization of Americans with disabilities constitutes discrimination under the Americans with Disabilities Act. I urge my colleagues on both sides of the aisle to support this important amendment and to support the freedom of choice for Americans with disabilities.

There being no objection, the material was ordered to be printed in the Record, as follows:

THE ARC AND UCP
PUBLIC POLICY COLLABORATION,

Hon. GORDON SMITH,
U.S. Senate, Russell Senate Office Building,
Washington, DC.

DEAR SENATOR SMITH: On behalf of United Cerebral Palsy and The Arc of the United States, as original co-sponsor of S. AMDT. 991 to the Prescription Drug and Medicare Improvement Act that would authorize the Money Follows the Person initiative proposed by President Bush, I applaud his proposal in his FY 2004 budget as part of his New Freedom Initiative.

Senate Amendment 991 and the President’s proposal would create a five-year program to provide 100 percent federal reimbursement for one year on behalf of individuals who move from an institutional setting to the community with home and community services and supports.

Money follows the Person would assist states in meeting their obligations under the Olmstead Supreme Court decision to provide people with disabilities the least restrictive setting. The Arc and UCP believe that the Money Follows the Person initiative would increase access to community-based supports for people with disabilities and help states take greater steps to permanently re-balance their long-term support delivery system.

Changes in the institutional bias in the Medicaid program are long overdue. The Money Follows the Person initiative would assist states in making long-term decisions for people who want to leave institutional settings.

UCP is a national organization that works with and for people with cerebral palsy and related developmental and physical disabilities. It is committed to promoting and improving services and supports for people with disabilities so that they can live, work, go to school and otherwise be a part of their communities. UCP also supports a broad range of research and education efforts on cerebral palsy and related disabilities.

The Arc is the national organization of and for people with mental retardation and related developmental disabilities and their families. It is devoted to promoting and improving services and supports for people with mental retardation and their families. The Arc also fosters research and education regarding the prevention of mental retardation in infants and young children.

Again, thank you for introducing Amendment 991 during the prescription drug and Medicare debate.

Sincerely,

SAM LEAM
President.

PATRICK E. ROGERS
Government Relations Director.

The following statement was ordered to be printed in the Record.

Mr. KERRY. Mr. President, I have been a long-standing supporter of the Olmstead decision to end the institutional bias in care for people with disabilities. Unfortunately, States have been slow to implement this landmark decision. To better help States in this effort, I am proud to say that I am an original cosponsor of Senator Harkin’s MICA S S A legislation, S. 971, the Medicaid Community-Based Attendant Services and Supports Act of 2003, a bill to ensure that “the money follows the people” and that true choice is granted for people with disabilities to decide whether they wish to live in their own communities instead of being institutionalized. The bill also provides major Federal resources to assist...
States with the costs of paying for community-based attendant and support services. Had I been present for the vote, I would have voted against the motion to table the Harkin amendment and would have voted in favor of its inclusion in the Medicare prescription drug bill.

The PRESIDENT pro tempore. The Senator from Pennsylvania is recognized for 1½ minutes.

Mr. SANTORUM. Mr. President, I think what the Senator from Iowa has done is a very worthy thing. The President has focused on this. Part of the President’s plan is what the Senator from Iowa has before us. The problem with this is that this is a Medicaid proposal that is under the jurisdiction of the Finance Committee. The Finance Committee would like the opportunity, in the context of looking at the Medicaid Program, to work this through the structure of A, to have this amendment come to the floor, not having gone through the normal process, I think is inappropriate; B, this is a Medicare bill, not a Medicaid bill. I say to the Senator from Iowa, I know Senator GRASSLEY has said to me that the pending amendment be temporarily laid aside. The PRESIDENT pro tempore. Without objection, it is so ordered.

AMENDMENT NO. 1037

Mr. ALLARD. I send amendment No. 1037 to the desk.

The PRESIDENT pro tempore. The clerk will report.

The bill clerk reads as follows:

The Senator from Colorado (Mr. ALLARD), for himself, Mr. FEINGOLD, Mr. KOHL, and Mr. LEAHY, proposes an amendment numbered 1037.

Mr. ALLARD. Mr. President, I ask unanimous consent that the amendment be dispensed with.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The amendment is as follows:

Pursuant To provide for temporary suspension of OASIS requirement for collection of data on non-medicare and non-medicaid patients

At the end of title V, insert the following:

SEC. 6. TEMPORARY SUSPENSION FOR COLLECTION OF DATA ON NON-MEDICARE AND NON-MEDICAID PATIENTS.

(a) IN GENERAL.—During the period described in subsection (b) of this section, the Secretary may not require, under section 4602(e) of the Balanced Budget Act of 1997 or otherwise under OASIS, a home health agency to gather or submit information that relates to an individual who is not eligible for benefits under either title XVIII or title XIX of the Social Security Act (such information in this section referred to as "non-medicare/medicaid OASIS information").

(b) PERIOD OF SUSPENSION.—The period described in this subsection—

(1) begins on the date of the enactment of this Act; and

(2) ends on the last day of the 2nd month beginning after the date on which the Secretary has published final regulations regarding the collection and use by the Centers for Medicare and Medicaid Services of non-medicare/medicaid OASIS information following the submission of the report required under subsection (c).

(c) REPORT.—

(1) STUDY.—The Secretary shall conduct a study on how non-medicare/medicaid OASIS information is and can be used by large home health agencies.

(A) whether there are unique benefits from the analysis of such information that cannot be derived from other information available to, or collected by, and

(B) the value of collecting such information by small home health agencies compared to the administrative burden related to such collection.

In conducting the study the Secretary shall obtain recommendations from quality assessment experts in the use of such information and the necessity of small, as well as large, home health agencies collecting such information.

(2) REPORT.—The Secretary shall submit to Congress a report on the study conducted under paragraph (1) by not later than 18 months after the date of the enactment of this Act.

(d) CONSTRUCTION.—Nothing in this section shall be construed as preventing home health agencies from collecting non-medicare/medicaid OASIS information for their own use.

Mr. ALLARD. Mr. President, Medicare home health disputes are a paperwork crisis. Current regulations of the Centers for Medicare and Medicaid Services, CMS, requires that caregivers administer voluminous paperwork to patients when they administer care.

These paper requirements are too excessive for both patients and caregivers. Caregivers must administer numerous forms including data collection, patient privacy information, a plan of care, advance directives, a visit schedule, a comprehensive assessment, and more.

One of these requirements, called OASIS, or the Outcome and Assessment Information Set, is 94 questions long and takes a few hours to fill out. Before being reviewed by physical therapists, physical therapists, and physical therapists, caregivers must sit down and answer questions and fill out this paperwork. Colorado providers have told me they spend more time filling out paperwork than they do caring for patients.

As a result of this excessive data collection and dissemination, home health caregivers are leaving the home health industry. Two weeks ago a home health administrator in Colorado Springs told me that she was leaving the industry. On her plane trip here, she and the patient must sit down and answer questions and fill out this paperwork. Colorado providers have told me they spend more time filling out paperwork than they do caring for patients.

As a result of this excessive data collection and dissemination, home health caregivers are leaving the home health industry. Two weeks ago a home health administrator in Colorado Springs told me that she was leaving the industry. On her plane trip here, she and the patient must sit down and answer questions and fill out this paperwork. Colorado providers have told me they spend more time filling out paperwork than they do caring for patients.

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As a result of this excessive data collection and dissemination, home health caregivers are leaving the home health industry. Two weeks ago a home health administrator in Colorado Springs told me that she was leaving the industry. On her plane trip here, she and the patient must sit down and answer questions and fill out this paperwork. Colorado providers have told me they spend more time filling out paperwork than they do caring for patients.
June 26, 2003

CONGRESSIONAL RECORD—SENATE
S8609

Senator Feingold for introducing legislation last Congress to reform OASIS and I commend Senator Murkowski and Senator Kerry for their work on the MARCIA regulatory reform legislation, which included an OASIS suspension.

My colleagues and I believe OASIS data collection is helpful and should be applied. Even providers and patients, who must comply with the law, believe this. Yet the requirements to collect data should be achievable and inexessive.

I am pleased to offer this amendment and urge my colleagues to support this effort for caregivers and patients.

Mr. Allard. Mr. President, I ask unanimous consent that the two additional cosponsors be added to the amendment, Senator Kohl and Senator Leahy.

The PRESIDENT pro tempore. Without objection, it is so ordered.

The Senator from Pennsylvania.

VOTE ON AMENDMENT NO. 991

Mr. Santorum. Mr. President, I move to table the Harkin amendment and ask for the yeas and nays.

The PRESIDENT pro tempore. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. Reid. I announce that the Senator from Massachusetts (Mr. Kerry) and the Senator from Connecticut (Mr. Lieberman) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. Kerry) would vote "nay".

The PRESIDENT pro tempore. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 50, nays 48, as follows:

[Yeas—50]

NAYS—48

To: Members of the United States Senate:

The undersigned organizations are writing in opposition to the amendment offered by Senator Edwards regarding changes to Direct to Consumer advertising of pharmaceutical products. This amendment would impose serious restrictions on information which is of considerable value to the millions of patients we represent.

Our organizations are advocates for millions of Americans who suffer from a broad range of illnesses. Early detection and treatment of these illnesses is an important factor in helping those individuals lead longer and healthier lives. Communication, public education and awareness are key components in the outcomes American patients can hope to achieve. Limiting access to credible information is bad healthcare policy and we urge you to oppose the Edwards amendment and any other efforts to deny Americans information.

Respectfully,

The National Alliance for the Mentally Ill.
The National Mental Health Association.
The American Association of Diabetes Educators.
The American Foundation for Urologic Disease.
The American Lung Foundation.
The American Liver Foundation.
The American Foundation for Urologic Disease.
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The American Liver Foundation.
The amendment (No. 1052) was rejected.

Mr. GRASSLEY. Madam President, I move to reconsider the vote.

Mr. BAUCUS. I move that lay motion on the table.

The motion to lay on the table was agreed to.

The PRESIDING OFFICER. The amendment (No. 1052), as modified, is before the Senate.

Mr. GRASSLEY. Madam President, I send to the desk of the Clerk of the Senate a modified version of the amendment filed last night. I ask that I have a right to modify my amendment.

The PRESIDING OFFICER. Without objection, the amendment is modified. It is the pending amendment at this time.

The amendment as modified is reported:

Subtitle D—Evaluation of Alternative Payment and Delivery Systems

SEC. 231. ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.

(a) ESTABLISHMENT OF ALTERNATIVE PAYMENT SYSTEM FOR PREFERRED PROVIDER ORGANIZATIONS IN HIGHLY COMPETITIVE REGIONS.—

Section 1853(s) as added by section 212(b) is amended by adding at the end the following new section:

"(5) ALTERNATIVE PAYMENT METHODOLOGY FOR HIGHLY COMPETITIVE REGIONS.—

(1) ANNUAL DETERMINATION AND DESIGNATION.—

(A) IN GENERAL.—

(i) IN GENERAL.—The total amount expended as a result of the application of this subsection in the previous year compared to the total amount that would have been expended under this title in the year if this subsection had not been enacted.

(ii) APPLICATION OF LIMITATION.—In determining which preferred provider regions to designate as highly competitive regions under subparagraph (A) or (B), the Secretary shall consider the following:

(I) Whether the application of this subsection to the preferred provider region would enhance the participation of preferred provider organization plans in that region.

(ii) Whether the Secretary anticipates that there is likely to be at least 3 bids submitted under subsection (d)(1) with respect to the preferred provider region if the Secretary designates such region as a highly competitive region under subparagraph (A) or (B).

(iii) Whether the Secretary expects that Medicare Advantage eligible individuals will elect preferred provider organization plans in the preferred provider region if the region is designated as a highly competitive region under subparagraph (A) or (B).

(iv) Whether the designation of the preferred provider region as a highly competitive region will permit compliance with the limitation described in paragraph (5).

(b) PROVISIONS APPLICABLE TO HIGHLY COMPETITIVE REGIONS.—

In determining which preferred provider regions to designate as highly competitive regions under subparagraph (A) or (B), the Secretary shall give special consideration to preferred provider regions where no bids were submitted under subsection (d)(1) for the previous year.

(2) EFFECT OF DESIGNATION.—If a preferred provider region is designated as a highly competitive region, the Secretary shall—

(A) the provisions of this subsection shall apply to such region and shall supersede the provisions of this part relating to benchmark for preferred provider regions; and

(B) such region shall continue to be a highly competitive region until such designation is rescinded pursuant to subparagraph (B)(ii).

(3) SUBMISSION OF BIDS.—

(A) IN GENERAL.—Notwithstanding subsection (d)(1), for purposes of applying section 1853(s) as added by section 212(b), the Secretary shall accept bids for a highly competitive region that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1831, the plan bid for a highly competitive region that would have been expended under this title in the year if this subsection had not been enacted; and

(iii) the Secretary designates as a highly competitive region under subparagraph (A) or (B) of paragraph (1) pursuant to subparagraph (B)(i) with respect to a preferred provider region, the Secretary shall provide for an appropriate transition of the payment system applicable under this subsection to the payment system described in the other provisions of this section in that region. Any amount expended by reason of the preceding sentence shall be considered to be part of the total amount expended as a result of the application of this subsection for purposes of applying the limitation under subparagraph (A).

(4) DETERMINATION.—Notwithstanding paragraph (1)(B), on or after January 1 of the year in which the fiscal year described in section 1831 begins, the Secretary may designate appropriate regions under subparagraph (A) or (B) of paragraph (1) as determined by the Secretary under subparagraph (B)(ii).

(5) LIMITATION OF JUDICIAL REVIEW.—There shall be no administrative or judicial review section 1867, section 1878, or otherwise, of designations made under subparagraph (A) or (B) of paragraph (1).
the applicable amount described in paragraph (5)(A); and

(ii) a certification from the Chief Actuary of the Centers for Medicare & Medicaid Services that such steps will meet accepted actuarial principles and methodologies.

(B) REQUIREMENTS.—A report submitted under subparagraph (A) shall—

(i) specify the steps (if any) that the Secretary will take pursuant to paragraph (5)(B) to ensure that the total amount expended as a result of the application of this subsection during the subsequent years in order to ensure that the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(ii) contain a description of the benefits or services consistent with the goals described in subparagraph (A), (B), and (C) of paragraph (1) that the Secretary will establish for the purpose of monitoring expenditures made under title XVIII of the Social Security Act by reason of the projects under this section during the subsequent years in order to ensure that the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(iii) projects under this section to ensure that the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(iv) the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(D) FUNDING.—

(1) A report submitted under subparagraph (A) shall—

(i) contain a description of—

(A) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the subsequent years in order to ensure that the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(B) how the Secretary will change the payment system under the projects, and

(C) amounts remaining within the funding limitation specified in paragraph (2).

(ii) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the subsequent years in order to ensure that the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(iii) the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(iv) the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(2) LIMITATION.—The total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act during the period if the projects had not been conducted plus $6,000,000,000, and any fiscal year following the fiscal year during the period if the projects had not been conducted, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act during the period if the projects had not been conducted plus $6,000,000,000; and

(3) MONITORING AND REPORTS.—

(A) ONGOING MONITORING BY THE SECRETARY TO ENSURE FUNDING LIMITATION NOT VIOLATED.—The Secretary shall continually monitor expenditures made under title XVIII of the Social Security Act by reason of the projects under this section to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

(B) REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

(i) a detailed description of—

(A) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the subsequent years in order to ensure that the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(B) how the Secretary will change the payment system under the projects, and

(C) amounts remaining within the funding limitation specified in paragraph (2).

(ii) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the subsequent years in order to ensure that the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(iii) the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(iv) the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(4) ENSURE FUNDING LIMITATION NOT VIOLATED.—The Secretary shall continually monitor expenditures made under title XVIII of the Social Security Act by reason of the projects under this section to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

(5) REPORT.—Not later than January 1, 2011, and biennially thereafter, the Comptroller General of the United States shall submit to Congress a report on the designation of highly competitive regions under this subsection and the payment system applicable in highly competitive regions under this subsection; and

(6) CONGRESSIONAL RECOGNITION.—The total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act during the period if the projects had not been conducted plus $6,000,000,000, and any fiscal year following the fiscal year during the period if the projects had not been conducted, an amount equal to the total amount that would have been expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act during the period if the projects had not been conducted plus $6,000,000,000; and

(7) MONITORING AND REPORTS.—

(A) ONGOING MONITORING BY THE SECRETARY TO ENSURE FUNDING LIMITATION NOT VIOLATED.—The Secretary shall continually monitor expenditures made under title XVIII of the Social Security Act by reason of the projects under this section to ensure that the limitations described in subparagraphs (A) and (B) of paragraph (2) are not violated.

(B) REPORTS.—Not later than April 1 of each year (beginning in 2010), the Secretary shall submit a report to Congress and the Comptroller General of the United States that includes—

(i) a detailed description of—

(A) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the subsequent years in order to ensure that the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(B) how the Secretary will change the payment system under the projects, and

(C) amounts remaining within the funding limitation specified in paragraph (2).

(ii) the total amount expended under the medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act (including all amounts expended as a result of the projects under this section) during the subsequent years in order to ensure that the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(iii) the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;

(iv) the total amount that would have been expended under the original medicare fee-for-service program in the year if the projects had not been conducted;
Mr. BAUCUS. Madam President, I ask unanimous consent that the order for the quorum call be rescinded. The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1054

Mr. BAUCUS. Madam President, I ask unanimous consent that all pending amendments so that I might call up amendment No. 1054 on behalf of Senator FEINGOLD, with respect to Medicare beneficiaries. The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk read the following:

The Senator from Montana [Mr. BAUCUS], for Mr. FEINGOLD, proposes an amendment numbered 1054.

Mr. BAUCUS. Madam President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To establish an Office of the Medicare Beneficiary Advocate)

At the end of subtitle D of title I, add the following:

SEC. 133. OFFICE OF THE MEDICARE BENEFICIARY ADVOCATE.

(a) ESTABLISHMENT.—Not later than 1 year after the date of enactment of this Act, the Secretary shall establish within the Department of Health and Human Services, an Office of the Medicare Beneficiary Advocate (in this section referred to as the "Office").

(b) DUTIES.—The Office shall carry out the following activities:

(1) Establishing a toll-free telephone number for Medicare beneficiaries to use to obtain information on the Medicare program, and particularly with respect to the benefits provided under part D of title XVIII of the Social Security Act and the Medicare Prescription Drug plans and Medicare Advantage plans offering such benefits. The Office shall ensure that the telephone number accommodates beneficiaries with disabilities and limited-English proficiency.

(2) Establishing an Internet website with easily accessible information regarding Medicare Prescription Drug plans and Medicare Advantage plans and the benefits offered under such plans. The website shall—

(A) be updated regularly to reflect changes in services and benefits, including with respect to the plans offered in a region and the associated monthly premiums, benefits offered, formularies, and contact information for such plans, and to ensure that there are no broken links or errors;
(B) have printer-friendly, downloadable fact sheets on the Medicare coverage options and benefits;
(C) be easy to navigate, with large print and easily recognizable links; and
(D) provide links to the websites of the eligible entities participating in part D of title XVIII.

(3) Providing regional publications to Medicare beneficiaries that include regional contacts for information, and that inform the beneficiaries of the prescription drug benefit options under title XVIII of the Social Security Act, including with respect to—

(A) monthly premiums;
(B) formularies; and
(C) the specific benefits offered.

(4) Conducting outreach to Medicare beneficiaries to inform the beneficiaries of the Medicare coverage options and benefits under parts A, B, C, and D of title XVIII of the Social Security Act.

(5) Working with local benefits advocates, ombudsmen, local service providers, and advocacy groups to ensure that Medicare beneficiaries are aware of the Medicare coverage options and benefits under parts A, B, C, and D of title XVIII of the Social Security Act.

(c) FUNDING.—Of the amounts authorized to be appropriated under the Secretary's discretion for administrative expenditures, $2,000,000 may be used to establish the Office in accordance with this section.

(2) OPERATION.—With respect to each fiscal year occurring after the fiscal year in which the Office is established under this section, the Secretary may use, out of amounts authorized to be appropriated under the Secretary's discretion for administrative expenditures for such fiscal year, such sums as may be necessary to operate the Office in that fiscal year.

Mr. BAUCUS. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. GRASSLEY. Madam President, I ask unanimous consent that the amendment No. 942 be the pending business. The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. Madam President, I ask that the pending amendments be set aside and that the Senator from Washington be recognized for an amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Washington.

AMENDMENT NO. 942

Ms. CANTWELL. Madam President, I ask unanimous consent that amendment No. 942 be the pending business. The PRESIDING OFFICER. Without objection, it is so ordered. The amendment is as follows:

AMENDMENT NO. 942, AS MODIFIED

Ms. CANTWELL. Madam President, I ask unanimous consent that the amendment be modified with the changes I send to the desk.

The PRESIDING OFFICER. The Senator has a right to modify her amendment. The amendment is so modified. The amendment (No. 942), as modified, is as follows:

On page 204, after line 22, insert the following:

SEC. 133. PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS.

(a) MEDICARE.—Subpart 3 of part D of title XVIII of the Social Security Act (as added by section 101) is amended by adding at the end the following new section:

"PHARMACY BENEFIT MANAGERS TRANSPARENCY REQUIREMENTS "SEC. 1860D–27. (a) PROHIBITION.—The following shall be prohibited:

(I) IN GENERAL.—Notwithstanding any other provision of law, an eligible entity offering a Medicare Prescription Drug plan under this part or a Medicare Advantage organization offering a Medicare Advantage plan under part C shall not enter into a contract with any pharmacy benefit manager (as defined by section 1860D–27) that is owned by a pharmaceutical manufacturing company.

Robert A. Sunshine
(For Douglas Holtz-Eakin, Director.)
Mr. GRASSLEY. Madam President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.
"(2) PROVISION OF INFORMATION.—A PBM that manages prescription drug coverage under this part or part C shall provide the following information, on an annual basis, to the Assistant Attorney General for Antitrust of the Department of Justice and the Inspector General of the Health and Human Services Department:

(A) An aggregate amount of any and all rebates, discounts, administrative fees, promotional allowances, and other payments received or recovered from each pharmaceutical manufacturer:

(B) The amount of payments received or recovered from each pharmaceutical manufacturer for each of the top 50 drugs as measured by volume (as determined by the Secretary).

(C) The percentage differential between the price the PBM pays pharmacies for a drug described in subparagraph (B) and the price the PBM charges a Medicare Prescription Drug Plan or a Medicare Advantage organization for such drug.

"(d) FAILURE TO DISCLOSE.—

(1) CIVIL PENALTY.—Any PBM that fails to comply with subsection (a) shall be liable for a civil penalty determined appropriate through regulations promulgated by the Attorney General. Such penalty may be recovered in a civil action brought by the United States.

(2) COMPLIANCE AND EQUITABLE RELIEF.—If any PBM fails to comply with subparagraph (a) or (b), the United States district court may order compliance and equitable relief as the court in its discretion determines necessary or appropriate, upon application of the Assistant Attorney General.

(c) DISCLOSURE EXEMPTION.—Any information filed with the Assistant Attorney General under subsection (a)(2) shall be exempt from disclosure under section 522 of title 5, and no such information may be required to be disclosed by regulations promulgated by the Attorney General. Such penalty may be recovered in a civil action brought by the United States.

Ms. CANTWELL. Madam President, I rise today to offer the Cantwell-Lincoln Prescription Drug transparency amendment to S. 1, the Medicare prescription drug bill. I thank my cosponsor, Senator Lincoln, for working with me on this important amendment that will help protect consumers against high prescription drug prices.

This amendment does three things. First, it requires any PBM contracting with Medicare to disclose to the Department of Justice how much of the rebates and discounts negotiated for Medicare are being passed back.

Second, the disclosure of these financial arrangements to the Department of Justice provides an incentive for PBMs to return as much as possible of the rebates and other savings to Medicare. That is why my amendment requires the information be handed over to the Department of Justice the financial arrangements that dictate what percentage of rebates and other savings are being passed back to the client.

This disclosure creates a major incentive for PBMs to return as much as possible of the rebates and other savings to Medicare. This incentive will also help reduce prescription drug prices.

The PBMs have argued that reporting this financial information would kill their ability to continue to negotiate low drug prices. I am a businesswoman, and I understand the need to keep financial arrangements confidential. That is why my amendment mandates that the information be handed over to the Department of Justice, where it remains confidential.

Department of Justice oversight also allows for regular review of these financial arrangements to weed out any potential collusion on pricing. This added protection also will help lower drug costs for seniors.

The Cantwell-Lincoln amendment also prohibits PBMs from being owned by pharmaceutical manufacturers. This prohibition would likely result in cost savings because it could allow for pharmaceutical companies to collude with PBMs to favor manufacturers more expensive drugs over less expensive alternatives.

A report on PBMs by the National Health Policy Forum points out the concerns raised by close relationships between PBMs and drug manufacturers. Close ties between the two could lead to a lack of drug choice for consumers, with one manufacturer's drug receiving preferential treatment by the PBM.

Actions taken this week by the U.S. attorney in Philadelphia reinforce the
need for greater PBM oversight as outlined in the Cantwell-Lincoln amendment.

Madam President, I ask unanimous consent that articles from the Washington Post and Wall Street Journal be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[U.S. is joining lawsuits that says Medco puts profits before patients.](By Barbara Martinez)

The Justice Department is joining a lawsuit that alleges Merck & Co.'s Medco pharmacy-benefits subsidiary adopted an "aggressive profits-before-patients policy." Medco's approach resulted in a potentially dangerous lack of oversight in filling prescriptions and increased pharmaceutical costs for the federal government, the suit says.

The department's involvement in the suit, brought by two former Medco pharmacists, doesn't necessarily mean that it believes all the allegations. But it signals that the government is watching the accusations and found at least some of them worth pursuing in court. The government, which also joined a second Medco lawsuit Friday, said that made similar allegations, intends to file its own complaint within 90 days. Justice Department investigators have been examining Medco and other pharmacy-benefit managers, or PBMs, for several years, but this is the first time they have indicated that any suit would be filed. PBMs handle prescription-drug-card benefits for millions of employees.

The complaint alleges that after Merck—one of the world's largest drug companies—purchased Medco in 1993, the PBM began to "systeme changes in its mail-order prescription-filling system—disregarding safety and instead promoting higher profits per prescription.

In a statement, Medco said, "We are confident that when all the facts are presented they will show that our business has one focus: highest quality of prescription health care to our clients and members." It added: We are prepared to present a rigorous defense and believe that we will prove that the allegations in the complaint "are absolutely untrue or reflect years-old isolated issues that were identified and corrected and in no way at any time compromise the quality of patient care." The airing of previously sealed allegations in the suit comes at a difficult time for both Hill, too, where PBMs are locked in a tail-pharmacy industry, over details of Medicare drug benefits to more than 60 million Americans, including millions of federal and state employees. Medco's annual revenue totals about $30 billion.

The case could have repercussions on Capitol Hill, too, where PBMs are locked in a tail-pharmacy industry, over details of Medicare drug benefits to more than 60 million Americans, including millions of federal and state employees. Medco's annual revenue totals about $30 billion.

The government has decided to intervene in two lawsuits brought by three whistle-blowers. Those suits allege that Medco点击查看原始文档的全文。
that may enhance the clout of pharmacy-benefit managers, industry analysts say. The companies are expected to administer government drug spending under some plans, according to congressional testimony provided by the National Association of Chain Drug Stores, and to receive a larger share of government reimbursements for prescription drugs.

More than 62 million Americans get prescriptions processed through Medco, according to the company. Medco handles pharmacy claims for more than 100 million lives, or nearly $30 billion a year, including $1.2 billion from Blue Cross/Blue Shield as part of the Federal Employees Health Benefits Program.

George Bradford Hund and Walter W. Gauger, who both worked as pharmacists in Medco's Las Vegas processing facility, and Joseph Placentile, a physician, allege in their complaints that on busy days Medco would cancel or destroy prescriptions to avoid penalties for delays in filling orders. Customers would be told that the prescriptions had never been received, Sheehan said.

The company is also accused of fabricating records and, when the handwriting on precriptions was unclear or difficult to read, simply guessing at what they said, according to Sheehan. The government's suit against Medco could ask for damages in the millions of dollars in the tight system.

Merck acquired Medco in 1993 at a time when other drugmakers were purchasing pharmacy-benefit managers. By the end of the 1990s, all pharmaceutical manufacturers had such units, but Medco had sold its units amid concerns that the drug companies would use the benefit managers to push their own drugs, rather than what was best for clients.

1998 Merck signed a settlement agreement with the Federal Trade Commission stating that "Medco has given favorable treatment to Merck's drugs," but seeking to promote other products. Last year, Medco agreed to pay $425 million to settle a class-action lawsuit alleging that the company improperly promoted higher priced Merck drugs rather than seeking the best price from alternative pharmaceutical companies. Medco announced it intended to spin off Medco last year, but delayed the initial public offering of shares because of the depressed stock market.

Yesterday's announcement marks the first significant legal action by a federal agency against a pharmacy benefit manager. Previously, attorneys general of at least 25 states have opened inquiries into Medco to determine whether it has violated state laws, and New York State Attorney General L. Spitzer said last Friday that his office was investigating another company, Express Scripts Inc., for allegedly overbilling state government reimbursements for prescription drugs, and to receive a larger share of government payments for drug coverage for employee health plans, making it the nation's largest manager of pharmacy benefits, and the company is supposed to use its bulk-purchasing power to lower drug costs.

The suits say Merck routinely induce physicians to switch patients to Medco drugs, even if a patient had been doing well on another medication that cost less.

The government also says the company failed to keep doctors from explaining prescriptions that were unclear, and fabricated records to make it appear as if calls from pharmacists to physicians had been received. The three whistleblowers—a New Jersey doctor and two Nevada pharmacists who once worked for Medco—claim the firm also mislabeled or destroyed $2.5 billion in rebates from pharmaceutical companies in exchange for promoting their products.

"If we improperly favored any drug by any single company, we could never succeed."

Medco spokesman Jeffrey Simek said the charges are "either absolutely untrue, or they reflect years-old isolated issues that were identified and corrected."

Mr. President, I ask unanimous consent that letters of support be printed in the RECORD. There being no objection, the material is ordered to be printed in the RECORD, as follows:


DEAR SENATOR: As the Senate continues to debate S. 1, the "Prescription Drug and Medicare Improvement Act of 2003," Consumers Union urges you to redouble your efforts to improve the legislation so that it better meets the needs of seniors and people with disabilities, many of whom are in dire need of meaningful protection from the devastating impact of spiraling prescription drug costs.

Some of Consumers Union's most serious concerns about S. 1 are:

- The amount set aside in the Congressional budget resolution for a Medicare prescription drug bill, $400 billion over 10 years, is inadequate for the task and limits coverage to only 22 percent of the projected prescription drug expenditures over this period.
- Prescription drug coverage provided by S. 1 is skimpy, leaving many beneficiaries who lack coverage in 2003 actually paying more out of their own pockets for prescription drugs in 2007, when they have coverage. (For more information, please see our report, Skimpy Benefits and Unchecked Expenditures: Medicare Prescription Drug Bills Fail to Offer Adequate Protection for Seniors and People with Disabilities, at www.consumersunion.org).
- The bill lacks a standard, uniform benefit, does not guarantee the availability of a prescription drug benefit through the Medicare program, and leaves all beneficiaries uncertain about what coverage will be available to them (and uncertain about the premium they will be charged).

While the Senate has approved helpful amendments that would accelerate the introduction of generics and possibly provide beneficiaries access to lower-priced drugs from Canada, the bill's reliance on hundreds of private insurance companies and HMOs to determine the possibility of the federal government using its purchasing power to negotiate deep discounts for consumers. It does too little, therefore, to rein in spiraling prescription drug expenditures.

The bill creates confusion for Medicare beneficiaries, forcing them to sort out the

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options in the drug-only marketplace and options in the HMO/PPO marketplace, and it further complicates the “comparison shopping” task by allowing the prescription drug benefits to vary from the basic parameters (e.g., deductible, cost-sharing, doughnut, catastrophe coverage). Simply-put, the confusing options that will face Medicare beneficiaries from the many PBM and pharmacy prac-
tice are underway that would undermine the traditional fee-for-service Medicare program—the very program that assures beneficiaries that they have the freedom to go to the doctor of their choice—by providing extra subsid-
sization to private PPOs and HMOs. By enriching the private sector in the Medicare marketplace, PPOs and HMOs will attract relatively healthy people; the traditional fee-for-service Medicare option will erode over time. To avoid this design of the sub-
sides and desires to cut costs. The steepest and most vulnerable will be severely dis-
advantaged.

There are several amendments that would help address some of the problems with S. 1. We urge you to support amendments that would:

- Expand the prescription drug benefits so they are comparable to prescription drug coverage in employer-based health insur-
ance plans.
- Reim in prescription drug expenditures through the use of the federal government’s buying power to negotiate deep discounts;
- Provide for scientific study of the comparative effectiveness of alternative pre-
scription drugs.
- Guarantee that beneficiaries would have access to a prescription drug benefit through the Medicare program at a set premium;
- Count the contributions made by employ-
ers toward beneficiaries’ out-of-pocket costs;
- Maintain a level-playing field so that bene-
fits in PPOs and HMOs are not more gen-
erous than benefits available in traditional
fee-for-service Medicare;
- Instruct the National Association of Insur-
ance Commissioners to adjust medigap ben-
efit packages to allow beneficiaries to buy additional coverages.
- Increase the transparency of transactions by pharmaceutical benefit managers;
- Cut the time before the prescription drug benefits begin.

The current debate about a Medicare pre-
scription drug benefit has led seniors and
retiree coverage because any coverage is not counted toward retirees’ out-of-pocket costs; and

While the bill provides for a relatively gener-
sous subsidy for low-income consumers, it requires them to get their prescription drug benefit through Medicare instead of the current-ly universal Medicare program, even though they qualify for Medicare coverage by virtue of their age or disability.

We are deeply troubled by discussions that are underway to amend S. 1 in a manner that would undermine the traditional fee-for-service Medicare program. Seniors and retirees are very concerned about the current activi-
ties involving prescription drug benefits for Medicare beneficiaries. We urge you to support amendments that would ensure that all savings generated by Pharmacy Benefit Managers (PBM) are used to benefit Medicare beneficiaries. We believe that this is a critical means of controlling costs for this new benefit.

PBM creates most of their cost savings and their power to negotiate with drug manufac-
turers to receive favorable rates on a pharmaceutical company’s drugs in exchange for including the drugs on the PBM’s formulary of preferred medications. This bill would require that all contracts with PBMs to provide the Medicare benefit with a private insurer or the government itself include language that all negotiations with a pharmacy be passed back to the government or the private insurer admin-
istering the benefit on behalf of the govern-
ment.

We believe it is crucial that PBMs be re-
quired to disclose the percentage of rebate they have negotiated with the pharma-
cutical companies that are passed onto their clients. Your amendment would do pre-
cisely that—giving some assurance to con-
sumers and the government that the savings achieved by the PBMs are being shared.

I believe that your amendment goes a long way toward ensuring that Medicare bene-
ficiaries do not lose the savings produced by contracts with PBMs, and AFSCME strongly supports its adoption.

Sincerely,

CHARLES BOFFERDING, Executive Director.

AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOY-

Hon. MARIA CANTWELL,
U.S. Senate, Washington, DC.

DEAR SENATOR CANTWELL: On behalf of AFSCME’s 1.4 million members, I am writing to express my strong support for your amendment to S. 1, the Medicare prescrip-
tion drug bill, that would make certain that costs savings generated by Pharmacy Benefit Managers (PBM) on behalf of the Medicare program are used to benefit Medicare beneficiaries. We believe that this is a critical means of controlling costs for this new benefit.

PBM create most of their cost savings and their power to negotiate with drug manufac-
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cutical company’s drugs in exchange for including the drugs on the PBM’s formulary of preferred medications. This bill would require that all contracts with PBMs to provide the Medicare benefit with a private insurer or the government itself include language that all negotiations with a pharmacy be passed back to the government or the private insurer admin-
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I believe that your amendment goes a long way toward ensuring that Medicare bene-
ficiaries do not lose the savings produced by contracts with PBMs, and AFSCME strongly supports its adoption.

Sincerely,


Hon. MARIA CANTWELL,
U.S. Senate, Washington, DC.

DEAR SENATOR CANTWELL: The Washington State Pharmacy Association, representing pharmacy practitioners from all practice arenas in the State of Washington, strongly endorses your amendment to ensure that the costs savings generated by Pharmacy Benefit Managers (PBM) on behalf of the Medicare program are used to benefit Medicare beneficiaries. We believe that this is a critical means of controlling costs for this new benefit.

PBM create most of their cost savings and their power to negotiate with drug manufac-
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cutical company’s drugs in exchange for including the drugs on the PBM’s formulary of preferred medications. This bill would require that all contracts with PBMs to provide the Medicare benefit with a private insurer or the government itself include language that all negotiations with a pharmacy be passed back to the government or the private insurer admin-
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I believe that your amendment goes a long way toward ensuring that Medicare bene-
ficiaries do not lose the savings produced by contracts with PBMs, and AFSCME strongly supports its adoption.

Sincerely,

RONALD F. POLLACK, Executive Director.

WASHINGTON STATE PHARMACY ASSOCIATION,

Hon. MARIA CANTWELL,
U.S. Senate, Washington, DC.

DEAR SENATOR CANTWELL: The Washington State Pharmacy Association, representing pharmacy practitioners from all practice arenas in the State of Washington, strongly endorses your amendment to ensure that the costs savings generated by Pharmacy Benefit Managers (PBM) on behalf of the Medicare program are used to benefit Medicare beneficiaries. We believe that this is a critical means of controlling costs for this new benefit.

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I believe that your amendment goes a long way toward ensuring that Medicare bene-
ficiaries do not lose the savings produced by contracts with PBMs, and AFSCME strongly supports its adoption.

Sincerely,

ROD SHAFER, R.Ph., CEO.

AMERICAN FEDERATION OF STATE, COUNTY AND MUNICIPAL EMPLOY-

Hon. MARIA CANTWELL,
U.S. Senate, Washington, DC.

DEAR SENATOR CANTWELL: The Washington State Pharmacy Association, representing pharmacy practitioners from all practice arenas in the State of Washington, strongly endorses your amendment to ensure that the costs savings generated by Pharmacy Benefit Managers (PBM) on behalf of the Medicare program are used to benefit Medicare beneficiaries. We believe that this is a critical means of controlling costs for this new benefit.

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I believe that your amendment goes a long way toward ensuring that Medicare bene-
ficiaries do not lose the savings produced by contracts with PBMs, and AFSCME strongly supports its adoption.

Sincerely,
Ms. CANTWELL. Madam President, these groups and others have been trying to call attention to problematic PBM practices. These groups rightly point out that strong consumer protections are needed in any Medicare drug benefit.

The American Association of State, County and Municipal Employees agrees that these protections provide "a critical means of controlling costs.

A recent coalition of workers representing more than 20 states also are supportive of efforts to monitor PBMs. Many in this coalition currently use PBMs to provide benefits and many of them are wondering why drug costs continue to rise.

There is a balance to be had here, and the Cantwell-Lincoln amendment makes sure the scale is not tipped too far one way. It is a good amendment that will lower prescription drug prices, provide much needed consumer protections and ensure strong government oversight. I urge my colleagues to support it.

Mr. GRASSLEY. Is the amendment before us now?

The PRESIDING OFFICER. The amendment is before us.

Mr. GRASSLEY. We have looked at the amendment on this side. It has been modified, and I urge we accept it on a voice vote.

Mr. BAUCUS. We have looked at this amendment. I agree with Senator Grassley. We accept the amendment.

Mr. GRASSLEY. I move to reconsider the vote.

Mr. BAUCUS. I move to lay on the table.

Mr. BAUCUS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BYRD. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BYRD. Madam President, I ask unanimous consent that I may speak out of order.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BYRD. I thank the Chair.

The remarks of Mr. BYRD are printed in today's Record under "Morning Business."

AMENDMENT NO. 1095

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, I ask unanimous consent the pending amendments be temporarily set aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. REID. On behalf of the Senator from South Dakota, Senator JOHNSON, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Nevada [Mr. REID], for Mr. JOHNSON, for himself and Mr. COCHRAN, proposes as an amendment No. 1095.

Mr. REID. I ask unanimous consent the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide for a 1-year medication therapy management services program and to ensure that such services are provided properly to Medicare beneficiaries.

At the end of subtitle A of title I, add the following:

SEC. 105. MEDICATION THERAPY MANAGEMENT ASSESSMENT PROGRAM.

(a) Establishment.—

(1) IN GENERAL.—The Secretary shall establish an assessment program to contract with qualified pharmacists to provide medication therapy management services to eligible beneficiaries who receive care under the original Medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) SITES.—The Secretary shall designate not less than 3 geographic areas, each containing no more than 3 sites, at which to conduct the assessment program under this section. At least 2 geographic areas designated under this paragraph shall be located in rural areas.

(b) DURATION.—The Secretary shall conduct the assessment program under this section for a 1-year period.

(c) IMPLEMENTATION.—The Secretary shall implement the program not later than January 1, 2005, but may not implement the assessment program before October 1, 2004.

(d) PAYMENT TO QUALIFIED PHARMACISTS.—

(1) IN GENERAL.—The Secretary shall enter into contracts with qualified pharmacists to provide medication therapy management services to eligible beneficiaries residing in the area served by the qualified pharmacist.

(2) NUMBER OF QUALIFIED PHARMACISTS.—The Secretary shall, in conjunction with contracts under subsection (c), the location of such pharmacists, and the number of eligible beneficiaries served by such pharmacists, and the types of payment methodologies being tested under subsection (d)(2).

(e) REPORT.—

(1) IN GENERAL.—Not later than 6 months after the completion of the assessment program under this section, the Secretary shall submit to Congress a final report summarizing the final outcome of the program and evaluating the results of the program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(f) ASSESSMENT OF PAYMENT METHODOLOGIES.—The final report submitted under paragraph (1) shall include an assessment of the feasibility and appropriateness of the various payment methodologies tested under subsection (d)(2).

(ii) DEFINITIONS.—In this section:

(i) MEDICATION THERAPY MANAGEMENT SERVICES.—The term "medication therapy management services" means services or programs furnished by a qualified pharmacist, individually or on behalf of a pharmacy provider, which are designed—

(A) to ensure that medications are used appropriately by such individual;

(B) to enhance the individual's understanding of the appropriate use of medications;

(C) to increase the individual's compliance with prescription medication regimens;

(D) to reduce the risk of potential adverse events associated with medications;

(E) to reduce the need for costly medical services through better management of medication therapy.

(ii) ELIGIBLE BENEFACTOR.—The term "eligible beneficiary" means an individual who is entitled to or enrolled for benefits under part A and enrolled for benefits under the Medicare+Choice programs established under title XIX and title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.; 1395 et seq.) and (B) not enrolled with a Medicare+Choice plan or a Medicare+Choice Advantage plan under part C of title XVIII of the Social Security Act (42 U.S.C. 1395w et seq.; 1395 et seq.).

(iii) MEDICATION THERAPY MANAGERS.—The term "medication managers" means individuals who are employed by health care providers.
(i) the treatment of asthma, diabetes, or chronic cardiovascular disease, including an individual on anticoagulation or lipid reducing medications; or
(ii) other chronic diseases as the Secretary may specify.

(3) QUALIFIED PHARMACIST.—The term "qualified pharmacist" means an individual who is a pharmacist in good standing.

Mr. MCCONNELL. Mr. President, I ask unanimous consent that this morning the Senate proceed to a vote in relation to the McConnell amendment, to be followed immediately by a vote in relation to the Bingaman amendment numbered 1036, with no second degrees in order to the three above amendments prior to the vote, with 2 minutes equally divided prior to the vote, and with 10 minutes equally divided before the first vote.

Mr. REID. Mr. President, it is my understanding that as soon as Senator KENNEDY finishes his speech Senators MCCONNELL and BOXER will be recognizing the President pro tempore with the time equally divided, and then we go into the series of votes. Is that right?

Mr. MCCONNELL. That is my understanding.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

The Senator from Massachusetts is recognized.

AMENDMENT NO. 1092

Mr. KENNEDY. Mr. President, we will have a chance to have greater discussion and debate on one of the important amendments that is before the Senate. But I wanted to bring to the attention of our Members as we go through the course of the day the Grassley-Baucus amendment, which has two different parts to it. I would like to address the part of the amendment which I find enormously compelling and which deserves the broad support of all the Members of this body.

This amendment provides equal funding for Medicare and the private plan demonstration plans. That is effectively what will be in the Grassley-Baucus amendment. The Republicans say the private sector can do a better job providing health care for seniors and we say Medicare can do a better job. This amendment tests both. This amendment improves the coordination of care for seniors with multiple chronic conditions who remain in Medicare. Republicans have said we need to move seniors into private plans if we want to provide chronic care coordination, disease management, or enhanced preventive services. I am confident this demonstration program in new Medicare can do an even better job than private plans in providing preventive health services and ensuring care coordination. Care for patients with chronic conditions is especially critical. These patients account for 95 percent of Medicare spending, according to “Care Coordination for People with Chronic Conditions”, an analysis published this year by Johns Hopkins University.

Currently, 1 in 2 Americans have multiple chronic conditions, and that number is expected to grow to 175 million by the year 2020. Sixty-two percent of seniors have multiple chronic conditions, but their care is fragmented. For example, an individual may get treatment for their diabetes from one doctor, care for her arthritis from a second doctor and attention for her high blood pressure from a third.

A recent study shows that improving the coordination of care for those with multiple chronic conditions can improve outcomes and reduce costs. For example, in Laconia, NH, the Home and Community Based Care program improved disease management for seniors with multiple conditions. This program served an average of $3,100 in health care costs for each senior served and decreased admission to nursing homes.

In Georgia, the Service Options Using Research and a Community Environment—SOURCE—program improved disease management for 1,600 beneficiaries in 80 counties. The costs of caring for those seniors in the SOURCE program over two years was over $4,000 lower than for those who were not in the program.

My own state of Massachusetts is part of the New England States Consortium, a multi-state effort funded by the Robert Wood Johnson Foundation to study the improvements that can be made in health care through better care coordination.

Expert groups in health care have said that care coordination should be one of the highest priorities for our health care system. For example, in its recent report, Priority Areas for National Action: Transforming Health Care Quality, the Institute of Medicine identified 20 “priority areas” for improving health care.

The Institute of Medicine has carefully examined the issue of care quality. The Institute’s recent report, “Priority Areas for National Action” has a series of recommendations on improving the quality of health care in America. For example, in amendment 13 of the 20 priority items that have been identified by the Institute of Medicine that will make a significant difference in quality. The amendment will have an important impact in reducing costs by improving care coordination and providing needed preventive services.

A recent study funded by the Robert Wood Johnson Foundation reaches the same conclusion. The study examined the outcomes for patients with diabetes. Care coordination and simple preventive services dramatically improved the outcomes for patients with diabetes in terms of their blood glucose levels. Elevated blood glucose is a major concern for patients with diabetes, and preventive services are effective in keeping blood glucose levels down. As we know, diabetes is one of the principal health concerns for our country, and is of particular concern for our seniors.

A decrease of even one percentage point in the blood glucose level of a patient with diabetes can have a profound effect on health. That seemingly small decrease results in a 21 percent drop in mortality from the complication of depression, a 12 percent decrease in renal failure, and a remarkable 43 percent drop in the amputations that so many patients face as a result of this cruel disease. More effective management of blood glucose levels is also effective in keeping patients out of hospitals or nursing homes and thus reducing costs. A reduction in blood glucose levels of just one percent reduces health care costs by $800 per patient.

These kinds of extraordinary improvements in health care quality are what this amendment is all about. We are going to provide some $6 billion nationwide over a 5-year period to give Medicare beneficiaries the right to receive the kinds of improvement efforts, and we are going to challenge the private sector to do it as well.

We believe that the kinds of quality improvement initiatives included in this amendment will be a major factor for the support for this legislation. Health care quality and its impact on health care costs is an aspect of the health care debate that has not received sufficient attention.

This amendment will give us an opportunity to take dramatic steps forward in Medicare which will strengthen and improve the quality of health care for our seniors. The amendment will also have a very positive impact in terms of cost reductions.

This amendment also addresses the whole question of prevention which is equally critical to keeping people healthy. Immunizations, managing high blood pressure, cancer screening, and patient education can all have an enormous impact on keeping people healthy and reducing costs. Too often Medicare pays huge amounts to care for people who are sick but fails to invest adequately in keeping them healthy.

Failure to invest adequately in preventive services is a tragic consequence of the repayment system we now have under the Medicare system. When the original Medicare system was established, we did not have the knowledge, awareness, and understanding of the importance of prevention nearly to extent we have it today. Preventive care was not reimbursed the way it should be.

With this amendment, we will have the opportunity to provide the kinds of real, effective support for prevention programs they deserve. Increased support for preventive services will mean
lower costs and better quality of care for our seniors under Medicare.

As I mentioned, too often we pay huge amounts to care for people who are sick, but fail to invest in keeping people healthy. This amendment gives Medicare a way to invest in keeping people healthy. Too often the care for people with the highest cost, the most serious illnesses, such as cancer and stroke, is not optimal.

This demonstration will help Medicare assure the highest quality care for the sickest patients. Medicare is a fine program. It has kept our senior citizens secure for 40 years. Today let us make Medicare even better with this amendment. I will include the selective parts of the studies I referred to previously in the Record. I ask unanimous consent that the selective parts be printed in the Record at the conclusion of my remarks.

Mr. KENNEDY. Mr. President, as I mentioned, the New England Journal of Medicine—in a major study published a few years ago, focuses on the problem of quality. The study demonstrates that the problem most likely to occur in our health care system is not overutilization of services, but underutilization. This point bears repeating. Patients are not receiving the services they need to keep them healthy. 46 percent of patients did not receive the recommended care, while only 11 percent received care that was not recommended and was potentially harmful. That means that four times as many patients did not receive the care they needed as received care they did not need. The problem in our health care system is not overutilization of services, but underutilization.

The problem of not receiving needed care is particularly acute for some of the most serious disorders that affect seniors. The New England Journal article states that less than one-quarter of patients with diabetes received recommended blood tests. Fewer than two-thirds of patients with high blood pressure received the recommended care. These two diseases alone take an extraordinary toll on the lives of our citizens. Nearly 600,000 seniors die each year from heart disease, and complications of diabetes kill over 50,000 seniors. We could dramatically reduce the serious toll of these diseases—and many others—by improving access to preventive services and enhancing the quality of care.

Modern medicine—and a strong Medicare program—have been effective in allowing seniors to live with chronic conditions that once were fatal. Millions of seniors are alive today because of advances in the treatment of heart disease, cancer, diabetes, and other serious illnesses. As a result of this success, however, millions of seniors have multiple chronic conditions which put them at higher risk for illness and hospitalization. The Institute of Medicine reports that only 0.7 percent of seniors with just one chronic condition require hospitalization in any given year. 6.2 percent of seniors with 4 chronic conditions are hospitalized, in contrast. If 10 or more chronic conditions require a hospital stay. Currently, 60 million Americans have multiple chronic conditions, and that number is expected to grow to 157 million over the next two decades.

Improving the coordination of care for those with multiple chronic conditions can markedly improve outcomes. Yet the average Medicare beneficiary sees more than six different doctors in a year. Clearly, we need to do more to see that seniors receive the most appropriate care for all their conditions—not just the one that any particular doctor among these six is treating individually. Study after study cited by the Institute of Medicine indicates that care is inadequately coordinated for patients with some of the most serious diseases.

Our health care system also fails to provide adequate preventive services. Survival rates for many forms of cancer increase dramatically if the disease is detected early—yet far too few patients receive the type of early screening that can literally mean the difference between life and death. For example, early diagnosis of colon cancer results in a survival rate of only 15 percent, but that survival rate drops precipitously if the cancer spreads or grows before it is detected. Early detection not only saves lives—it reduces costs too. Proper screening can save up to $25,000 for every patient who avoids painful and lengthy treatment through early detection of cancer. Despite this compelling evidence of the value of preventive services, only a third of patients receive the recommended form of colon cancer screening.

The story is the same with adult immunization. Pneumonia and influenza are the seventh leading cause of death in the United States, and the fifth leading cause of death among seniors. Over one-third of seniors with invasive pneumococcal pneumonia will die of the disease. Many cases of these diseases are preventable with a simple immunization—yet one-third to one-half of all seniors do not receive needed immunizations. Coverage rates for high-risk seniors are particularly low. Tragically, only about a quarter of seniors with chronic disease receive a flu shot.

This very important amendment will address these barriers which the Institute of Medicine, the Robert Wood Johnson Foundation, and the New England Journal of Medicine have all commented on as being critical if we are going to strengthen quality and begin to get a greater handle on costs.

I will support the amendment that addresses these questions. Page 13 of the amendment describes the enhanced benefits that will now be available to beneficiaries in terms of care coordination, disease management and preventive services not otherwise covered under section 18 of the Social Security Administration. I ask unanimous consent to include the section of the bill containing this provision in the Record.

The amendment provides chronic care coordination services, disease management services and other benefits that the Secretary will determine to improve preventive health care for Medicare beneficiaries. These services will improve chronic disease management and management of complex life-threatening or high-cost conditions. The amendment will make a real difference in improving the health of millions of seniors. This is really a historic opportunity. I can say, having been here for some period of time, the idea that you would get $6 billion over 5 years to be able to support prevention and the coordination of care for our seniors—I didn’t believe it would ever be needed to have that chance with this amendment.

I think one of the most important aspects of this legislation is its emphasis on the area of prevention, which is so important, as I have just described. In fact, support for care in the best health care services will improve and strengthen the quality of health care and also result in savings for the Medicare system. We have seen how these services help the intensely ill and sick elderly. And we will increase the coordination of services as well. All of this makes a great deal of sense. And we have the evidence—ample evidence—to show that action in this area can make a very important difference to the elderly.

I will let others describe the other part of the amendment dealing with private plans. But we challenge them, after the 5 years in which the resources will be spent—with a GAO study that we will report back on how the money has been spent—we challenge them to see which will make the greatest difference in terms of quality of care for our senior population and will make a difference in terms of the savings in the Medicare system. There is no question in my mind—no question in my mind—what that GAO report will demonstrate. We have clear documentation and scientific information that talks about the various studies that have been done to date, and also the conclusion that back how the money has been spent in this thoughtful, nonpartisan groups in this very area.

We welcome the opportunity to show to the American people which system is really going to work effectively. At the end of that period of time, we will have the chance to enhance and improve on that, to make sure the future generations’ health care will be strengthened.

Mr. President, both this amendment, which will be before us very soon, will receive overwhelming support because I think it will have a real chance to evaluate the different approaches and see what
is going to be most effective in terms of quality and cost.

**BLOOD GLUCOSE—REDUCTIONS PAY OFF**

Longitudinal studies demonstrate that a one percentage point reduction in Hemoglobin A1C (blood glucose) results in: 14% decrease in total death; 25% decrease in diabetes-related deaths; 14% decrease in myocardial infarction; 12% decrease in strokes; 45% decrease in amputations; 24% decrease in renal failure; and $800 reduction in health care costs.

**PROBLEMS WITH QUALITY OF CARE**

The problem with quality that is most likely to occur, is underuse: 46.3 percent of patients receive recommended care. With overuse, 11.3 percent of participants received care that was not recommended and was potentially harmful.

**VARIATIONS IN QUALITY**

There is substantial variability in the quality-of-care patients receive for the 25 conditions for which at least 100 persons were eligible for analysis. Persons with severe conditions were more likely to receive recommended care; persons with alcohol dependence received 10.5 percent of the recommended care. The aggregate scores for individuals with chronic conditions were generally not sensitive to the presence or absence of any single indicator of quality.

**DISCUSSION**

Overall, participants received about half of the recommended processes involved in care. These deficits in care have important implications for the health of the American public. For example, only 24 percent of participants were reached on time for the checks or medications recommended. Such deficits in care are generally not sensitive to the presence or absence of any single indicator of quality.

**FINAL LIST OF PRIORITY AREAS**

The committee’s selection process yielded a final set of 20 priority areas for improvement in health care quality. Improving the delivery of care in any of these areas would enable stakeholders at the national, state, and local levels to begin setting a course for quality health care while addressing unacceptable disparities in care for all Americans. The list made no attempt to rank the priority areas selected. The first 2 listed—care coordination and self-management/health literacy—are cross-cutting and are essential to process-related measures of quality of care for hypertension. Persons whose blood pressure is persistently above normal are at increased risk of cardiovascular disease, stroke, and death. Poor blood-pressure control contributes to more than 68,000 preventable deaths annually.

**RATIONAL FOR SELECTION**

Cancer screening for colorectal cancer begins at age 50 (American Cancer Society, 2002). The estimated long-term cost of treating stage I colon cancer is approximately $90,000 (Brown et al., 2002).

Cervical cancer is the ninth most common cancer among women in the United States, with an estimated incidence of 13,000 cases annually. Cervical cancer ranks thirteenth among all causes of cancer death, with about 4,100 women dying of the disease each year (American Cancer Society, 2002). The incidence of cervical cancer has steadily declined, dropping 46 percent between 1975 and 1999 from a rate of 14.8 per 100,000 women to 8.0 per 100,000 women (Ries et al., 2002). Despite these gains, cervical cancer continues to be a significant public health issue. It has been estimated that 60 percent of cases of cervical cancer are due to a lack of or deficiencies in screening (Sawaya and Grimes, 1999).

**PREVENTION—CANCER SCREENING**

**Impact**

Early diagnosis of colorectal cancer while it is still at a localized state results in a 90 percent survival rate at 5 years (Ries et al., 2002). The American Cancer Society’s (ACS) guidelines recommend screening for colorectal cancer beginning at age 50 for adults at average risk using one of the following five screening regimens: fecal occult blood test (FOBT) annually; flexible sigmoidoscopy every 5 years; FOBT plus flexible sigmoidoscopy every 5 years; double contrast barium enema every 5 years; or colonoscopy every 10 years (American Cancer Society, 2002). The United States Preventive Services Task Force strongly recommends screening for men and women 50 years of age and older for colorectal cancer. Screening has been found to be cost-effective in saving lives, with estimates ranging from $10,000 and $25,000 per life-year saved.

**IMMUNIZATION (ADULT)—RATIONAL FOR SELECTION**

**Impact**

Pneumonia and influenza are the seventh leading cause of death in the United States (The Commonwealth Fund, 2002). Pneumococcal disease causes 10,000 to 14,000 deaths annually; influenza causes an average of 110,000 hospitalizations and 20,000 deaths annually. The United States Department of Health and Human Services (2003). Approximately 30-40 percent of elderly people who have invasive pneumonia will die from the disease (United States Preventive Services Task Force, 1996). The elderly are also at increased risk for complications associated with influenza, and approximately 90 percent of the deaths attributed to the disease are among those aged 65 and older (Vishnu-Priya et al., 2000).

To decrease the burden of these diseases, including incapacitating malaise, doctor visits, hospitalizations, and premature deaths, experts recommend vaccination. Yet one-third to one-half of older adults (aged 65 and older) do not receive the vaccine (The Commonwealth Fund, 2002). Coverage rates for high-risk adults who suffer from chronic disease are especially poor, with only 26 percent receiving an influenza vaccination and 13 percent a pneumococcal vaccination (Institute of Medicine, 2008).

**Mr. KENNEDY. Mr. President, I suggest the absence of a quorum.**

**The PRESIDING OFFICER. The clerk will call the roll.**

**Mr. MCCONNELL. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.**

**The PRESIDING OFFICER. Without objection, it is so ordered.**
Mr. MCCONNELL. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report the amendment.

The clerk, read as follows:

The Senator from Kentucky [Mr. MCCONNELL] proposes an amendment numbered 1097.

SEC. 1. PROTECTING SENIORS WITH CANCER.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with cancer shall be protected from high prescription drug costs in the following manner:

(1) Subsidy eligible individuals with an income below 100 percent of the Federal poverty line—if the individual is a qualified medicare beneficiary (as defined in section 1860D–19(a)(4) of such Act), such individual shall have the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for at least one Medicare Prescription Drug Plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(1) of such Act.

(2) Subsidy eligible individuals with an income between 100 and 135 percent of the Federal poverty line—if the individual is a qualified medicare beneficiary (as defined in paragraph 1860D–19(a)(4)(C) of such Act) who is diagnosed with cancer, such individual shall have the full premium subsidy and reduction of cost-sharing described in section 1860D–19(a)(2) of such Act, including payment of—

(A) deductible;

(B) no monthly premium for any Medicare Prescription Drug Plan described paragraph (1) or (2) of section 1860D–17(a) of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19(a)(2) of such Act.

(3) Subsidy eligible individuals with income between 135 percent and 175 percent of the Federal poverty line—if the individual is a subsidy-eligible individual (as defined in paragraph 1860D–19(a)(4)(D) of such Act) who is diagnosed with cancer, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only $50;

(B) only a percentage of the monthly premium described in section 1860D–19(a)(3)(A)(i); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D–19(a)(2).

(4) Eligible beneficiaries with income above 100 percent of the Federal poverty level—if an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with cancer, such individual shall have access to qualified prescription drug coverage (as described in section 1860D–6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of $275;

(B) the limits on cost-sharing described section 1860D–6(c)(2) of such Act up to, for 2006, an initial coverage limit of $4,500, and

(C) for 2006, a copayment of $3,700 with 10 percent cost-sharing after that limit is reached.

(5) Construction.—Notwithstanding the provisions of this section, nothing in this section shall be construed in a manner that would provide an individual who is diagnosed with cancer with benefits under part D of title XVIII of the Social Security Act (as added by section 101) that are different from the benefits that the individual would have been eligible for if such individual was not diagnosed with cancer.

Mr. MCCONNELL. Mr. President, the amendment I just sent to the desk ensures protection of seniors diagnosed with cancer from the high prescription drug costs associated with that illness.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To protect seniors with cancer)

At the end of subtitle A of title I, add the following:

AMENDMENT NO. 1097

The Senator from Kentucky [Mr. MCCONNELL] proposes an amendment numbered 1097.

Amendment tabled by unanimous consent.

Mr. REID. Mr. President, I yield 2 minutes to Senator Boxer from California.

Mr. REID. Mr. President, I yield 2 minutes to Senator Boxer from California.

Senator Boxer. Mr. President, I am pleased to report that there is overwhelming bipartisan support in this Senate for the Boxer amendment.

Mr. President, it is a truly bipartisan legislation. It finds the additional resources to fill this gap in the future for all diseases.

I encourage all senators to support this legislation. It provides the additional resources to fill in this gap in the future for all diseases.

My amendment states that any senior in Medicare who is diagnosed with cancer shall have the right to a drug plan in which the beneficiary shall pay no deductible, no monthly premium, no more than a 5 percent copayment for any drug spending up to $4,500 a year, no more than a 5 percent copayment for drug spending between $4,500 and $5,800 a year, and no more than a 2.5 percent copayment for any drug spending over $5,800 a year.

Mr. President, I believe that any senior in Medicare diagnosed with cancer shall have the right to a drug plan in which the beneficiary shall pay no deductible, no monthly premium, no more than a 5 percent copayment for drug spending up to $4,500 a year, and no more than a 5 percent copayment for drug spending between $4,500 and $5,800 a year, and no more than a 2.5 percent copayment for any drug spending over $5,800 a year.

My amendment provides that any senior in Medicare diagnosed with cancer, with an income between 135 percent and 175 percent of the poverty level, shall have the right to a drug plan in which the beneficiary shall pay no more than a $50 deductible, an average monthly premium not greater than $35, no more than a 10 percent copayment for drug spending up to $4,500, no more than a 20 percent copayment for drug spending between $4,500 and $5,800, and no more than a 10 percent copayment for any drug spending over $5,800.

My amendment also provides that any senior in Medicare diagnosed with cancer, with an income above 160 percent of the poverty level, shall have the right to a drug plan in which the beneficiary shall pay no more than a $275 deductible, an average monthly premium not greater than $35, no more than a 50 percent copayment for drug spending up to $4,500, and no more than a 10 percent copayment for drug spending over $5,800.

With this amendment, which conforms to the provisions within the bill, all seniors with cancer get help with prescription drug costs, especially the poor and moderate-income seniors.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. Two minutes.

Mr. MCCONNELL. Mr. President, I reserve the remainder of my time.

The PRESIDING OFFICER. Who yields time?

The Senator from Nevada.

Mr. REID. Mr. President, the Boxer amendment is very simple. It says if a person is receiving cancer drugs and they come to a period of time—as this bill is written—they run out of the ability to get help from the Medicare Program, that they, in effect, are covered.

We want a cancer patient to have no donut hole, no gap in coverage. That is what the Boxer amendment is all about.

Mr. KENNEDY. Mr. President, do we have any time?

Mr. REID. We have at least 4 minutes.

Mr. KENNEDY. Will the Senator yield me a minute?

Mr. REID. Of course.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. REID. Mr. President, I yield 2 minutes to the Senator from Massachusetts.

Mr. KENNEDY. Mr. President, the Boxer amendment provides the additional resources for the treatment of cancer. I think all of us understand the importance of the continuity of care in the treatment of disease generally.

That is why I am going to continue to vigorously fight for additional resources to fill in this gap in the future for all diseases.

But it is particularly important to fill this gap for people who are afflicted with the disease of cancer. They are waiting for Congress to fill in this gap.

It does seem to me, because of the compelling reasons for the continuity of care in terms of diseases generally we ought to be able to find the additional resources to fill this gap.

Mr. President, how much time do I have remaining?

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. MCCONNELL. Mr. President, I yield the remainder of my time.
The amendment we just voted for did nothing, not one thing, for cancer patients, except reiterate what is already in the underlying bill.

What my amendment does, and why I hope we will rise to the occasion and support it, is to send a strong message to anyone diagnosed with cancer, and to their families, friends, and loved ones, that if and when they are diagnosed with cancer, they will not face the benefit shutdown that is now in this bill.

I will show my colleagues on this chart that at $4,500 of drug costs, the benefit shuts down. I want my colleagues to think about someone they know with cancer, someone who is battling cancer. Do we want to put this burden on them? They must take their drugs. They cannot cut their pills in half in order to survive.

The Cancer Society tells us that 6 million to 7 million Medicare beneficiaries are battling some form of cancer, and 3,000,000 of them will die of cancer. Please, let us relieve this burden of them having to pay 100 percent of their drug costs during this benefit shutdown. I beg my colleagues to take a stand. I beg my colleagues to be compassionate. I beg my colleagues to be independent for once on an amendment and support the cancer patients who are counting on us today to at least relieve them of this terrible financial burden that will hit them just when they are the sickest.

I urge an aye vote.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Before I use my time, I have a unanimous consent request. That unanimous consent request is that the time lapse between the next two votes be 10 minutes instead of 15 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. GRASSLEY. President, first, from a parliamentary point of view, this amendment, if adopted, would subject the entire bill to a budget point of order. We have enough people in this body who maybe do not want a prescription drug bill that could take down the whole bill.

The other reason is, all the concerns the Senator has mentioned we have taken into account within the $400 billion capibility of our legislation. We have before us this $400 billion to provide prescription drug benefits to our seniors. We have used that $400 billion to help lower-income seniors with prescription drug costs if they have cancer, diabetes, or anything else for which they need drugs.

We have used the $400 billion to limit the catastrophic costs of prescription drugs to all seniors. We do not create two drug classes for the sick and the ill, and that is why we should move forward with this amendment so it does not bring down the whole bill on a potential budget point of order.

I move to table the amendment, and I ask for the yeas and nays.
Mrs. DOMENICI. I believe the amendment should be adopted.

The PRESIDING OFFICER. The amendment (No. 1065) was agreed to.

Mr. BINGAMAN. Mr. President, I move to reconsider the vote.

I move to lay that motion on the table.

The motion to lay on the table was agreed to.

CHANGE OF VOTE

Ms. LANDRIEU. Mr. President, on rollcall vote No. 251, I voted nay. I intended to vote yea. It does not change the outcome of the vote. I ask unanimous consent that the Record reflect as I have stated.

The PRESIDING OFFICER. Without objection, it is so ordered.

(The foregoing tally has been changed to reflect the above order.)

Mr. FRIST. Mr. President, I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. FRIST. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. BUNNING). Without objection, it is so ordered.

Mr. FRIST. Mr. President, I ask unanimous consent that at 2:30 the Senate proceed to a vote in relation to a McConnell or designee amendment regarding Alzheimer’s, to be followed immediately by a vote in relation to the Durbin amendment on the same subject, again, with no second degrees in order to either amendment prior to the votes; provided further that the Senate then proceed to a vote in relation to the Dorgan second-degree amendment on premiums to the Grassley-Baucus amendment No. 1092. Finally, I ask unanimous consent that following disposition of the Dorgan amendment, the Senate then proceed to a vote in relation to the underlying Grassley-Baucus amendment, with no other amendments in order to amendment No. 1092 other than the mentioned Kyl and Dorgan amendments. I also ask unanimous consent that there be 2 minutes equally divided for debate between each of the votes in this series as well.

Mr. REID. Reserving the right to object, everyone here is working in the best of faith to try to work through
Mr. McCONNELL. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To protect seniors with Alzheimer’s disease)

At the end of subtitle A of title I, add the following:

SEC. 3. PROTECTING SENIORS WITH ALZHEIMER’S DISEASE.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with Alzheimer’s disease shall be protected from excessive prescription drug costs in the following manner:

(1) Subsidy eligible individuals with an income below 100 percent of the Federal Poverty Line—If the individual is in a qualified Medicare beneficiary (as defined in section 1860D–19(a)(4)(A) of such Act), such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19a(1) of such Act, including the payment of—

(A) no deductible;

(B) no monthly beneficiary premium for any Medicare Prescription Drug plan available in the area in which the individual resides; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19a(1) of such Act.

(2) Subsidy eligible individuals with an income between 100 and 135 percent of the Federal Poverty Line—If the individual is a specified low income Medicare beneficiary (as defined in paragraph 1860D–19(c)(8) of such Act) or a qualifying individual (as defined in paragraph 1860D–19(c)(7) of such Act) who is diagnosed with Alzheimer’s disease, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D–19a(2) of such Act, including payment of—

(A) no deductible;

(B) no monthly premium for any Medicare Prescription Drug plan described paragraph (1) or (2) of section 1860D–19a of such Act; and

(C) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D–19a(2) of such Act.

(3) Subsidy eligible individuals with income between 125 and 135 percent of the Federal Poverty Line—If the individual is a subsidy-eligible individual (as defined in section 1860D–19a(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D–19(c)(9) of such Act) who is diagnosed with Alzheimer’s disease, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only $50;

(B) only a percentage of the monthly premium (as defined in section 1860D–19a(3)(A)(i)); and

(C) reduced cost-sharing described in clauses (iii), (iv), and (v) of section 1860D–19a(3)(A).

(4) Eligible beneficiaries with income above 135 percent of the Federal Poverty Level—If an individual is an eligible beneficiary (as defined in section 1860D–19a(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with Alzheimer’s disease, such individual shall have access to qualified prescription drug coverage (as defined in section 1860D–19a(1) of such Act), including payment of—

(A) for 2006, a deductible of $275;

(B) the limit for cost-sharing described section 1860D–6(c)(2) of such Act up to, for 2006, an initial coverage limit of $4,500; and

(C) for 2006, an annual out-of-pocket limit of $3,700 with 10 percent cost-sharing after that limit is reached.

Mr. McCONNELL. Mr. President, very briefly, the amendment I just sent to the desk ensures protection of seniors diagnosed with Alzheimer’s from the high prescription drug costs associated with that illness.

My amendment states specifically that any senior on Medicare diagnosed with Alzheimer’s shall have the right to a drug plan in which the beneficiary shall pay no deductible, no monthly premium, no more than a 2.5-percent copayment for drug spending up to $4,500, no more than a 5-percent copayment for drug spending between $4,500 and $5,800, and no more than a 2.5-percent copayment for any drug spending over $5,800 if their income is below the poverty level.

My amendment states that any senior on Medicare diagnosed with Alzheimer’s with an income between 100 and 135 percent of the poverty level shall have the right to a drug plan in which the beneficiary shall pay no deductible, no monthly premium, and no more than a 5-percent copayment for drug spending up to $4,500, no more than a 10-percent copayment for drug spending between $4,500 and $5,800, and no more than a 2.5-percent copayment for any drug spending over $5,800.

My amendment provides that any senior on Medicare diagnosed with Alzheimer’s with an income above 160 percent of the poverty level shall have the right to a drug plan in which the beneficiary shall pay no more than a $50 deductible, an average monthly premium not greater than $35, no more than a 10-percent copayment for drug spending up to $4,500, no more than a 20-percent copayment for drug spending between $4,500 and $5,800, and no more than a 10-percent copayment for any drug spending above $5,800.

My amendment also provides that any senior on Medicare diagnosed with Alzheimer’s with an income above 160 percent of the poverty level shall have the right to a drug plan in which the beneficiary shall pay no more than a $275 deductible, an average monthly premium not greater than $35, no more than a 50-percent copayment for drug spending up to $4,500, no more than a 10-percent copayment for drug spending over $4,500, and no more than a 10-percent copayment for any drug spending over $5,800.

With this amendment, which conforms to the provisions within the bill, all seniors with Alzheimer’s get help with drug costs, especially the poor and moderate-income seniors.

The PRESIDING OFFICER. Who yields time? The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I yield the floor.
Mr. REID. Mr. President, I ask unanimous consent that the Dorgan amendment be offered now and the pending amendment be set aside.

The PRESIDING OFFICER. Is there objection? Without objection.

The Senator from North Dakota.

Mr. DORGAN. Mr. President, I send an amendment to the desk and ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk reads as follows:

The Senator from North Dakota [Mr. DORGAN] for himself and Mr. PARRISH, proposes an amendment numbered 1103.

Mr. DORGAN. Mr. President, I ask unanimous consent that further reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To reduce aggregate beneficiary obligations by $2,400,000,000 per year beginning in 2009.)

In lieu of the matter proposed to be inserted, insert the following:

SEC. 4. AGGREGATE REDUCTION IN MONTHLY BENEFICIARY OBLIGATIONS.

Section 1900A(b)(1)(B) as added by section 101 is amended by adding at the end thereof the following:

"(d) AGGREGATE REDUCTION IN MONTHLY BENEFICIARY OBLIGATIONS.—The Administrator shall for each year (beginning with 2009) determine a percentage which—

(1) shall apply in lieu of the applicable percentage determined under subsection (c) for that year, and

(2) will result in a decrease of $2,400,000,000 for that year in the aggregate monthly beneficiary obligations otherwise required of all eligible beneficiaries enrolled in a Medicare Prescription Drug Plan or a Medicare Advantage plan that provides qualified prescription drug coverage.

This subsection shall not apply in determining the applicable percent under subsection (c) for purposes of section 1900A(b)(1)(B).

Mr. DORGAN. Mr. President, this is an amendment that deals with the question of what to do about the $12 billion of remaining available out of the $400 billion Congress set aside for a prescription drug benefit plan in the Medicare Program. According to CBO, the underlying bill is $12 billion of that $400 billion, so what do we do with that $12 billion? If the bill on the floor of the Senate to add prescription drugs to the Medicare Program costs $388 billion, and we have allocated $400 billion, the obvious question is, what do you do with the other $12 billion? So we have a group of people—I am not quite sure who they were—negotiate over a period of time, and they have now developed a plan for what to do with the $12 billion.

By the Senator from North Dakota, most direct, and most appropriate use of the $12 billion would be to improve the prescription drug benefit for Medicare recipients. After all, that is why we are here. That is the purpose of this discussion and debate. That is the purpose of writing this legislation, to provide a prescription drug benefit to the Medicare Program that serves the interests of our senior citizens.

Regrettably, the Grassley amendment before us, to which I have just offered a second-degree amendment, does not accomplish those goals. So I offer an amendment that is very simple. It says let's try to improve this prescription drug benefit plan for senior citizens with the $12 billion that is available.

Let me just mention a word generally about Medicare. We have people on the floor of the Senate who don't like Medicare. They don't say it, but they know it. One of them said it yesterday in New York City. It is the only flash of candid comment that I have seen recently. Congressman THOMAS, in the New York Times, dated 6/26, says:

"Some of our friends on the other side of the aisle are saying that if this bill becomes law [meaning the prescription drug bill] it will be the end of Medicare as we know it. Our answer to that is, we certainly hope so."

When I was a young boy in a town of 400 people, my dad asked me to drive an old fellow to the hospital in Dickinson, ND. He was a man with a very serious health problem, had no relatives, had no vehicle, had no resources. So I was a teenager just about out of high school. I got him in my car and drove him to St. Joseph's Hospital in Dickinson, ND, and dropped him off there to be treated. He had a serious health problem but no insurance, no money, nothing.

The fact is, that was at a period of time in the late 1950s and early 1960s when a good many senior citizens had no capability to get health care. They had some insurance. They had some money, but no resources. It wasn't the case that insurance companies were running off old folks to ask them: Can we please sell you a health insurance policy? They want to insure 22-year-olds—healthy, vibrant, young 22-year-olds.

That is where they make money. That is where they make money. They don't make money by chasing 75-year-old people and selling them health insurance policies. Back in the early 1960s, one-half of America's elderly had no health insurance—none at all.

Then along came Medicare. The Congress had a real debate about that. I wasn't here then, but you know there were naysayers who say no to everything for the first time. They said no, no, no; we can't create Medicare. Well, we did create Medicare, and now 99 percent of the senior citizens in this country don't have to go to bed at night worrying about whether they can get medical care because they have health coverage under Medicare. God bless them for that. They needed it; they deserved it, and this country provided it through the Medicare Program.

Some say: We have incredible problems financing this program. Yes, we have some financial problems, no question about that. Do you know how we solve those problems? Go back to the old life expectancy. Go back 100 years in this country. People used to live to 48 years of age in this country. Now people live to 76 to 77 years of age. Life expectancy has increased dramatically in this country. That is good news. Our financing problems with Medicare are born of good news. People are living longer. Good for them. Good for us. Good for our country.

Is it a problem to have good news? I do not think so. We will solve those issues. But even as we have done that, even as people are living longer and better lives, these new miracle medicines that have been created since Medicare was created are very expensive but very necessary for people to live a better life. And we have no prescription drug coverage in the Medicare Program.

Clearly, if we wrote Medicare starting from scratch today, we would have prescription drug coverage. That is clear. If the prescription drugs were not a key medical expense when Medicare was created, so now we have to put that coverage in the Medicare Program.

Some people do not like the Medicare Program—to wit my colleague, Congressman THOMAS who said, "certainly we hope this will be the end of Medicare as we know it,"—they want to privatize Medicare. Now, keep in mind that the people who are the sector that would not insure the people in the first place, which is the reason why Congress had to develop the Medicare Program.

That brings us back to this question of what to do with the $12 billion. We are struggling to put together a benefit that means something to the people who need it. This is not theory. It is not a debate in the abstract. It is about some 85-year-old widow who, today, goes into the pharmacy store and tries to figure out how much her prescription drugs are going to cost so she can figure out how much money she has left for groceries. That is happening in a real sense today across this country.

We have $12 billion. We also have a bill that says to senior citizens: You pay $35 a month on an optional basis if you want this program of ours, and after a year you pay the first $275 in prescription drugs. Between $275 and $4,500, the Federal Government will help you by paying 50 percent of your prescription drug costs. And then between $4,500 and $5,800, there is what is famously called the "doughnut hole," which means you receive no coverage.

So you are not covered until you spend $275, then you are partially covered, then you are not covered again, and then you get some prescription coverage. This is the most Byzantine, complicated system we could possibly put together. It clearly is done by committee. We could not have done this so
badly if it were done without a committee.

Having said all of that, the question is, What do we do with the $12 billion? We are told today, with the Grassley amendment, that we will provide $6 billion of that $12 billion to test another alternative bidding system for paying PPOs—and if this is not complicated enough, just stay with me—that would reimburse these PPOs based on the median amount of the three lowest bids. There is nothing here that protects Medicare patients by ensuring they are not paying private health plans substantially more than traditional Medicare costs.

Here is what it means in English. It means we are going to have an experiment with private sector delivery, but we are going to incentivize insurance companies. We are going to provide them some of this money so that they will actually want to offer this plan, so we can say at the end of it that somehow it is a good plan.

We already know that does not work. My colleague, Senator Hollings, says there is no education in the second kick of a mule. We know this does not work. We know what happens. We know the Medicare Payment Advisory Committee, MedPAC, which is a non-partisan committee that advises Congress on Medicare payment policies, says private plans cost 15 percent more than traditional Medicare. We know that. We do not have to spend $6 billion on giving money to private insurers to do an experiment. We know what does not work. We know the cost advantage of Medicare, and yet our colleagues continue to resist and continue to insist that we move Medicare beneficiaries into the private sector. And now with half of the $12 billion, they say let’s do this little experiment.

Will it enhance the health of senior citizens? No. Will it improve health care? No. Will it improve the underlying bill, improve the benefits, reduce the costs? No, not at all. This is just like a puppy dog following the master home. It is putting more and more money down this chute to pursue this dream of trying to demonstrate something we already know does not work.

Mr. DURBIN. Will the Senator yield?

Mr. DORGAN. I am happy to yield.

Mr. DURBIN. Do I understand that senior citizens, given the choice between traditional Medicare and Medicare HMOs, have already voted and that 88 or 89 percent of them want traditional Medicare; that they do not want to put their medical fate in the hands of these HMO private insurers who are unreliable, who may or may not cover the procedures they need? Haven’t the seniors of this country, with their experience, already voted on this issue we are considering?

Mr. DORGAN. They have already made that judgment. They have already decided that. So we want to take $6 billion and give it to private health insurers at a time when Senators have been coming to the Chamber and saying we cannot improve this plan because we do not have any money. I have quotes of all the Senators, and I shall not name them all. I could read all of them. I can remember articles or statements of 50 Senators. Why can’t we improve it? Because we are limited by money. So now we have $12 billion more? That is what happens when you go into a room, shut the door, make a little deal, and say this is how we want to use this money: here is an experiment that we tried, and try this as an experiment that we failed at previously. It makes no sense to me. It is a Byzantine failure, in my judgment, to do it this way.

What I am arguing in my amendment is use the money to actually improve the program for senior citizens. We can drive down the cost of the prescription drug policies and improve the coverage.

Mr. DURBIN. I ask the Senator, if he will yield further, is the Senator aware of a recent survey of seniors—over 600 across the United States—where they were told what this plan, S. 1, is all about? They said the fact that the $35 premium is not mandated in this law may be aying a suggestion; if it is, higher; the fact private insurance companies that provide the prescription drug benefit may decide to change the benefit or go out of business every 2 years; the fact there is a $275 deductible for the first year; the sickness of the senior citizens—when they looked at all those items, is the Senator aware of the fact that most of the seniors, when asked, said they did not believe that S. 1 really answered the need in America that seniors are looking for?

Mr. DORGAN. I know that is the case. I have seen the same survey to which the Senator referred. I think there are some provisions in this bill that will improve some things. I prefer, if we do not do something rather than do nothing, but when we do something, let’s do something right and something that benefits senior citizens. This is the case when you cite the polls, when you cite what our previous experience has been. It is a case, especially with respect to the use of this $6 billion, of the old joke from the movies: What are you going to believe, me or your own eyes?

The fact is, we have already had this experiment, and how much additional costs are involved in the private sector delivery of this benefit, and we also know what Medicare does and how Medicare works. We know the private insurers have about a 24-percent overhead in administrative costs and delivering their service. We know that. We also know Medicare has about a 4-percent cost, a dramatic advantage.

For that reason alone, you would want to have $6 billion for the traditional Medicare delivery system. Against all odds, we have people in this Chamber who, I guess, although they do not say it, believe along with Congressman Thomas that this bill ought to be the end of Medicare as we know it. Congressman Thomas said: Our answer to that is, we certainly hope so.

Mr. DURBIN. I ask the Senator, is it possible that HMOs are going to refuse to take some of these services with the six—I will withdraw that question. I ask the Senator, if one believes in privatization and competition, why does the private sector need a $6 billion subsidy to compete with Medicare? If they are not efficient, if they are customer friendly, why do they need this Federal subsidy of $6 billion to offer an attractive health care package to seniors?

Mr. DORGAN. First, they do not need it, and no subsidy is warranted. The point of my amendment is to say if you have $12 billion, and they say let’s take $6 billion and use it for an experiment that we know does not work, let’s instead use that money to help seniors.

Mr. DURBIN. Senator Hollings looks like he is under the impression that we would take another $6 billion and test whether focusing on wellness will work, which we know it does work. We do not exactly have to have an experiment on that. Do things that promote wellness. It is a very inexpensive amendment that deals with that very kind of wellness approach.

If senior citizens have heart disease, Medicare covers cholesterol screening. It makes sense, does it not? But Medicare does not cover cholesterol screening if one does not know they have heart disease. It does not make sense.

Heart disease is our biggest killer in this country. We ought to cover cholesterol screening across the board. That is the way one can discover who is at risk for heart disease at a point when steps can be taken to prevent it. Yet Medicare does not cover that screening unless a person already has evidence of heart disease.

There are many things we should do to improve Medicare’s preventive coverage. My hope is that perhaps we will have that amendment approved before the end of this process.

My colleague from Illinois talked about HMOs a moment ago. We are not in the trenches of the HMO debate as it was first envisioned by the White House, which said to senior citizens, here is a Faustian bargain: we will give you a prescription drug benefit but only if you enroll in an HMO. Talk about a goofy proposal; that is it.

We have been talking about HMOs. There were some HMOs that did some good things, held down some prices. I understand that. But we have also heard the stories of HMOs not taking...
good care of people. I guess we do not revisit the HMO stories about what happens to patients when profits were at stake. For instance, a woman falls off a cliff in the Shenandoah Mountains, sustains very serious head injuries and is rushed to a hospital but is hauled into an emergency room on a gurney in a coma. After a long convalescence, she finally gets out of the hospital only to be told by her HMO that they will not cover her emergency room treatment because she did not have prior approval to use the emergency room. This is a woman who is hauled in on a gurney in a coma.

I will not revisit all of those HMO stories because it will take too much time, but I will say this: With Medicare, we know what works. Some of my colleagues make the case that it costs too much. Do my colleagues really know what costs too much in Medicare? It costs too much because people are living too long. What a wonderful set of problems this country has. With great health care, people are living longer. I probably should not talk about my uncle again, but I have an 81-year-old uncle who runs the 400 meter and 800 meter Olympic trials. He is probably out running today. He runs 3 miles a day at 81 years old. Forty years ago, one reached 81 years old and they had to be in a chair somewhere, but not any longer. People live longer, doing things, no one ever expected them to do. And that includes my uncle. Good for them. Good for him. But because people live longer, Medicare costs more. That is not a sign of failure; it is a sign of success.

Now we are trying to add to Medicare that which should have been added some long while ago: The miracle drugs that do provide miracles but only if one can afford them. We are talking about covering the drugs that keep seniors out of the hospital and they do not have to go into an acute care hospital bed. That is what we are dealing with.

With this amendment, we are dealing with $12 billion. Instead of bifurcating it into two different experiments, one of which failed and one of which we do not need because we know the answer, what I propose we do is use that $12 billion to reduce from $43 to $38 the premium our senior citizens will have to pay to get prescription drug benefit, starting in 2009.

There are people who live on $300 or $450 a month, their total income from their miserable little Social Security payment, who are living alone in a small town, are struggling to buy food, struggling to buy the necessities of life. There are people who have been told by their doctor: Oh, by the way, you have heart disease and diabetes, and here are the prescription drugs you need; and they sit at home knowing they do not have a penny to pay for those prescription medicines. Talk to those seniors and understand how important this coverage is. The coverage ought to be good and extensive coverage, and it ought to provide what we know we should provide for senior citizens.

Second, it ought to be done in an affordable way. Unfortunately, another way to save $12 billion is to have no definition of the drug prices increase, the monthly premium will increase. The expectation is that the monthly premium starts at $35 and goes to $60 in a 10-year period. My amendment proposes about a $6 reduction in the premium for senior citizens. That is a more effective way to use this $12 billion. Either that, or I would propose we extend the coverage through the $1,300 gap that exists in coverage, which I think would also represent a meaningful way of using this amount of money.

My colleague, Senator Pryor from Arkansas, is in the Chamber and he may wish to address this issue as well. I will defer a comment on behalf of myself and my colleague Senator Pryor, so I yield the floor in the hope that Senator Pryor will wish to make some comments as well.

Mr. Grassley. Mr. President, it is unfair for Medicare, and if we look to the other side of the scale to give us statistics that say 89 percent of the seniors are in fee-for-service Medicare and only 11 percent are in Medicare+Choice and that is a nationwide average. It is an accu- mulation of the seniors who belong to the seniors of America who like Medicare+Choice and I have figures from four cities—Miami, New York, San Francisco, and Chicago.

In Miami, 45 percent of the senior citizens have chosen managed care, the Medicare+Choice option, as opposed to fee-for-service; New York, 22 percent; San Francisco, 29 percent. In Chicago, it was only 6 percent. That may be one reason why one may keep bringing this up quite regularly. This data is from the Congressional Research Service, and it is as recent as March 2003.

When people, wherever they are in the Senate, want to denigrate Medicare+Choice by saying only 11 percent of the people in this country join in and that is such a small percentage and that these figures are evidence it is not liked, go to Miami and ask 45 percent of the citizens who belong to Medicare+Choice why they like it.

I yield the floor.

The PRESIDING OFFICER. The Senator from Arkansas.

Mr. Pryor. Mr. President, last night was a difficult night for me because I was lying in bed worrying about the insurance companies and how we were not getting them enough money during this Congress. Of course, I am being facetious because I think we have a very clear choice.

I commend Senator Dorgan, Senator Durbin, and a number of others who have shown national leadership on this effort to try to make this bill better. I think there is a broad consensus that we want to add a prescription drug benefit to Medicare. We want to help seniors all over this country, but at the same time we have to make sure it is set up the right way. It has to make sense.

Quite frankly, one of the things that to me does not make sense, and probably to most people around the country does not make sense, is that we might put or add a little bit of money to the insurance industry.

All over the country—and I know it is certainly true in my State—insurance companies are raising premiums. It may be health care premiums—everybody knows those are going up. It may be property and casualty; it may be homeowners policies, auto policies, medical malpractice, legal malpractice. You name it, across the board, as far as I know, the price of everything kind of insurance in this country is going up.

Nonetheless, there are some in this Congress who want to actually give them a sizable chunk of money that could go to people who really need the help.

I take my hat off to Senator Dorgan for his leadership. One thing he has figured out is a way to make the premium less for people. Now, saving $6 a month to someone at my income level, and all of our income levels, that is not a lot of money, but for those senior citizens all over this country who live below the poverty level—the only money they get every month is Social Security, maybe a little help from the family—$6 is a lot of money. Six dollars may make this program affordable for them. It is real money. It is money that at the end of the year, if you add it up, is only $72 a year, but that is real money to so many Americans all over the country.

The purpose of the bill, not just this amendment but the whole bill, is to help Americans afford their prescription drugs. I know that Senator Durbin, who is in the Chamber, and Senator Dorgan and a number of others in this Chamber have tried to make prescription drugs more affordable in this legislation. There have been different efforts tried in different ways. One of the things I tried was to strengthen re-importation from Canada to try to make prescription drugs more affordable, but certainly making the premiums more affordable makes the program more accessible to more Americans. That is a win/win/win for everybody.

So I thank the Senator from North Dakota for yielding me some of his time. I know he is frantically talking to colleagues to try to have them adopt this amendment when we vote on it this afternoon.

Let's run through the numbers very quickly one more time so we understand clearly what we are talking about. This amendment expends $2.4
Mr. DURBIN. I thank my colleague from Arkansas as well as my colleague from North Dakota. They have come to the floor and said to the Members of the Senate, look, we found $12 billion. Imagine $12 billion over a period of time. We are in the middle of debating a prescription drug bill. What would the Senate do with new found money, $12 billion worth?

We took a look at the underlying bill, the prescription drug bill. There are a lot of problems with it. There is no guaranteed monthly premium, it is deductible. It has a period of time when there is no coverage. You are paying prescription drug bills and you have no protection, no coverage. There are a lot of uncertainties in this bill.

You would think the first thing you would do with the $12 billion is make this a stronger bill, try to take care of some of the weaknesses, the deficiencies.

Wrong. Given $12 billion, an agreement has been reached not to give the money to the seniors to help them pay for prescription drugs but to give $6 billion to HMOs and private insurance companies, a $6 billion Federal subsidy so they can experiment with alternatives to Medicare.

I am like my colleague from Arkansas; I could not get a moment’s rest last night for fear that we just were not going to give enough money to the insurance companies when this was all over with. I could not sleep all my sleep the night before worried about the fact that maybe pharmaceutical companies would not get all the money that we could possibly throw their way. Then along comes this amendment. We can rest easy tonight because we will give $6 billion to HMOs. This industry which manufactures the milk of human kindness for seniors and families across the America by denying basic health care coverage so they can run up profits is going to have a Federal subsidy.

Well, thank you, Senator Dorgan, Senator Pryor, and others and say if you have $12 billion, for goodness’ sake, put it into this bill. Make this bill a little better for seniors. Reduce the cost for seniors. Give them some assurance of what they will pay. Provide more prescription drug coverage. That is one option. I will support it.

If it does not succeed, I will offer a second option. It reaches a point under the bill we are debating, during the course of a year, when there is a gap in coverage where the Federal Government will not help pay one penny on your prescription drugs, and about $3,700 into the year out of pocket expenses for prescription drugs, this plan cuts off. The underlying plan says you are on your own until you get in the range of $5,500. Then we will start paying you again. So there is a gap in coverage where that senior citizen, that widower, and his or her spouse, he or she has to pay all of the prescription drug bills until she reaches the catastrophic coverage level.

This would not be a problem if you did not have over $3,700 in prescription drugs a year. But a lot of seniors do. I will join my colleagues in the Senate that says simply this: We want to give assurance to all Americans people whom suffer from some of the most expensive diseases that afflict senior citizens can pay for their medication. So we will take the $12 billion and we will put it into the basic bill and cover heart disease, cancer, Alzheimer’s, diabetes and its complications.

We are not going to leave you high and dry. At the end of $3,700 of subsidy from the Government, we are going to take the $6 billion and put it on the table and try to get to Medicare.

When they write the history of this debate, this amendment will stand out. This amendment is a tribute to selfishness, a tribute to shortsightedness. Why is the world not helping the people who need it the most? Why are we giving the money to the HMOs so they can experiment with an effort to end Medicare?

I just ran into Bill Thomas in the hallway, chairman of the House Ways and Means Committee, most powerful man when it comes to Medicare in the House of Representatives. He said in today’s New York Times:

Some of our friends on the other side of the aisle think if this bill becomes law, it will be the end of Medicare as we know it. Our answer to that is, we certainly hope so.

Well, thank you, Congressman Thomas, for your candor. And your candor is the reason why so many Senators have now come to the Senate and said the time has reached not to give the companies’ subsidy HMOs with even more money so they can be more profitable and try to force Medicare out of business. That is what it is all about.

My colleagues will have two choices. They can join me in voting with Senator Dorgan, Senator Pryor, and others and say if you have $12 billion, for goodness’ sake, put it into this bill. Make this bill a little better for seniors. Reduce the cost for seniors. Give them some assurance of what they will pay. Provide more prescription drug coverage. That is one option. I will support it.

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patients are now on Thalidomide. Said drug is very expensive. With a low dose [and this is in the year 2000] it is $455.99 a month.

Incidentally, we checked. That same low dose now costs $645 a month. So in 3 years that amounts to over 40 percent. It costs them $5,500 a year just for that drug. This is an elderly couple in their retirement on a fixed income, fighting cancer, putting every dollar in their savings into keeping one of them alive. I think about this. I think about seniors trying to survive on $1,100 a month on Social Security. And think about this bill which says to this family from Illinois and others just like them: I am sorry, but at some point we are going to stop paying.

Doesn’t it make more sense for us to take the $6 billion and not give it in a subsidy to these private insurance companies but instead give it to these seniors to help them pay these bills? I think so.

I don’t have to tell you the story of Alzheimer’s. Is there a family in America that does not have a loved one or a friend who is struggling with some form of Alzheimer’s? God bless. They are living longer, but as we do life gets more complicated. Let me give an example of a gentleman in Maplewood, MN. His annual out-of-pocket drug costs for Alzheimer’s are seven thousand—annual cost. This man is 78 years old. He pays as much out of pocket for prescription drugs as he does for all of his other household expenses combined. He is a World War II vet, father of three. He is a full-time caregiver for his wife. He hasn’t been on vacation in 5 years. He has given up what he loves to do because he just can’t afford them.

“I am managing the cost, but I’m pretty nervous about it,” he says. Medicare can do something to help. Yes, it can. That is our choice. Are we going to do something to help these seniors facing the most expensive medical conditions or are we going to give $6 billion to private HMOs in a Federal subsidy?

The last one I include is diabetes and its complications. I am sad to report to you, those who are following this debate, diabetes is reaching epidemic proportions in America. Over 6 percent of the American population suffers from some form of diabetes. In the late stages of diabetes, the complications become horrible: Amputations, blindness, severe problems.

Faced with this in your senior retirement years, if you are thinking about a prescription drug plan, do you really want to say to these people and these families battling diabetes and its complications: We are going to cut you off. We are going to stop paying. We would love to give you more but frankly we can’t afford it. We are going to stop paying for the HMO insurance companies. Those are the ones that really need a helping hand.

You couldn’t take that argument to any town in America. You couldn’t take it to any public meeting. You couldn’t take it to any senior citizen. You couldn’t take it to any family with a loved one struggling with one of these diseases.

So my friends on the floor of the Senate are going to have a choice: $6 billion in Federal subsidies for HMOs or $6 billion to help seniors struggling with these terrible, life-threatening, expensive conditions, to pay their prescription drug bills. I think that choice is easy. I hope the majority of the Senate agrees.

I reserve the remainder of my time. The PRESIDING OFFICER. Who yields time? The Senator from Iowa.

Mr. GRASSLEY. Mr. President, I yield myself such time as I might consume to address the issue of the amendment by the Senator from North Dakota and his attempt to take money from the $12 billion that is the bipartisan compromise that is a major compromise on this amendment between Republicans and Democrats. The $12 billion is being divided: $6 billion to make the marketplace provider organizations more competitive, to save money, and to get people into organizations that have particularly chronic disease; and the other $6 billion to go for Medicare demonstration projects to do the same, have about the same result, to have chronic disease management.

The reason for this compromise is both approaches deal with the issue that 5 percent of the sick people under Medicare are responsible for about 50 percent or 55 percent of the cost of Medicare. It is a small segment of people. If we take the other 95 percent of the employees, or a certain problem we had with our business that was just 5 percent of it, but it was 50 percent of the cost of our business, we would have to address that. That is why it is a bipartisan piece of legislation.

I don’t know how, in good conscience, the Senator from North Dakota can take money that would reduce a monthly premium by $2.50, still costing $32.50, away from chronic disease management and a lot of other things that people on his side of the aisle are very concerned about.

It would not be possible to do these projects that we have in the underlying Grassley-Baucus amendment. It seems to me that the Grassley-Baucus amendment with this bipartisan compromise of $6 billion enhanced membership in PPOs as well as $6 billion for chronic disease management in the older fee-for-service Medicare Program is preferable to the second-degree amendment offered by the Senator from North Dakota.

I urge my colleagues to not support the amendment by the Senator from North Dakota. This is the second or third time I have heard that seniors have voted on whether they like fee for service or Medicare+Choice, the argument being 89 percent of the people in this country are in fee for service. Eleven are in managed care, Medicare+Choice, HMO, whatever you want to call it. That is true for the Nation as a whole.

But remember that in the vast geographical area of America HMOs are not available. In the State of Iowa, only one county out of 99 has an HMO for our seniors to join. We have 4,000 Iowans in Medicare+Choice. No place else in Iowa can my citizens get it. The Des Moines Register is always editorializing why more of Iowa cannot have Medicare+Choice so the seniors of our country have that opportunity.

But what is unfair about the 89 percent versus the 11 percent, and Seniors advocating chronic disease is so overwhelming that seniors do not like Medicare+Choice, is the fact that if more had that choice more would take it.
I use, as a basis for my statement, that in the larger cities of America a much higher percentage of seniors have decided to join Medicare+Choice. They do it voluntarily. They can do this in one year and get out the next, if they don't like it. The percentage voting by a higher percentage in favor of Medicare+Choice. They like it because they get more for their money. First, they do not have to pay Medigap insurance. Second, they might get things such as eye glasses and a better deal on prescription drugs than people who are in traditional Medicare for service. Where they have had a chance to have that option, a much higher percentage of seniors than 11 percent will join. All you have to do is talk to people in my State who go to Arizona, California, and Florida for maybe the winter and find out about what people in those States have when they join Medicare+Choice. They ask, Why can't we have that in more places in the country?

A couple of speakers on the other side of the aisle have talked about wasting money with Medicare+Choice. It sounds like you ought to ask the seniors who join and who like it. That is a much higher percentage than 11 percent in a lot of the cities. It is not a fair comparison to imply that since only 11 percent of the people in the country have it and because such a high percentage can't get it that Medicare+Choice is not desired by seniors of America.

Our underlying legislation, the Grassley-Baucus bill, is going to make that opportunity more available for people down the road as we bring in new options. What we want to do in the underlying bill is give our seniors the right to choose. Not enough of them have a right to choose. They have a right to choose prescription drugs. They don't want to join for prescription drugs. They might not have a right to choose between traditional Medicare. If seniors say they are satisfied with what they have, I can say to those seniors that they can keep what they have. It is their choice. But if you want to go out here and join something that has more options, you will have that right to choose. You should have that right to choose.

One of the complaints people made about the President's program was that you are going to give the prescription drugs you had to go over to a new type of Medicare. In traditional Medicare, you could not get prescription drugs—or at least not much of a program; at least not equal to what you could get over here in the new program.

That is where Senator BAUCUS and I disagree with the President of the United States. We believe in equal benefits. If you want prescription drugs, if you want to join it voluntarily, and if you want to stay in traditional Medicare fee for service, you can have prescription drugs. If you want to go over here and choose a new form and have prescription drugs with it, that is your choice.

The right to choose and fairness and equality and no pressure is the basis for this bipartisan Grassley-Baucus legislation. That is the basis for the compromise that is before us which the Senator from North Dakota wants to get to from and use the money someplace else.

I think we need to keep this balanced approach. We need to keep the fairness, the right to choose, the right to choose. Seniors should have options just as other people have. I yield the floor.

The PRESIDING OFFICER. Senator from Illinois.

Mr. DURBIN. Mr. President, I call up my amendment, which I send to the desk pursuant to the unanimous consent request. The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Illinois [Mr. DURBIN] proposes an amendment numbered 1108.

Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To provide additional assistance for certain eligible beneficiaries under part D)

At the appropriate place insert the following:

SEC. ADDITIONAL ASSISTANCE FOR CERTAIN ELIGIBLE BENEFICIARIES UNDER PART D.

Section 1860D-26, as added by section 101, is amended by adding at the end the following:

'(d) ADDITIONAL ASSISTANCE FOR CERTAIN ELIGIBLE BENEFICIARIES.—

'(1) PROGRAM.—Subject to paragraph (2), the Administrator shall implement a program for the period beginning on January 1, 2009, and ending on September 30, 2013, to provide additional assistance to applicable eligible beneficiaries during the initial coverage limit described in section 1860D-6(c)(3) for the year but have not reached the annual out-of-pocket limit under section 1860D-6(c)(4)(A) for the year in order to reduce the cost-sharing requirement during this coverage gap.

'(2) FUNDING LIMITATION.—The Administrator shall implement the program described in paragraph (1) in such a manner that will result in a decrease of $12,000,000,000 in cost-sharing for covered drugs under part D by applicable eligible beneficiaries during the period described in such paragraph. The Administrator shall take appropriate steps to ensure that the costs of the program during such period do not exceed $12,000,000,000.

'(3) APPLICABLE ELIGIBLE BENEFICIARY.—For purposes of this subsection, the term 'applicable eligible beneficiary' means an eligible beneficiary with cardiovascular disease, diabetes and its complications, cancer, or Alzheimer's disease who is enrolled under part D.'

Mr. DURBIN. Mr. President, I will speak briefly because I have to go to another meeting and return for the vote.

I have great respect for the Senators from Iowa and Montana, but I struggle to understand why we are giving a $6 billion subsidy to the HMOs in America. If they are so good, if they are so efficient, if the free market is truly better than the Government-run Medicare system, why in the world do they want $6 billion in Federal money? You know that of that $6 billion hundreds of millions of dollars are going to go to them in profits. We are literally subsidizing the profits of these companies. We are creating this artificial environment that suggests these companies can do a better job or better than Medicare with the $6 billion Federal subsidy to make it work.

I can't understand why my colleagues on the conservative side who are hidebound apostles of the free market don't even wince when it comes to spending $6 billion to the HMOs and the private insurance industry in order to let them play on the field for health care for seniors in America. I don't get it. I certainly don't understand why you wouldn't do that same money to the most vulnerable people in America—our senior citizens who are struggling with heart disease, cancer, Alzheimer's, and diabetes and its complications. Why is the money for the boards of the HMOs going to low expenditure of tax dollars and the money for the family rooms of senior citizens struggling with these deadly diseases not a good investment with taxpayer dollars?

The underlying bill is the biggest breakthrough for the American pharmaceutical industry since the establishment of patents in the Constitution. This amendment with $6 billion in flat out tax subsidies to HMOs is the answer to the prayers of the insurance companies in America.

Is that what the Senate is all about? Am I supposed to come here to make certain that the wealthiest corporations in America get wealthier? I don't think so. They are doing quite well. The rate of return for pharmaceutical companies across America is 18 percent. The average for the S&P companies is 3 percent. These companies are immensely wealthy and profitable. We help them even more with this bill. We know how well the insurance companies are doing. We know the bonuses they give their executives and we are going to plow in $6 billion to make it even wealthier.

There is something else wrong. We know that a lot of average citizens in America—particularly senior citizens—are struggling. Pick up the morning papers. Whether it is the Washington Post or the New York Times, they go to speak to seniors in their real-life environment and talk to them about how they survive. Some of them are well off. Some are lucky. They have saved a little bit of money or had a little bit of a generous retirement but a lot of them do not. A lot of them are literally struggling month to month, some even week to week, just to get by.
This morning in the Washington Post there was a story about a widow lady who said: At the end of the month, I’m lucky if I have a dollar left over. At the end of the article she said: I wonder how many Senators have ever thought about trying to live on $1,100 a month. I don’t know how she does it. I don’t know how a lot of people do it in my State. Why wouldn’t we want to help these people? Why is it the pharmaceutical companies and the HMOs are more important than the most vulnerable people who suffer from some of the worst and most demanding diseases.

I reserve the remainder of my time.

The PRESIDING OFFICER (Mr. AN-EXANDER). Who yields time?

Mr. BAUCUS. Mr. President, I listened quite closely to the Senator from Illinois and the Senator from North Dakota. They are each offering a separate amendment, but they are both similar in an attempt, generally, to accomplish the same result.

I say to my good friend from Illinois, as well as my good friend from North Dakota, who is presently not in the Chamber, I am very sympathetic. If I had my way, we would be spending this newly found $12 billion very much in the way the Senator suggested. In fact, there are a lot of good ways. It is not only now with Alzheimer’s, but it is also lowering the premium. There are a lot of ways we could be spending dollars to help get more drug benefits to more seniors. There is no doubt about that. But, unfortunately, we are 100 Senators.

The Senator from Illinois, the Senator from North Dakota, and I have a view of how some of these dollars should be spent in a perfect world, but the world is not perfect. This is a democracy. It is messy. As Winston Churchill once said—I will paraphrase very poorly, but the Senator knows this quote—basically, Winston Churchill said: A democracy, for all its fits and starts and delays and inefficiencies and horse trading, and all that, is the world’s worst form of government, except for all the others.

Here we are, in a democratic process, trying to figure out how to get prescription drug benefits to seniors. We have 100 Senators. I don’t know how many of you very many Senators. We don’t have many Senators who don’t speak their views. I don’t know very many Senators who don’t have strong views about subjects. I don’t know of many Senators who are not thoughtful, articulate, and fighting hard for their constituents. And we have, as it turns out, Senators from two political parties: 51 Republicans, 48 Democrats, and 1 independent. At this time we are attempting to finally get prescription drug benefits to seniors.

This issue has been debated for 4 years, at least. It has been a politicized issue for 4 years. There has been a lot of talk for 4 years, rhetoric on both sides of the aisle for 4 years, and during all the talking there has not been any action; it has been all words, no deeds.

Well, here we are, at a time—after 4 years of just political posturing, to a large degree—where we are on the brink of getting prescription drug benefits passed for our seniors in our country.

Is it the best bill in the world? No. Could it be better? Yes. Do all Senators wish it could be better? Yes. But is it a good start? Is it a beginning? Is it a platform on which we can begin to build? Absolutely.

If we go back and look at the history of health care and assistance by the Government in providing health care to the needy and to Americans generally, it is a history of building, of starting somewhere, building on it, and making it better and better all the time.

Back in the 1930s it was the Wagner-Murray-Dingell legislation that was introduced to provide national health insurance for Americans. That was the idea: We need national health insurance for Americans.

Well, it was debated and debated. Not a lot more really happened. Then suddenly things changed in the 1960s. The idea of Medicare came along: Why not help at least our seniors? If we can’t get national health insurance, the very least we can do is help our senior citizens get a break with respect to their health care bills. That is a good place to at least give a good, solid segment of the population. And we did, back in 1965, by providing Medicare. And look what has happened since then. We have kept building on Medicare to make it better.

When Medicare was first enacted, 50 percent of a Part B premium was paid by the senior and the Government paid the other 50 percent of the premium for Part B. That is for doctor services. Now, it has been improved over time. We also have added more benefits, some screening provisions. End-stage renal treatment has been added. There is a list of new additions to help our senior citizens.

Here we are now, on getting another major benefit: prescription drugs. After all these years, all the years of talking and talking and politicking and giving statements and speeches, we are finally on the brink of getting prescription drug benefits passed.

It has not been easy. Why has it not been easy? It has not been easy because there are two competing philosophies on the floor of the Senate on how to get prescription drug benefits to seniors. Even though the two competing philosophies are very different from each other, Senators on both sides of the aisle—most Senators, I think, even all Senators, but certainly most Senators—still want to work as hard as they can to try to fit these competing philosophies together in order to pass legislation this year to begin finally getting prescription drug benefits to seniors.

Also, these two competing philosophies are very different. One is competition. The argument is: Let private companies, themselves, with assistance from the Government, design how they give prescription drug benefits to our senior citizens, make them available at a big discount for senior citizens. The other philosophy is: Medicare should be the agency that should be the way—traditional Medicare, basically—to provide these discounts for senior citizens to get drugs.

Essentially, the competing philosophies are 50-50. You have 51 Republicans, 48 Democrats, and 1 Independent. What are we going to do? Well, if we can do it, if we can get this done, is to just try our best to put these two together in a fair, balanced way—and the private competition model gets a break, gets a fair chance to see the degree to which it might work. But that senior citizens really do get the benefits and are not taken advantage of during our efforts to pass legislation.

It is a balance. It is trying to find the right way to accomplish that balance. It has been extremely difficult. I do not have to tell the Presiding Officer just how hard this has been. But we are right on the brink.

We are limited to $400 billion in providing the drug benefits for seniors in the next 10 years—both the House and the Senate—saying we are going to set aside $400 billion for prescription drug benefits for seniors. We never set aside anything like that in the past. So we have an opportunity now to use it. I don’t think Senators want to miss this opportunity. I think they want to use the dollars that are there to get prescription drug benefits for seniors.

Well, as it turned out, when the Senate Finance Committee wrote this bill, trying its hardest to be balanced—and it is balanced; the best evidence of that is it passed by a large majority from both parties in the Finance Committee—we found it actually cost only about $388 billion. There was $12 billion remaining.

So the question before us is how we can spend that $12 billion. That is the question. In an attempt to contain a balance and to work on two competing models and in an attempt to get the legislation passed so we can provide a prescription drug benefit to seniors, we
have decided to split it, 6 and 6; $6 billion to the PP0s, if that is needed for the bidding process, beginning in the year 2009. I don't know how many Senators are going to be here in 2009, but at least then. The other $6 billion, beginning in 2009, will then go, under Medicare fee for services, for disease management, chronic care, to help particularly seniors who really need that disease management and chronic care. They are needed because there is very little disease management today under traditional Medicare. That is one of its shortcomings. That is what we have done.

Again it is a balance, a start, a beginning. I have a lot of sympathy with my friends on this side of the aisle. If I had my druthers and I were the only one writing this bill, I would take that $12 billion and spend it along the lines they are suggesting. But I am not the only Senator here. I am one of 100. It is my job to serve the committee, Senator Grassley, to try to find a balance—not for the sake of balance but for the sake of getting legislation passed so we can finally get prescription drugs to seniors.

Mr. BAUCUS. Mr. President, on behalf of the Senator from New Jersey, and in the absence of the chairman of the committee, Senator Grassley, to try to find a balance—not for the sake of balance but for the sake of getting legislation passed so we can finally get prescription drugs to seniors. If the amendments offered by the Senators from North Dakota or Illinois were to pass, guess what would happen. First of all, those are killer amendments. If those amendments were to pass, that would mean $12 billion and spend it along the lines they are suggesting. That would mean senior citizens may not get the prescription drug benefits we are all trying to get; albeit just a first step, or it could also mean, on the other hand—and this is perhaps even more likely— that if that amendment were to pass, I will bet you dollars to donuts—which is not a good phrase to use because we are trying to put dollars in the donut hole—the conservative part of this body, the Republican side of the aisle, would be going to lose $12 billion and spend it our way. And they have the votes. They have the White House. So this amendment puts in jeopardy a very delicate, very balanced kind of deal between competing philosophies, fairly and evenly, so that we can get prescription drug legislation passed, so that we are not just talking about it anymore and finally doing something about it.

If it were to pass or looked like it would pass, the other side, which has more votes than this side has, would say: We will spend it our way. Then colleagues on my side of the aisle would be quite distressed. They would be forced to ask themselves if they would support on final passage a bill way off to the right for competition instead of the bill which currently exists, particularly with the underlying amendment. I wish we could do more but at least it is a first step. If the history of Medicare is any indication in the future years we will continue to make it better. We will work on that donut hole. We will fill in the gaps. We will make sure premiums are not too high. We will try to help with Alzheimer's and all the other measures we desperately need to pay attention to as the days and years go by.

I implore my colleagues to think a little bit. Resist the siren song of doing something that sounds good but which could very well jeopardize the whole deal. This is fair. It has $6 billion which may or may not be used for PP0s, depending upon what the bids are. This bill cuts off after a 5-year period; no more $6 billion can be spent. And $6 billion management under traditional Medicare which will be spent. That is the question. Do you want balance or do you want to try to get something else passed right now that you like in the short term but could very well jeopardize the whole bill, which means another year, year 5, Congress is talking about this issue, Congress is not doing anything about it. Rather, we want year 1, we have finally got it done.

We are very close to getting it done. It is not perfect, but we will keep working on it over the years.

The PRESIDING OFFICER. Who yields time?

AMENDMENT NO. 1037, AS MODIFIED

Mr. BAUCUS. Mr. President, on behalf of the Senator from New Jersey, and in the absence of the chairman of the committee, Senator Grassley, to try to find a balance—not for the sake of balance but for the sake of getting legislation passed so we can finally get prescription drugs to seniors.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be set aside so that I may send to the desk on behalf of Senator Levin an amendment to ensure that current retirees who have prescription drug coverage, who will lose their coverage as a result of enactment of this legislation, would have the option of drug coverage under Medicare fallback.

The PRESIDING OFFICER. Without objection, it is so ordered.

The clerk will report.

The legislative clerk read as follows: The Senator from Montana [Mr. BAUCUS], for Mr. Levin, proposes an amendment numbered 1111.

Mr. BAUCUS. Mr. President, I ask unanimous consent that reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To ensure that current retirees who have prescription drug coverage who will lose their coverage as a result of the enactment of this legislation, would have the option of drug coverage under Medicare fallback.)

Insert the following in the appropriate place: The Secretary of Health and Human Services shall retain or designate one or more Medicare backup plans so that beneficiaries initially covered by a private insurer under this act who are subsequently covered by a Medicare fallback plan have the option of retaining a Medicare fallback plan or entering private insurance under this act.

AMENDMENT NO. 1111

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be temporarily laid aside.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be set aside so that I may send to the desk on behalf of Senator Levin an amendment to ensure that current retirees who have prescription drug coverage, who will lose their coverage as a result of enactment of this legislation, would have the option of drug coverage under Medicare fallback.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To ensure that current retirees who have prescription drug coverage who will lose their coverage as a result of the enactment of this legislation, would have the option of drug coverage under Medicare fallback.)

Insert the following in the appropriate place: The Secretary of Health and Human Services shall retain or designate one or more Medicare backup plans so that the 39% of current retirees who have prescription drug coverage, estimated by the Congressional Budget Office who will lose their current retiree Medicare coverage as a result of the enactment of this legislation will have the option to enter either a Medicare backup plan or private insurance under this act.

Mr. BAUCUS. Mr. President, I ask unanimous consent that time under the quorum call be charged equally against both sides.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. BAUCUS. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENTS NOS. 1027 AND 1041, EN BLOC

Mr. BAUCUS. Mr. President, I ask unanimous consent that the pending amendments be temporarily laid aside and amendments numbered 1027 and 1041 be immediately considered.

The PRESIDING OFFICER. Without objection, it is so ordered.
The clerk will report that the amendment numbered 1041 is agreed to; that the bill, as amended, be read a third time and passed; that the motion to reconsider be laid on the table; and that any statements relating to the bill be printed in the Record.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the amendment numbered 1041 be agreed to; that the bill, as amended, be read a third time and passed; that the motion to reconsider be laid on the table; and that any statements relating to the bill be printed in the Record.

The amendments are as follows:

AMENDMENT NO. 1041

Mr. BAUCUS. Mr. President, on behalf of the chairman of the committee, Senator GRASSLEY, I ask unanimous consent that the following amendments be set aside and that the following amendments be agreed to en bloc, and that the motions to reconsider be laid on the table:

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the following amendments be agreed to en bloc, and that the motions to reconsider be laid on the table:

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the amendments be agreed to en bloc, and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the amendments be agreed to and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the amendments be agreed to en bloc, and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the amendments be agreed to and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the amendments be agreed to en bloc, and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the amendments be agreed to and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the amendments be agreed to en bloc, and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the amendments be agreed to and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the amendments be agreed to en bloc, and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the amendments be agreed to and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the amendments be agreed to en bloc, and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the amendments be agreed to and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the amendments be agreed to en bloc, and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the amendments be agreed to and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the amendments be agreed to en bloc, and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the amendments be agreed to and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the amendments be agreed to en bloc, and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the amendments be agreed to and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the amendments be agreed to en bloc, and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the amendments be agreed to and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the amendments be agreed to en bloc, and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the amendments be agreed to and that the motions to reconsider be laid on the table.

The amendments were agreed to and the motions to reconsider were laid on the table.
(vi) in subparagraph (B)(iii)—
   (I) by inserting “with respect to fiscal year 1998, 1999, or 2000,” after “subsection (e),” and
   (ii) by striking “2002” and inserting “2004,” and
   (b) by adding at the end the following new subparagraph:
      “(ii) EXPENDITURES DESCRIBED.—For purposes of subparagraph (A), the amount specified in subparagraph
      (ii) in its heading, by striking “fiscal year 2000,” and inserting “fiscal year 2001,” and
      inserting “fiscal year 1999, or fiscal year 2000,” after “fiscal year 2002,”;
   (ii) by striking “or November 30, 2001,” and inserting “November 30, 2001, or November 30, 2002,” respectively.

(c) IN EXTENSION AND REVISION OF RETAINED AND REDISTRIBUTED ALLOTMENTS FOR FISCAL YEAR 2001—
   (A) PERMITTING AND EXTENDING RETENTION OF FISCAL YEAR 2001 ALLOTMENTS.—Paragraph (2) of section 2104(g), as amended in paragraph (2)(A)(ii), is further amended—
      (i) in the heading, by striking “and” and inserting “as of April 15, 1997, has an income eligibility standard that is
      at least 200 percent of the poverty line, or has an income eligibility standard that is at least 200 percent of
      the poverty line under a waiver under section 1115 that is based on a child’s lack of health insurance;
      (ii) by subjecting to subparagraph (B), does not limit the acceptance of applications for children;
      (iii) by providing that the eligibility of such children for child health assistance under this title with
      respect to children whose family income is at or below 200 percent of the poverty line, the
      State who apply for and meet eligibility requirements for establishing eligibility for benefits under title XIX and
      this title;
      (C) REDISTRIBUTION AMENDMENTS.—Such section
      2104(g) is further amended—
      (i) in its heading, by striking “and” and inserting “2000,” and
      inserting “2000, and 2001,” and
      inserting “2000,” and
      inserting “2000,” and
      inserting “2003,” respectively.

(d) EFFECTIVE DATE.—This subsection, and
      (1) STATE OPTION.—
      (A) IN GENERAL.—Notwithstanding any other provision of law, with respect to children who apply for and meet eligibility
      requirements for establishing eligibility for benefits under section 1902(a)(10)(A), the State who applies for and meets the
      eligibility standard that is at least 200 percent of the poverty line for a child who is eligible for medical assistance under
      title XIX and this title with respect to children whose family income is at or below 200 percent of the poverty line, the
      State who apply for and meet eligibility requirements for establishing eligibility for benefits under title XIX and
      this title;
      (ii) ELIMINATION OF ASSET TEST.—The State who applies for and meets the
      eligibility standard that is at least 200 percent of the poverty line for a child who is eligible for medical assistance under
      title XIX and this title;
      (iii) ADOPTION OF 12-MONTH CONTINUOUS ENROLLMENT.—The State who applies for and meets the
      eligibility standard that is at least 200 percent of the poverty line for a child who is eligible for medical assistance under
      title XIX and this title.
      (C) INITIAL ELIGIBILITY DETERMINATIONS AND REDETERMINATIONS FOR MEDICAID ELIGIBILITY.—With respect to children who are eligible for medical assistance under title XIX and this title.
      (D) IN GENERAL.—With respect to children who are eligible for medical assistance under title XIX and this title.
      (E) SAME VERIFICATION AND REDETERMINATION POLICIES; AUTOMATIC REASSESSMENT OF ELIGIBILITY.—With respect to children who are eligible for medical assistance under title XIX and this title.
      (iv) REDISTRIBUTION OF RETAINED AND REDISTRIBUTED ALLOTMENTS FOR FISCAL YEAR 2001—
      (A) PERMITTING AND EXTENDING RETENTION OF FISCAL YEAR 2001 ALLOTMENTS.—Paragraph (2) of section 2104(g), as amended in paragraph (2)(B), is further amended—
      (i) in subparagraph (A), by inserting “2001, 2002, and 2003 exceed the State’s allotment for fiscal year 2000 under subsection
      (b); and
      (ii) by striking “or November 30, 2002,” and inserting “November 30, 2002, or November 30, 2003,” respectively.

(e) EFFECTIVE DATE.—This subsection, and
      (1) STATE OPTION.—
      (A) IN GENERAL.—Notwithstanding any other provision of law, with respect to children who apply for and meet eligibility
      requirements for establishing eligibility for benefits under section 1902(a)(10)(A), the State who applies for and meets the
      eligibility standard that is at least 200 percent of the poverty line for a child who is eligible for medical assistance under
      title XIX and this title with respect to children whose family income is at or below 200 percent of the poverty line, the
      State who apply for and meet eligibility requirements for establishing eligibility for benefits under title XIX and
      this title;
      (ii) ELIMINATION OF ASSET TEST.—The State who applies for and meets the
      eligibility standard that is at least 200 percent of the poverty line for a child who is eligible for medical assistance under
      title XIX and this title;
      (iii) ADOPTION OF 12-MONTH CONTINUOUS ENROLLMENT.—The State who applies for and meets the
      eligibility standard that is at least 200 percent of the poverty line for a child who is eligible for medical assistance under
      title XIX and this title.
      (C) INITIAL ELIGIBILITY DETERMINATIONS AND REDETERMINATIONS FOR MEDICAID ELIGIBILITY.—With respect to children who are eligible for medical assistance under title XIX and this title.
      (D) IN GENERAL.—With respect to children who are eligible for medical assistance under title XIX and this title.
micromanaged, and it has enough private sector involvement to deliver, for the very first time, through a competitive private delivery system, prescription drugs for all seniors regardless of where they are or in what program they happen to be enrolled.

It also says the private sector will offer, for the first time on a voluntary basis, to seniors who want to move into a new system a private delivery system that will cover drugs, will cover hospitals, and will also cover physician charges under Medicare. This is a historic opportunity to combine the best of what Government can do with the best of what the private sector can do.

There is going to be a very important amendment offered by Chairman Grassley and the ranking member, Senator Baucus. Because we were able to get a score that said there is $12 billion extra money available, the question then became, How do we divide it? I never in my life thought we would have such a difficult time spending money. We normally get into fights when we do not have enough money. Lo and behold, we found there was $12 billion in extra funds.

The question then for the Senate is how are we going to allocate that money? Senator Baucus and Senator Grassley, working with Senator Kennedy and others, came up with a plan that is fairly balanced. What it says to the Republican Members: Take half of it, and they want to utilize it for a demonstration program to determine whether PPOs or the provider networks in the private sector will work. We are not certain. We think they will. But let's do a test. And if it costs more, there will be $6 billion available to pay for it starting in the year 2009. That is what many Republicans thought was the right way to use half of the money.

On the other hand, Members on my side said, We need to do more for traditional fee-for-service. If they are going to experiment with the preferred providers in the private sector, we want to also know what will happen if we are able to put in more money for preventive health care and for people who want to stay in the old program.

What Senator Baucus and Senator Grassley did, working with Senator Kennedy, was to say to people who are interested in saying, Yes, I am a Democrat, and I think the legislation should do nothing. There are some Members of Congress who argue the Federal Government should do nothing with regard to Medicare—that the private sector should do everything and that the Federal Government should do nothing. There are others who, on the other hand, who take the position that with regard to Medicare, the Federal Government should do everything and the private sector should do nothing.

What we have been able to put together, under the leadership of the chairman and ranking member and many others who have worked so hard, is a compromise that says let's combine the best of what the Government can do with the best of what the private sector can do and put that package together. That is why we have gotten to the point we are today.

We saw a bill come out of the Senate Finance Committee in a bipartisan fashion with 16 votes in favor; only five votes against it. I predict when the final vote comes on this bill, we will see the same type of bipartisan representation with a significant number, maybe over three-fourths of the Senate saying, yes, this has sufficient improvement and reform in it for me to support it.

It has enough Government involvement to make sure it is paid for, enough Government involvement to make sure it run properly but not enough Government involvement to micromanage. I hope the Congress will stand up to the lobbyists by ensuring the legislation is properly important. When we are talking about saving money and giving people a better quality of life; disease management is important. Also, they can use the money for other benefits and services that the Secretary determines will improve preventive health care for the beneficiaries.

What we have crafted is an effort to do something that will allow for a lower cost, lower price, but we do not know that for sure, so let's do some testing on it in the demonstration program. If we save money, hallelujah for everybody. But if it costs money, they will have $6 billion to help pay for those extra charges.

The Democrats, on the other hand, have the provisions to have $6 billion over the period in order to provide disease management and preventive health care services in the traditional Medicare Program. That is as fair as it can be in a divided Senate. If one side holds their way, they would do it all with the preferred providers. If our side perhaps had their will, it would provide all the money to be put back in traditional Medicare, but we all know in a divided Senate that is not possible.

The best possible compromise has been crafted by the chairman, Senator Grassley; by the ranking member, Senator Baucus; and by Senator Kennedy's involvement and many others who have worked on this issue. It says to the Republican Members: Take half of it, and they want to utilize it for a demonstration program to determine whether PPOs or the provider networks in the private sector will work. We are not certain. We think they will. But let's do a test. And if it costs more, there will be $6 billion available to pay for it.

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What we have crafted is an effort to take the extra money and allow for a lower price, lower cost, but we do not know that for sure, so let's do some testing on it in the demonstration program. If we save money, hallelujah for everybody. But if it costs money, they will have $6 billion to help pay for those extra charges.

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I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "yea".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yees 98, nays 0, as follows:

[Roll Call Vote No. 252 Leg.]

YEAS—98

Kerry
Lieberman

The amendment (No. 1102) was agreed to.

Mr. HATCH. Mr. President, I move to reconsider the vote. Mr. REID. I move to lay that motion on the table. The motion to lay on the table was agreed to.

AMENDMENT NO. 1102, AS MODIFIED

Mr. HATCH. Mr. President, I ask unanimous consent that amendment 1102, which was just agreed to, be modified with the changes that are the desk.

The PRESIDING OFFICER (Mr. CRAPAO). Without objection, it is so ordered.

The amendment (No. 1102), as modified, is as follows:

(Purpose: To protect seniors with cardiovascular disease, cancer, diabetes, or Alzheimer's disease.)

At the end of subtitle A of title I, add the following:

SEC. 4. PROTECTING SENIORS WITH CARDIOVASCULAR DISEASE, CANCER, OR ALZHEIMER'S DISEASE.

Any eligible beneficiary (as defined in section 1860D(3) of the Social Security Act) who is diagnosed with cardiovascular disease, cancer, diabetes or Alzheimer's disease shall be protected from high prescription drug costs in the following manner:

(1) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BELOW 100 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a specified low income Medicare beneficiary (as defined in paragraph 1860D-19(a)(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D-19(a)(4)(C) of such Act), who is diagnosed with cardiovascular disease, cancer, or Alzheimer's disease, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D-19(a)(2) of such Act, including payment of—

(A) no deductible; and

(B) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D-19(a)(1) of such Act.

(2) SUBSIDY ELIGIBLE INDIVIDUALS WITH AN INCOME BETWEEN 100 AND 135 PERCENT OF THE FEDERAL POVERTY LINE.—If the individual is a specified low income Medicare beneficiary (as defined in paragraph 1860D-19(a)(4)(B) of such Act) or a qualifying individual (as defined in paragraph 1860D-19(a)(4)(C) of such Act), who is diagnosed with cardiovascular disease, cancer, or Alzheimer's disease, such individual shall receive the full premium subsidy and reduction of cost-sharing described in section 1860D-19(a)(2) of such Act, including payment of—

(A) no deductible; and

(B) reduced cost-sharing described in subparagraphs (C), (D), and (E) of section 1860D-19(a)(1) of such Act.

(3) ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 135 PERCENT OF THE FEDERAL POVERTY LEVEL.—If the individual is a subsidy-eligible individual (as defined in section 1860D-19(a)(4)(D) of such Act) who is diagnosed with cardiovascular disease, cancer, or Alzheimer's disease, such individual shall receive sliding scale premium subsidy and reduction of cost-sharing for subsidy-eligible individuals, including payment of—

(A) for 2006, a deductible of only $50;

(B) only a percentage of the monthly premium (as described in section 1860D-19(a)(3)(A) of such Act); and

(C) reduced cost-sharing described in clauses (ii), (iii), and (v) of section 1860D-19(a)(3)(A).

(4) ELIGIBLE BENEFICIARIES WITH INCOME ABOVE 100 PERCENT OF THE FEDERAL POVERTY LEVEL.—If an individual is an eligible beneficiary (as defined in section 1860D(3) of such Act), is not described in paragraphs (1) through (3), and is diagnosed with cardiovascular disease, cancer, or Alzheimer's disease, such individual shall have access to qualified prescription drug coverage (as described in section 1860D-6(a)(1) of such Act), including payment of—

(A) for 2006, a deductible of $275;

(B) the limits on cost-sharing described section 1860D-6(c)(2) of such Act up to, for 2006, an initial coverage limit of $4,500; and

(C) for 2006, an annual out-of-pocket limit of $3,700 with 10 percent cost-sharing after that limit is reached.

Mr. HATCH. Mr. President, I ask unanimous consent that the next three votes be 10 minutes in length each.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1108

Under the previous order, there will be 2 minutes equally divided on the Durbin amendment No. 1108.

Mr. DURBIN. Mr. President, with all due respect to my colleagues, the amendment we just agreed to did nothing. It did not add one penny or one new benefit to any senior suffering from Alzheimer's. This amendment I offer, along with Senator HARKIN, will put $12 billion into providing prescription drug coverage for the seniors we represent who suffer from heart disease, cancer, Alzheimer's, diabetes and its complications. Take your pick—a $6 billion tax subsidy for HMO and private insurance companies or $12 billion for your seniors struggling to pay impossible prescription drug bills who will be cut under this bill. It is an easy choice for me. If you take it home to your State, you will find it is an easy choice, too.

I hope you will vote for this amendment.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Mr. President, I rise in opposition. I want to stress my opposition is not because I do not understand or am not sympathetic to the difficult situation beneficiaries who are afflicted with cardiovascular disease, cancer, or Alzheimer’s disease experience.

But I also recognize there are millions and millions of other seniors who suffer from diseases just as debilitating and life-threatening as the ones my colleague has identified here. Under this proposal, they would be treated as second-class citizens because they do not suffer from cancer. The most basic, and really the most important, tenet of the Medicare program today is to provide a universal benefit to all seniors. We have done that under S. 1.

We crafted a prescription drug benefit that helps every senior and also targets the most help to those who are less able to afford the appropriate care.

While I am sympathetic to my colleagues’ desire to enhance the benefit, I can’t support a proposal that pits one group of seniors against the other based solely on this disease.

I urge my colleagues to vote against this amendment so we can remain faithful to the most basic tenet of the Medicare program, a universal benefit, and to ensure that the Senate does not discriminate against seniors based on their disease.

I move to table the amendment, and I ask for the yeas and nays.

The PRESIDING OFFICER. Is there a sufficient second?

There is a sufficient second.

The question is on agreeing to the motion. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) and the Senator from Connecticut (Mr. LIEBERMAN) are necessarily absent.

I further announce that, if present and voting, the Senator from Massachusetts (Mr. KERRY) would vote "nay.

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 57, nays 41, as follows:
Mr. GRASSLEY. Yes, $12 billion is a lot of money; $6 billion of that $12 billion he wants to take away from this provision, this bipartisan provision, that would be used for things he stands for. He is being talked about chronic disease management. He has been talking about managing to a better extent people with chronic diseases. We have put $6 billion into demonstration projects like that to save the taxpayers' money. Why? Because 5 percent of the seniors cause 50 percent of the costs to Medicare. That is why those demonstration projects are very important. That is why I hope you will vote against this amendment.

Mr. SANTORUM. Mr. President, I ask for the yeas and nays.

The PRESIDING OFFICER. The question is on agreeing to the amendment which will allow benefits to go to seniors.

The PRESIDING OFFICER. The amendment (No. 1103) was rejected.

The PRESIDING OFFICER. Under the previous order, there are now 2 minutes equally divided on the Grassley amendment.

The Senator from Montana.

Mr. BAUCUS. Mr. President, I say to my colleagues, this is the key amendment that will provide for the passage of this legislation and, therefore, prescription drug benefits for seniors. It is the key amendment.

Why do I say key amendment? Very simply because we have $12 billion, and we have to find a way, in an even-handed, balanced way, to spend that $12 billion. We have to marry two competing philosophies: private competition and Medicare.

We have, therefore, designed the solution that the $12 billion will be evenly divided to keep the balance so that we can get this legislation passed and, more importantly, so seniors get a prescription drug benefit as quickly as possible.

If this amendment is not adopted, we are going to be in the soup. There are going to be Senators from one side of the aisle who are going to spend all of it their way; there are going to be Senators on the other side of the aisle who want it all spent their way; and we are going to be nowhere. We are going to be back where we have been the last 4 years, talking about prescription drugs benefits but not doing something about it, not providing the benefits to seniors.

This is a key amendment. This is the amendment which will allow benefits to go to seniors.

The amendment (No. 1103) was rejected.
Several Senators addressed the Chair.

The PRESIDING OFFICER. The majority leader.

Mr. DORGAN. Mr. President, President, parliamentary inquiry. Who is recognized to speak in opposition to the amendment?

The PRESIDING OFFICER. The majority leader was recognized.

Mr. Frist. Mr. President, very briefly, this amendment is the culmination of several days of debate where both Democrats and Republicans have come together, again bringing different issues to the table, but together it is a positive, strong amendment for the American people and for seniors.

On the one hand, it invests $6 billion, that is not in the underlying bill, in preventive medicine, which almost does not exist in traditional Medicare, and in chronic disease management. All of us know 5 percent of the beneficiaries are responsible for 50 percent of the cost and we know we need to manage those people better. So we have $6 billion for preventive medicine and chronic disease management.

In there, if we have the $12 billion to support the concept of private enterprise, competition, the private entities, which we believe is the only salvation but critical if we are going to address the long-term, 75-year unfunded liabilities that are incurred when we add a new prescription drug benefit.

For that reason, I urge our colleagues on both sides of the aisle to recognize that we worked together, Democrats and Republicans, to come to this carefully negotiated agreement that will be to the benefit of seniors and individuals with disabilities.

Several Senators addressed the Chair.

The PRESIDING OFFICER. The Senator from North Dakota.

Mr. DORGAN. Mr. President, President, parliamentary inquiry. My understanding was prior to a vote there was to be time divided between opponents and supporters. We have just heard from three supporters.

The PRESIDING OFFICER. The agreement was the time was to be evenly divided.

Mr. DORGAN. Evenly divided between whom?

The PRESIDING OFFICER. The managers.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the Senator from North Dakota be given 2 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from North Dakota.

Mr. DORGAN. Mr. President, there does need to be opposition, it seems to me, for those who believe this is not the right way to use $12 billion. The $12 billion was made available. Twelve billion is what we discovered. The CBO estimate was below the $400 billion available for this program. So the question was: How shall the $12 billion be used?

We have spent all of our lives in this Chamber making choices. Too often we make the wrong choices in circumstances such as this. We come back with a plan that says let's use the $12 billion for two purposes, and both of them are for experiments. In both cases, we know the answer to the experiment, $6 billion to the insurance companies so we can incentivize—subsidize—the insurance companies to see if they can provide the prescription drug benefit at equivalent or less cost than Medicare does. We know the answer to that. That experiment has been done.

Ask senior citizens all across this country what would you rather have, better benefits or lower costs or would you like to have $12 billion in demonstration projects? That is the choice. The choice has been presented to us at this point in this amendment to say let's bifurcate this into two $6 billion pots, both of which will be demonstration projects, the answer to which we know in both cases. First, the circumstance with subsidizing the insurance companies, we know the answer to that. They are going to provide this benefit at higher costs. We know that. Second, does wellness and chronic care help? Yes, we know that. Why do we not take the $12 billion and use it to provide better benefits or lower costs for senior citizens? After all, that is why we started this process, to provide a prescription drug benefit that works for senior citizens.

We come to the end of this process, and we have a group of people who went into a closed room and come out with a deal that says we have decided how the $12 billion should be used. Ask senior citizens how they would like it used and I guarantee there is only one answer from every corner of this country: Use it to provide us benefits that were promised, deliver that which was promised to us.

The PRESIDING OFFICER. The Senator's time has expired.

Mr. SANTORUM. I ask for the yeas and nays.

The PRESIDING OFFICER. The PRESIDING OFFICER. Is there a sufficient second? There appears to be a sufficient second. The question is on agreeing to amendment No. 1092, as modified. The clerk will call the roll.

The assistant legislative clerk called the roll.

Mr. McCONNELL. I announce that the Senator from Ohio (Mr. VOINOVICH) is necessarily absent.

Mr. REID. I announce that the Senator from Massachusetts (Mr. KERRY) would vote "nay".

The PRESIDING OFFICER. Are there any other Senators in the Chamber desiring to vote?

The result was announced—yeas 71, nays 26, as follows:

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The amendment (No. 1092) was agreed to.

Mr. REID. Mr. President, I move to reconsider the vote.

Mr. ENSIGN. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

Mr. REID. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The assistant legislative clerk proceeded to call the roll.

Mr. BAUCUS. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered. The Senate will be in order.

The Senator from Montana.

Mr. BAUCUS. Mr. President, on behalf of myself and the chairman of the committee, Senator GRASSLEY, I ask unanimous consent that at 5 p.m. today the Senate proceed to a vote in relation to the Sessions amendment. Mr. Senator, today the Senate proceed to a vote in relation to the Sessions amendment. No. 1011, to be followed by a vote in relation to the Rockefeller amendment numbered 975, as modified; to be followed by a vote in relation to the Bingaman amendment numbered 1066, provided further that there be no amendment in order to the amendments prior to the votes, and there be 2 minutes equally divided for debate. The PRESIDING OFFICER. Is there objection to the motion to proceed?

Without objection, it is so ordered.

Mr. REID. Mr. President, I suggest the absence of a quorum, and I ask...
United States may, in accordance with para-
graph (3)(A) collect double damages against any such entity. In addition, the United States may recover under this clause from any exceeded payment from a primary plan or from the proceeds of a pri-
mary plan's payment to any entity.

(c) CLERICAL AMENDMENTS.—(1) CLERICAL AMENDMENTS.—Section 1902(b)(42)(U.S.C. 1395y(b) is amended—
(i) in paragraph (3)(A), by moving the in-
dentation of clauses (ii) through (vi) 2 ems to the left; and
(ii) in paragraph (3)(A), by striking such before paragraphs.

Mr. ROCKEFELLER. Mr. President, this amendment ensures that the Medi-
care prescription drug benefit we are de-
bating is, in fact, truly universal. It is a principle we have all espoused over the years.

The underlying bill, which we are de-
bating, precludes Medicare bene-
ficiaries who are eligible for Medicaid from enrolling in the Medicare drug benefit. That would be the first time ever that Medicare beneficiaries would be, in fact, precluded from being Medi-
care beneficiaries.

The group, which is referred to as dual eligibles, consists of those who are the poorest seniors. They are those who live below 135 percent of poverty. If my colleagues are inter-
ested, that income level is $6,645. That is their total gross income. The major-
ity of them are single. The majority of them are women who are in poor health and more likely to be over the age of 85.

Precluding these people is wrong, and my amendment would fix it. I am happy to say the amendment is budget neutral. I will explain that in a minute.

Prescription drugs are optional as a benefit under Medicaid. We all know that. States can limit the number of prescriptions they make available. Some allow two or three prescriptions per year. They can cap the benefits. They can charge any copayments they want and it all together.

So you have States, predictably, al-
ready in a situation with very different Medicaid levels. Because of our finan-
cial situation nationally, and in our States, Medicaid is always going to be the very first benefit which will be cut. It has already happened, and will hap-
pen substantially more over the com-
ing years.

I remind, again, my colleagues these are the poorest of the poor, the oldest of the poor, the absolute sick of the sick we are talking about.

I strongly urge my colleagues to pro-
vide all of the seniors in their States with the benefit of a real Medicare drug benefit by supporting this amend-
ment.

If a State gets to the position where it is simply unable to continue with prescription drugs under the Medicaid program, and they virtually eliminate it, that poor person, below 74 percent of poverty—which is just a little bit over $6,000 a year—has nowhere else to go. Always—including presently—that per-
sion can return to Medicare. This un-
derlying bill would preclude that from

happening. My amendment would fix that in a budget-neutral fashion.

I hope my colleagues will support this amendment which I consider one of the most moral and humane of amendments that has come before this body on this issue.

I thank the Presiding Officer.

Mr. GRASSLEY. Mr. President, I rise in opposition to this amendment. In S. 1, beneficiaries who are enrolled in both Medicare and Medicaid will con-
tinue to receive the generous drug cov-
erage that they currently know through the Medicaid program.

Some of my colleagues have argued that by having dual eligibles remain in the Medicare program, Congress is treating these vulnerable seniors as second-class citizens and subjecting them to a lower quality benefit.

This is not the case. In fact, this let-
ter from the Long Term Care Phar-
mary Alliance applauds S. 1 for keep-
ing the duals in Medicaid.

Specifically, the letter states,”This approach will preserve the time-tested safeguards designed to prevent medica-
tion errors and ensure quality care for the majority of these beneficiaries in the institutional setting.”

The policy decision to cover the drug cost for dual eligibles in Medicaid was not made in vacuum. These vulnerable citizens deserve the best benefit avail-
able, which is the benefit provided through Medicaid. I also remind my colleagues that the intent of this legis-
lation is to expand prescription drug coverage to our senior citizens who do not have access to any drugs, or who are faced with paying a large share of their income for their drug coverage.

This does not describe the current coverage experienced by those who are dually eligible.

These seniors currently have a drug benefit through the Medicaid program. In fact, many advocates and bene-
ficiaries describe and know this benefit to be very inadequate.

Medicaid was created to assist indi-
viduals who do not have the means to pay for their share of health care costs. That is a responsibility shared between the Federal Government and the States. Medicaid pays for many bene-
fits that Medicare does not.

We all know that the purpose of S. 1 is to provide prescription drugs to sen-
iors that do not currently have access to drugs or are paying extremely high drug costs.

However, recognizing the costs asso-
ciated with covering the cost of pro-
viding prescription drug coverage to the dual eligible population, S. 1 does provide nearly $18 billion in new Federal dollars to compensate States for some of these costs.

This is because S. 1 provides min-
umum standards that ensure that every aspect of the benefit provided through Medicaid is the same high quality that is provided through Part D of the Medi-
care program.

I remind my colleagues that adoption of this amendment will not expand cov-

erage at all; it will simply shift the cost to the Federal Government and in-
time to the other Medicare bene-
ficiaries.

In closing, I remind my colleagues that S. 1 helps to deliver care that is con-
tent with the custodial care that is fa-
miliar to vulnerable beneficiaries.

I urge my colleagues to defeat this amendment.

I ask unanimous consent to print the letter to which I referred in the RECORD.

There being no objection, the mate-
rial was ordered to be printed in the RECORD, as follows:

LONG TERM CARE PHARMACY ALLIANCE, 

Hon. CHARLES E. GRASSLEY, 
Chairman, Committee on Finance, U.S. Senate, 
Dirksen Building, Washington, DC.

DEAR CHAIRMAN GRASSLEY: On behalf of the Long Term Care Pharmacy Alliance, I appre-
ciate this opportunity to express our support for provisions of Medicaid legislation you have advanced to protect the nation's frail elderly beneficiaries residing in nursing fac-
ilities. In particular, we believe that your legislation would allow dual eligible beneficiaries to retain their prescription drug coverage under Medicaid.

While most Medicare beneficiaries are able to walk into pharmacies to pick up their pre-
scriptions or to receive vials of pills through the mail, a sizable percentage of bene-
ficiaries cannot do so and need special serv-
ces that retail and mail order pharmacies do not provide. Nursing home residents have specific diseases and multiplicity of conditions that require specialized pharmacy care.

To meet these needs, long-term phar-
macies provide specialized packaging, 24-
hour delivery, infusion therapies, geri-
ciatric-specific formularies, clinical con-
sultation and other services that are indis-
ensible in the long-term care environment. Without such treatment, we cannot expect positive therapeutic outcomes for these pa-
tients.

Failure to take into consideration the special pharmacy needs of the frail and insti-
tutionalized elderly will lead to a marked in-
crease in medication errors and other ad-
verse events.

In recognition of these concerns, your pro-
posed legislation designates the current system of Medicaid coverage to provide spe-
cialized pharmacy services to dual-eligible beneficiaries residing in nursing facilities.

This approach will provide the time-
tested safeguards designed to prevent medication errors and ensure quality care for the major-
ity of these beneficiaries in the institutional setting. Medicaid today provides generous benefits to dual eligible beneficiaries and has experience in addressing the special needs of nursing home patients. The proposed new Part D benefits do not contemplate the impact on nursing home resi-
dents which must be considered to protect these patients.

We are encouraged that Section 104 of the Senate bill requires the Secretary to provide recommendations to cover dual eligible beneficiaries by the new Medicare Part D before statutorily mandating such action. Nevertheless, we strongly rec-
commend additional language to address the special pharmacy needs of beneficiaries res-
siding in nursing facilities who are not du-
ally-eligible for Medicare and Medicaid. Such language would require the Secretary of Health and Human Services to review the current standards and practice for pharmacy services provided to patients in nursing fac-
cilities and to report to the Congress its
findings prior to implementation of the new prescription drug benefit. This report would include a detailed description of the Department’s plans to implement the provisions of this Act, consistent with applicable state and federal laws designed to protect the safety and quality of care of nursing facility patients. Such provisions were included in legislation approved by the House Ways and Means and Energy and Commerce Committees, and we would respectfully request that you adopt similar language.

We appreciate your leadership in carefully considering the multitude of complex issues related to the creation of a new Medicare prescription drug benefit. We are grateful for the choices you are making constructively with respect to patient safety and to ensure the continued provision of quality pharmacy services to the most vulnerable seniors.

If you have any questions or would like additional information, please feel free to contact me. Again, thank you for your efforts to ensure patient safety and promote quality care for Medicare beneficiaries residing in nursing facilities.

Sincerely,

PAUL BALDWIN, Executive Director.

Mr. KENNEDY. One of the great strengths of Medicare is that it is for everyone. Rich and poor alike contribute to the system. Rich and poor alike benefit from it.

At bottom, Medicare is a commitment to every senior citizen and every disabled American that we will not have two-class medicine in America. When a senior citizen enters a hospital, Medicare covers the same amount for their care whether they are a pauper or a millionaire. When a senior citizen goes to a doctor, she has the peace of mind knowing that Medicare has the same obligation to pay for her treatment no matter what her financial circumstances—and the doctor has no financial interest in rationing her care according to the contents of her bank account.

Through the Medicaid Program, we try to provide extra help for those who would otherwise go without coverage. But the fact that the Medicaid program provides extra assistance for the poor does not reduce Medicare’s obligation to provide equal treatment for all. Medicare always has primary payment responsibility for the care it covers. Medicaid is always supplementary.

Medicaid provides critical help to the poor and elderly, but it does not provide the same reliable guarantees of equal treatment that Medicare does. Under Medicaid, States have limited the number of days of hospital care they would provide or the number of doctor visits they will support. States have placed arbitrary limits on the number of prescriptions.

This legislation sets an undesirable precedent for the treatment of poor senior citizens who are eligible for both Medicare and Medicaid. For every other benefit, these senior citizens enroll in Medicare, and Medicaid supplements Medicare’s coverage. But for this benefit, the budget assumes that the poor have earned by a lifetime of hard work. The PRESIDING OFFICER. Who yields time?

Mr. BINGAMAN addressed the Chair. The PRESIDING OFFICER. Who yields time to the Senator from New Mexico?

Mr. BINGAMAN. Mr. President, I request that the manager allot me 5 minutes.

Mr. BAUCUS. Mr. President, I yield 5 minutes to the Senator from New Mexico.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. BINGAMAN. I thank the Senator from Montana.

Mr. President, I would like to take this opportunity to support amendment No. 1066, which is scheduled to be one of the amendments considered in this next block of amendments.

Mr. President, I am concerned that the prescription drug coverage in S. 1 is designed to fully meet the needs of our seniors and that those seniors who elect to participate in Part D and get this prescription drug benefit will be restricted from purchasing supplemental coverage. The Kaiser Family Foundation estimates that in 2006—which is the year this legislation really takes effect, this benefit occurs—the average Medicare beneficiary will spend $3,160 per year on prescription drugs. Under the current plan, those individuals will have $1,700 that same year in out-of-pocket expenses in addition to the $420 they pay in Part D premiums. Therefore, the average Medicare beneficiary who elects Part D will have approximately $2,100 a year in out-of-pocket expenses. This can mean, for example, $175 a month. That is a significant expenditure for a lot of individuals and couples on a fixed income.

It would seem reasonable to allow these individuals who want to protect themselves against unpredictable and increasing prescription drug expenses to purchase supplemental insurance coverage that would allow additional prescription drugs to be purchased.

Medigap was designed to fill the gaps in Medicare. A sizable gap exists in the prescription drug benefit we are offering in this bill. Yet the current bill specifically prohibits seniors from filling that gap with a Medigap policy.

Section 103 of S. 1, which is the bill we are considering, explicitly prohibits people who elect Part D prescription drug coverage from purchasing additional prescription drug coverage as part of any Medigap plan.

Let me give you the quotation out of the bill. It says:

No Medicare supplemental policy that provides coverage for expenses for prescription drugs may be sold, issued, or renewed under this section to an individual who is enrolled under Part D.

So you essentially have a choice: Am I going to enroll in this new Part D and get this benefit and therefore forego any Medigap policy or am I going to stay out?

We are telling seniors whose cost burden, on average, will be $2,100 a year, and 10 percent of whom are likely to have out-of-pocket expenses of $4,000 or more per year, they will not be allowed to seek additional prescription drug relief.

The amendment I am offering would give seniors the option of purchasing more prescription coverage as part of a comprehensive Medigap plan. The amendment calls on the National Association of Insurance Commissioners to devise two new Medigap plans that would each offer prescription drug coverage to beneficiaries who elect Part D. These are currently 10 standard Medigap plans. They are designated A through J, and they offer insurance to seniors. Of those, plans H, I, and J offer prescription drug coverage. The amendment to Part A and Part B wraparounds. Of these, H and J are the most common elected plans.

Under S. 1, the way it now stands, seniors who elect Part D would no longer qualify for H, I, or J. However, if the amendment is adopted, the two new policies designed by the National Association of Insurance Commissioners would be similar to the current Medigap policies of H and J, but their prescription drug coverage would be tailored to wrap around the Part D coverage. So seniors who are currently H or J subscribers would have the option of electing Part D and still maintaining a Medigap plan similar to what they have now.

The amendment would give the National Association of Insurance Commissioners 18 months to develop and report back on these two new plans. In my view, it would be a substantial improvement to the current bill.

As I said, my amendment will give the National Association of Insurance Commissioners 18 months to develop and report back on two new plans. The NAIC is the appropriate body to develop these plans because they have a system already in place for doing so with appropriate representation from all interested and affected parties.

The NAIC can best determine how the benefits proposed in this amendment can be designed in order to avoid over-utilization and to coordinate with the existing Medigap benefit packages. They were the body employed to develop the current Medigap plans A through J and they are the body best equipped to develop these two new plans.

This amendment is similar to language already included in the House version of the bill and the House already has a great deal of support in the House of Representatives.

This amendment also provides a provision to stabilize the Medigap market.
Mr. GRAHAM of Florida. Mr. President, I rise to speak on an issue that will come before the Senate shortly. That is an amendment to strike the language from this legislation which is found in section 605, the legal immigrant child health provision. Let me give the background on section 605. What this legislation would do would be to allow States on a State option basis to elect to provide health care for pregnant women, for the period of their pregnancy, plus 60 days thereafter, and immigrant children. In both categories we are talking about legal immigrants, not people who have arrived outside the system and undocumented. These categories of immigrants have come to the United States under all of the procedures that allow for legal immigration, with the most prominent category being family reunification.

The reason the amendment has already been considered by the Senate Finance Committee, first in 2001, then in June of 2002, and most recently in the consideration of this legislation. This provision was sustained in the chairman’s mark, included in place by Senator Grassley and Senator Baucus, by a vote of 13 to 8. There has been both consideration and approval of this provision by the Finance Committee.

It has been alleged that the provision of these services will encourage illegal immigration. We are talking exclusively about pregnant women and children who have entered the United States on a legal basis.

Prior to 1996, there was no restriction on health care benefits for legal immigrants. We are now carving out from the current exclusion for health care two categories, which are both humane and very much in the public interest, that provide the necessary care and access to health care and that children grow up with adequate health care.

It has been alleged that there are a number of benefits which have also been made available to legal immigrants. Services, Head Start programs, foster care, school lunches, and food stamps. Those can be debated on their own merits but they are not substitute for providing to legal immigrants, children, and pregnant women a place to get appropriate health care.

It has also been stated that this should be a responsibility of the sponsor. The PRESIDING OFFICER. The Senator from Oklahoma.

Mr. NICKLES. Mr. President, I believe our side has 2 minutes remaining. I ask unanimous consent for 4 minutes and yield the Senator from Alabama 2 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. SESSIONS. Mr. President, included in the Medicare prescription drug reform bill in section 605 is a Medicaid reform of work for noncitizens, reversing a policy adopted by this Senate in 1996 by a vote of 74 to 24. Section 605 is a very substantial change in our current policy. It will cost, according to CBO estimates, $500 million over just 3 years. It is not to be taken lightly. Frankly, we haven’t had debate on it.

I have offered an amendment that would strike the existing language in section 605, along with a sense of the Senate this fall, the time when the Finance Committee plans to addressing Medicaid reform. That is what this is. It is Medicaid reform, not Medicare senior citizens reform. This is clearly unconnected to the purpose of the bill. It was slipped in as some sort of compromise. We ought not to allow that to happen, to erode a very important part of the 1996 Welfare Reform Act. The administration, which is very favorable to matters that would help immigrants in this country, opposes this change. They say it should be done, if at all, as part of the welfare reform of this fall.

That is why our sense of the Senate calls on the Finance Committee to reevaluate it as part of their requirement this fall on reform welfare. Millions of people come to this country legally. They should not, this with the Finance Committee. Those sponsors say they will pay for the medical welfare needs of those people they sponsor. That is by affidavit and it should be honored, not undercut.

Mr. NICKLES. Mr. President, I ask unanimous consent that the Senator from Oklahoma.

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and any spouse or children immigrating with him or her, and to reimburse any Government agency or private entity that provides these sponsored immigrants with Federal, State, or local public benefits.

This provision in the underlying bill would turn this law on its head and would basically take hundreds of millions of dollars away from Medicare recipients and give them to immigrants. So this is changing immigration law and Medicaid law. It needs to be dealt with in the Medicaid bill and welfare reform bill. It doesn’t belong in this bill.

I urge my colleagues to vote in favor of the Sessions amendment.

In proposing this amendment, Senator Sessions argues that the restoration of health benefits to legal immigrants has not been fully reviewed or discussed. He also argues that SCHIP and Medicaid provisions are welfare reform measures and therefore not germane to the prescription drug bill. The amendment also states that Congress deliberately limited benefits available to legal immigrants when it removed these benefits in 1996.

I respectfully disagree with all of these three assertions.

First of all, the Senate Finance Committee has already extensively reviewed this issue. In 2003, the Finance Committee held a series of hearings on health coverage for the uninsured, including legal immigrants. During the TANF reauthorization mark-up in June 2002, there was a full debate on the restoration of health benefits to legal immigrants, and the Immigrant Children’s Health Improvement Act passed as an amendment by a vote of 12 to 9. This year, during Finance Committee mark-up of the prescription drug bill, there was once again full debate on the provision of health benefits to legal immigrants. Senator Nickles offered an amendment to strike the immigrant children’s health provision from the chairman’s mark and that amendment failed by a vote of 8 to 13.

Second, I disagree with Senator Sessions’ argument that Section 605 of the bill is not germane to Medicare prescription drug legislation. Every time this sort of provision comes to a vote, my colleagues on the other side of the aisle question the vehicle. When the immigrant health provisions came up in committee last year, as part of the TANF reauthorization mark-up, Senator Hatch remarked that, “If we start playing with health care policy, this bill isn’t going to go through.” This year, Senator Sessions is saying that TANF reauthorization is the appropriate vehicle. I ask my colleagues on the other side of the aisle—then—which one is the appropriate vehicle?

In fact, the restoration of health benefits to legal immigrants is also a major component of the effort to add a prescription drug benefit under Medicare. Senators Grassley and Baucus realized this when they included this provision in the prescription drug mark as part of a compromise agreement that included both Senator Kyl’s undocumenated aliens provision to reimburse hospitals for the cost of treating undocumented all and Senator Graham’s legal immigrants provision.

Finally, benefits to legal immigrants were cut in 1996 as a cost-saving measure, not as a matter of welfare reform. Section 605 of the underlying bill is not consistent with policies approved by President Bush. Last year, the President signed legislation restoring food stamp benefits for legal immigrant children. The immigrant child health provisions would make these same children eligible for Medicaid and SCHIP. In an interview with the Associated Press in May 2002, Tommy Thompson, Secretary of the Department of Health and Human Services, stated that he had no “philosophical objection” to lifting the ban on providing health care benefits to legal immigrants.

Senator Sessions’ amendment also has significant dire consequences for women and children, and could add costs to the Medicaid program, which I am certain Senator Sessions did not intend. Current restrictions prevent thousands of legal immigrant children and pregnant women from getting the same access to preventive health care services that they would otherwise receive. As a result of the restrictions, immigrant children have fewer opportunities to see a pediatrician and receive treatment before minor illnesses become serious and life-threatening. Families who are unable to get basic preventive care for their children have little choice but to turn to emergency rooms—the least cost-effective place to provide care—when their children become sick. Similarly, without prenatal care, a woman may give birth to a baby with low birth weight, placing the baby at risk and resulting in hundreds of thousands of dollars in neonatal intensive care costs.

Frankly, I am saddened that we must fight over a bipartisan, thoughtful and extensively reviewed provision that will protect the health of children who legally came to our country and had no control over the length of time they were legal immigrants. We must ensure that it is adopted.

Mr. Daschle. Mr. President, with all deference to my colleague from Alabama, I strongly oppose this amendment to strike the provisions that would allow States to cover legal immigrants under Medicaid and SCHIP. As health care measures, these provisions are an appropriate addition to this legislation, and I am grateful that the chairman of the Senate Finance Committee included them in his bill.

Legal immigrant children are now receiving Federal benefits under a number of programs, including Medicaid, for 5 years. The argument was made that people shouldn’t come to this country if they are going to be a public charge.

But the reality is that legal immigrants don’t come here for our benefits. They come because they want to work so they can make better lives for themselves and for their children. They work hard and they make a vital contribution to our economy. Many are forced to take low-paying jobs. And many of these jobs do not provide health insurance.

Immigrant families need access to health insurance just as much as citizen families. They are just as deserving of this coverage as citizen families. Immigrants work hard. They pay taxes. They give back to their communities. Immigrant children are also required to register with that Selective Service when they turn 18. According to the American Immigrant Law Foundation, 60,000 legal immigrants are on active duty in the United States.

Now, when an immigrant woman becomes pregnant, or her child gets sick, she has few places to turn except to emergency care, which is the most expensive and means of providing care. Many States have realized that this is not an acceptable way to address the health care needs of these families.

Some 20 States now provide health care services to legal immigrants using their own funds. The burden of caring for these families has been transferred to States and hospitals.

To respond to this situation, Senator Graham introduced S. 945, the Immigrant Children’s Health Improvement Act, or ICHIP, which allows States to use Federal Medicaid and SCHIP funding to provide coverage for pregnant women and children who are legal immigrants. The chairman of the Finance Committee included this provision as an amendment in States and the United States.

The administration has suggested that this proposal would somehow create a new burden on the States. In fact, the proposal only gives States the option to provide this coverage, and allows them to use Federal resources to do so, giving them significant fiscal relief. No new burden would be imposed on the States. The National Governors Association and the National Conference of State Legislatures both support restoring these benefits. Even Governor Bush of Florida has indicated he supports this proposal for all of the children live in poor or “near-poor” noncitizen families. That is more than one-quarter of the total population of poor or “near-poor” children. Almost half of all low-income and immigrant children are uninsured and they are more than twice as likely to be uninsured as low-income citizen children with native-born parents.
Many of these children will eventually become American citizens. By denying all but emergency health care, we increase the risk that these children will suffer long-term health consequences, which could reduce their ability to develop, and become productive, contributing citizens.

It is also worth noting that the Medicaid/SCHIP ban also affects citizens living in immigrant families. As many as 85 percent of immigrant families have at least one child who is a citizen. Although many of these children are eligible for Medicaid and SCHIP, receipt among eligible citizen children of noncitizen parents is significantly below that for other poor children. Parents may be confused about their children's eligibility, or concerned that somehow claiming these benefits will affect the status of other family members.

Making sure that pregnant immigrant women, and their children, have access to health care, including preventative care, is an investment in the future workforce of this Nation. I believe providing health care for all of our citizens, including pregnant women and children who are immigrants, is vital for our future economic strength. It is also the right thing to do. For that reason, I urge my colleagues to oppose this amendment.

The PRESIDING OFFICER (Mr. CORNYN). The Senator from Montana is recognized.

Mr. BAUCUS. Mr. President, I know we have an agreement that the vote will start at about 5 o'clock. I ask unanimous consent to speak for 2 minutes.

The PRESIDING OFFICER. Without objection, it is so ordered.

AMENDMENT NO. 1033, AS MODIFIED

Mr. GRASSLEY. Mr. President, I send a modification of Senator Mikulski's amendment to the desk on municipal health services and ask unanimous consent that it be modified.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The amendment (No. 1033), as modified, is as follows:

At the end of title VI, add the following:

SEC. 361. EXTENSION OF MUNICIPAL HEALTH SERVICE DEMONSTRATION PROJECTS.

The last sentence of section 921(a) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (42 U.S.C. 1396b-1 note), as previously amended, is amended by striking "December 31, 2004", and inserting "December 31, 2006".

AMENDMENT NO. 1067, AS MODIFIED

Mr. GRASSLEY. Mr. President, I send a modification of Senator Lien-coln's amendment No. 1067 on kidney disease to the desk and ask unanimous consent that it be modified. The PRESIDING OFFICER. Is there objection? Without objection, the amendment is so modified.

The amendment (No. 1067), as modified, is as follows:

On page 510, after line 18, add the following:

SEC. 1881. MEDICARE COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.

(a) COVERAGE OF KIDNEY DISEASE EDUCATION SERVICES.

(i) IN GENERAL.—Section 1861 of the Social Security Act (42 U.S.C. 1395x) is amended—

(A) in subsection (s)(2)—

(i) in subparagraph (U), by striking "and" at the end;

(ii) in subparagraph (V), by adding "and" at the end; and

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

"(W) kidney disease education services (as defined in subsection (ww));"; and

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

"KIDNEY DISEASE EDUCATION SERVICES "

(ww) The term 'kidney disease education services' means educational services that are—

(A) furnished to an individual with kidney disease who, according to accepted clinical guidelines identified by the Secretary, will require dialysis or a kidney transplant;

(B) provided, upon the referral of the physician managing the individual's kidney condition, by a qualified person (as defined in paragraph (2)); and

(C) designed—

(i) to provide comprehensive information regarding—

"(i) the management of comorbidities;"

"(ii) the prevention of uremic complications; and"

"(iii) each option for renal replacement therapy including peritoneal dialysis, hemodialysis (including vascular access options), and transplantation; and"

"(iv) to ensure that the individual has the opportunity to actively participate in the choice of therapy.

"(v) The term 'qualified person' means—

"(A) a physician (as described in subsection (r)(1));

"(B) an individual who—

"(i) is—

"(i) a registered nurse;"

"(ii) a registered dietitian or nutrition professional (as defined in subsection (v)(2));

"(iii) a clinical social worker (as defined in subsection (hh)(3));

"(iv) a physician assistant, nurse practitioner, or clinical nurse specialist (as those terms are defined in subsection (aa)(5)); or

"(v) a transplant coordinator; and"

"(ii) meets such requirements related to experience and other qualifications that the Secretary finds necessary and appropriate for furnishing the services described in paragraph (i); or"

"(C) a renal dialysis facility subject to the requirements of section 18991(b)(1) with personnel who—

"(i) provide the services described in paragraph (i); and"

"(ii) meet the requirements of subparagraph (A) or (B)."

(2) PAYMENT UNDER PHYSICIAN FEE SCHEDULE.—Section 1881(b) of such Act (42 U.S.C. 1395ww(b)), as amended by section 433(b)(5), is further amended by adding at the end the following new paragraph:

"(13) For purposes of paragraph (7), the single composite weighted formula determined under such paragraph shall not take into account the amount of payment for kidney disease education services as defined in section 18611(ww). Instead, payment for such services shall be made to the renal dialysis facility on an assignment-related basis under section 1848.".

(4) ANNUAL REPORT TO CONGRESS.—Not later than April 1, 2004, and annually thereafter, the Secretary of Health and Human Services shall submit to Congress a report on the number of Medicare beneficiaries who are entitled to kidney disease education services (as defined in section 18611(ww) of the Social Security Act, as added by paragraph (1))
under title XVIII of such Act and who receive such services, together with such recommendations for legislative and administrative action as the Secretary determines to be appropriate to fulfill the legislative intent that resulted in the enactment of that subsection.

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

NOTICE
Incomplete record of Senate proceedings.
Today’s Senate proceedings will be continued in the next issue of the Record.
EXTENSIONS OF REMARKS

TAX INCENTIVES FOR TELECOMMUNICATIONS BUSINESSES

HON. CHARLES B. RANGEL OF NEW YORK
IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. RANGEL. Mr. Speaker, today I am introducing legislation to provide tax incentives to encourage greater diversity of ownership in telecommunications businesses. My bill is a response to the increasing ownership of television and radio properties by large media companies.

I strongly believe that promoting a diversity of views on the airwaves is an important public policy goal. The only way to accomplish that goal is to broaden the ownership of broadcast stations. The television and radio spectrum is a limited resource. The trend in recent years has been a greater concentration of ownership of that resource by the large media companies. We need to reverse that trend.

Mr. Speaker, small businesses that wish to enter telecommunications businesses face significant barriers. To enter a broadcast business, a small business must purchase an existing property. Owners of those properties often demand large, unreasonable prices. Therefore, small businesses quite often do not have a seat at the table when there are negotiations over the sale of broadcast properties.

My bill would attempt to reduce those barriers by providing limited deferral of capital gain taxation when a telecommunications property is sold to a small business. It would provide the sellers of those properties a positive incentive to consider a small business purchaser.

Large segments of our society historically have been underrepresented in the ownership of radio and television properties. I believe that it is vital that those groups have access to the television and radio spectrum so that their views may be represented on our airwaves. Therefore, my bill would provide a larger deferral of capital gain taxation when the sale is to a small business owned and controlled by individuals from these historically underrepresented groups.

Mr. Speaker, I understand that some may attack my bill as being the re-enactment of a flawed prior program. The provisions in my bill are quite similar to the tax certificate program that was repealed by the Congress in 1995. I do not quarrel with those who assert that there were abuses in that program. However, it is unfortunate that the Congress chose repeal and not reform because that program had been effective in accomplishing its goal of expanding ownership of radio and television businesses.

In 1978, before the implementation of that program, only .05 percent of all broadcast stations in this country were owned by minority groups. By 1994, the year before the program was repealed, the program had succeeded in increasing minority ownership sixty-fold to 3 percent. Since that program was repealed, the number of minority-owned broadcast properties has declined.

The bill that I am introducing today contains provisions specifically designed to address the abuses in the prior program. It is limited to small business purchasers, it contains restrictions on the number of purchases that can be made by any one business, it contains recapture provisions to prevent the use of the small business as a front for another party, and it contains provisions designed to prevent avoidance of the ownership requirements through options or other sophisticated transactions.

I am hopeful that we can avoid the emotionally charged rhetoric that occurred in 1995 when this issue was last considered. All small businesses, regardless of their ownership, would be eligible for the benefits of my bill. It is true that the bill provides a slightly larger incentive when the small business purchaser is owned and controlled by individuals who are from segments in our society historically underrepresented in ownership of broadcast businesses. I believe this incentive is appropriate so that the views of those groups are heard on our Nation's airwaves. The bill simply attempts to ensure that small businesses, including minority owned small businesses, have a seat at the table when a broadcast property is being sold.

Mr. Speaker, I am hopeful that we will be able to deal with this issue on a bipartisan basis. We should all support the goal of expanding diversity in ownership of broadcast properties.

Mr. Speaker, I rise in opposition to H.R. 8, Permanent Death Tax Repeal Act and in support of the Democratic substitute.

I have long been a supporter of providing estate tax relief to American families, small business owners, and farmers who have worked their entire lives to transfer a portion of their estates upon their death. I have also been an advocate, however, for ensuring that we transfer to our children and grandchildren a healthy economy and a government that maintains its commitment to Social Security and Medicare.

In the last Congress, I voted to repeal the estate tax and later voted to override President Clinton's veto of that legislation. Again, in the 107th Congress, I voted to repeal the estate tax as a stand-alone measure and later voted for President Bush's $1.35 trillion tax cut, which contained a provision to phase out and ultimately repeal the estate tax.

When I voted for the president's tax bill last year, I did so with his assurance that we would have the money to pay for it without dipping into the Social Security Trust Funds. Unfortunately, due to the recession and the war on terrorism, the budget surpluses projected last year did not materialize and we are now borrowing money from Social Security Trust Funds to pay for even our most basic needs including the war on terrorism.

While I agree that we should fix provisions of last year's tax cut to increase certainty in the tax code that will help people plan for their financial future, we should also make sure that we are not borrowing money—particularly from the Social Security Trust Funds—to pay for these cuts while we are simultaneously trying to enhance our national security needs. We should also ensure that we aren't raising other taxes to pay for provisions that are, quite frankly, political in nature and have nothing to do with addressing the tax burden is reduced on our small businesses and farms.

For example, Mr. Speaker, the underlying bill contains a hidden tax on all decedents. By fully repealing the estate tax, this bill would have the effect of repealing a provision in the code, referred to as the “step up in basis,” that protects heirs from paying capital gains on estates.

Anyone who has ever sold a “capital” asset, such as real estate, stocks, bonds, mutual funds, knows that cost basis is what the gain or loss on the sales price is measured against. Generally speaking, cost basis is the purchase price of property subject to certain adjustments upward or downward. For example, if property was purchased in 1950 at a cost of $10,000 and sold in 2001 at $100,000, an individual would have a taxable capital gain of $90,000. The step-up basis interacts with estates such that when this property passes by reason of death, the heir inherits the asset with a new cost basis equivalent to the market value of the asset on the date of the benefactor's death. Taking the example above, if the property were transferred in 2001 at a value of $100,000 and the heir sold the property in 2006 for $120,000, the heir would only have a taxable capital gain of $20,000 instead of $110,000.

Should this bill become law, an owner of farmland, stocks, mutual funds, or even a personal residence would have lost the opportunity to pass the asset to the next generation without paying along the owner's cost basis, thus reducing the future capital gains bill that will have to be paid when the heirs sell the asset. In short, this amounts to a tax increase on all estates due simply to the increased cost basis of the estate.

I believe there is a more responsible way to provide estate tax relief to our small business owners and farmers. The substitute will provide substantial and immediate relief by increasing a family's exclusion from $1 million to $6 million. It would also preserve the step-up...
bills will continue to drive our nation into debt, and reduce our ability to deal with the long-term challenges facing Social Security and Medicare. Until we deal with the long term financial problems facing Social Security, we need to be very careful about any tax or spending bills that would place a greater burden on the budget in the next decade, effectively transferring these costs and burdens to our children and grandchildren.

Mr. Speaker, the substitute is also paid for. In this environment when our budget is in crisis, it is critically important that we do not continue to drown ourselves in red ink. The major- ity’s bill would cost over $60 billion a year, at a time when we are running a $400 billion annual deficit. We simply cannot afford to borrow even more money to provide additional tax cuts.

Again, I have supported previous efforts to provide estate tax relief because, in the past, we have been able to afford it. I am concerned, however, that the total costs of these bills will continue to drive our nation into debt, and reduce our ability to deal with the long-term challenges facing Social Security and Medicare. Until we deal with the long term financial problems facing Social Security, we need to be very careful about any tax or spending bills that would place a greater burden on the budget in the next decade, effectively transferring these costs and burdens to our children and grandchildren.

Mr. Speaker, today, as we consider a resolution recognizing the work of our late colleague in the alleviation of hunger, I would like to honor George Thomas “Mickey” Leland for his contributions to this country and the world. He may have been the greatest advocate for the hungry that the House of Representatives has ever known. Mickey was born on November 27, 1944, in Lubbock, Texas. From 1972, when he was first elected into public office, until his death in 1989, Mickey Leland fought on behalf of the hungry, poor and less fortunate around the world. Neither partisanship nor race nor political boundaries prevented Mickey from reaching those who needed him. Republicans and Democrats alike respected Mickey for his determination and moral rectitude. I urge my friends and colleagues in this chamber to honor Mickey’s memory by rededicating ourselves to eradicating world hunger and the poverty which is its cause.

In 1984, Leland co-authored legislation creating the House Select Committee on Hunger. It was the Committee’s responsibility to focus solely on the widespread problems of hunger and malnutrition. Mickey chaired the Committee from its inception until his death. The Committee’s efficacy stemmed from his unwavering moral leadership. He legislated on infant mortality, fresh food for at-risk women and children, and comprehensive services for the homeless. Mickey Leland refused to narrow the scope of his energy and dedication to his own country. Following reports of famine in sub-Saharan Africa, Speaker “Tip” O’Neill appointed Leland to lead a bipartisan Congressional delegation created to assess the magnitude of Africa’s needs. The findings of that delegation resulted in $800 million in humanitarian relief.

In his pursuit to help the needy, Mickey traveled around the world. He met with Fidel Castro to reunite Cuban families and traveled to Moscow as part of joint U.S.-Soviet food initiative to Mozambique following the Cold War. He met privately with Pope John Paul II in 1987 and 1989 to garner support for his efforts in Africa. Mickey did everything he could. Those of us who were privileged to serve with him in this Congress were always inspired and challenged by Mickey to do more to alleviate the suffering of the people whom Jesus called “the least of these.”

Mickey died just as he lived, trying to help. He never passed leadership to others when he could infuse a project with his warmth and energy. Mickey was leading a mission to a refugee camp in Ethiopia when his plane crashed, killing him and 15 others. Mickey died on August 7, 1989, near Gambela, Ethiopia.

Proponents of this legislation make baseless claims that it will help small businesses, farmers and working families. The claim that the estate tax puts small family farms out of business. The National Farmers Union disputes this assertion, “There is no evidence that the estate tax has forced the liquidation of any farms, and existing estate tax already exempt 98 percent of all farms and ranches.” The fact is that the estate tax currently affects only the richest 2 percent of estates, and the number dramatically shrinks as the exemption rises to $3.5 million in 2009. H.R. 8 eliminates the tax on the wealthiest 2 percent of all Americans—people like Bill Gates and Ken Lay. In my home state of Illinois less than 2500 families currently serve or have served in the military. Nearly 674,000 children or one in four children back in my home state of Illinois would have qualified for this aid. This is an outrage. Talk about having your priorities backwards!

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Let me be clear. I am a strong supporter of small businesses and family farms and I am not against reforming the estate tax. I believe that families with modest assets should be exempt from the estate tax. That is why I support the Pomeroy substitute which exempts estates worth less than $3 million for an individual and $6 million for families from the estate taxes. The substitute would exempt 99.65 percent of all estates.

The Bush Administration and their Republican colleagues have a one track mind. They are once again attempting to lower taxes for the richest 1%. Just last month the Bush Administration and Congress passed tax cuts for millionaires and tax dodging corporations. President Bush made it a top priority and Vice President Cheney personally negotiated the final bill language with the Republican Congressional leadership. The tax bill passed last month will provide a $604,000 tax break for Vice President Cheney and $332,000 to Treasury Secretary John Snow. In total, it could provide up to $3.2 million in total tax savings for President Bush, Vice President Cheney, and Secret. I wonder how much the families of President Bush, Vice President Cheney, and the Cabinet would benefit from repeal of the estate tax?

H.R. 8 undermines our basic sense of fairness. The legislation undermines progressive aspects of our tax code. It replaces it with a regressive tax code that puts more of a burden on middle and low wage families. A regressive tax code restricts opportunities for those who are not born into wealthy families. William Gates Sr., a supporter of the estate tax, recently said, “What makes America great is the broad ownership of property and enterprise. We all succeed to the extent that children are born without vast disparities in access to education, health care, and opportunity. We are weakened when our policy makers are more concerned with preserving existing wealth and power than creating avenues for new asset creation and opportunity.”

I couldn’t agree with him more.

Finally, the estate tax gives wealthy individuals an incentive to contribute to charity. Charitable organizations are very concerned about efforts to repeal the estate tax. According to the Joint Economic Committee Democrats, eliminating the estate tax could reduce contributions by 6 to 12 percent. This would reduce revenues for soup kitchens, AIDS prevention programs, and other vital community organizations that rely on charitable contributions to stay afloat.

Support America’s families. Oppose the underlying bill and support the Pomeroy substitute.

TRIBUTE UPON RETIREE OF PAUL POGORZELSKI

HON. JAMES P. MORAN
OF VIRGINIA
IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. MORAN of Virginia. Mr. Speaker, I rise to pay tribute to Paul Pogorzelski of Falls Church in Virginia. Paul was honored by the United States Navy tomorrow for his 42 years of Federal service. But his abiding love of country and honor of service actually began at the young age of 12 when Paul joined the Civil Defense as a messenger with the 72nd Precinct in Brooklyn, New York.

In 1956, Paul enlisted in the Coast Guard. Upon promotion, he was assigned to the Marshall Island loran station, and was responsible for the operation, maintenance and communication of loran equipment. After his return to the United States, Paul became an instructor of electronics in Connecticut. In 1960, he was honorably discharged with a good conduct medal.

He first came to Washington in the early 1960s representing Raytheon and General Electric on the TARTAR radar missile program. Paul then received a professional appointment from Undersecretary Vance to the Naval Ordnance Command, working on patrol gun-boat missile systems, Antelope and Ready; the Hydrofoil program; R&D and introduction of the frigate program; guided projectile program between NAVSEA and the Army at the Picatinny Arsenal in New Jersey; the readiness of all Navy ships improving their readiness through the GASREP program. He also traveled to Holland to purchase the forerunner of the MK-92 fire control system.

As an intelligence liaison officer at NAVSEA, Paul handled special projects including nuclear powered submarines. He provided survivability assessments for SEA-05, SEA-08, and the PE0s. As facilities manager he engineered and built sensitive, compartmented information facilities in both Crystal City and the Washington Navy Yard and established interconnectivity with the intelligence community.

Paul has received numerous awards and citations for his efforts in providing the Command with accurate and timely intelligence information regarding the survivability and vulnerability of our ships that were hit by foreign weapons, such as the USS Stark, USS Samuel B. Roberts, USS Bridgetown, USS Princeton, and USS Cole.

Our Nation is privileged to have had such a dedicated civil servant for these many years. I ask that my colleagues join me in honoring him today for his lifetime commitment of outstanding service to this Nation.

IN MEMORY OF THE HONORABLE BOB STUMP

HON. SILVESTRE REYES
OF TEXAS
IN THE HOUSE OF REPRESENTATIVES

Wednesday, June 25, 2003

Mr. REYES. Mr. Speaker, it is with a heavy heart that I reflect today on the passing of my dear friend Congressman Bob Stump. Bob was a great man and I am deeply saddened by his passing. He was a great American, a respected legislator, and a good friend.

He served with great distinction in Congress for twenty-six years, two years as Chairman of the House Armed Services Committee and six years as Chairman of the Veterans Affairs Committee.

I had the honor and privilege to serve on both of these committees with Bob as my Chairman. Although we did not always see eye to eye, I always had a great deal of respect for Bob’s patriotism and leadership. Bob was a true supporter of men and women in uniform. Under his leadership, we made huge strides to improve the quality of life for our troops and veterans, increasing pay, housing, and healthcare allowances, increasing assistance to disabled veterans and their survivors, and strengthening the Montgomery GI Bill to help millions of veterans fulfill their educational and career goals.

Bob was a modest and decent man who, in dedicating the majority of his life to public service, was a dedicated patriot and a true American Hero. Bob’s enthusiasm and spirit touched the lives of all who had the pleasure of meeting him. Although his presence is greatly missed in the halls of the House, I know that Bob is and will be well remembered.

My thoughts and prayers are with the Stump family and with everyone else who loved and admired him.

Thank you, Mr. Speaker.
Along with Reverend Jackson, and many others, I was at the Supreme Court the day when this case was heard. I was very proud to speak to the thousands and thousands of young people, the Michigan students, and BLM who had come to Washington from all over the country to protest the effort to eliminate affirmative action.

I believe it is important to acknowledge the role of energy and involvement by our young people, and as adults we must support their organization efforts. Thank God, they are preparing themselves to take over the world. This victory speaks volumes to their efforts.

I was sitting in the audience when Solicitor General Ted Olson, the Administration’s brief, mentioned the research against affirmative action, declaring that the University of Michigan—and by implication all other universities and institutions—should use “neutral merit methods for its admissions.”

I thought how sad it was to witness our own government arguing against the interest of so many of its own people.

I would suggest race-neutral admissions would be fine—just as soon as this becomes a race-neutral country. And not a day sooner.

In upholding the University of Michigan’s law school’s affirmative action program, race will continue to be a critical component in achieving parity and equal opportunity. And while we may war all day on affirmative action, the court has spoken, and so too have the people.

I was there when Justice Scalia told the University of Michigan that it had a choice: it could choose to use a race-blind standard or it could lower its standards and pursue racial diversity.

How simple—and wrong—can you get?

Justice Scalia was, in fact, offering a false dichotomy: in reality, you cannot be a top-flight university without diversity.

While it is true that the Bush administration, it does not escape corporate America, the military, or many members of Congress, all of whom voiced their support for the University of Michigan and the principle of affirmative action.

Sixty-five major businesses, all Fortune 500 companies, submitted a brief as a friend to the court on this case.

These global businesses have annual revenues of over a trillion dollars.

As employers, they are deeply interested in this outcome. In addition, and I quote here from their brief, “the existence of racial and ethnic diversity in institutions of higher education is vital to [our] efforts to hire and train and to maintain a diverse and competent work force.”

And it is not just the employees of diversity who are affected by affirmative action. The corporations cited in their amicus brief that the use of affirmative action ‘increases the skills of our employees and broadly enhances our productivity.”

I also want to acknowledge the many elected officials, members of the clergy, and community leaders, and phenomenal women here today, and to acknowledge everyone who is part of the struggle to compel our nation to live up to its own promises of liberty and justice for all. And in the memory of our fallen hero Mayor Maynard Jackson, let us recommit ourselves to our work for political, social, and economic justice.

Today the Supreme Court issued a decision on a monumental affirmative action case. This morning the Supreme Court rejected the Bush Administration’s efforts to eliminate affirmative action as we know it. I say monumental because this judgment will echo far beyond the boundaries of the University of Michigan and far beyond the realm of higher education.

We are still studying the Court’s ruling to understand its ramifications; however, the Supreme Court did uphold affirmative action and that is a clear defeat for the Bush administration. This decision is a testament to the broad mobilization to defend civil rights, it validates the “power of the people” and the legality of affirmative action and requires us to be vigilant as we move forward.

Many of you, including myself, are proud products of affirmative action. We are duty-bound to keep fighting.

This is one of the most important civil rights cases in the last quarter century. Affirmative action is still necessary, not just in the name of color, but in the interests of women and country as a whole.

What was at stake here is the University of Michigan’s attempts to create a classroom that not only reflects the reality of this country, but also its persistent economic inequalities.

What is also on trial here is the principle of affirmative action, and in this case the Bush administration weighed in on the side of reversing progress rather than pursuing justice.
Prop 209 passed. Thank God for our historically Black Colleges. Our African American students are now going south benefiting from their excellent education. But what we have learned is that 90 percent of these students do not return to California. What a brain drain we have in California.

Shame on California.

One year ago, I described the process of eliminating affirmative action, at Boalt Hall, the University of California's premiere law school, as "watching justice die."

In looking at the Administration’s position on affirmative action, we have to face that particular choice within the larger context of the Bush Administration’s class war on America’s working families and their policies of rewarding the rich.

This Administration and its allies in Congress are rolling back advances in racial equality, economic opportunity, and gender equity.

First Trent Lott lamented the defeat of Strom Thurmond’s white supremacist Dixiecrat Party in 1948. The Administration may have rushed to disown itself from those remarks, but its policies are taking us back to those days nonetheless.

The Administration is creating massive tax cuts for the rich, but twelve million children of America’s working families were left off their master plan for the child tax credit. They did this deliberately. It was not a mistake.

So were single mothers who apparently don’t deserve tax credits in the world of George Bush. They left out over 200,000 military families. What a disgrace.

We have an Administration that preaches leave no child behind, but then wants to gut Head Start and leaves tens of thousands of children behind. Instead of pre-school. They want to block grant head start, remove it from the Department of Health and Human Services, put it in the Department of Education and require four year olds to take a literacy test. Their proposal would end head start as we know it.

We have an Administration that would like to privatize Social Security and Medicare, leaving our parents and grandparents with neither financial security nor real prescription drug coverage.

We have an Administration that is trying to block section 8 housing programs, dismantling section 8 as we know it.

And we have an Administration that is stripping away our civil liberties, one by one. We must stop Patriot Act II from getting through Congress.

It’s an Administration that is wiping out decades of progress on Clean Air and Clean Water, even though asthma, childhood cancer rates, and scores of other health problems associated with pollution are on the rise, especially among low income families. And it’s an administration that puts our tax dollars into a $400 billion dollar defense budget to build more missiles, yet cuts after school programs and won’t fully fund education.

This is an administration that is launching a similar assault on women’s rights.

Look at its attack on Title IX, for example, a program that is featured in this Congress, especially on the House floor. It’s an administration that puts its tax dollars into a $400 billion dollar defense budget to build more missiles, yet cuts after school programs and won’t fully fund education.

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Mrs. MCCARTHY of New York. Mr. Speaker, I rise before you today to express my deep appreciation and recognition of Mr. Rao S. Anumolu of Hauppauge, NY for his tireless efforts in support of our nation's defense. As President and CEO of ASR International Corporation, Mr. Anumolu has assisted the Department of Defense in its fight to protect our homeland since the attack on our country on September 11th and particularly during the Iraq war. Since its conception in 1986, ASR International has developed cost-effective technology and systems to protect our national airports, waterways, railroads and highways.

Most recently, ASR International has developed the “SAFETY/SECURITY ASSURANCE SYSTEM” in order to further support our efforts at Homeland Security in a comprehensive and cost-effective manner.

In addition to Mr. Anumolu’s arduous work with ASR International, he has made quite a name for himself outside their doors. Earning a MS in Industrial Engineering and a MBA in Management, Mr. Anumolu furthered his education in the field of Defense by enrolling in numerous courses at Defense Systems Management College as well as Harvard University and other esteemed institutions. With this stellar academic background, Mr. Anumolu entered the workforce, holding such prestigious positions as Senior Engineer, Program Manager and Director of Prime Defense contractors before founding ASR International in 1986.

This is not the first time Mr. Anumolu has been recognized for his efforts. In 1993, Mr. Anumolu received the Business Excellence Award from the U.S. Small Business Administration for his work in the field of Defense. Now, it is my turn to say “Thanks.”

Mr. Speaker, I ask my colleagues to join with me in expressing our gratitude to Mr. Anumolu for his exemplary work and dedication to the technology and protection of all Americans. His many accomplishments have helped make the United States a safe place for all.

HONORING FATHER WALTER L. DOLAN

HON. DENNIS J. KUCINICH
OF OHIO
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. KUCINICH. Mr. Speaker, I rise today in honor and recognition of Father Walter L. Dolan, O.F.M., upon the occasion of his retirement from active ministry.

Father Dolan has served as President of Padua Franciscan High School in Parma for the past nine years. Under his leadership, the high school has flourished in many ways. Enrollment has steadily increased at Padua, and today the high school is the largest Catholic co-educational secondary school in northern Ohio. Not only has Father Dolan significantly raised the bar on academic standards and excellence at Padua, he also focused on the improvement of the school's athletic facilities. These significant exterior developments created new baseball and softball fields, new track fields and facilities, parking and roadway improvements, and a new football stadium. Father Dolan ensured that appropriate landscaping graced the boundaries of every new development.

Moreover, Father Dolan’s goal for Padua included financial stability for the school, and aid for eligible students. During his tenure, Father Dolan secured a major funding effort to build a strong endowment, entitled “The Campaign For Tomorrow.” This significant endeavor exists to increase the amount of financial aid to students in need. This endowment is also designed to maintain the school’s technological level, and also provides teachers with cutting-edge educational training.

Mr. Speaker and Colleagues, please join me in honor and recognition of Father Walter L. Dolan as he retires as President of Padua Franciscan High School, and as he retires from active ministry. Father Dolan’s contributions throughout his ministry are significant and immeasurable, and his work and service will be greatly missed. His leadership, experience, guidance and concern for others have served to uplift the entire Padua community, and the entire Cleveland community, and his gift of faith and compassion will forever light our community.

IN HONOR OF ROY BOHNER

HON. MARTIN FROST
OF TEXAS
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. FROST. Mr. Speaker, I rise today in honor of Mr. Roy Orthmor Bohner, who recently celebrated his 51st anniversary working with Lockheed Martin Missiles and Fire Control in Dallas, TX.

Roy Bohner has been a dedicated employee of MFC since he began working there many years ago as an Engineering Trainee and a junior hydraulics design engineer. Some of his notable accomplishments include a design of an autopilot for a radio controlled drone aircraft, a successful R&D program to do flight control analysis, and design studies for a “fly-by-wire” control system named Electro-RAAM. In addition to his service in Dallas, Roy spent some time at the General Dynamics plant, now Lockheed Martin Aeronautics in Fort Worth, as part of the Industry Assist program.

Prior to joining MFC, Roy served our country in World War II as a member in the 11th Army Division. He continues to contribute to this Nation through his loyalty and dedication to his projects at Lockheed Martin. A man of ardor and great humor, Roy’s objective is to be the oldest living employee at Missiles and Fire Control in Dallas.

Roy is an exemplary model of the American worker who is dedicated to continue serving this great Nation.

Mr. Speaker, Roy Bohner deserves special recognition for his tremendous achievement and dedication. He serves as a role model to the rest of us, and I wish him success in his future endeavors.

TRIBUTE TO MARIE DAVIS OF NORTH ADAMS, MI

HON. NICK SMITH
OF MICHIGAN
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. SMITH of Michigan. Mr. Speaker, I rise today to honor Marie Davis of North Adams, Michigan. A lifelong resident of North Adams, Marie has enriched the lives of others through her outstanding participation in civic and volunteer activities, and her many accounts of life in North Adams.

Marie was born on August 14, 1909 and is a lifelong resident of North Adams. She attended school there and graduated from North Adams High School, and has been a member of the North Adams United Methodist Church. Marie has also represented North Adams as a member of the Women’s Congress at the Hillsdale County fair for many years. Mrs. Davis is best known for her historical accounts of life in North Adams and has kept diaries of all major events that have occurred there. She has written and published five books about local history, including: “This is North Adams,” “100 Years of Sports in North Adams,” “The History of North Adams Schools,” and “1886–2002: The History of the North Adams Fire Department.”

Marie Davis will celebrate her 94th birthday on August 14, 2003, and is still considered North Adams’ official historian, continuing to chronicle the lives and events of that community.

North Adams is a small midwestern town with tree-lined streets, friendly neighbors, and thanks to Mrs. Davis, a preserved heritage. I am pleased to recognize the efforts of Marie Davis in preserving the memories, stories and values of the past for present and future generations.

GENERAL ERIC K. SHINSEKI

HON. CURT WELDON
OF PENNSYLVANIA
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. WELDON of Pennsylvania. Mr. Speaker, I rise today to celebrate the outstanding service of one of America’s true heroes, General Eric K. Shinseki.

General Shinseki retires from the Army after a career that spanned the globe and 38 years of service in peace and war. Let me be very clear, what General Shinseki has accomplished as chief is tied directly to the welfare of soldiers and their ability to remain the world’s greatest warfighters and we owe him a debt of gratitude.

General Shinseki was just a young cadet at West Point, when General of the Army Douglas MacArthur, gave his distinguished Farewell speech on the balcony of the Hudson to the Corps of Cadets. General MacArthur’s words embodied the creed of military service: “Duty,” “honor,” “country”—those three hallowed words reverently dictate what you are
want to be, what you can be. They are your rallying points to build courage when courage seems to fail, to regain faith when there seems to be little cause for faith, to create hope when hope becomes forlorn.—General Douglas MacArthur’s Farewell Speech, May 12, 1962

These ideals—of duty, honor and country so eloquently expressed by General MacArthur that once again personified General Shinseki’s distinguished career. General Shinseki graduated from the United States Military Academy in 1965 and later received a Master of Arts Degree in English Literature from Duke University.

As a young officer, General Shinseki served two combat tours in Vietnam. He was twice wounded, and earned two Purple Hearts as well as four Bronze Star Medals. He then went on to serve for more than ten years throughout Europe in positions of increasing authority and responsibility. In 1996, General Shinseki was promoted to lieutenant general and returned to the Pentagon as Deputy Chief of Staff for Operations and Planning.

General Shinseki’s duties culminated with his promotion as the Director of the Joint Staff of the Army in 1999. Already, as Vice Chief of Staff, he had developed an innovative plan to prepare the Army to face the unique challenges of the 21st century. Soon after becoming Chief of Staff of the Army, General Shinseki set forth a bold plan to transform the Army to a lighter, more lethal, more flexible and transportable force that would be fully capable of meeting the full range of threats that face today’s Army. He was a visionary who began transformation long before the term became popular.

Perhaps most poignantly, General Shinseki should be remembered as the gladiator President Roosevelt spoke of so long ago:

It is not the critic who counts, not the man who points out how the strong man stumbles, or where the doer of deeds could have done better. The credit belongs to the man who is actually in the arena; whose face is marred by dust and sweat and blood; who strives valiantly; who errs, and comes short again and again, because there is no effort without error and shortcoming; but who does actually strive to do the best who he can, who works hard, and who knows the great enthusiasms, the great devotions; who spends himself in a worthy cause; who at the worst, if he fails, while others might succeed, will know that he未能 to the end, this was, at least, failure and not水肿. It is the man of plowed ground and of the field—"They make up their own laws." - Hernando de Soto, The Power of Ideas, 1995

In Central America today, the basic labor-management dynamic is like the United States at the turn of the last century.

In Nicaragua and El Salvador, an employer can fire any employee whom it believes is sympathetic to an organizing effort simply by paying severance. In one plant I visited in Nicaragua workers had quite recently been working 70- to 80-hour shifts. Protests finally forced new management to adopt a middle class.

In Guatemala, we talked with a worker who had personally witnessed other employers who had been trying to organize being beaten with bats at work. In Nicaragua and Guatemala, we heard numerous reports of employers using the criminal process in order to break up unions in maquilas and other sectors.

In El Salvador, we visited a free trade zone in which a plant was shut down to avoid its workers being able to organize. We heard that the leaders of the organizing effort were subsequently blacklisted as they sought other employment.

In Guatemala, it is not legally possible for a union to attempt to organize within an entire industry, like the garment industry, without having in advance 50 percent plus one of the workers signed up and registering with the government.

Nicaraguan and Guatemalan employees cannot strike without government approval. The State Department Human Rights Report, and numerous other reports from groups like Human Rights Watch, confirm that the facts and incidents are the constant reality.

THE CASE FOR LABOR STANDARDS IN TRADE AGREEMENTS

HON. BARNEY FRANK
MASSACHUSETTS
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. FRANK of Massachusetts. Mr. Speaker, I ask that excerpts of a recent speech by Mr. Levin of Michigan be printed.

In recent years the major industrial growth in El Salvador, Nicaragua and Guatemala has been in the maquilas, assembling apparel in free trade zones. More than 100,000 to 150,000 people work in the garment maquilas of each nation. 75-85 percent of the workers on average are women, and 80-90 percent are young women. A majority are the sole source of income for themselves and their children.

By law, the work week is supposed to be 44 hours, with overtime on a voluntary basis. The typical worker receives about 65 to 75 percent of the average could work. Almost every nation in the world has agreed through the International Labor Organization (ILO) to respect five core labor standards: prohibitions on child labor and forced labor, non-discrimination, and the rights to associate and to bargain collectively. In the garment maquilas, the most salient are the right to organize and to bargain collectively.

In Central America today, the basic labor-management dynamic is like the United States at the turn of the last century.

In Nicaragua and El Salvador, an employer can fire any employee whom it believes is sympathetic to an organizing effort simply by paying severance. In one plant I visited in Nicaragua workers had quite recently been working 70- to 80-hour shifts. Protests finally forced new management to adopt a middle class.

In Guatemala, we talked with a worker who had personally witnessed other employers who had been trying to organize being beaten with bats at work. In Nicaragua and Guatemala, we heard numerous reports of employers using the criminal process in order to break up unions in maquilas and other sectors.

In El Salvador, Beatrice Alamanni de Carillo, a veteran judge and professor, serves as Prosecutor for the Defense of Human Rights. She was appointed by the National Assembly, with a majority from the conservative Arena Party. Her comments:

In the private sector an anti-union culture persists in great measure and for many years, employers have generated a climate that does not contribute to the promotion of worker organization in their workplace. . . . The Ministry of Labor and Social Welfare has not demonstrated a real will to guarantee in practice the rights of workers, either individually or collectively. There is a very loud clamor that the authorities of that Ministry do not make their best efforts to adequately check working conditions in businesses, and, in addition, they tolerate and promote an anti-union culture in the country.

In each country, the rights to associate and organize and to bargain collectively are not realities. The laws themselves are inadequate. Even where there are laws on the books, they are not well enforced and are often used against workers trying to organize.

As far as I could determine, there is not a single effective collective bargaining agreement in any of the garment maquilas of the three countries, though there are almost 400,000 workers.

Nicaragua, a leader of the union connected with the Christian Democrats put it this way: the problem is that employers have “impunity,” “they make up their own laws.”

You may jump to the conclusion that I came back discouraged. That is not accurate.

The issue of core labor standards is addressed in CAFTA by including a fully enforceable obligation to adopt these standards, it will have an important impact on socio-economic dynamics in these countries by helping develop a middle class.

In the last decade the apparel/textile maquilas have been the major source of economic growth and new employment in each of the three nations I visited, and in Honduras. The realtities within the maquilas today are built on a total imbalance in relationships between employer and employee. The vast majority of workers, young women, are particularly vulnerable, with overriding fear that for them losing a job means an end to their income.

It is essential in order to provide opportunities to the CAFTA countries to expand trade and strengthen commercial ties with the region. It is equally essential that the rules of trade and investment be shaped in a way that maximizes the benefits to those countries and the U.S.

For workers to be able to break the cycle of poverty, they need to have the ability to join together, to participate, to improve their economic status. This is an antecedent to helping those workers use the potential of globalization to create, join, or expand the middle class.

Hernando de Soto recently authored The Mystery Of Capital: Why Capitalism Succeeds In The West And Fails Everywhere Else, which posits that economies develop where property rights are formalized, are clearly and efficiently defined, are enforceable, and may be exercised by all; in this way all property can become capital. Labor market standards help workers maximize a key property right—property in one’s own labor.
A key reason to seek a minimum floor of respect for the five core, internationally-recognized labor standards is to ensure that the CAFTA countries will not compete in a race to the bottom in their efforts to promote trade and attract investment. Some argue that the race to the bottom is a myth; that income levels will rise when trade and investment flows increase, and all domestic standards will rise as income levels increase. These arguments ignore the fact that, with all other economic factors, investment dollars are scarce and there is intense pressure to attract those dollars. When the competition is over labor-intensive industries, one of the key points of competition is the labor market pool.

A New York Times article from about two years ago quoted the President of El Salvador regarding inter-regional competition, who stated, "The difficulty in this region is that there is labor that is more competitively priced than El Salvador."

Another article from about one year ago in the Washington Post described the interesting changes in apparel, textiles, and banana trade, with Ecuador attracting an increasing share. The explanation, according to one major fruit company executive, is that "the costs in Ecuador are so much lower. There are no unions, no labor standards, and the pay is as low as two dollars a day.

If the promise of expanded trade—increased incomes and lower levels of income inequality—is to be realized, it is important that the CAFTA countries not compete with each other based upon abuse of core labor standards. The best way to do that is to establish over a reasonable period of time a floor—adopting the five core labor standards as rules of competition in this critical economic area in the CBI itself—just as we establish floors through rules of competition in other areas like intellectual property, investor rights, and tariff levels.

The Central American nations do not need to suppress their workers in order to compete. There is an opportunity to build an economic structure based upon adherence to these core labor standards so that garments from those nations could bear a label reading "made under internationally recognized labor standards," which many competing goods will not possess.

The alternative is an increasing effort by consumer groups in the U.S. to boycott companies that make garments under conditions that violate these standards.

Efforts by American retailer-purchasers to promote and implement private business codes will not make up for a lack of a basic governmental and societal structure. In the Washington Post argument, above, an official from a major American retailer said "We can't be the whole solution. The solution has to be labor laws that are adequate, respected, and enforced."

By addressing core internationally recognized labor standards in the CAFTA negotiations, it is more likely that the domestic coalition necessary to tackle the tough market access issues issues with the United States can be assembled.

Total two-way trade between the United States and the CAFTA countries is about $20 billion. Combined, the CAFTA countries constitute the 18th largest export market for the U.S. and about half of all foreign direct investment in these countries comes from the U.S.

Beyond the current relationship, the United States is seeking better market access for goods and service providers, protection for investors, and improved intellectual property protection from the CAFTA countries. These countries are seeking more investment and more U.S. market access, primarily in the textiles and apparel and agriculture sectors. Otherwise, CAFTA will provide no significant benefits for Central America beyond those provided by the Caribbean Basin Initiative (CBI).

I joined with several others in helping to shape the enhanced market access in textiles and apparel when we expanded the CBI a few years ago. The result has been a move toward a floor on CAFTA textiles and apparel. I believe that further integration is necessary. If not, once quotas are removed in 2005 much more of this market will be lost to goods from other areas.

One of the keys to increased market access will be squarely facing up to the core labor standards issue. When we considered the expansion of CBI, the core labor standards issue was directly addressed by heightening the labor standards criterion in the CBI program. Under that criterion, the United States may unilaterally judge whether a nation is implementing the core labor standards. With the negotiation of CAFTA, and the consequent elimination of the CBI labor standards criteria, including a fully enforceable obligation to enforce the five core labor standards, is even more important.

The further integration in apparel and textile, as well as agriculture, means some further displacement in the United States. Comparative advantage is sound economics, but the distortion of the labor market by suppression of wages to gain a competitive advantage is unsound as an economic and policy matter, is unnecessary, and will only deepen opposition from competing workers and businesses in the United States.

Facing the issues surrounding core labor standards is not a vehicle for "protectionism." Indeed, it is an opportunity for expanded trade.

Only a coalition that is far broader and solidly bipartisan, much more than the narrow votes in the U.S. House achieved by last week's vote, can be the basis for working out decisions on the tough issues of apparel and textiles and agriculture in CAFTA, and beyond.

More broadly, CAFTA can and should be a building block towards effective negotiation of an FTAA.

The CAFTA negotiations present the opportunity for the United States to negotiate fully enforceable core labor standards, combined with a phased-in compliance period, a significant and ongoing commitment of U.S. technical assistance to help them achieve compliance before and in the initial years of the agreement, and positive market access incentives for countries that improve their laws and enforcement record (for instance, by accelerating implementation of market access phase-ins or by providing improved access that is required by the terms of the FTA).

The goal of those of us who seek to establish rules in this area is to expand trade, not shut it off.

There are many similarities between Central American nations and the United States and rest of Latin America. Where there are, what is negotiated in CFTA will matter. That will be true, for example in investment, intellectual property, customs obligations, and labor standards.

Where there are differences, it is a serious mistake to use an agreement for one country as a model for another, turning a building block into a stumbling block.

This is what seems to be evolving as to use of the Chile and Singapore agreements for negotiations in CAFTA. Last week USTR tabled in the CAFTA negotiations on core labor standards using the Chile and Singapore provisions as a model. Use of a standard of enforcing one's own laws is viable where a nation's laws embody the five ILO core labor standards and there is a record of enforcement of those laws. The laws of China and Singapore do embody the five core labor standards and these are enforced in practice.

The opposite is true in the Central American nations I visited; the standard of "enforce your own laws" would be a backward step in the CAFTA and benefit those with the worst laws.

This sparked the letter last week to Ambassador Zoellick from the Democratic leadership of the House and Mr. Rangel, Mr. Matsui and myself. We said "We write as supporters of negotiations for a U.S.-Central American free trade agreement. . . That said, we are not supportive of the provisions of the proposed U.S. draft text for the FTA's labor chapter. . . The current version of this text does not adequately address the economic and individual impact of the egregious conditions for workers in the region, and should not be the starting point for consideration of these issues.

Inclusion of a core labor standards provision in the CAFTA, and in future trade agreements, will help answer arguments of those who complain that globalization is harmful to the poor and anti-the "little guy."

I came home from my trip with a positive view of the opportunities that can be achieved, but only if we address the significant challenges. A key challenge is to place core labor standards in a broader perspective, and to understand that it is vital to the future of each Central American nation, the Central American region, the integration of the hemispheric market and the future of U.S. trade policy.
Creation of a FEMA-like office within USAID to manage a database and serve as a clearinghouse for post-conflict reconstruction experts, and to provide support for post-conflict operations.

Creation of a NATO unit to respond to post-conflict scenarios, and authorization of the President to provide a U.S. contribution of personnel to the unit.

Establishment of a U.S. post-conflict training center, building on existing training programs in the country.

Creation of a Civilian Police Reserve to train and deploy American police officers interested in serving overseas in post-conflict environments.

Creation of a "Security Development Fund"—$300 million in a drawdown account to provide resources to cover immediate and unforeseen costs in declared post-conflict situations, and potential U.S. contributions to multilateral operations.

The "Winning the Peace Act of 2003" is designed to fill a vacuum in U.S. foreign policy. It creates institutional mechanisms where only ad hoc arrangements exist. It establishes a permanent source of funding instead of relying on the Congressional appropriations calendar, or emergency supplemental bills. Equally important, the bill lays the groundwork, through training and education, for a new cadre of post-conflict experts, both civilians and military, in the governmental and non-governmental sectors.

The United States has faced post-conflict situations in the past—in the 1940s in Germany and Japan, and more recently in Somalia, Haiti, Bosnia and Kosovo, to name a few. We, along with other countries and multilateral institutions—have observed and learned much in recent history. While it is true that no two situations are identical, it can be said there are always common challenges. The "Winning the Peace Act of 2003" addresses those challenges and will strengthen the capacity of the United States to pursue its foreign policy objectives in the future.

INTRODUCTION OF THE KILAUEA POINT NATIONAL WILDLIFE REFUGE EXPANSION ACT OF 2003

HON. ED CASE
OF HAWAII
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. CASE. Mr. Speaker, I rise today to introduce a bill to authorize expansion of the Kilauea Point National Wildlife Refuge on the island of Kaua‘i. This bill is a vital component of one of my principal goals in Congress: to ensure that federal and/or state or private protection is extended to as many of Hawaii’s threatened and irreplaceable areas as possible, both to ensure the survival and recovery of Hawaii’s unique endangered and threatened species and to preserve the remaining unspoiled natural treasures of our beautiful islands for future generations.

The Kilauea National Wildlife Refuge, located at the northwesternmost tip of Kaua‘i, was established in 1985. The initial acreage of 31 acres was increased to 203 acres through additional acquisitions in 1993 and 1994. The refuge provides invaluable habitat for many native seabirds, including the Laysan Albatross, the Red-footed Booby, and the Wedge-tailed Shearwater, as well as for the endangered nene (Hawaiian Goose). Native plants have also been reintroduced to the area. The Refuge and its historic lighthouse have become one of Hawaii’s world-class tourist destinations, visited by some 400,000 visitors each year.

The proposed expansion area consists of three indispensable land parcels that are currently available for purchase and could be added to the eastern boundary of the Refuge. The Kilauea River runs through the land, which also includes an extensive lo‘i (irrigated terrace for traditional cultivation of taro, the staple crop of Native Hawaiians) which could be restored to support endangered Hawaiian water birds, including the Koloa duck, Hawaiian coot, Hawaiian stilts, and Hawaiian moorhen.

There is also a high quality estuarine ecosystem at the lower reaches of the river, which includes habitat for endangered birds as well as native stream life, such as the hiihiwai (an endemic snail) and o’opu (native goby). The proposed addition also provides an excellent habitat for the nene, Hawaii’s state bird, which was only recently saved from extinction. The beach is also sometimes used by endangered Hawaiian monk seals, and endangered sea turtles nest in the area.

These three parcels are available for sale and each of the owners has expressed a desire to see the land protected from development. But given rampant urbanization on Kaua‘i (and elsewhere in Hawaii) and the high demand for waterfront property, we could very well lose this remarkable opportunity to add high quality wildlife habitat to our national refuge system.

The Kilauea community strongly supports protecting the land from development. In fact, the Kilauea Point National Wildlife Refuge is a model for management of other federal refuges nationwide. The operations of the Refuge are supported by community volunteers, who give daily tours of the Refuge and help in the preservation of native plant species. The principal volunteer group, Kilauea Point Natural History Association, even has a small store in the Visitor Center, the proceeds of which go to the Refuge and for environmental education throughout Hawaii.

I urge my colleagues to join me in supporting this bill, and invite you to come to the Island of Kaua‘i to visit the Refuge. I know that if you did so, you would be convinced as I am of the importance of protecting these lands.
TRIBUTE TO ADRIAN SPOTTEN HOOPER, A LEGACY OF MARITIME ACHIEVEMENTS

HON. CURT WELDON
OF PENNSYLVANIA
IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. WELDON of Pennsylvania. Mr. Speaker, today I rise today to honor the memory of Adrian Spotten Hooper, one of Pennsylvania’s most distinguished and distinguished leaders. Mr. Hooper was Chairman of Penn’s Landing Corporation, in Philadelphia, PA, during the area’s initial development and head of the Independence Seaport Museum when it was moved to the waterfront. In fact, there would be no Independence Seaport Museum without Adrian’s leadership.

Mr. Hooper, born and raised in West Philadelphia, had been fascinated by the sea since his youth. He ran away from home at the age of 15 and tried to join the Merchant Marine, but was forced to return after his father intervened and arranged for him to sail on a Norwegian vessel in the North Atlantic for a few months. Mr. Hooper got sailing out of his system for a while, and graduated from Lower Merion High School in 1941. But to the sea he soon returned. As soon as World War II broke out, Adrian joined the Navy. He wanted to be at sea and fight in the war so badly that he memorized the eye chart, because he was blind in one eye. He went on to serve our country as a torpedoman on a destroyer in the Atlantic and the Pacific until 1945.

After the war, Mr. Hooper earned a bachelor’s in business from the University of Pennsylvania’s Wharton School in 1950. That year, he married Elizabeth Wharton Shober, and they moved to Devon, PA. He also began his professional career as a dispatcher for Interstate Oil Transport Company and served as chief executive officer until the company was sold in 1981 to Southern Natural Resources.

Mr. Hooper’s career was interrupted in 1951 when he joined the Army during the Korean War. He served stateside until 1953. After the war, Mr. Hooper returned to the Interstate Oil Transport Company and served as chief executive officer until the company was sold in 1981 to Southern Natural Resources.

Mr. Hooper’s public service began in the early 1970s, when former Mayor Frank L. Rizzo appointed him chairman of Penn’s Landing Corporation. At the time, the 22.5-acre area along the Delaware River from Market to Lombard Streets, commemorating where Philadelphia began more than 300 years ago, was fallow. Under Mr. Hooper’s direction and able leadership, Penn’s Landing became an entertainment center and the site of the Independence Seaport Museum when it was moved to the waterfront in 1995.

Mr. Hooper had many other exciting ventures outside of Philadelphia. In 1958, Mr. Hooper through the late Charles P. "Pete" Conrad, Apollo 12 commander, founded Universal Space Net, a satellite tracking firm in California. The firm has done work for NASA, the Air Force, and aerospace firms.

Mr. Hooper’s first wife died in 1996, and he married Susan M. Borresen Hooper in 1999. In addition to his wife, Mr. Hooper is survived by daughters Suzanne, Elizabeth, and Dana; a son, Adrian Jr.; stepchildren Karen and Devon Walsh; and four grandchildren.

Mr. Hooper’s legacy is one not only in the principles he stood for and the improvements he brought to Pennsylvania, but also his wonderful family, his wife and children. Mr. Hooper’s legacy is sure to include his keen understanding that the most important elements of our maritime infrastructure are people—shoreward workers, commercial sealers, merchant fleet operators, and many others who make America the maritime nation that it is today.

Mr. Speaker, our region has lost an exceptional leader, and I have lost a good friend. I wish the family of Adrian Hooper my heartfelt condolences and may they find comfort in knowing that the many people he impacted deeply value his dedication and generosity and the example of his life and work. Adrian Hooper exemplified the spirit of service that has made this country great. It is proper to remember and honor a man of such worth and character with great respect for what he accomplished and stood for.

THE REALITY PRINCIPLE

HON. BARNEY FRANK
OF MASSACHUSETTS
IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. FRANK of Massachusetts. Mr. Speaker, President Bush’s serious personal involvement in the effort to bring about Middle East peace deserves both praise and, more important, strong support from all Americans. As a strong supporter of the State of Israel and its right to exist as a democratic, Jewish state in a secure environment, I firmly believe that what President Bush is doing is very much in furtherance of the achievement of that goal, and I am pleased that he is taking the risks that are inherent when any president genuinely pushes for peace in the Middle East. As Thomas Friedman noted in a recent column in the New York Times, President Bush’s involvement is essential if we are to reach peace.

As Mr. Friedman also notes, and those of us who seek peace must be prepared to acknowledge this, “it may be that the Palestinians are capable only of self-destructive revenge, rather than constructive restraint and reconciliation.” That is, no one can be sure that peace is attainable on grounds that will allow Israel to live securely and without the constant threat of terrorist attacks on its citizens. But as Mr. Friedman adds, “surely Israel has more to gain in the long term by giving Mr. Abbas every chance to prove otherwise, and to empower him to do so.

There are two very tough decisions now facing the government of Israel, and I believe that those of us who have been and are consistent defenders of Israel’s right to exist, in the face of the overwhelming hostility of so many neighboring countries, should be explicit in urging the Israeli government to take the necessary action to test the Palestinians willingness to embrace genuinely a two-state solution. One of those decisions is to be willing to
withdraw settlements from much of the West Bank and all of Gaza. The other, even harder given the understandable emotion that the murder of innocent civilians triggers, is to show the restraint that the Bush Administration has asked Israel to show with regard to retaliation against the leaders of Hamas and other terrorist groups that deny Israel the right to act in its own defense, but I do urge the government to consider seriously the wisdom of Mr. Friedman’s argument for restraint as a very important step towards testing the prospects for peace.

Hamas is stuck, in conversations with Israeli government officials, by the confidence they have expressed in the good intentions of the new Palestinian Prime Minister, Mahmoud Abbas. But it is also clear that he faces great difficulties, including, sadly, the hostility of Yaser Arafat, whose unwillingness seriously to make peace has been a major factor contributing to the turmoil in the region. Refraining from actions which will unnecessarily undercut Prime Minister Abbas, is clearly in the interest of Israel, certainly until it becomes clearer as to whether Abbas will be able to achieve the peace that Israel believes he seeks.

Thomas Friedman’s article in the New York Times for Saturday, June 21, spells out this complex set of considerations very well, and I ask that this important article be reprinted here.

THE REALITY PRINCIPLE
(By Thomas L. Friedman)

Have you noticed how often Israel kills a Hamas activist and the victim is described by Israelis as “a senior Hamas official” or a “key Hamas military official”? How many senior Hamas officials could there be? We’re not talking about I.B.M. here. We’re talking about a ragtag terrorist group.

By now Israel should have killed off the entire Hamas leadership twice. Unless what is happening is something else, something I call Palestinian math: Israel kills one Hamas operative and three others volunteer to take his place, in which case what Israel is doing is actually self-destructive.

Self-destructive is, in fact, a useful term to describe some Palestinians today. “Both sides,” notes the Israeli political theorist Yaron Ezrati, “have crossed the line where self-defense has turned into self-destruction. Hamas’s terrorism becomes self-destruction, only an external force can bring people back to their senses. And that force is President Bush. I think he is the only reality principle that left that either side might listen to, and I hope he understands that.”

You know that both sides are in self-destruction mode when you can look at their military actions and say that even if they succeeded they would be worse off. The question is not whether Israel has a right to kill senior Hamas people. They are bad guys. The question is whether it’s smart for Israel to do it now.

The fact is, the only time Israelis have enjoyed peace in the last decade has been when Palestinian security services disciplined their own people, in the heyday of Oslo. Unfortunately, Yasser Arafat proved unwilling to do that consistently. The whole idea of the Bush peace process is to move Mr. Arafat aside and replace him with a Palestinian prime minister, Mahmoud Abbas, to rebuild the Palestinian security services, and, in the context of an interim peace settlement, corralling Hamas.

Hamas knows this. So its tactic is to goad Israel into attacks that will unravel the whole process. The smart thing for Israel to do—and it’s not easy when your civilians are being murdered—is not to play into Hamas’s hands. The smart thing is to say to Mr. Abbas: “How can we help you crack down on Hamas? You don’t do it to own Hamas’s demise. Palestinians have to root out this cancer within their own society. If Israelis try to do it, it will only metastasize.”

The alternative is that if America can go after Osama bin Laden, Israel can go after Hamas. Of course Israel is entitled to pursue its mortal enemies, just as America was. But it cannot do so with reckless abandon, notes Mr. Ezrati, for one reason: America will never have to live with Mr. bin Laden’s children. They are far away and al- ways will be. But, Israel will have to live with the Palestinians, after the war. They are right next door and always will be.

The fact is, Ariel Sharon’s two years of using the Israeli Army alone to fight terrorism have not made Israel’s more secure. He needs a Palestinian partner, and he has to operate and negotiate in a way that will nurture one. And the people who get that the best are Israelis. In a Yediot Ahronot poll released Friday, two-thirds of Israelis were critical of Mr. Sharon’s tactic of targeted assassinations of Hamas officials and said they wanted Mr. Abbas to be given a chance to establish his authority.

It may be that Mr. Abbas can’t step up to this. It may be that the Palestinians are capable only of self-destructive revenge, rather than constructive restraint and reconciliation. But surely Israel has more to gain in the long term by giving Mr. Abbas every chance to prove otherwise, and to empower him to do so, rather than killing one more Hamas “senior operative,” who will only be replaced by three others.

Because if the two sides cannot emerge from this dead end, then you can forget about a Palestinian state. It is what both Hamas’s followers and the extremist Jewish settlers want. They each want a one-state solution, in which their side will control all of Israel, the West Bank and Gaza. The one-state solution would mean the end of the Zionist enterprise, because Israel can rule such an entity, in which there would soon be more Arabs than Jews, only by apartheid or ethnic cleansing. It would also mean the end of Palestinian nationalism, because the Israelis will crush the Palestinians rather than let a Palestinian state. That is the outcome we are heading toward, though, unless the only reality principle left, the United States of America, really intervenes—with its influence, its wisdom and, if necessary, its troops.

INTRODUCING THE “SMALL BUSINESS FEDERAL SAFEGUARD ACT”

HON. ED CASE
OF HAWAII

IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. CASE. Mr. Speaker, small businesses are the lifeblood of our economy and generate nearly half of our nation’s GDP, yet the federal government is shutting small businesses out of the federal contracting process by bundling small contracts together into large megagreements.

In my State of Hawaii for example, the federal government has created large megagreements for military housing projects. This allows huge corporations to swoop in and win the contracts, even though Hawaii’s small businesses could do the work. Bundling has put these projects, and many other government contracts, out of the reach of small businesses and forces them to become subcontractors. I have heard from countless small business owners who said subcontracting for a large prime contractor is detrimental to their financial health and unfairly forces them to abide by the large employer’s rules.

Today I introduce a companion bill to S. 633. This bill will strengthen the definition of a bundled contract and prevent federal agencies

HONORING CLINICA MARIPOSA

HON. SAM FARR
OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. FARR. Mr. Speaker, I rise today to honor Clinica Mariposa, Planned Parenthood of Watsonville, CA. During a time when healthcare services are continually becoming more expensive, and information on reproductive health is becoming more restricted, Planned Parenthood has been a consistent and valuable service to the Watsonville community.

For nearly thirty years, Clinica Mariposa has offered education, outreach, and medical services to an ever-growing population that depends on these affordable services.

Since the establishment of Planned Parenthood in Watsonville in 1974, there has been a demonstrated commitment to affordability, cultural sensitivity, confidentiality, and high medical standards. All of these things contribute to the achievement of Planned Parenthood’s goal of “every child, a wanted child, every family a healthy family.”

It is frightening that in a country based on opportunity and equality, there are so many people who are without healthcare. Planned Parenthood has been a crucial part of the local healthcare network that provides a broad range of affordable services. Over the years, the growing health needs of the Watsonville community have been answered by Planned Parenthood and their ever-expanding services and facilities. By utilizing community-based satellites at farm labor camps and community agencies in addition to the Penny Lane location, Planned Parenthood fills a special role serving low-income residents regardless of their insurance status.

In an atmosphere where the constitutionally established right to reproductive choice is being threatened, and access to comprehensive sex education is being limited, the presence and services of Planned Parenthood are critical now more than ever. The presence of Planned Parenthood in Watsonville has ensured that residents have the full spectrum of choices and opportunities regarding their health. In addition, through school based education programs, Planned Parenthood has worked to reduce unintended teen pregnancies by giving young people the information and skills they need to make healthy choices.

The exceptional services that Planned Parenthood offers would be impossible without the dedication of the staff, the generosity of their many supporters, and the support of the community. I applaud the hard work of all those who have devoted their time and energy to the cause of affordable, high-quality healthcare at the Watsonville Planned Parenthood.
from circumventing statutory safeguards intended to prevent contract bundling.
This is a fair and temperate solution, and I ask for my colleagues’ support.

A PROCLAMATION HONORING MR. AND MRS. THOMPSON ON THEIR 70TH WEDDING ANNIVERSARY

HON. ROBERT W. NEY
OF OHIO
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. NEY. Mr. Speaker, Whereas, Victor and Ruth Thompson were united in marriage June 26, 1933, and are celebrating their 70th anniversary this year; and
Whereas, Victor and Ruth have demonstrated love and a firm commitment to each other; and
Whereas, Victor and Ruth have proven, by their example, to be a model for all married couples; and
Whereas, Victor and Ruth must be commended for their incredible devotion to each other;
Therefore, I join with the residents of the entire 18th Congressional District of Ohio in congratulating Victor and Ruth Thompson as they celebrate their 70th Wedding Anniversary.

IN HONOR AND REMEMBRANCE OF SAMUEL LADERMAN

HON. DENNIS J. KUCINICH
OF OHIO
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. KUCINICH. Mr. Speaker, I rise today in honor and remembrance of Samuel Laderman—beloved family man, respected attorney and CPA, and friend and mentor to countless.
Mr. Laderman began his career in the late 1940s first as an accountant. A few years later, he earned a law degree from Cleveland Marshall Law School, which singled him out as one of the few attorneys who also held a CPA license. Mr. Laderman built his career in law and accounting based on expertise, integrity, and a strong work ethic. He forged lifelong professional relationships based on trust, fairness, good will and his ever-present vivacious personality and quick wit.
Aside from his great professional success, Mr. Laderman possessed a kind heart, great sense of humor, and his main priority, focus and greatest love was his family. He was happily married to his college sweetheart, Cecile “Cec” Perry for 58 years. Together they lovingly raised two daughters, Flora and June, and a son, Gerald. Their closeness as a family and deep faith carried them through the tragic loss of their daughter June, who lost her battle with leukemia as a teenager. In her honor and memory, Mr. and Mrs. Laderman worked to help others through their creation of the June Beverly Laderman Memorial Fund with University Hospitals of Cleveland. Mr. Laderman volunteered his time and talents within our community on a regular basis. He was a member of the Cuyahoga County Bar Association, and was first president of the Hillel Alumni Association of Cleveland. In addition, Mr. Laderman was past president of the Cleveland Heights Chapter of B’nai Brith, and served on the board of B’nai Jeshurun Synagogue.
Mr. Speaker and Colleagues, please join me in honor and remembrance of Samuel Laderman—beloved family man, respected attorney, CPA, and friend and mentor to countless. I offer my deepest condolences to his beloved wife Cecile; beloved children, Flora and Gerald; to his three adoring grandchildren, extended family, and to his many colleagues and friends. Mr. Laderman’s life has left a luminous mark upon our community, and his spirited work and personal and professional legacy will be remembered always.

IN HONOR OF DUANE SCHAEZLER

HON. MARTIN FROST
OF TEXAS
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. FROST. Mr. Speaker, I rise today to recognize the outstanding service of Arthur Duane Schaezler, a gentleman who has recently celebrated his 51st anniversary with Lockheed Martin Missiles and Fire Control in my district.
Duane Schaezler served this country as an Air Force navigator for three years before he obtained his BS in Aeronautical Engineering from the University of Texas in 1949. Duane joined what was then-Chance Vought Aircraft in 1951 and has since applied his vast expertise and expert technical knowledge in the areas of guidance, navigation, flight dynamics and control systems.
Duane is an excellent example of a dependable and dependable American whose positive work ethic and loyalty are so important in today’s society.
Today, I ask my colleagues to join me in congratulating Duane Schaezler on his incredible accomplishment of fifty-one years with Lockheed Martin and wish him continued success in the future.

TRIBUTE HONORING 2003 LEGRAND SMITH SCHOLARSHIP FINALISTS

THOMAS CLEVENGER OF JACKSON, MICHIGAN, AND JEREMY WAGNER-KAISER OF BATTLE CREEK, MICHIGAN

HON. NICK SMITH
OF MICHIGAN
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. SMITH of Michigan. Mr. Speaker, It is with a sincere pleasure to recognize the finalists of the 2003 LeGrand Smith Congressional Scholarship Program. This special honor is an appropriate tribute to the academic accomplishment, demonstration of leadership and responsibility, and commitment to social involvement, demonstration of leadership and responsibility, and commitment to social involvement displayed by these remarkable young adults. We all have reason to celebrate their success, for it is in their promising and capable hands that our future rests.
The finalists of the LeGrand Smith Congressional Scholarship Program are being honored for showing that same generosity of spirit, depth of intelligence, and capacity for human service that distinguished the late LeGrand Smith of Somerset, Michigan. They are young men and women of character, ambition, and initiative, who have already learned well the value of hard work, discipline and commitment.
These exceptional students have consistently displayed their dedication, intelligence and concern throughout their high school experience. They stand out among their peers due to their many achievements and the disciplined manner in which they meet challenges. While they have already accomplished a great deal, these young people possess unlimited potential, for they have learned the keys to success in any endeavor.
As a Member of Congress of the United States of America, I am proud to join their many admirers in extending our highest praise and congratulations to the finalist of the 2003 LeGrand Smith Congressional Scholarship program.

HOORING RALPH AND ELEANOR LOCHER ON THE OCCASION OF THEIR 64TH WEDDING ANNIVERSARY

HON. DENNIS J. KUCINICH
OF OHIO
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. KUCINICH. Mr. Speaker, I rise today in honor and recognition of Mayor Ralph and Eleanor Locher, as they celebrate the sixty-fourth year of their marriage. Their committed partnership to each other also reflects their deep commitment and service to our entire Cleveland community.
Mayor and Mrs. Locher met in their rural hometown of Bluffton, Ohio. As a young boy, Mayor Locher and his family emigrated from Romania and settled in Bluffton. Mrs. Locher was born and raised in Bluffton. Their dedication for each other and their politics originated during their teen years in high school, as they were avid members of the high school debate team—and they’ve been inseparable ever since.
Mayor and Mrs. Locher attended Dayton University together. After they graduated, they moved to Cleveland and were married in June of 1939. Mr. Locher went on to attend law school at Western Reserve University, while Mrs. Locher worked as a teacher. Soon after, their daughter Virginia was born. Mrs. Locher became the steel frame of the Locher family, evolving into the role of mother, supportive wife and civic activist. Throughout Mayor Locher’s impressive career as attorney, mayor and judge, Mrs. Locher was a constant and committed advocate, organizer and friend. Their unbreakable alliance has served to encourage, uplift, and bring out the best in one another.
Mr. Speaker and colleagues, please join me in honor and recognition of Mayor Ralph Locher and Eleanor Locher as they celebrate sixty-four years of marriage. The longevity of their union underscores a deep and abiding love and commitment to each other—and reflects their deep respect, admiration and solid friendship that continues to grow stronger throughout their journey. Family has always
been central to their life together—daughter Virginia Wells; grandson Andrew and his wife Heather; and great-granddaughter Caroline. We stand in celebration of the wedding anniversary of Ralph and Eleanor Locher—the spirit of love within their union is cause for celebration and is an inspiration to us all.

"Love is the river of life in the world"—Henry Ward Beecher.

HONORING GUY REDMOND
HON. MARTIN FROST
OF TEXAS
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003
Mr. FROST. Mr. Speaker, it is my privilege today to recognize an outstanding engineer from my district. Mr. William Guy Redmond, Jr., recently celebrated the remarkable accomplishments of over 50 years of service to Lockheed Martin Missiles and Fire Control in Dallas, Texas.

Guy Redmond came to what was then-Chance Vought Aircraft Company as a young man after serving in the U.S. Navy and receiving degrees from SMU and MIT. Over the years, Guy has amassed over 20 patents. He is highly respected by all for his integrity and technical expertise and unwavering dedication to his organization.

In 1983, Guy was recognized through a nomination for the coveted IEEE Pioneer award for his contributions to the company and the community.

Mr. Speaker, I would like to recognize Guy Redmond again today for his enormous accomplishments at Lockheed Martin and offer my heartfelt congratulations on his 51st anniversary. I’m sure the members of this body will agree with me that 50 years of constancy and dedication is a feat not accomplished by many, and I wish him great success in his future endeavors.

CONDEMNING TERRORISM INFLECTED ON ISRAEL SINCE AQABA SUMMIT AND EXPRESSING SOLIDARITY WITH THE ISRAELI PEOPLE
SPEECH OF
HON. ZOE LOFGREN
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003
Ms. LOFGREN. Mr. Speaker, today Mr. HONDA, Ms. ESHOO, and I rise to recognize the achievements of Jim and Ann McEntee for their contributions to Santa Clara County. Jim McEntee is retiring as the Director of the Office of Human Relations after 27 years of dedicated service to the people of Santa Clara County and Ann is retiring after 40 years in teaching.

Jim and Ann have been happily married for 30 years during which time they have served the community as a team. He and his wife Ann, a teacher, have raised a large multi-cultural family.

Jim's first career was as a Roman Catholic priest, during which he served as an Associate Pastor in the Roman Catholic Archdiocese of San Francisco for 16 years before working for Santa Clara County.

Jim has a long history of building bridges between communities, bringing programs and services to the people in Santa Clara County. He is a founder and the chairperson of the Second Harvest Food Bank of Santa Clara County, a founding member of the Emergency Housing Consortium and the Help House the Homeless Coalition. Jim has also worked very closely with the United Farm Workers of America since 1985.

Jim and Ann worked together to help organize and actively promote many community activities that serve to promote an appreciation of local ethnic cultures, e.g. The Martin Luther King Celebration, Cinco de Mayo Celebration, and the Tet Festival. They also take a leadership role in promoting social justice in the community through a church-based organization called "Just Faith."

Ann has dedicated her career to teaching, and for the past 11 years she has taught Special Education at Lee Mathson Middle School where she reaches out to students and families by making regular home visits. Ann also developed a school dispute resolution program at Lee Mathson to help students develop the skills to resolve their problems constructively and peacefully.

We wish to thank Jim and Ann McEntee for their tireless service to the County and wish them the best in their future endeavors. Furthermore, they have our personal thanks for our years of friendship. Though we will miss their compassion, expertise and commitment, their dedication has left its mark on Santa Clara County.

CONDEMN TERRORISM INFLICTED ON ISRAEL SINCE AQABA SUMMIT AND EXPRESSING SOLIDARITY WITH THE ISRAELI PEOPLE
SPEECH OF
HON. ERIC CANTOR
OF VIRGINIA
IN THE HOUSE OF REPRESENTATIVES
Wednesday, June 25, 2003
Mr. CANTOR. Mr. Speaker, I rise today to support H. Res. 294, and I thank Mr. DELAY for scheduling this important resolution this week.

On June 4, 2003, President Bush, Prime Minister Sharon, and Prime Minister Abbas came together to pledge their commitment to the "Road Map" to Peace. At this summit, Mr. Abbas promised to reign in the terror groups that have plagued Israel with 3 years of relentless terror. Since this summit, 29 Israelis have been murdered and over 120 have been wounded in terrorist attacks by Palestinian organizations such as Hamas, Islamic Jihad, and Yasser Arafat's own Fatah. In all, the Israeli defense forces have counted 319 separate attacks on soldiers and civilians.

Mr. Speaker, the United States sustained a horrifying terrorist attack on September 11, 2001, and responded by pursuing and attacking those responsible for the cowardly murder of innocent civilians on American soil. Israel has lived with a perpetual September 11 since its inception and must be allowed to pursue those who wish to murder innocent Israeli civilians. The terrorist actions of the last few weeks demonstrate that these organizations are not interested in peace, but rather the complete eradication of the State of Israel. We must condemn those who use terror against civilians as a means to destroy freedom and peace.

Israel, like the United States, was founded on the common values of democracy, freedom, and peace. Today, I reiterate that we
must stand by Israel, our strongest ally in the Middle East, in its fight against the terrorist organizations that seek to destroy the peace. We must maintain our commitment to Israel’s security and the safety of its citizens.

Peace must come with security, not in spite of it. Israel has always made a sincere commitment to peace in the region. Many times its commitment to peace has come at the expense of innocent life. Before the process can move forward, we must compel the Palestinian authority to take immediate and effective steps to dismantle the terrorist infrastructure on the West Bank and Gaza Strip. Only then can we come to a peaceful solution of this conflict in which Israel, the Jewish State, can live side by side with a democratic Palestinian State in peace and security.

THREE PENCE DESK IN THE HOUSE OF REPRESENTATIVES

TRIBUTE TO MAYOR PAUL BAUMUNK

HON. PHILIP M. CRANE
OF ILLINOIS

IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. CRANE. Mr. Speaker, I arise today to recognize the mayor of Lindenhurst, Illinois, Paul Baumunk, whose outstanding leadership and commitment to community service has significantly benefited the people of Lindenhurst.

A longtime resident of Lindenhurst, Mayor Paul Baumunk served as a teacher in Lake County for 31 years, both with the Lake Forest High School and the College of Lake County Vocational Center. He also served as a member of the Lindenhurst Plan Commission and the Lindenhurst Lakes Commission. In addition, Paul somehow found the time to participate in the Chamber of Commerce, the Lindenhurst Men’s Club, the Lyons Club and in VFW Post #489.

Although he has always been a devoted public servant, Paul has always held his family as a top priority. He and Joy, his wife of 32 years, originally settled in the community of Lindenhurst in 1977 to raise their son Philip and daughter Amy. Paul’s retirement will allow him to spend more time with his family, something he will greatly cherish.

Mr. Speaker, I ask that you and my other distinguished colleagues join me in congratulating Mayor Paul Baumunk on his retirement after 12 years of diligent service to the Village of Lindenhurst, Illinois. Paul has been a valuable member of the community for which he cares so deeply, and his service will be greatly missed. I wish him the best of luck in future endeavors, and I know he will enjoy his retirement for many years to come.

PERSONAL EXPLANATION

HON. ERNIE FLETCHER
OF KENTUCKY

IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. FLETCHER. Mr. Speaker, on Wednesday, June 25, 2003, I had been present for Rollcall Vote No. 312, 313, 314, 315, 316, and 317, I would have voted the following way: Rollcall Vote No. 312, 313, 314, 315, 316, and 317, I would have voted the following way: Rollcall Vote No. 312, S. 858—“Yea.” Rollcall Vote No. 313, H.R. 2474—“Yea.”

THE U.S. SUPREME COURT DECISION ON AFFIRMATIVE ACTION IN HIGHER EDUCATION

HON. HILDA L. SOLIS
OF CALIFORNIA

IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Ms. SOLIS. Mr. Speaker, I rise to applaud the Supreme Court’s decision to uphold affirmative action. The Court’s ruling this week was a tremendous victory for all those who believe that diversity is one of our nation’s greatest strengths.

The historical significance of this important ruling cannot be underestimated. For millions of minority students—Latino, African-American, Native American—it means the opportunity at a better education, higher wages, and a promising future.

The Court’s ruling is especially important to Latinos, our nation’s fastest growing and now largest minority group. Fewer than 10 percent of college-age Latinos 18-24 are enrolled in college. Only 16 percent of Latinos between the ages of 25-29 have bachelor’s degrees. Clearly, many challenges remain to increase Latino enrollment at colleges and universities across the country. Affirmative action is key to breaking down the barriers to higher education for Latinos.

Affirmative action is not only beneficial to minority students, but also to non-minority students. Greater diversity on our college campuses ultimately produces students who are better equipped to thrive in an economy and society that is increasingly multicultural. As Justice O’Connor noted in the Court’s decision, the future of our nation relies on leaders who are comfortable with “diverse people, cultures, ideas and viewpoints.” O’Connor was most likely influenced in her opinion by an unlikely coalition of business, military, civil rights, and education groups that urged the Court to uphold affirmative action because its produces leaders who are prepared for today’s increasingly global economy.

The country’s highest court has ruled that race may be a factor in college admissions because the nation has a compelling need for racial and ethnic diversity on our college campuses. The ruling calls into question race-neutral affirmative action plans used in several states, including my own state of California.

Given the Supreme Court’s decision, I hope California will review and revise its affirmative action policies so that public universities in my state truly reflect the state’s very diverse population. The Court has spoken about the importance of diversity. Now should California.

Throughout the United States, there are millions of Latinos and Latinas who want to succeed. They want equal educational and economic opportunities. The Court’s ruling provides great hope for these young people. Again, I applaud the Court for this landmark decision.
Mr. Speaker, I am proud to showcase the heroism of Chief Warrant Officer David Williams for his service as a Prisoner of War during Operation Iraqi Freedom. Iraqi forces detained him for 21 days as a POW after his helicopter was grounded near Karbala, Iraq. Williams valiantly fought and survived imprisonment after being captured.

Chief Warrant Officer Williams moved to Hampton Roads’ Newport News area with his family and grew up in Chesapeake, Virginia. From early childhood, David was always enthralled with planes and the magic of air flight. After graduating from Great Bridge High School in Chesapeake, Williams enrolled in community college and joined the Army as a full-time reserve. As a warrant officer, he served as a crew chief on a med-evac Huey helicopter, Williams searched for a bigger challenge. He was assigned to the Army’s 106th Special Operations Aviation Regiment and also went through Survival, Evasion, Resistance and Escape school while traveling the world doing preparatory combat missions.

Next week, we will welcome back David Williams to his hometown of Chesapeake, Virginia with a host of events and celebrations for his heroic return. We are pleased to salute him for protecting our flag and our freedom. The Independence Day holiday is a perfect time to show our deep appreciation to this brave citizen and soldier who spent his childhood in the Fourth District of Virginia.

Williams showed tremendous bravery and commitment to his country while held by his Iraqi captors. Today we recognize him for his unwavering patriotism and dedication to both his job and the American people.

Mr. Speaker, please join me in honoring Chief Warrant Officer David Williams for his bravery and dedication abroad, his service to the Commonwealth of Virginia, and the American people.

PERSONAL EXPLANATION

HON. JIM SAXTON
OF NEW JERSEY
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. SAXTON. Mr. Speaker, yesterday, June 25, 2003, I was unable to cast my vote for rollcall numbers 312, 313, 314, 315, 316, and 317 due to the fact that I was attending a funeral for my dear friend from Arizona, Representative Bob Stump.

Had I been presented, I would have voted "aye" for all 6 votes.

LEGISLATION ADDRESSES SHOCKING PROBLEM OF PRISON RAPE

HON. FRANK R. WOLF
OF VIRGINIA
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. WOLF. Mr. Speaker, I recently shared with our colleagues several personal accounts related by survivors of the brutal and inhumane act of sexual assault in our nation’s prisons.

H.R. 1707, the Prison Rape Reduction Act of 2003, will address the problem of prison rape. I was pleased to co-author this legislation with my Virginia colleague, Rep. Bobby Scott. The bill is pending mark-up in the House Judiciary Committee and we are hopeful that it will be on the House floor soon. I believe in being tough on crime. But this has nothing to do with being tough on crime. It has everything to do with human dignity and ending deliberate indifference toward sexual assaults in prisons, maintaining order in prisons, and reducing social and economic costs to a society left to deal with physically and psychologically damaged former inmates.

Today I want to share additional stories from those whose lives have been forever changed by the sexual assaults happening every day in the prison system. I imagine knowing that someone you love is being repeatedly raped, abused, and degraded and that there is little to nothing that you can do about it.

For the last two and a half years, my family and I have been paralyzed by this knowledge and our inability to stop the rape and abuse.

My name is Vivian Edwards and I am here to tell you about my nephew, Roderick John Hernandez. In my family, he goes by Keith.

Keith is a Navy vet and a man imprisoned in Marshall, Texas in January of 2000 for a non-violent crime. He wrote a check even though he knew that he did not have the funds to cover the cost of the crime. He served 10 years in prison and was released in 2010. From the beginning, my nephew knew that being a gay man put him at risk so he informed prison officials that he was gay in hopes that he would be offered protection. My nephew was offered no protection. While at Alled, he was placed in the general population.

He might as well have been put in a lions’ den. Hernandez was immediately called CoCo by the other inmates which made it clear to all inmates that he was available for sexual exploitation. The prison officials also began to call Keith by this nickname and refer to him as “she” or “her.”

Keith was raped by a member of the gang called ‘Gangster Disciples’ in early October 2000. My nephew informed prison officials about what had happened and that he feared for his life. He asked for medical attention. He was denied help and denied medical assistance. They told him that the care he needed was only available for an emergency. My nephew was raped! How can someone say that is not an emergency?

Keith was raped! How can someone say that is not an emergency?

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forced to perform sexual acts against his will. He was traded between various gangs in prison—the Bloods, the Crips, the Tangos, the Mandingo Warriors—and sold out for $5 and $10 for sex.

By December of 2001, Keith feared for his life so much that he purposely incurred a serious injury on his body. He was given the maximum punishment and received 35 days in solitary confinement. Ironically, this was the first and only protection that he ever received. Sadly, this punishment also included extending his sentence for more than two years past the date that he would have been eligible for release.

After Keith’s seventh life endangerment claim, he began writing the ACLU and other outside organizations for assistance. The ACLU National Prison Project came to his rescue. They filed a federal lawsuit on behalf of my nephew against several Texas prison officials that ignored his pleas for protection against gangs who forced him into sexual slavery.

Keith had asked us to pray for him, and we did. One day, a few days after he was moved to a safety protection unit soon after the ACLU National Prison Project filed the lawsuit, Keith had tested negative for HIV, but still lives in constant fear that he might have contracted other diseases from countless forced sexual encounters. Prison rape is a crime that not only affects the victim, but also the family. As I said before, my entire family has been horrified and devastated for the past two and half years because of what has happened to Keith. Today we are praying for Keith, but we are also fighting for him and for every other prisoner that has been a victim of rape while in prison as well.

I have tried to write this story many times, but I find myself in tears at the thought of recounting the events. But now, after two years, I am finding the courage, little by little, to speak out. I pray that this courage will be with me today.

My name is Hope. In July 1997 I was incarcerated following an arrest for a drug related offense. I had been sent to a rehab facility in Virginia, but because of my extreme withdrawal symptoms from heroin and cocaine, they pulled me out of this facility and sent me, instead, to jail.

I went to the DC jail on no particular charges, but simply because I needed medical attention and was pending indictment. From the DC jail I was transferred to a medical unit at CCA (a privately contracted jail adjacent to DC jail). This was where anyone with medical concerns, pregnancy, injury, extreme illness, or other debilitating circumstances was sent.

The unit consisted of male and female inmates. When I got there, I was surprised to realize that male guards were on staff guarding the mixed population. Male guards were allowed to watch us changing, showering, and using the toilet.

Also to my surprise, male and female inmates were allowed recreational time together on this unit. I met a woman pregnant with her third child all of whom were conceived in jail.

I was denied a shower for more than 2 weeks. When I finally was permitted to have one, the guard threatened me with violent attack if I did not get to me at 3 a.m. He took me to a private, hospital-type room. He proposed I smoke a cigarette with him (smoking was not permitted in this facility).

I smoked this he thought allowed him access to rape me. He attacked me while I was showering.

I was terrified, and I didn’t know what to do. I tried to call a mental health counselor because of my withdrawal, and I didn’t know who would believe me.

Then, it happened again on a subsequent night. I was doped up on the psyche meds that had been prescribed to aid with my withdrawal symptoms. Again, he took me to the toilet, showed me his violence, and physically weakened by the drugs. The nurses were asleep in their station 20 feet up the hall, and the relieving guard was on a break. Afterwards, he gave me back my paper jumpsuit. I was putting it on when another guard entered the room and became extremely suspicious. You’d think this eye-witness would have been enough to prosecute him. But it wasn’t. An “inconclusive” rape test conducted after my shower meant there was no follow up.

Since then, my hands have been tied. I have not been able to prosecute the rapist. I have no avenue for seeking justice. I practice daily forgiveness when the mind numbing thoughts won’t go away. I pray and I pray to help me get through this. I keep praying because it’s my life.

I will never forget that night in March of 2000. That was the night I was raped by a federal prison guard.

My name is Marilyn Shirley and I am here today as living proof that prison rape does happen.

I was convicted of a drug charge and placed in the Federal Medical Center at Carswell in Fort Worth, Texas. On January 12, 1998, until September 10, 2000.

While in prison I took all of the required Bureau of Prisons courses—from substance abuse prevention to classes that taught me job skills. I never once had an incident report written against me. In fact, I was rewarded with time credited for good behavior. Upon my release, I walked away with a $250 check from the Bureau of Prisons and a permanently devastated emotional and mental state as a result of my rape.

On that night I was woken up at approximately 3:30 a.m. by prison guard Michael Miller, a Senior Officer of the Bureau of Prisons. He told me, in the presence of a male guard, that I was wanted at the officer’s station.

I was scared to death that they’d called me because something had happened to my husband who had heart problems and diabetes, or to my twins.

I could not have been more wrong. I should have feared for my own safety. After entering the officer’s station, I was making a phone call stating that if a Lieutenant heads for the Camp to give him the “signal.”

After hanging up, Miller started forcing himself on me, kissing me and groping my breasts. I was pushed into a store-room where clothes were kept for the inmates. He continued to assault me; the more violent he became. He tried to force me to perform oral sex on him. He then threw me against the wall and violently raped me.

I still remember him whispering in my ear during the rape: “Do you think you’re going to get away with this? You’ll be the one thinking of telling, but because it’s your word against mine, and you will lose.” Miller also said to me “who do you think you will believe, an inmate or a fine upstanding officer like me?”

I gave statements and answered questions. The semen stained sweatpants were taken as evidence to the FBI Crime Lab. I was given a lie detector test, which I passed. Meanwhile, Michael Miller is still under criminal investigation.

I owe a lot to my attorneys who believed in me and my family who supported me. Miller has continued to work as a corrections officer with the Federal Bureau of Prisons. Even after I reported the rape, he was only transferred to a men’s prison. I cannot believe that this rapist is getting paid with people’s tax dollars; it’s not right.

One of the hardest things that I ever had to do was to leave my mouth open. Having nowhere to turn, I was left with paralyzing panic attacks, awful nightmares, and a terrible state of depression all of the time.

Rape should not have been part of my punishment. Though I am still struggling with the emotional damage I have suffered from this rape, it is important for me to speak out. With God’s help, I get strength from this rape, it is important for me to speak out. With God’s help, I get strength from this rape, it is important for me to speak out. With God’s help, I get strength from this rape.

Mr. Speaker, I rise in honor of Dr. Israel “Ike” Tribble, Jr., a remarkable man who dedicated his whole life to equipping African-American young people in our community, our state and our country with the educational tools they need to succeed in their personal and professional lives.

Ike had an amazing ability to see the good in everyone, and he knew that education was the key to fully unlocking everyone’s God-given potential. After earning a masters in school administration and a doctorate in administration and policy analysis, Ike began a career focused on providing higher education opportunities for all people.

Ike first blessed Floridians with his talents in 1982 when he moved to Tallahassee to serve TRIBUTE TO DR. ISRAEL “IKE” TRIBBLE, J.R.

HON. JIM DAVIS
OF FLORIDA
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003
as associate vice chancellor for academic programs for the Florida Board of Regents. From there he was recruited to start the Florida Education Fund, a program designed to help African-Americans earn doctorates and law degrees. During his 17 years leading the Fund to new heights, Ike helped thousands of young people on the road to higher education.

When Ike was not working long hours at the Fund, he was devoting his energies to a host of other civic boards and committees. He served on the Advisory Committee on the Education of Blacks in Florida and as Chairman of the Board of Commissioners of the Tampa Housing Authority. As the first African-American chairman of the Greater Tampa Chamber of Commerce, Ike was responsible for making the board more representative of our diverse business community and focusing business and community leaders on the virtues of educating our young people.

In 1999, Ike was diagnosed with acute leukemia. Ike faced his illness with the same courage and positive attitude that he applied to all other facets of his life. Through chemotherapy, multiple transplants, Ike fought to the end, and he never stopped giving back to his community. I consider it the highest honor, privilege and joy to have called Ike Tribble my dear friend and a mentor. Ike’s passion and commitment to improving the lives of those around him has inspired countless numbers of people to do more—often unsung heroes who contribute every day, unselfishly and unwaveringly, to the health and well-being of our communities.

In recognition of his unwavering commitment and dedication that Susan has demonstrated is indeed a reflection of all that the Rotary stands for. It is wonderful to see her work so proudly recognized by our community.

In 1999, Ike was diagnosed with acute leukemia. Ike faced his illness with the same courage and positive attitude that he applied to all other facets of his life. Through chemotherapy, multiple transplants, Ike fought to the end, and he never stopped giving back to his community.

I would like to congratulate Mayor Louis Congemi for his leadership in guiding the development of the Resource Center from initial idea to grand opening.

The Hispanic Resource Center proclaims and symbolizes the vitality of the Hispanic community in Kenner. I am confident that the Center will make a meaningful difference in the lives of many who hope in America’s promise and pursue the American dream. I am pleased to extend my best wishes to all of those involved in the work of the Hispanic Resource Center upon this happy occasion.

HONORING SUSAN BOOTH FOR HER OUTSTANDING COMMITMENT TO PUBLIC SERVICE

HON. ROSA L. DELAuro
OF CONNECTICUT
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003
Mr. DELAuro. Mr. Speaker, it is with great pleasure that I rise today to join the many gathered to pay tribute to an outstanding member of our community, Susan Booth, as she is honored by the Devon Rotary and named a Paul Harris Fellow. The Paul Harris Fellow recognition was created in memory of Paul Harris, the founder of Rotary as a way to show appreciation for contributions to the Foundation’s charitable and educational program. Every Paul Harris Fellow receives a pin, medallion and a certificate when he or she becomes a Fellow, identifying the recipient as an advocate of the Foundation’s goals of world peace and international understanding. The commitment and devotion that Susan has demonstrated is indeed a reflection of all that the Rotary stands for. It is wonderful to see her work so proudly recognized by her community.

Funder of the Archway Foundation, Susan has spent nearly fifteen years collecting donations to feed and clothe homeless children in Romania. Inspired by a television program about Romanian orphans abandoned when communism collapsed, Susan, a railroad conductor on a commuter train between Connecticut and New York’s Grand Central Station, switched to night shifts so that she could earn a master’s degree in Social Work. Upon completing her degree, Susan went to Bucharest on a week’s vacation in search of these Romanian orphans who were living in sewers and abandoned buildings. With only a short list of contacts, Susan was fortunate to find an individual who knew where to look. “In that sewer, I found my life’s work,” she has said. Indeed, she has dedicated countless hours to her mission.

Operating out of her own home and a post office box, Susan collects clothing and donations and has been awarded hundreds of thousands in charitable grants. Through her hard work and the generosity of her contributors, Archway has been able to purchase two homes in Romania as well as employ a local man to perform the maintenance and repairs. The homes are used as a soup kitchen from which volunteers take food out to hundreds of homeless children every week and provides groceries to squatter families who take refuge in abandoned buildings.

It is not often that you find an individual with such dedication and commitment. Susan’s good work has touched the lives of thousands of needy children. More importantly, she has inspired countless numbers of people to donate their time and energy to provide one of life’s most precious gifts—hope.

I am proud to be voting today to join the Devon Rotary and the many family and friends who have gathered this evening in extending my sincere thanks and heart-felt congratulations to Susan Booth as she is named a Paul Harris Fellow. Yours is a legacy that is sure to continue to inspire generations to come.

PERSONAL EXPLANATION

HON. ROBERT MENENDEZ
OF NEW JERSEY
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003
Mr. MENENDEZ. Mr. Speaker, I rise to offer a personal explanation. On June 23, 2003, I was absent from the Chamber as I attended my son’s high school graduation. During that time I was not present to vote on rollcall votes 297, 298, 299, and 300. Had I been present, I would have voted “yea” on rollcall votes 297–300.

HONORING THE CAREER OF CHARLOTTE LESSEr

HON. JANE HARMAN
OF CALIFORNIA
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003
Ms. HARMAN. Speaker, in the course of my career as a public official I have been privy to work with some truly remarkable people—often unsung heroes who contribute every day, unselfishly and unwaveringly, to the health and well-being of our communities. One such person is my friend and constituent Charlotte Lesser, and I rise today on the occasion of her retirement as Director of Health Education at the Beach Cities Health District (BCHD) to commend her for her many achievements and contributions.

For 10 years, Charlotte Lesser has successfully spearheaded BCHD efforts to provide critical assistance to South Bay citizens in need. Under her leadership, BCHD has developed new programs and services that promote health education activities and fitness awareness for the residents of Manhattan Beach, Redondo Beach and Hermosa Beach.

And as is the case with so many local leaders, Ms. Lesser volunteered her time to strengthen South Bay communities through her involvement with the South Bay Family Healthcare Center, the South Bay Youth Project, the Wellness Community, and the South Bay Coalition for Alcohol and Drug-Free Youth.

In addition to her work as a champion of local health care services, Charlotte Lesser chaired the Redondo Beach Chamber of Commerce and founded and directed the Manhattan Beach Neighborhood Watch.

In recognition of her unwavering commitment to the community, in 1999, Charlotte Lesser was named Los Angeles County Woman of the Year. But Charlotte is also my trusted friend and has been a wonderful resource to my staff and me.

Mr. President, I join the community in thanking Charlotte Lesser for her years of service and accomplishment, for they are evidence of her dedication and boundless energy. Although she is retiring from BCHD, her achievements will not end there. I look forward to her upcoming appointment to the Los Angeles County Commission for Women. I know she will continue to be an active leader and community advocate.
HON. JAMES L. OBERSTAR
OF MINNESOTA
IN THE HOUSE OF REPRESENTATIVES

Thursday, June 26, 2003

Mr. OBERSTAR. Mr. Speaker, today Cong. JERRY COSTELLO, LINCOLN DAVIS, other Members of the Committee on Transportation and Infrastructure, and I have introduced the Rebuild America Act of 2003.

In the 107th Congress, the Democrats on Transportation and Infrastructure Committee introduced similar legislation to invest in the safety and security of the Nation’s infrastructure. At that time, we were alarmed by the negative effects that the policies of the Bush Administration were having on our Nation’s economy. Now, almost two years later, our concerns have been proven correct. Figures for the first month show that the national unemployment rate has increased from 4.2 percent in January 2001 to 6.1 percent, the highest level since July 1994. Further since January 2001, the number of people unemployed has increased from 5.95 million to more than 8 million—an increase of more than 3 million, or more than 50 percent.

Moreover, workers who have lost their jobs are having more trouble finding new jobs. The average length of unemployment is now almost 20 weeks, the longest it has been in nearly two decades. In the past two years, the number of workers who have been unemployed for longer than six months has increased by 1.3 million to nearly 1.9 million—an increase of more than 216 percent. One-half of all jobs are out of work for more than 10 weeks and one in five have been out of work for more than six months.

The response of the Bush Administration has been tax breaks for the wealthy. The Administration could have developed a bipartisan plan to use the surplus it inherited to invest in our Nation’s infrastructure, shore up the Social Security Trust Fund, and pay down the national debt, however, it has squandered each of those opportunities. Instead, the Administration continues to pursue policies that favor only a small portion of the population (the ultra-wealthy) and push our economy further and further into debt and recession. As the economy continues to founder, the need for legislation that will create jobs has become even more apparent.

Unlike the Republican “trickle down” approach to the economy, the Rebuild America Act of 2003 stimulates the economy by creating jobs—especially jobs in nonresidential construction—and rebuilding our Nation’s infrastructure. This bill provides $50 billion to enhance the safety, security, and efficiency of our Nation’s infrastructure, including improvements to rail, highway, transit, aviation, maritime, water resources, environmental, and public building infrastructure. By leveraging Federal infrastructure investments, the 10-year cost to the Federal Treasury would be less than $34 billion.

Moreover, the bill fully offsets this $34 billion cost to the Treasury by cracking down on abusive corporate tax shelters (e.g., Enron), pre-tax corporate tax shields, and extending customs user fees.

According to the U.S. Department of Transportation, each $1 billion in new infrastructure investment creates 47.500 jobs and $6.2 billion in economic activity. The bill will create more than two million jobs—virtually eliminating the job losses that have occurred since the Bush Administration came into office—and restore more than $310 billion to our economy. Moreover, in the wake of the September 11, 2001 terrorist attacks, the bill gives priority to infrastructure investments that focus on enhanced security for our Nation’s transportation and environmental infrastructure systems.

By ensuring that the funds are invested in ready-to-go projects, the bill will provide a much-needed jumpstart to our economy. The bill provides funds for each of the critical areas of our Nation’s transportation and environmental infrastructure, including: $5 billion for highways and transit; $3 billion for airports; $21.5 billion for rail including high-speed rail, freight rail, and Amtrak; $13 billion for environmental infrastructure including wastewater, drinking water, wet weather, and Corps of Engineers projects; $2.5 billion for port security; and $2 billion for economic development and public buildings.

In addition, this infrastructure investment will increase business productivity by reducing the costs of producing goods in virtually all industrial sectors of the economy. Increased productivity results in lower labor, capital, and raw materials and generally leads to lower product prices and increased sales. Also, the bill takes into account the fiscal crises that the states are currently facing and allows recipients of the funds an extended period of time to meet their state and local match requirements.

Simply put, this bill will strengthen the fabric of our Nation’s infrastructure while creating jobs for the millions of people who have lost their jobs under the Bush Administration. This investment will specifically help unemployed construction workers. The number of unemployed private construction workers is 715,000—an 80 percent increase over the comparable period in the last year of the Clinton Administration. The unemployment rate for construction workers is now 8.3 percent—more than 68 percent higher than the rate in May 2000. A recent national survey found that transportation construction contractors hire employees within three weeks of obtaining a project contract. These employees begin receiving paychecks within two weeks of hiring. By giving priority to those projects that can award bids within 90 days of enactment, the bill ensures that this money is readily dispersed to needed projects that will get people working again.

This investment will also help address the disproportionate effect that the increase in unemployment has had on people of color. The rate of unemployment for African Americans is 10.8 percent—twice the rate for whites. The unemployment rate for Hispanic Americans is 8.2 percent—more than 50 percent higher than the rate for whites. Under the existing highway, transit, and aviation laws, as a general rule, states, cities, and transportation authorities are required to provide at least 10 percent of the amounts made available to Disadvantaged Business Enterprises, including minority and women-owned businesses, and $310 billion to our economy.

There are thousands of projects that are ready to begin construction in all sectors of our transportation and infrastructure systems. For example, a survey of the State Departments of Transportation by the American Association of State Highway and Transportation Officials found that, as of April 2003, the states have 2,710 projects, totaling $17.1 billion, that are ready to go to construction within 90 days if additional funding is made available.

Accordingly, the bill provides $5 billion in additional authority for Federal-aid highway capital investments and gives states the authority to obligate $5 billion of existing budget authority (contract authority) in state highway accounts. This proposal would create more than 237,500 jobs and $31 billion of economic activity.

Similarly, a survey of transit authorities by the American Public Transportation Association found that public transportation authorities have $12 billion in projects that are ready to go to construction within 90 days if additional funding is made available. Accordingly, the bill provides $3 billion in transit and operating grants and would create more than 142,500 jobs and $18.6 billion of economic activity.

In aviation, an Airliner Financial Surveillance Group survey of airport authorities estimates that $5 billion is needed to install explosive detection systems at U.S. airports. In addition, the Federal Aviation Administration has deferred millions of dollars for airport capacity and safety projects because of the lack of reinvestment in airport improvement program (AIP) funds to security projects. To address these issues, the bill provides $3 billion for airport development projects, including $2 billion for AIP grants to enhance airport safety, efficiency, and capacity and $1 billion for airport security improvements. The proposal would create more than 655,000 jobs and $86 billion of economic activity.

In the area of high-speed rail, there are currently several corridors that are completing environmental analyses of high-speed rail projects and are ready to go to construction. The bill provides funding for projects and for the acquisition and rehabilitation of rolling stock. With regard to the infrastructure needs of short line and regional railroads, a recent study concluded that it will take approximately $1 billion every year to keep the rail system in good working order and $250 million for grants to provide the credit risk premium for at least $5 billion in new capital investments to rehabilitate the track, bridges, and other elements of their infrastructure to enable them to carry the 286,000-pound railcar that is becoming the industry standard.

In order to address these needs, the bill provides $7.5 billion for capital investment for passenger and freight rail, including: $2.5 billion for capital investment for Amtrak; $500 million for direct grants for short-line and regional railroads to improve their infrastructure; and $250 million for grants to provide the credit risk premium for at least $5 billion in new capital investments to rehabilitate the track, bridges, and other elements of their infrastructure projects under the Railroad Rehabilitation and Improvement Financing (RRIF) program. This proposal would create more
more than 150 percent of the national average. These economically distressed communities and regions rely on federal investments to complete basic transportation and public infrastructure projects. The Economic Development Administration and existing regional commissions have no shortage of requests for assistance, but are woefully underfunded, and face drastic budget cuts under the Administration’s FY2004 budget proposal.

This bill addresses this severe underfunding by providing $1.5 billion in grants to economically distressed communities for economic development infrastructure projects. Grants are administered through the Economic Development Administration ($1 billion), the Appalachian Regional Commission ($150 million), the Delta Regional Authority ($150 million), and the Northern Great Plains Regional Commission ($150 million). This proposal would create more than 71,000 jobs and $9.3 billion of economic activity.

Further, the General Services Administration (GSA)-controlled inventory of 1,860 existing Federal buildings is aging and requires extensive repair and renovation to ensure that Federal employees are housed in safe, modern facilities. GSA estimates that it needs $5 billion over the next five years to fund the necessary repair and rehabilitation of Federal buildings and it currently has approximately 5,500 work items pending for repair and alteration. The bill provides $500 million for repair and alteration of Federal buildings and would create more than 23,000 jobs and $3.1 billion of economic activity.

This package of infrastructure, transportation, and environmental investment and security enhancement makes sound economic sense. It provides funds where they are needed most and will get America working again. Our Nation needs an economic stimulus program that creates jobs in hard hit sectors of our economy, rehabilitates our basic infrastructure to allow us to remain competitive in world markets, addresses the infrastructure security needs of our transportation and environmental systems, and helps to revive our stagnant economy. Let us start by passing this bill.

CONCERNING THE SAFETY, SECURITY, AND FREEDOM OF THE PEOPLE OF TAIWAN

HON. ROBERT E. ANDREWS
OF NEW JERSEY
IN THE HOUSE OF REPRESENTATIVES
Thursday, June 26, 2003

Mr. ANDREWS. Mr. Speaker, 54 years ago, on June 27, 1949, President Harry Truman deployed the U.S. Navy’s 7th Fleet to the Taiwan Strait to protect Taiwan against the possibility of an invasion by the People’s Republic of China, PRC. Since then, we have committed ourselves to defending Taiwan, as enshrined in the Taiwan Relations Act of 1979. President Bush himself declared in 2001 that America would do whatever it takes to defend Taiwan. In light of the threat posed by the PRC’s military buildup in Fukien, we must unequivocally stand by our promises to support Taiwan. America cannot afford to lose their safety, security, and freedom.

I rise today to call attention to an important resolution that I introduced today concerning the safety and security of Taiwan, and the right of Taiwan’s 23 million people to determine their own future. In the past 2 decades, Taiwan has undergone a remarkable transformation from a one party, martial law dictatorship to a full-fledged democracy that respects human rights and human freedoms. Twice, again, Taiwan has proven herself one of America’s staunchest allies, recently pledging her support for continued humanitarian aid to both Afghanistan and Iraq. At the same time, however, Taiwan’s democracy faces a serious military threat from the People’s Republic of China. The PRC continues to regard Taiwan as a renegade province, despite the fact that it has never exercised control over the island. The PRC continues to openly entertain the use of force against Taiwan, thereby jeopardizing the stability of the entire Asian Pacific region.

A Washington Post report of June 11, 2003, reveals the PRC’s plans to build up its military for the purpose of “unification with Taiwan.” Already, the PRC has set up 400 short-range ballistic missiles in the province of Fukien, directly targeted at Taiwan. The PRC is purchasing advanced weaponry systems, such as fighter aircrafts, submarines, and destroyers. The Washington Post reports that the PRC is accelerating its military acquisitions and notes that this buildup is “intended to create a force capable of bullying Taiwan and thwarting U.S. intervention in any conflict between China and Taiwan.” In other words, the PRC is preparing to use force and coercion to take over a territory it has no legal right to, and to impose its totalitarian ideology on a people who have fought long and hard for their freedom, and who have no wish to live under Communist rule.

The resolution I introduced today is a step towards protecting a fellow democracy from the threat of Chinese aggression. The resolution calls on the Bush administration to seek from the leaders of the PRC a public and immediate renunciation of any threat or use of force against Taiwan. This includes the dismantling of the Fukien missiles and other military apparatus designed to intimidate Taiwan. The administration must let the PRC government know that America will no longer tolerate the constant harassment targeted towards the people of Taiwan. If the PRC government refuses to dismantle the missiles, the administration should then authorize the release of the Taiwan system to Taiwan so as to enable Taiwan to defend itself against any Chinese attack.

Mr. Speaker, these PRC missiles in Fukien province are not conducive to a peaceful resolution of current Taiwanese-Chinese relations. We can not expect the people of Taiwan to live their daily lives under such threatening and uncertain conditions. In the name of democracy, we must ensure that the future of Taiwan is determined peacefully, and with the expressed consent of the Taiwanese people. Also, I urge both my colleagues and the administration to support Taiwanese efforts to hold a referendum vote on the issue of admittance into the World Health Organization,
WHO. The people of Taiwan deserve to have their voices heard in this ongoing debate, the outcome of which will have a monumental effect on their health and well-being. As the foremost promoter of freedom and democracy around the world, we cannot in good faith deter the people of Taiwan from holding their referendum. There can be no double standard when it comes to exercising democracy.

Mr. Speaker, no group but the citizenry of Taiwan has the right to determine the future of Taiwan. I ask that my colleagues join me in supporting democracy for the Taiwanese people, and ensuring their safety and security. Let us ensure that it will never be necessary to send the 7th Fleet to the Taiwan Strait again.
HIGHLIGHTS

Senate passed S. 1—Prescription Drug and Medicare Improvement Act.

House Committee ordered reported the Defense and Legislative appropriations for fiscal year 2004.

House Committees ordered reported 11 sundry measures.

House passed H.R. 1, Medicare Prescription Drug, Modernization, Health Savings and Affordability Act.


daily digest

Chamber Action

Routine Proceedings, pages S8605–S8645

Measures Introduced: Thirty-one bills and six resolutions were introduced as follows: S. 11, S. 1338–1367, S. Res. 187–190, and S. Con. Res. 56–57. (See next issue.)

Measures Reported:

S. 1025, to authorize appropriations for fiscal year 2004 for intelligence and intelligence-related activities of the United States Government, the Community Management Account, and the Central Intelligence Agency Retirement and Disability System, with amendments. (S. Rept. No. 108–80)


S. Res. 62, calling upon the Organization of American States (OAS) Inter-American Commission on Human Rights, the United Nations High Commissioner for Human Rights, the European Union, and human rights activists throughout the world to take certain actions in regard to the human rights situation in Cuba.

S. Res. 138, to amend rule XXII of the Standing Rules of the Senate relating to the consideration of nominations requiring the advice and consent of the Senate.

S. Res. 149, expressing the sense of the Senate that the international response to the current need for food in the Horn of Africa remains inadequate, and with an amended preamble.

S. Res. 174, designating Thursday, November 20, 2003, as “Feed America Thursday”.

S. Res. 175, designating the month of October 2003, as “Family History Month”.

S. Res. 178, to prohibit Members of the Senate and other persons from removing art and historic objects from the Senate wing of the Capitol and Senate office buildings for personal use.

S. 148, to provide for the Secretary of Homeland Security to be included in the line of Presidential succession. (See next issue.)

Measures Passed:

State Children’s Health Insurance Program Amend Act: Senate passed S. 312, to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children’s Health Insurance Program, after agreeing to the following amendment proposed thereto:

Grassley Amendment No. 1113, to make a technical correction. Pages S8633–35
Prescription Drug and Medicare Improvement Act: By yeas to nays (Vote No. 262), Senate passed S. 1, to amend title XVIII of the Social Security Act to make improvements in the Medicare program, to provide prescription drug coverage under the Medicare program, after agreeing to the committee amendment in the nature of a substitute, and after taking action on the following amendments proposed thereto: Pages S8605–33, S8635–44 (continued next issue)

Adopted:
Baucus (for Cantwell) Modified Amendment No. 942, to prohibit an eligible entity offering a Medicare Prescription Drug plan, a Medicare Advantage Organization offering a Medicare Advantage plan, and other health plans from contracting with a pharmacy benefit manager (PBM) unless the PBM satisfies certain requirements. Pages S8606, S8612–17

By 97 yeas to 1 nay (Vote No. 249), McConnell Amendment No. 1097, to protect seniors who are diagnosed with cancer from high prescription drug costs.

By 69 yeas to 29 nays (Vote No. 251), Bingaman/Domenici Modified Amendment No. 1065, to update, beginning in 2009, the asset or resource test used for purposes of determining the eligibility of low-income beneficiaries for premium and cost-sharing subsidies.

Nelson (FL) Amendment No. 936, to provide for an extension of the demonstration for ESRD managed care.

Nelson (FL) Amendment No. 938, to provide for a study and report on the propagation of concierge care.

Thomas/Lincoln Modified Amendment No. 988, to provide for the coverage of marriage and family therapist services and mental health counselor services under part B of the Medicare program.

Baucus (for Snowe) Amendment No. 1027, to express the sense of the Senate regarding the implementation of the Prescription Drug and Medicare Improvement Act of 2003.

Baucus (for Murkowski/Stevens) Amendment No. 1041, to require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project.

Subsequently, the adoption of Amendment No. 1041 (listed above) was vitiated.

By a unanimous vote of 98 yeas (Vote No. 252), McConnell Amendment No. 1102, to protect seniors who are diagnosed with Alzheimer’s disease from high prescription drug costs. Pages S8624, S8635–36

Subsequently, the amendment was modified. Page S8635

By 71 yeas to 26 nays (Vote No. 255), Grassley/Baucus Modified Amendment No. 1092, to evaluate alternative payment and delivery systems.

By 71 yeas to 26 nays (Vote No. 255), Grassley/Baucus Modified Amendment No. 1092, to evaluate alternative payment and delivery systems.

By 71 yeas to 26 nays (Vote No. 255), Grassley/Baucus Modified Amendment No. 1092, to evaluate alternative payment and delivery systems.

Baucus (for Dodd) Amendment No. 1015, to provide for a study on making prescription pharmaceutical information accessible for blind and visually-impaired individuals.

Grassley (for Hatch) Amendment No. 1059, to direct the Secretary of Health and Human Services to conduct a review and report on current standards of practice for pharmacy services provided to patients in nursing facilities.

Grassley (for Hatch/Wyden) Amendment No. 1106, to establish a Citizens Health Care Working Group to facilitate public debate about how to improve the health care system for Americans and to provide for hearings by Congress on the recommendations that are derived from this debate.

Grassley (for Murkowski) Amendment No. 1086, to ensure that pharmacies operated by the Indian Health Service and Indian health programs are included in the network of pharmacies established by entities and organizations under part D.

Baucus (for Mikulski) Modified Amendment No. 1033, to extend certain municipal health service demonstration projects.

Baucus (for Lincoln) Modified Amendment No. 1067, to provide coverage for kidney disease education services under the Medicare program.

Lincoln Amendment No. 959, to establish a demonstration project for direct access to physical therapy services under the Medicare program.

Lincoln Amendment No. 935, to clarify the intent of Congress regarding an exception to the initial residency period for geriatric residency or fellowship programs.

Reid (for Jeffords) Amendment No. 1038, to improve the critical access hospital program.

Reid (for Johnson/Cochran) Amendment No. 1095, to provide for a 1-year medication therapy management assessment program.

Grassley (for Murkowski/Stevens) Amendment No. 1096, to require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project.
Grassley (for Brownback/Nelson (NE)) Amendment No. 1122, to provide for improvements in access to services in rural hospitals and critical access hospitals.  
(See next issue.)

Grassley (for Coleman) Amendment No. 1074, to amend title XVIII of the Social Security Act to make improvements in the national coverage determination process to respond to changes in technology.  
(See next issue.)

Grassley (for Collins) Amendment No. 1023, to provide for the establishment of a demonstration project to clarify the definition of homebound.  
(See next issue.)

Grassley (for Kyl) Amendment No. 1114, to require the GAO to study the impact of price controls on pharmaceuticals.  
(See next issue.)

Grassley (for Kyl) Amendment No. 1115, to express the sense of the Senate concerning Medicare payments to physicians and other health professionals.  
(See next issue.)

Grassley (for Chambliss) Amendment No. 1045, to provide for a demonstration project for the exclusion of brachytherapy devices from the prospective payment system for outpatient hospital services.  
(See next issue.)

Grassley (for Craig) Amendment No. 1058, to restore the Federal Hospital Insurance Trust Fund to the financial position it would have been in if a clerical bookkeeping error had not occurred.  
(See next issue.)

Grassley (for Baucus) Amendment No. 1117, to establish the Safety Net Organizations and Patient Advisory Commission.  
(See next issue.)

Grassley (for Bayh) Amendment No. 1044, to adjust the urban health provider payment.  
(See next issue.)

Grassley (for Shelby) Amendment No. 1056, to prevent the Secretary of Health and Human Services from modifying the treatment of certain long-term care hospitals as subsection (d) hospitals.  
(See next issue.)

Grassley (for Murray) Modified Amendment No. 961, to make improvements in the Medicare-Advantage benchmark determinations.  
(See next issue.)

Grassley (for Bond/Roberts) Amendment No. 1013, to ensure that patients are receiving safe and accurate dosages of compounded drugs.  
(See next issue.)

Grassley (for Kyl) Amendment No. 1121, to express the sense of the Senate concerning the structure of Medicare reform and the prescription drug benefit to ensure Medicare’s long-term solvency and high quality of care.  
(See next issue.)

Grassley (for Collins) Modified No. 989, to increase Medicare payments for home health services furnished in a rural area.  
(See next issue.)

Grassley (for Doles/Edwards) Amendment No. 1126, to provide for the treatment of certain entities for purposes of payments under the Medicare program.  
(See next issue.)

Grassley (for Reed) Amendment No. 996, to modify the GAO study of geographic differences in payments for physicians’ services relating to the work geographic practice cost index.  
(See next issue.)

Grassley (for Specter) Amendment No. 1118, to express the sense of the Senate regarding the establishment of a nationwide permanent lifestyle modification program for Medicare beneficiaries.  
(See next issue.)

Grassley (for Specter) Amendment No. 1085, to express the sense of the Senate regarding payment reductions under the Medicare physician fee schedule.  
(See next issue.)

Allard/Feingold Amendment No. 1017, to provide for temporary suspension of OASIS requirement for collection of data on non-Medicare and non-Medicaid patients.  
Pages S8608–09

Baucus (for Harkin) Amendment No. 968, to restore reimbursement for total body orthotic management for nonambulatory, severely disabled nursing home residents.  
Page S8606

Graham (SC) Modified Amendment No. 948, to provide for the establishment of a National Bipartisan Commission on Medicare Reform.  
Page S8606

Dayton Modified Amendment No. 960, to require a streamlining of the Medicare regulations.  
Page S8606

Baucus (for Feingold) Amendment No. 1054, to establish an Office of the Medicare Beneficiary Advocate.  
Page S8612

Enzi Amendment No. 1030, to encourage the availability of Medicare-Advantage benefits in medically underserved areas.  
Page S8606

Grassley Amendment No. 1133, to provide for a managers’ amendment.  
(See next issue.)

Rejected:

Harkin Modified Amendment No. 991, to establish a demonstration project under the Medicaid program to encourage the provision of community-based services to individuals with disabilities. (By 50 yeas to 48 nays (Vote No. 247), Senate tabled the amendment.)  
Pages S8606–09

By 39 yeas to 59 nays (Vote No. 248), Edwards/ Harkin Amendment No. 1052, to strengthen protections for consumers against misleading direct-to-consumer drug advertising.  
Pages S8606, S8609–10

Reid (for Boxer) Amendment No. 1036, to eliminate the coverage gap for individuals with cancer.
Durbin Amendment No. 1108, to provide additional assistance for certain eligible beneficiaries under part D. (By 57 yeas to 41 nays (Vote No. 253), Senate tabled the amendment.)

Pages S8606, S8622

Kerry Amendment No. 958, to increase the availability of discounted prescription drugs.

Pages S8606

Lincoln Modified Amendment No. 934, to ensure coverage for syringes for the administration of insulin, and necessary medical supplies associated with the administration of insulin.

Pages S8606

Baucus (for Jeffords) Amendment No. 964, to include coverage for tobacco cessation products.

Pages S8606


Pages S8606

Akaka Amendment No. 980, to expand assistance with coverage for legal immigrants under the Medicaid program and SCHIP to include citizens of the Freely Associated States.

Pages S8606

Akaka Amendment No. 979, to ensure that current prescription drug benefits to Medicare-eligible enrollees in the Federal Employees Health Benefits Program will not be diminished.

Pages S8606

Bingaman Amendment No. 973, to amend title XVIII of the Social Security Act to provide for the authorization of reimbursement for all Medicare part B services furnished by certain Indian hospitals and clinics.

Pages S8606

Baucus (for Lautenberg) Amendment No. 986, to make prescription drug coverage available beginning on July 1, 2004.

Pages S8606

Murray Amendment No. 990, to make improvements in the MedicareAdvantage benchmark determinations.

Pages S8606

Dayton Amendment No. 977, to require that benefits be made available under part D on January 1, 2004.

(See next issue.)

Baucus (for Dorgan) Amendment No. 993, to amend title XVIII of the Social Security Act to provide for coverage of cardiovascular screening tests under the Medicare program.

Pages S8606

Smith/Bingaman Amendment No. 962, to provide reimbursement for Federally qualified health centers participating in Medicare managed care.

Pages S8606

Hutchison Amendment No. 1004, to amend title XVIII of the Social Security Act to freeze the indirect medical education adjustment percentage under the Medicare program at 6.5 percent.

Pages S8606

Conrad Amendment No. 1019, to provide for coverage of self-injected biologicals under part B of the Medicare program until Medicare Prescription Drug plans are available.

Pages S8606

Conrad Amendment No. 1020, to permanently and fully equalize the standardized payment rate beginning in fiscal year 2004.

Pages S8606
Conrad Amendment No. 1021, to address Medicare payment inequities.

Clinton Amendment No. 999, to provide for the development of quality indicators for the priority areas of the Institute of Medicine, for the standardization of quality indicators for Federal agencies, and for the establishment of a demonstration program for the reporting of health care quality data at the community level.

Clinton Amendment No. 953, to provide training to long-term care ombudsman.

Clinton Amendment No. 954, to require the Secretary of Health and Human Services to develop literacy standards for informational materials, particularly drug information.

Reid (for Corzine) Modified Amendment No. 1037, to provide conforming changes regarding federally qualified health centers.

Reid (for Inouye) Amendment No. 1039, to amend title XIX of the Social Security Act to provide 100 percent reimbursement for medical assistance provided to a Native Hawaiian through a Federally-qualified health center or a Native Hawaiian health care system.

Enzi/Lincoln Amendment No. 1051, to ensure convenient access to pharmacies and prohibit the tying of contracts.

Hagel/Ensign Amendment No. 1012, to provide Medicare beneficiaries with an additional choice of Medicare Prescription Drug plans under part D that consists of a drug discount card and protection against high out-of-pocket drug costs.

Baucus (for Akaka) Amendment No. 1061, to provide for treatment of Hawaii as a low-DSH State for purposes of determining a Medicaid DSH allotment for the State for fiscal years 2004 and 2005.

Stabenow/Levin Amendment No. 1075, to permanently extend a moratorium on the treatment of a certain facility as an institution for mental diseases.

Stabenow/Levin Amendment No. 1076, to provide for the treatment of payments to certain comprehensive cancer centers.

Stabenow/Levin Amendment No. 1077, to provide for the redistribution of unused resident positions.

Enzi/Lincoln Amendment No. 1024, to amend title XVIII of the Social Security Act to repeal the Medicare outpatient rehabilitation therapy caps.

Smith/Feingold Amendment No. 1073, to allow the Secretary to include in the definition of ‘specialized Medicare+Choice plans for special needs beneficiaries’ plans that disproportionately serve such special needs beneficiaries or frail, elderly Medicare beneficiaries.

Baucus (for Mikulski) Amendment No. 1088, to provide equitable treatment for children's hospitals.

Baucus (for Mikulski) Amendment No. 1089, to provide equitable treatment for certain children's hospitals.

Baucus (for Mikulski) Amendment No. 1090, to permit direct payment under the Medicare program for clinical social worker services provided to residents of skilled nursing facilities.

Baucus (for Mikulski) Amendment No. 1091, to extend certain municipal health service demonstration projects.

Baucus (for Levin) Amendment No. 1110, to ensure that beneficiaries initially covered by a private insurer under this act who are subsequently covered by a Medicare fallback plan have the option of retaining a Medicare fallback plan.

Baucus (for Murkowski/Stevens) Amendment No. 1041, to require the Secretary of Health and Human Services to conduct a frontier extended stay clinic demonstration project.

A unanimous-consent agreement was reached providing that following passage of S. 1 (listed above), the bill be held at the desk, and when the Senate receives H.R. 1, House companion measure, all after the enacting clause be stricken and the text of S. 1 be inserted in lieu thereof; Senate insisted on its amendment, request a conference with the House thereon, and the Chair be authorized to appoint conference on the part of the Senate; providing further, passage of S. 1 be vitiated and the bill be returned to the Senate Calendar.

Check Truncation Act: Senate passed H.R. 1474, to facilitate check truncation by authorizing substitute checks, to foster innovation in the check collection system without mandating receipt of checks in electronic form, and to improve the overall efficiency of the Nation’s payments system, after striking all after after the enacting clause and inserting the text of S. 1334, Senate companion measure.

Subsequently, S. 1334 was returned to the Senate Calendar.

Commending August Hiebert: Senate agreed to S. Res. 186, commending August Hiebert for his service to the Alaska Communications Industry.

Rhodes Scholarships: Senate agreed to S. Res. 187, expressing the sense of the Senate regarding the centenary of the Rhodes Scholarships in the United States and the establishment of the Mandela Rhodes Foundation.
Honoring Maynard Holbrook Jackson, Jr.: Senate agreed to S. Res. 188, honoring Maynard Holbrook Jackson, Jr., former Mayor of the City of Atlanta, and extending the condolences of the Senate on his death. 

(See next issue.)

Commending General Eric Shinseki: Senate agreed to S. Res. 190, commending General Eric Shinseki of the United States Army for his outstanding service and commitment to excellence. 

(See next issue.)

Adjournment Resolution—Agreement: A unanimous-consent agreement was reached providing that when the Senate receives an adjournment resolution from the House, it be agreed to, providing that the text is identical to the resolution being held at the desk. 

(See next issue.)

Nominations Confirmed: Senate confirmed the following nominations:

Joshua B. Bolten, of the District of Columbia, to be Director of the Office of Management and Budget. 

(See next issue.)

Nominations Received: Senate received the following nominations:

Rick A. Dearborn, of Oklahoma, to be an Assistant Secretary of Energy (Congressional and Intergovernmental Affairs). 

Scott J. Bloch, of Kansas, to be Special Counsel, Office of Special Counsel, for the term of five years. 

Penrose C. Albright, of Virginia, to be an Assistant Secretary of Homeland Security. (New Position)

Rene Acosta, of Virginia, to be an Assistant Attorney General

Routine lists in the Army. 

Messages From the House: 

(See next issue.)

Measures Referred: 

(See next issue.)

Measures Placed on Calendar: 

(See next issue.)

Measures Read First Time: 

(See next issue.)

Executive Communications: 

(See next issue.)

Committee Meetings

(Committees not listed did not meet)

HEALTHY FORESTS RESTORATION ACT

Committee on Agriculture, Nutrition, and Forestry: Committee concluded hearings to examine H.R. 1904, to improve the capacity of the Secretary of Agriculture and the Secretary of the Interior to plan and conduct hazardous fuels reduction projects on National Forest System lands and Bureau of Land Management lands aimed at protecting communities, watersheds, and certain other at-risk lands from catastrophic wildfire, to enhance efforts to protect watersheds and address threats to forest and rangeland health, including catastrophic wildfire, across the landscape, after receiving testimony from Senator McCain; Mark Rey, Under Secretary of Agriculture for Natural Resources and the Environment; Lynn Scarlett, Assistant Secretary of the Interior for Policy, Management, and Budget; Michael Carroll, Minnesota State Forester, St. Paul, on behalf of the National Association of State Foresters; Frederick M. Stephen, University of Arkansas, Fayetteville, on behalf of the Society of American Foresters; Tom Nelson, Sierra Pacific Industries, Redding, California, on behalf of the American Forest and Paper Association; Jacquellin L. McAvoy, City Council, Post Falls, Idaho, on behalf of the Idaho Women in Timber; Michael Petersen, The Lands Council, Spokane, Washington; Norman L. Christensen, Jr., Duke University Nicholas School of the Environment and Earth Sciences, Durham, North Carolina; Hal Salwasser, Oregon State University Department of Forest Resources, Corvallis; Donald J. Kochan, George Mason University School of Law, Arlington, Virginia; and Patrick Parenteau, Vermont Law School, South Royalton.

APPROPRIATIONS—LABOR/HHS/EDUCATION AND MILITARY CONSTRUCTION

Committee on Appropriations: Committee ordered favorably reported the following business bills: 

An original bill (S. 1356) making appropriations for the Departments of Labor, Health and Human Services, and Education and related agencies for the fiscal year ending September 30, 2004; and

An original bill (S. 1357) making appropriations for military construction, family housing, and base

FAIR CREDIT REPORTING ACT
Committee on Banking, Housing, and Urban Affairs: Committee concluded hearings to examine affiliate sharing practices in relation to the Fair Credit Reporting Act, focusing on privacy protections, security risks and threats to the credit reporting system, retail credit card programs, and merchandise returns, after receiving testimony from Vermont Assistant Attorney General Julie Brill, Montpelier; Joel R. Reidenberg, Fordham University School of Law, and Martin Wong, Citigroup, Inc., both of New York, New York; Ronald A. Prill, Target Financial Services, Minneapolis, Minnesota, on behalf of the National Retail Federation; Edmund Mierzwinski, U.S. Public Interest Research Group, Washington, D.C.; Terry Baloun, Wells Fargo Bank, Sioux Falls, South Dakota; and Angela Maynard, Keycorp, Cleveland, Ohio.

BUSINESS MEETING
Committee on Commerce, Science, and Transportation: Committee ordered favorably reported the following business items:

S. 1264, to reauthorize the Federal Communications Commission, with amendments;
H.R. 1320, to amend the National Telecommunications and Information Administration Organization Act to facilitate the reallocation of spectrum from governmental to commercial users, with an amendment;
An original bill to authorize funds for highway safety programs, motor carrier safety programs, hazardous materials transportation safety programs, and boating safety programs;
S. 1262, to authorize appropriations for fiscal years 2004, 2005, and 2006 for certain maritime programs of the Department of Transportation, with amendments; and
S. 1218, to provide for Presidential support and coordination of interagency ocean science programs and development and coordination of a comprehensive and integrated United States research and monitoring program, with an amendment in the nature of a substitute.

NOMINATIONS:
Committee on Finance: Committee concluded hearings to examine the nominations of Josette Sheeran Shiner, of Virginia, to be a Deputy United States Trade Representative, with the rank of Ambassador, and James J. Jochum, of Virginia, to be an Assistant Secretary of Commerce, after each nominee testified and answered questions in their own behalf.

Committee on Foreign Relations: Committee ordered favorably reported the following business items:

S. Res. 90, expressing the sense of the Senate that the Senate strongly supports the nonproliferation programs of the United States, with an amendment;
S. Res. 62, calling upon the Organization of American States (OAS) Inter-American Commission on Human Rights, the United Nations High Commissioner for Human Rights, the European Union, and human rights activists throughout the world to take certain actions in regard to the human rights situation in Cuba;
S. Res. 149, expressing the sense of the Senate that the international response to the current need for food in the Horn of Africa remains inadequate, with an amendment; and
The nominations of Robert W. Fitts, of New Hampshire, to be Ambassador to Papua New Guinea, and to serve concurrently and without additional compensation as Ambassador to the Solomon Islands and Ambassador to the Republic of Vanuatu, Marsha E. Barnes, of Maryland, to be Ambassador to the Republic of Suriname, John E. Herbst, of Virginia, to be Ambassador to Ukraine, Tracey Ann Jacobson, of the District of Columbia, to be Ambassador to Turkmenistan, George A. Krol, of New Jersey, to be Ambassador to the Republic of Belarus, John F. Maisto, of Pennsylvania, to be Permanent Representative of the United States of America to the Organization of American States, with the rank of Ambassador, Greta N. Morris, of California, to be Ambassador to the Republic of the Marshall Islands, Roger Francisco Noriega, of Kansas, to be an Assistant Secretary of State (Western Hemisphere Affairs), William B. Wood, of New York, to be Ambassador to the Republic of Colombia, and certain Foreign Service Officer promotion lists.

INTERNATIONAL PARENTAL ABDUCTION
Committee on Foreign Relations: Committee concluded hearings to examine the Department of State's Office of Children's Issues, focusing on responding to international parental abduction, after receiving testimony from Senator Lincoln; and Maura Harty, Assistant Secretary of State, Bureau of Consular Affairs.

NOMINATIONS:
Committee on Governmental Affairs: Committee ordered favorably reported the nominations of Judith Nan Macaluso, to be an Associate Judge of the Superior Court of the District of Columbia; Fern Flanagan Macaluso, to be an Associate Judge of the Superior Court of the District of Columbia; and Joshua B. Bolten, of the District of Columbia, to be Director of the Office of Management and Budget.
BUSINESS MEETING

Committee on Indian Affairs: Committee ordered favorably reported the following business items:

S. 281, to amend the Transportation Equity Act for the 21st Century to make certain amendments with respect to Indian tribes, to provide for training and technical assistance to Native Americans who are interested in commercial vehicle driving careers, with an amendment in the nature of a substitute; and

The nominations of Lisa Genevieve Nason, of Alaska, Georgianna E. Ignace, of Wisconsin, John Richard Grimes, of Massachusetts, each to be a Member of the Board of Trustees of the Institute of American Indian and Alaska Native Culture and Arts Development, and Charles W. Grim, of Oklahoma, to be Director of the Indian Health Service, Department of Health and Human Services.

BUSINESS MEETING

Committee on the Judiciary: Committee ordered favorably reported the following business items:

S. Res. 174, designating Thursday, November 20, 2003, as “Feed America Thursday”;

S. Res. 175, designating the month of October 2003, as “Family History Month”; and

The nominations of Diane M. Stuart, of Utah, to be Director of the Violence Against Women Office, Department of Justice; and Thomas M. Hardiman, to be United States District Judge for the Western District of Pennsylvania.

Also, committee resumed markup of S. 1125, to create a fair and efficient system to resolve claims of victims for bodily injury caused by asbestos exposure, but did not complete action thereon, and recessed subject to call.

GROWING WAHHABI INFLUENCE

Committee on the Judiciary: Subcommittee on Terrorism, Technology, and Homeland Security concluded hearings to examine the ideological structure of Wahhabism, an extreme and violent form of Islam, and its potential for political and social influence in the United States, after receiving testimony from David Aufhauser, General Counsel, Department of the Treasury; Larry A. Mefford, Assistant Director, Counterterrorism Division, Federal Bureau of Investigation, Department of Justice; and Alex Alexiev, Center for Security Policy, and Stephen Schwartz, Foundation for Defense of Democracies, both of Washington, D.C.

House of Representatives

Chamber Action

Measures Introduced: Measures introduced will appear in the next issue of the Record.

Additional Cosponsors: (See next issue.)

Reports Filed: Reports were filed today as follows:

H.R. 438, to increase the amount of student loans that may be forgiven for teachers in mathematics, science, and special education, amended (H. Rept. 108–182);

H.R. 2211, to reauthorize title II of the Higher Education Act of 1965, amended (H. Rept. 108–183);

H.R. 2210, to reauthorize the Head Start Act to improve the school readiness of disadvantaged children, amended (H. Rept. 108–184); and

H.R. 74, to direct the Secretary of Agriculture to convey certain land in the lake Tahoe Basin Management Unit, Nevada, to the Secretary of the Interior, in trust for the Washoe Indian Tribe of Nevada and California (H. Rept. 108–185). (See next issue.)

Guest Chaplain: The prayer was offered by the guest Chaplain, Rabbi Milton Balkany, Dean, Bais Yaakov of Brooklyn, New York.

Journal: Agreed to the Speaker’s approval of the Journal of June 25 by yea-and-nay vote of 357 yeas to 68 nays, Roll No. 327.


Agreed To:

Hastings of Florida amendment No. 4 printed in H. Rept. 108–176, debated on June 25, that directs the Director of Central Intelligence to establish a pilot project to improve recruitment of ethnic and cultural minorities and women with diverse skills
and language abilities (agreed to by recorded vote of 418 ayes with none voting “no”, Roll No. 318; Pages H5943–44

Rejected:
Kucinich amendment No. 5 printed in H. Rept. 108–176, debated on June 25, that sought to direct the Inspector General of the Central Intelligence Agency to conduct an audit of all communications between the CIA and the Office of the Vice President that relate to weapons of mass destruction obtained or developed by Iraq (rejected by recorded vote of 76 ayes to 347 noes, Roll No. 319); and Pages H5944–45

Lee amendment No. 6 printed in H. Rept. 108–176, debated on June 25, that sought to require a GAO study on intelligence sharing by the Department of Defense and intelligence community with United Nations inspectors searching for weapons of mass destruction (rejected by recorded vote of 185 ayes to 239, Roll No. 320).

H. Res. 295, the rule that provided for consideration of the bill was agreed to on June 25. Page H5946

Recess: The House recessed at 11:48 a.m. and reconvened at 12:53 p.m. Pages H5951–52

Motions to Suspend the Rules on Wednesdays During the Remainder of the One Hundred Eighth Congress: The House agreed to H. Res. 297, providing for motions to suspend the rules by recorded vote of 226 ayes to 203 noes, Roll No. 323. Pages H5946–51, H5973–74

Late Report: The Committee on Appropriations received permission to have until midnight to file a privileged report making appropriations for the Legislative Branch for the fiscal year ending September 30, 2004. Page H5979


Rejected the Obey motion to recommit the bill to the Committee on Appropriations. Earlier, a point of order was sustained against another Obey motion that sought to recommit the bill to the Committee on Appropriations with instructions to report it back forthwith with an amendment that increases funding for various programs including fitness facilities, family housing, and barracks. Page H5986

Point of order was sustained against the Obey amendment that sought to reinstate funding for various programs including fitness facilities, family housing, and barracks. Pages H5989–90

Earlier, the House agreed to H. Res. 298, the rule that provided for consideration of the bill by voice vote. Agreed to order the previous question by yeaa-and-nay vote of 220 yeas to 200 nays, Roll No. 324. Pages H5978–79

Suspension—Support for Freedom in Hong Kong: The House agreed to suspend the rules and agree to H. Res. 277, expressing support for freedom in Hong Kong (agreed to by 2/3 yea-and-nay vote of 426 yeas to 1 nay, Roll No. 326). The motion was debated on June 25. Pages H5990–91

Order of Business—DoD Appropriations: Agreed that it be in order on Tuesday, July 8, for the Speaker, as though pursuant to clause 2(b) of rule 18, to declare the House resolved into the Committee of the Whole House on the state of the Union for consideration of a bill reported pursuant to section 6 of H. Res. 299, making appropriations for the Department of Defense for the fiscal year ending September 30, 2004, which shall proceed according to the following order: the first reading shall be dispensed with; all points of order against consideration of the bill are waived; general debate shall be confined to the bill and shall not exceed one hour equally divided and controlled by the chairman and ranking minority member of the Committee on Appropriations; after general debate the bill shall be considered for amendment under the five-minute rule; points of order against provisions in the bill for failure to comply with clause 2 of rule XXI are waived; during consideration of the bill for amendment, the Chairman of the Committee of the Whole may accord priority in recognition on the basis of whether the member offering an amendment has caused it to be printed in the portion of the Congressional Record designated for that purpose in clause 8 of rule XVIII. Amendments so printed shall be considered as read. At the conclusion of consideration of the bill for amendment the Committee shall rise and report the bill to the House with such amendments as may have been adopted. The previous question shall be considered as ordered on the bill and amendments thereto to final passage without intervening motion except one motion to recommit with or without instructions. Page H5992

State Children’s Health Insurance Program (SCHIP) Allotments: The House passed H.R. 531, to amend title XXI of the Social Security Act to extend the availability of allotments for fiscal years 1998 through 2001 under the State Children’s Health Insurance Program (SCHIP) by unanimous consent. Pages H6006–07

Medicare Prescription Drug, Modernization, Health Savings and Affordability Act: The House passed H.R. 1, to amend title XVIII of the Social
Security Act to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program and to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements by 216 ayes to 215 noes with 1 voting “present,” Roll No. 332.

Pursuant to Section 3 of the rule in the engrossment of H.R. 1, the Clerk shall add the text of H.R. 2596, as passed by the House as a new matter at the end of H.R. 1, conform the title of H.R. 1 to reflect the addition of the text of H.R. 2596 to the engrossment, and then lay H.R. 2596 on the table.

Rejected the Thompson of California motion to recommit the bill jointly to the Committee on Ways and Means and the Committee on Energy and Commerce with instructions to report the same back to the House promptly with amendments in the nature of a substitute that establishes the Prescription Drug and Medicare Improvement Act. By recorded vote of 208 ayes to 223 noes, Roll No.

Rejected the Rangel amendment in the nature of a substitute numbered 1 printed in H. Rept. 108–181 that sought to provide prescription drug coverage for all Medicare beneficiaries, enhance Medicare+Choice plans, includes payments for oncology providers and related cancer drug therapy programs; improve rural health delivery; and implement various provisions dealing with Medicare Parts A and B, Medicaid, regulatory reduction and the re-importation of prescription drugs by recorded vote of 176 ayes to 255 noes with 1 voting “present”, Roll No. 330.

H. Res. 299, the rule that providing for consideration of both H.R. 1, Medicare Prescription Drug and Modernization Act, and H.R. 2596, Health Savings and Affordability Act was agreed to by recorded vote of 221 ayes to 203 noes, Roll No. 322. Earlier agreed to order the previous question by yea-and-nay vote of 226 yeas to 203 nays, Roll No. 321.

Health Savings and Affordability Act: The House passed H.R. 2596, to amend the Internal Revenue Code of 1986 to allow a deduction to individuals for amounts contributed to health savings security accounts and health savings accounts, to provide for the disposition of unused health benefits in cafeteria plans and flexible spending arrangements by yea-and-nay vote of 237 yeas to 191 nays, Roll No. 328.

Section 3 of H. Res. 299, the rule providing for consideration of the bill, provides that in the engrossment of H.R. 1, the clerk shall add the text of H.R. 2596, as passed by the House as a new matter at the end of H.R. 1, and then lay H.R. 2596 on the table.

Independence Day District Work Period: The House agreed to H. Con. Res. 231, providing for a conditional adjournment of the House of Representatives and a conditional recess or adjournment of the Senate.

Senate Concurrence in Adjournment Resolution: Agreed that when the House adjourns today, it adjourn to meet at 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its concurrence in H. Con. Res. 231, in which case the House shall stand adjourned pursuant to that concurrent resolution.

Calendar Wednesday: Agreed to dispense with the Calendar Wednesday business of Wednesday, July 9.

Speaker Pro Tempore: Read a letter from the Speaker wherein he appointed Representative Tom Davis of Virginia to act as Speaker pro tempore to sign enrolled bills and joint resolutions through Monday, July 7.

Senate Messages: Messages received from the Senate today appear on pages H5941, and H5992.

Referrals: S. 163 was referred to the Committees on Education and the Workforce and Resources, S. 498 was referred to the Committee on Financial Services, S. 867 was referred to the Committee on Government Reform, and S. 1207 and S. 312 were held at the desk.

Call of the House: On the Call of the House, 421 members reported their presence, Roll No. 329.


Adjournment: The House met at 10 a.m. and at 2:47 a.m. on Friday, June 27, pursuant to the provisions of H. Con. Res. 231, the House stands adjourned until 2 p.m. on Tuesday, July 1, 2003, unless it sooner has received a message from the Senate transmitting its adoption of H. Con. Res. 231, in which case the House shall stand adjourned pursuant
to that concurrent resolution until 2 p.m. on Monday, July 7.

**Committee Meetings**

**MANDATORY COUNTRY OF ORIGIN LABELING LAW REVIEW**

Committee on Agriculture: Held a hearing to review the mandatory country of origin labeling law. Testimony was heard from the following officials of the USDA: Charles Lambert, Deputy Under Secretary, Marketing and Regulatory Programs; Nancy Bryson, General Counsel; and Keith Collins, Chief Economist; and public witnesses.

**DEFENSE AND LEGISLATIVE APPROPRIATIONS**

Committee on Appropriations: Ordered reported the following appropriations for fiscal year 2004: Defense and Legislative.

**FOREIGN RELATIONS AUTHORIZATION ACT**


**FINANCIAL MAINSTREAM—BROADEN ACCESS**

Committee on Financial Services: Subcommittee on Financial Institutions and Consumer Credit held a hearing entitled “Serving the Underserved: Initiatives to Broaden Access to the Financial Mainstream.” Testimony was heard from Wayne Abernathy, Assistant Secretary, Financial Institutions, Department of the Treasury; Dennis Dollar, Chairman, National Credit Union Administration; and public witnesses.

**COMPETITIVE SOURCING FOR 21ST CENTURY**

Committee on Government Reform: Held a hearing titled “New Century, New Process: A Preview of Competitive Sourcing for the 21st Century.” Testimony was heard from David M. Walker, Comptroller, GAO; Angela Styles, Director, Office of Federal Procurement Policy, OMB; Philip Grone, Principal Assistant Deputy Under Secretary, Installations and Environment, Department of Defense; Scott J. Cameron, Deputy Assistant Secretary, Performance and Management, Department of the Interior; and public witnesses.

**ASIA AND THE PACIFIC—U.S. SECURITY POLICY**

Committee on International Relations: Subcommittee on East Asia and the Pacific held a hearing on U.S. Security Policy in Asia and the Pacific: Restructuring America’s Forward Deployment. Testimony was heard from the following officials of the Department of Defense: Peter Rodman, Assistant Secretary, International Security Affairs; and Adm. Thomas B. Fargo, USN, Commander, U.S. Pacific Command; and Christopher LaFleur, Special Envoy, Northeast Asia Security Consultations, Bureau of East Asian and Pacific Affairs, Department of State.

**AMERICAN SERVICEMEMBERS’ PROTECTION ACT AMENDMENTS**

Committee on International Relations: Subcommittee on Europe approved for full Committee action H.R. 2550, to amend the American Servicemembers’ Protection Act of 2002 to provide clarification with respect to the eligibility of certain countries for United States military assistance.

**HOMETOWN HEROES SURVIVORS BENEFITS**

Committee on the Judiciary: Subcommittee on Crime, Terrorism, and Homeland Security held a hearing on H.R. 919, Hometown Heroes Survivors Benefits. Testimony was heard from Michael E. Williams, Jr., Fire Rescue Training Specialist, Office of the State Fire Marshall, Department of Insurance, State of North Carolina; and public witnesses.

**OVERSIGHT—CONSULAR IDENTIFICATION CARDS**

Committee on the Judiciary: Subcommittee on Immigration, Border Security, and Claims held an oversight hearing on “The Federal Government’s Response to the Issuance and Acceptance in the U.S. of Consular Identification Cards.” Testimony was heard from Roberta S. Jacobson, Acting Deputy Assistant Secretary, Bureau of Western Hemisphere Affairs, Department of State; Steven McGraw, Assistant Director, Office of Intelligence, FBI, Department of Justice; C. Stewart Verdery, Assistant Secretary, Policy and Planning, Border and Transportation Security Directorate, Department of Homeland Security; and a public witness.

**MISCELLANEOUS MEASURES**

Committee on Resources: Subcommittee on Fisheries Conservation, Wildlife and Oceans held a hearing on the following bills: H.R. 1204, to amend the National Wildlife Refuge System Administration Act of 1966 to establish requirements for the award of concessions in the National Wildlife Refuge System, to provide for maintenance and repair of properties located in the System by concessionaires authorized to use such properties; and H.R. 2408, National Wildlife Refuge Volunteer Act of 2003. Testimony was heard from Marshall P. Jones, Jr., Deputy Director, U.S. Fish and Wildlife Service, Department of the Interior; and public witnesses.
NASA FLEXIBILITY ACT
Committee on Science: Subcommittee on Space and Aeronautics approved for full Committee action, as amended, H.R. 1085, NASA Flexibility Act of 2003.

COMPUTER RESERVATION SYSTEMS REGULATIONS AND SMALL BUSINESS—TRAVEL INDUSTRY
Committee on Small Business: Subcommittee on Regulatory Reform and Oversight held a hearing entitled: “CRS Regulations and Small Business in the Travel Industry” Testimony was heard from Tom Sullivan, Chief Counsel, Office of Advocacy, SBA; and public witnesses.

NATIONAL RAIL INFRASTRUCTURE FINANCING PROPOSALS
Committee on Transportation and Infrastructure: Subcommittee on Railroads held an oversight hearing on National Rail Infrastructure Financing Proposals. Testimony was heard from the following officials of the Department of Transportation: Allan Rutter, Administrator, Federal Railroad Administration; and Roger Nober, Chairman, Surface Transportation Board; Joseph Boardman, Commissioner, Department of Transportation, State of New York; and public witnesses.

VETERAN’S LEGISLATION
Committee on Veterans’ Affairs: Ordered reported the following measures: H.R. 1516, as amended, National Cemetery Expansion Act of 2003; H.R. 2297, as amended, Veterans Benefits Act of 2003; H.R. 116, as amended, Veterans’ New Fitzsimons Health Care Facilities Act of 2003; H.R. 1720, as amended, Veterans Health Care Facilities Capital Improvement Act; H.R. 2357, as amended, to amend title 38, United States Code, to establish standards of access to care for veterans seeking health care from the Department of Veterans Affairs; H.R. 2433, as amended, Health Care for Veterans of Project 112/Project SHAD Act of 2003; H.R. 2595, to restore the operation of the Native American Veteran Housing Loan Program during fiscal year 2003 to the scope of that program as in effect on September 30, 2002; and H. Con. Res. 159, declaring Emporia, Kansas, to be the founding city of the Veterans Day holiday and recognizing the contributions of Alvin J. King and Representative Ed Rees to the enactment into law of the observance of Veterans Day.

PROJECT BIOSHIELD ACT

NEW PUBLIC LAWS
(For last listing of Public Laws, see DAILY DIGEST, p. D713 )

COMMITTEE MEETINGS FOR FRIDAY,
JUNE 27, 2003
Senate
No meetings/hearings scheduled.

House
No committee meetings are scheduled.
Next Meeting of the SENATE
10:15 a.m., Friday, June 27

Senate Chamber
Program for Friday: Senate will be in a period of morning business.

Next Meeting of the HOUSE OF REPRESENTATIVES
2 p.m., Monday, July 7

House Chamber
Program for Monday: To be announced.

Extensions of Remarks, as inserted in this issue

HOUSE
Andrews, Robert E., N.J., E1375
Bradley, Jeb, N.H., E1359
Cantor, Eric, Va., E1369
Case, Ed, Hawaii, E1365, E1367
Crane, Philip M., Ill., E1370
Davis, Jim, Fla., E1372
Del. auro, Rosa L., Conn., E1373
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