United States
of America

Congressional Record

PROCEEDINGS AND DEBATES OF THE *108th* CONGRESS, FIRST SESSION

Vol. 149 WASHINGTON, WEDNESDAY, JUNE 18, 2003 *No. 90*

Senate

The Senate met at 9:30 a.m. and was called to order by the President pro tempore (Mr. STEVENS).

The PRESIDENT pro tempore. Today, once again, we are pleased to have as our guest Chaplain the Reverend Charles V. Antonicelli, St. Joseph's Roman Catholic Church in Washington, DC.

PRAYER

The guest Chaplain offered the following prayer:

Heavenly Father, we praise Your name today. With the Psalmist we proclaim, ''Praise the Lord, my soul. I will praise the Lord all my life; I will sing praise to my God while I live.''

We thank You for the gift of life and for the talents and abilities You have given us. Help us, Lord, to put them to good use so that Your glory might shine through us.

Bless the men and women of this Senate as they seek to do Your will this day, bless their staff members who do so much work behind the scenes, and bless the pages who serve in this Chamber. Help them all to know the importance of their work here and let them know Your goodness to them.

We ask this in Your holy name. Amen.

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, today the Senate will be in a period for morning business until 10 a.m. At 10 a.m., the Senate will resume consideration of S. 1, the prescription drug benefits bill. Chairman GRASSLEY will be in the Chamber at that time and will be prepared to offer the necessary changes to the legislation. It is then hoped we will begin an orderly consideration of amendments.

I know there are a number of Members on both sides of the aisle considering offering amendments. I encourage Senators to work with the chairman and ranking member, the managers of the bill, to schedule consideration of those amendments. As amendments are offered, we will begin scheduling votes in order to make progress on this bill over the course of this week.

As I had laid out previously, we will finish the legislation prior to the July 4 recess. I look forward to substantive debate as we go forward in addressing this bill.

We will have rollcall votes throughout today's session. For the information of all Senators so they can plan for the next week and a half, we will have votes on Friday and next Monday on this bill. We have had two good days of substantive opening statements where Members have been allowed to discuss their views on this important program of Medicare, how we can best strengthen it, how we can best improve it, and at the same time add a substantial prescription drug benefit in a way that can be sustained over the next 10, 15, 20 years, where we know there is going to be this unprecedented demographic shift of doubling of the number of seniors over the next 30 years.

So I am very pleased with the bipartisan progress we have made to date. I am pleased that we will be able to go with amendments early in the course of today and look forward to addressing a number of those amendments over the course of the day.

RECOGNITION OF THE ACTING MINORITY LEADER

The PRESIDING OFFICER (Mr. BROWNBACK). The Senator from Nevada is recognized.

Mr. REID. As we all knew yesterday, the problem with not having amendments was that CBO had not completed scoring on the Medicare bill. It is my understanding there is scoring on the bill and Senators GRASSLEY and BAUCUS will offer either some technical changes or maybe a substitute to comply with mistakes made by staff during the very busy weekend they had.

Is that the understanding of the leader?

Mr. FRIST. Mr. President, that is generally my understanding. Again, for our colleagues, in order for the process to start and to allow us to really begin the amendment process, we have to have what is called a scoring from CBO. We were in touch with them at 8:30 and 9 this morning. It is my understanding we will have that scoring, but before I can say anything further with absolute certainty, we will know something in the next 30 minutes or so. Once we get that scoring that is both in the aggregate but also line by line—and we did not have a line by line at 7 this morning, and people are working around the clock on it, but once we have that line by line, we will be able to go directly to the managers' package and then also directly to the amendments. I am very hopeful that at 10 this morning that process will start.

Mr. REID. Mr. President, I say to the leader, now that we have had people make a lot of opening statements, we are waiting to offer amendments. Senator STABENOW is going to offer our first amendment, following whatever the managers decide to do with their opening amendments.

So we are anxious to go to work, and hopefully we can do that as soon as possible. However, as we all know, it cannot be done until the scoring is complete. Otherwise, a point of order

● This "bullet" symbol identifies statements or insertions which are not spoken by a Member of the Senate on the floor.

would be available against any amendment. So we look forward to getting into this as quickly as we can.

Mr. FRIST. Again, all of this demonstrates that everybody is working as hard as they can to address this situation in a reasonable, step-by-step fashion. So I am very pleased with where we are today. Both sides are very anxious to begin the amendment process, which is very good because all too often people push their amendments off until the last minute and we have many amendments flowing. In this particular case, we have encouraged people to come forward and let the managers know what amendments they plan to offer and then talk about the amendments so they can adequately plan. Indeed, that is under way.

I yield the floor.

RESERVATION OF LEADER TIME

The PRESIDING OFFICER. Under the previous order, the leadership time is reserved.

MORNING BUSINESS

The PRESIDING OFFICER. Under the previous order, the Senate will begin a period for morning business until the hour of 10 a.m., with the time equally divided between the two leaders or their designees.

The Senator from the great State of New Hampshire.

ORDER OF PROCEDURE

Mr. GREGG. I ask unanimous consent that at 10, I be recognized to speak on the prescription drug/Medicare reform bill for up to half an hour.

The PRESIDING OFFICER. Is there objection?

Mr. FRIST. Mr. President, reserving the right to object.

Mr. REID. Mr. President, I was listening to someone else speak. What did my friend from New Hampshire say?

Mr. GREGG. I am seeking the right of recognition at 10 to speak on the Medicare bill for half an hour.

The PRESIDING OFFICER. Is there objection?

Mr. REID. My only question would be, and I say to my friend, I do know that we have Senator BOND and Senator MIKULSKI who asked to be recognized as in morning business, and if we do not go on the—well, I really do not see any problem with having debate on that.

Mr. GREGG. How long does Senator MIKULSKI wish to speak?

Mr. REID. She is in the Chamber. I did not see her behind me.

How long does the Senator wish to speak?

Ms. MIKULSKI. Speaking to the Senator through the Chair, my remarks are about 5 or 7 minutes. I might add, there is a crisis in national service with volunteers. Senator BOND and I have a legislative solution. That is why we wanted to speak in morning business.

The corporation is blaming Congress when they, my colleagues would be interested to know, oversubscribed by 20,000 volunteers. So Senator BOND wanted to share our fix with the people. I could do this in about 5 or 6 minutes.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Reserving the right to object, I do not see any problem at all having the Senator from New Hampshire begin his statement when the hour of 10 arrives. It is indicated that the two Senators will complete their statements prior to that time. I ask that following his statement, a Democrat, if one wishes to speak, be recognized.

The PRESIDING OFFICER. Is there objection?

Mr. FRIST. Reserving the right to object, my understanding is it would be for debate only until the managers come back to the Chamber. May we have a general understanding that this is for debate only until the managers come?

Mr. REID. I understood from the Senator from New Hampshire that that was part of his request, that it would be for debate only.

Mr. GREGG. That was not a part of the request, but if the leader wishes, I will make that part of the request.

The PRESIDING OFFICER. Is there objection to the request of the Senator from New Hampshire? If not, it is so ordered.

Who seeks time? The Senator from Maryland.

Ms. MIKULSKI. Mr. President, I wish to speak as in morning business.

The PRESIDING OFFICER. The Senator has that right.

Ms. MIKULSKI. I thank the Chair.

CORPORATION FOR NATIONAL AND COMMUNITY SERVICE

Ms. MIKULSKI. Mr. President, what a mess we have at the Corporation for National and Community Service. The Congress has funded 50,000 AmeriCorps volunteers, as we have year after year. But, guess what. The corporation has enrolled 70,000 volunteers. It seems the corporation cannot count. As a result, there will be fewer volunteers this year.

Fortunately, because of a bipartisan collegial relationship on the VA/HUD subcommittee, Senator BOND and I are going to fix this problem for the volunteers and for the communities they serve. We are introducing something called the Strengthen AmeriCorps Program Act, and, frankly, it gives AmeriCorps the fix it needs to straighten out the mess they created.

This bill is simple and straightforward. It gives the AmeriCorps Program the flexibility within the current funding for 2003 so there can be 50,000 AmeriCorps volunteers this year.

I have been reading in press reports, but most of all I have been getting calls from constituents and other Senators who support AmeriCorps. What are they concerned about? They are concerned that it appears there will be cuts by as much as 15,000 volunteers. I am concerned about that, too, and the effects on our communities and the young people who serve them while earning a scholarship for college.

I believe the public has a right to know what happened. So I want to explain to advocates and my colleagues what is happening and why the corporation has cut AmeriCorps. Congress has not cut AmeriCorps. It is because there is a persistent pattern of mismanagement at AmeriCorps. The corporation has over-enrolled 20,000 volunteers. When you make a mistake of 20,000 it is not a mistake, it is mismanagement. Two thousand would have been a mistake; 20,000 is mismanagement. The corporation has violated the law, mismanaged taxpayers dollars, and created uncertainty for our volunteers and our communities.

In April, at the VA/HUD subcommittee, I called on the National Service CEO, Dr. Leslie Lenkowsky, to fix the problem. He promised he would do that by June 1. But, guess what. He called on May 30 and said he just could not do it. Then out came the shrinking of the number of volunteers, and out came the blaming on Congress. Instead of fixing the problem, he blamed Congress. I wish the corporation was as good at accounting as it is blaming. They had 10 weeks to get their act together and they did not do it.

I was very stern with Dr. Lenkowsky and the Board of Directors at the hearing. I must say I thank the Board Chairman, Mr. Stephen Goldsmith, for responding constructively to the criticism of myself and other Members of the Congress. They took it to heart. They are beginning to reform national service. They are doing due diligence. They are putting more time into the oversight than, frankly, Dr. Lenkowsky.

Dr. Lenkowsky is the Chief Executive. He has failed to respond to the situation, failed to respond to the subcommittee request, failed volunteers, failed communities, and in the schools I went to when you get that many ''Fs'' you just flunk out.

Today, I am asking Dr. Lenkowsky to resign. I am really sorry we have gotten to this point, but we cannot continue this. I think if we are going to have a national service program, we need to have a national service program that serves the Nation and follows the directives of the Congress.

We have worked on a bipartisan basis in this subcommittee year after year after year. We saved this program. It is usually zeroed out in the House. It is a gimmick to get us to rescue it. And now, once again, thanks to the leadership and constructive relationship with Senator BOND, we are going to strengthen AmeriCorps. Without our cooperation and leadership at VA/HUD, AmeriCorps wouldn't even be here. So

we need to pass the Strengthen AmeriCorps Program quickly. It is an accounting fix that is certified and approved by OMB and GAO.

I support our President's call to national service. I want to work with President Bush in a bipartisan way to take national service into a new century. That is why I have worked with Senator MCCAIN, Senator BAYH, and others to do that. Most of all, I want to work with my colleague Senator BOND, once again, as we always have, to sustain national service. Now we have legislation to clean up the mess that the corporation had. But the only way I think the corporation is going to get any momentum is if its current executive either steps aside or steps down.

I hope Congress moves this bill in a matter of days. The Nation needs it because the volunteers need it and the communities need the volunteers.

I yield the floor.

The PRESIDING OFFICER. The Senator from Missouri.

Mr. BOND. Mr. President, it is a real pleasure today to rise to join my colleague and good friend, the Senator from Maryland, in introducing legislation that will strengthen the Corporation for National Community Service, the AmeriCorps Program.

I assure my colleagues the Strengthen AmeriCorps Act of 2003 is a bipartisan bill introduced with Senator MIKULSKI as ranking member, and the chair of the Appropriations Committee and members of the authorizing committee. The Senator from Maryland and I believe the bill will not only address some of the corporation's accounting problems but, more importantly, it will protect and expand volunteer service opportunities across the Nation.

Many of my colleagues—I wouldn't be surprised if all of our colleagues—have heard from their constituents and the media in recent weeks about the potential cuts to the AmeriCorps Program. This bill addresses, to the best extent we can, those concerns—some have longstanding concerns about the management and financial problems of the corporation—by creating a budgeting mechanism that ensures the corporation has the funds needed to pay educational awards.

Under this bill, the corporation would be able to enroll about 50,000 AmeriCorps members without the need for additional funds. Looking at the allocation that is available for the VA/HUD subcommittee, additional funds are not a very great prospect at this time, I regret to say. We have to deal with what OMB has given us and the allocations we received from our distinguished and all-knowing senior colleagues on the Appropriations Committee.

It is truly unfortunate—my colleague has already referred to it—that there has been a plague of significant and longstanding management problems, neglected for many years, in the corporation. One notable result of this neglect has been the inappropriate and illegal practice of enrolling more AmeriCorps members than the corporation had budgeted. One would think a group of dedicated public servants running the AmeriCorps Program could count. They have not.

Last year, the corporation overenrolled the AmeriCorps Program by more than 20,000 people. They have done it year after year, the year before and the year before that and the year before that. They came to the VA/HUD and Independent Agencies Appropriations Committee to bail them out. We were able to provide $43 million more than requested in the 2003 appropriations bill to meet the needs of these members and more. But because of continued poor budgeting practices, the VA/HUD subcommittee also approved another $64 million in deficiency appropriations in the 2003 supplemental appropriations to cover additional shortfalls.

When the overenrollment problem first surfaced, we asked the GAO and the corporation's inspector general to review the accounting practices of the corporation and its internal controls to determine the causes of this problem. Further, we asked the GAO's Comptroller General to review the corporation's underlying statute to determine whether the corporation's practice complied with the law, and other fiscal laws such as the Anti-Deficiency Act.

Both the General Accounting Office and the IG found the corporation did not comply with the law by incorrectly recording its funding obligation. GAO identified several factors that led to the corporation's incorrect accounting practice. The factors included inappropriate obligation practices, little or no communication among key corporation executives, too much flexibility given to grantees regarding enrollments, and unreliable data on the number of AmeriCorps participants.

That is the official word. My unofficial word is they can't count.

GAO also found that the corporation was not following the law in recording its legal liabilities.

This bill responds to the problems identified by the auditors and allows the corporation to maximize the number of AmeriCorps enrollees that can participate in the program.

In short, the bill allows the corporation to fund AmeriCorps grants based on the estimate of the number of members who will likely complete and use their education award to ensure that the AmeriCorps Program is accountable to taxpayers and the volunteers.

It is our expectation the corporation will use conservative assumptions in developing its funding formula. This is especially important since the corporation has repeatedly failed to meet funding obligations resulting in action by Congress to provide additional funding, including deficiency appropriations.

I serve notice here and now: Don't come back to us if you screw it up again. You are not going to get bailed out.

Further, because of poor data, the bill requires the central reserve fund to give the corporation an extra cushion in case the actual usage rate exceeds the assumption used in the formulary.

We believe we should pass this legislation as quickly as possible. It provides for clarification of the corporation in determining grant award allocations to its grantees in the States. Without this legislation, uncertainty and disagreement will delay and limit the enrollment of AmeriCorps volunteers.

Considering the demand and need for the program, we cannot afford to wait. We designed this legislation with significant input from the administration. This is one of the President's top priorities. It has, I can assure you, their undivided attention.

We think it is a reasonable and fair approach to the issue. It mitigates harm to the AmeriCorps Program in a manner that will ensure accountability and fiscal integrity.

Keeping in mind the problems identified by the auditors which led to the enrollee freeze last November, we designed this legislation to ensure that we do not repeat those past mistakes. The enrollee freeze was unfortunate. It was an avoidable mistake, if the corporation had properly managed and monitored its programs.

We need to put these enrollment issues behind us. This program has had a difficult and star-crossed history. It is unfortunate. And we are here in June revisiting the implementation of the program to ensure both accountability and credibility. We need to ensure the State and local programs are meeting both the program requirements and the community needs.

I will tell my colleagues the corporation has hired a very strong CFO in getting a handle on these problems. And they do have the full attention of not only the administration through OMB but GAO and the IG.

I urge my colleagues to support this legislation.

I ask unanimous consent that the bill I wish to introduce on behalf of myself, the Senator from Maryland, and Senators SPECTER, COLLINS, ALEXANDER, SANTORUM, and KENNEDY be held at the desk.

The PRESIDING OFFICER. Is there objection?

Mr. GREGG. Mr. President, reserving the right to object, as the Senator knows, by holding the bill at the desk, it will not be referred to the committee of jurisdiction which I happen to chair, and which the Senator from Missouri is a member, as is the Senator from Maryland, and whose abilities I greatly respect. Obviously, I always have reservations about not having a bill referred to the proper committee of jurisdiction and have it step outside the proper process in the Senate, which is the bill should go to the committee of jurisdiction.

But I believe the Senators from Missouri and Maryland are addressing a critical problem, and one for which, as appropriators, they have a unique responsibility. This issue has to be resolved. I hope in resolving it we can also address issues such as the Corporation of National Service, which is a very strong organization, and which because of the mismanagement of these funds may be cut out of the funding process.

But I am not going to make the objection which logically a chairman should make to this type of request of holding it at the desk because I do think the Senators from Maryland and Missouri are doing very excellent work here, and it needs to be passed quickly. Therefore, I am willing to forego the committee of jurisdiction to get this bill through.

I congratulate Senators for bringing the matter to the attention of the Senate.

The PRESIDING OFFICER. Is there objection to the unanimous consent request? Without objection, it is so ordered.

Mr. BOND. Mr. President, I express my deep appreciation to the chairman of the committee. We have shared this with the staff. But it was done on a very tight time schedule. I apologize to him for not being able to talk with him directly about it. I assure him it is a brief bill. If he has any questions, we will be happy to work with him.

I hope we can bring it up as quickly as possible because of the compelling nature of resolving this problem. If we can get it passed quickly, I will be happy to make a note of the particular organization in which he is interested and ensure that our friends at the Corporation for National Service know about the high priority the chairman of the authorizing committee places on this organization.

Ms. MIKULSKI. Mr. President, I, too, want to express my appreciation to the chairman of the HELP Committee, Senator GREGG. I think it is gracious of him to let us keep the bill at the desk knowing the urgency of the need to test it.

I think the point he raises about the need for regular oversight on national service is well taken. I look forward to participating in that hearing. I thank him for his courtesy and for his sensitivity to the urgency of the situation and his commitments regarding volunteers.

Mr. GREGG. Mr. President, if the Senator will yield, I will simply say I am always courteous to appropriators.

The PRESIDING OFFICER. The Senator from Illinois is recognized.

Mr. DURBIN. Mr. President, I understand there was a unanimous consent request that the Senator from New Hampshire be recognized. Is that right?

The PRESIDING OFFICER. The Senator is correct.

Mr. GREGG. Mr. President, if the Senator will yield, how much time does the Senator need? I would be happy to yield on my time.

The PRESIDING OFFICER. Is there objection? Without objection, it is so ordered.

Mr. DURBIN. Mr. President, I express my appreciation to the Senator from New Hampshire.

PRESCRIPTION DRUG BENEFITS

Mr. DURBIN. Mr. President, we are in the midst of debating a historic measure on the floor of the Senate; that is, the prescription drug bill. This is an issue which Americans understand. Seniors on fixed incomes understand how difficult it is to fill those prescription drugs to stay healthy.

For 8 or 10 years, we have been struggling to find some way to give them a helping hand to pay for their prescription drugs. There have been a lot of different proposals. Some people said the way to do it is to eliminate Medicare altogether. Others have said the best thing to do is put it, as appropriate, in Medicare.

What we have coming before us from the Senate Finance Committee by Senators GRASSLEY and BAUCUS is an effort to create a prescription drug benefit for seniors. To my mind, it falls short of what we need.

Isn't it interesting that in the course of this debate about this new bill there is one group which we have not heard from? Why is it the pharmaceutical companies and drug companies haven't said a word about the new prescription drug bill? I think the answer is obvious. Because this new prescription drug bill offered by Senators GRASSLEY and BAUCUS has no effort in it—none whatsoever, as far as I am concerned—to keep drug prices under control.

If you ask any family in America, or any senior, they will tell you the cost of prescription drugs has increased 10 to 20 percent a year. If you are a drug company, and the Federal Government says it is going to help your customers pay for the drugs, but they don't have to control your prices at all, you don't have to keep them under control, then, frankly, that is the best outcome you could hope for. You can continue to increase prices and know the Federal Government is going to pick up a portion of the tab.

Of course, if you are a customer buying prescription drugs, it is going to be an elusive target. Even though the Federal Government is offering you some help in paying for prescription drugs, if you do not do anything to contain the cost of prescription drugs, then ultimately it is going to go far beyond the family resources.

I stepped back and asked, Is there a better way to approach this? One that achieves the result, which is to help seniors pay for prescription drugs, and does it in a sensible way? I sat down and said: Take the $400 billion we allocated for this program and put into it some price competition. For example, in the Veterans' Administration we have established a formulary where they have said for 2,300 drugs, we will save 40 percent to 60 percent of the cost. If the drug company wants to do business with the Veterans' Administration, they have to bring down the prices. Let us apply the same principle to our use of the Medicare recipients and their drug prices.

I brought into question having this kind of formulary to reduce the cost. Then I brought in a proposal by Senators SCHUMER and GREGG that says let us encourage more generic drugs which are cheaper and just as effective. And then I added an element, which the Senator from Michigan, who is on the floor, has been pushing for and will offer as an amendment.

Why wouldn't we let the Medicare Program itself offer a prescription drug benefit? We know they have no profit margin. We know their cost of administration is lower than any drug company. So put those three things together, take the $400 billion, and what can you achieve?

Let me tell you what you can achieve. You can guarantee—guarantee; which this bill does not do—a $35 monthly premium for the seniors who volunteer to sign up for the program. You can eliminate the $275 deductible, which is part of the bill that is on the floor. And instead of a 50/50 split on the cost of prescription drugs, you can move to a 70-percent Government pay, 30 percent being paid by the seniors, and you can give full coverage. You do not have the gaps in coverage that are part of the existing bill on the floor.

How do you achieve this? Because, frankly, you keep the costs under control. You have generic drugs as part of it. You have Medicare as part of the competition. And what period of time would the $400 billion cover? We are waiting for an official CBO number, but we believe it would be a 5-year period. Then, at the end of 5 years, you can reauthorize the program, decide whether it has worked or whether it has not worked.

I think this approach, which we call Medisave, is much more preferable to the Grassley-Baucus bill because it does say to seniors: We are going to give you a better helping hand, 70 percent being paid by the Federal Government, no deductible, and a guaranteed $35 monthly premium. And the way we will achieve it is by reducing the cost of the drugs, as we do in the Veterans' Administration today. I think that is a sensible way to approach it.

To take the Grassley-Baucus approach is to open up the possibility that the drug costs will just continue to skyrocket 10 and 20 percent a year. And in that situation, the seniors will not be able to keep up with them.

The Senator from New Hampshire was kind enough to yield to me until 10:10. I see my friend, the Senator from Michigan, has come to the floor. If the Senator from New Hampshire would not mind, I will yield the remaining time I have until 10:10 to my colleague from Michigan.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, I thank my friend from Illinois. I commend the Senator for his substitute. What the Senator is talking about is exactly what the seniors of America are asking us to do to make sure they have a comprehensive prescription drug benefit under Medicare which they know will be there, which is stable, dependable, where you can choose your own doctor no matter where you live in the country; that whether you live in the upper peninsula of Michigan or Chicago, IL, you will have an opportunity to receive the health care you need and deserve under Medicare.

By simply expanding that to include prescription drugs, and then coupling that with the ability to keep prices down, I believe this is the best possible approach to come before the Senate—in fact, the U.S. Congress. I am hopeful that colleagues, when this comes to the floor, will rally around this plan.

What Senator DURBIN has done is put together a plan designed for seniors, not designed for pharmaceutical companies or insurance companies, which is, unfortunately, why this process has become so complicated. For example, people look at me with bewilderment when I am explaining that for the private sector plans in their region, if there are two or more, they would have to take one. But if there isn't, they could have a backup, but then they would have to drop it and go back to an insurance plan. When I explain that plan, they scratch their heads and say: Why are you doing that?

Well, unfortunately, we have a plan put forward—and I have to say it is a valiant effort by many people to try to come to some consensus, and I appreciate that—but the reality is, it is designed much more to benefit the pharmaceutical companies in particular than it is our seniors.

Why is our approach not supported by the pharmaceutical industry? For one simple reason: If we have all 40 million seniors and people with disabilities in one insurance plan, they can negotiate a big group discount, which is what they should be able to do. They should be able to come together, as one insurance plan, and negotiate a group discount. As Senator DURBIN indicated, when you do that, you are not paying retail. In fact, the Federal Government does that on behalf of our veterans through the VA, and we are able to get about a 40-percent discount, which is a terrific deal for the veterans of this country. I am proud we do that, but why shouldn't that same opportunity be available for every senior, for every person with a disability under Medicare?

So I just wanted to rise to congratulate the Senator's vision on putting forward the right plan that makes sure that, in fact, our seniors know they can count on a $35 premium. They would also not have to have a deductible. Seventy percent, as I understand, of their prescription drug costs would be paid for. There would be no gap in coverage for the last few months of the year. Or if you found yourself getting to a point where you reached the end of your coverage, and then, unfortunately, your doctor indicates you have an even more serious illness to deal with, you would not be left wondering what to do to pay for that treatment and medication.

This plan does what our seniors in this country are asking for. I believe it does what we should be doing for them. It is what they need, and it is what they deserve. It is what they have been waiting for.

I commend the Senator from Illinois for putting forward this option of which I encourage all of our colleagues to come together to embrace, standing together to achieve a bipartisan victory that is in the best interest of our American seniors.

TAX RELIEF, SIMPLIFICATION, AND EQUITY ACT OF 2003

Mr. SMITH. Mr. President, I ask the Chair to lay before the Senate a message from the House with respect to H.R. 1308; that the Senate disagree to the House amendments to the Senate amendments, agree to the request for a conference with the House on the disagreeing votes of the two Houses, and that the Chair be authorized to appoint conferees on the part of the Senate.

Mr. REID. Reserving the right to object, I believe this is on the Lincoln child tax credit legislation; is that true?

Mr. SMITH. I believe that is true.

Mr. REID. I am glad this is happening. I hope the message to the Republican leaders, at least from us, is that it will be a real conference and that they will work toward resolving this most important issue. I have no objection.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Presiding Officer said before the Senate the following message from the House of Representatives:

Resolved, That the House insist upon its amendments to the Senate amendments to the bill (H.R. 1308) entitled ''An Act to amend the Internal Revenue Code of 1986 to end certain abusive tax practices, to provide tax relief and simplification, and for other purposes'', and ask a conference with the Senate on the disagreeing votes of the two Houses thereon.

Ordered, That the following Members be the managers of the conference on the part of the House.

For consideration of the House amendments to the Senate amendments to the House bill, and modifications committed to conference: Mr. Thomas, Mr. DeLay, and Mr. Rangel.

The Presiding Officer (Mr. ALEXANDER) appointed Mr. GRASSLEY, Mr. NICKLES, Mr. LOTT, Mr. BAUCUS, and Mrs. LINCOLN conferees on the part of the Senate.

The PRESIDING OFFICER. The Senator from the great State of Nevada.

Mr. REID. Mr. President, the Senator from New Hampshire has been more than generous with his patience. I would ask, however, unanimous consent that the time until 11 o'clock be for debate only on this matter. I have spoken to the majority, and they are in agreement with that. So I ask the time until 11 o'clock be for debate only on the bill.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. REID. Has the bill been reported this morning?

The PRESIDING OFFICER. The Chair will now make that statement.

Mr. REID. Mr. President, my consent deals with the Medicare bill.

CONCLUSION OF MORNING BUSINESS

The PRESIDING OFFICER. Morning business is closed.

PRESCRIPTION DRUG AND MEDICARE IMPROVEMENT ACT OF 2003—Resumed

The PRESIDING OFFICER. Under the previous order, the hour of 10 a.m. having arrived, the Senate will proceed to the consideration of S. 1, which the clerk will report.

The assistant 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.

The PRESIDING OFFICER (Mr. CORNYN). The Senator from New Hampshire.

Mr. GREGG. Mr. President, I rise to talk about an issue which we, as the Senate, are going to address for the next 2 weeks, which is the question of how to put in place a drug benefit and to reform the Medicare system so that it is more viable.

This is, obviously, the most significant piece of legislation in the area of spending on which any of us in this Congress will vote. In fact, in my years in Congress, this is the most significant piece of spending legislation I have ever seen because it represents the most dramatic expansion, the greatest expansion of an entitlement in our history; therefore, it needs to be done right. In my opinion, there are issues which need to be addressed and which we need to discuss in order to accomplish that.

To understand the issue and to put it in context, you have to go back to the beginning of the problem. And the beginning of the problem, I hate to say it, was when I was born—1946, 1947 through 1955. It was that postwar period, where America was full of itself, and our people were returning from the war, and we repopulated our country with the largest baby boom in the history of our country. That baby boom meant an explosion of people in our country, people who have contributed, I hope—people think immensely—over those years and decades since that

time. But in each decade, the postwar baby boom generation has moved forward, it has changed fundamentally, not only the demographics of the country but also the reaction of the country to various issues.

For example, in the 1950s, we had to build literally hundreds of elementary schools in order to accommodate this generation. In the 1960s, there was, of course, the great upheaval of social consciousness, which was driven primarily by the coming of age of the baby boom generation and their concerns about civil rights, about the war in Vietnam, about the rights of women.

So as this generation has moved through the tube of its time, there has been a bubble which has significantly changed all around them. Now that generation is headed for retirement and, as a result, our retirement systems which were put in place with a very appropriate social purpose of making sure that senior citizens were properly cared for, which arose out of the period of the Depression in the 1930s, where so many people suffered—I was not alive then, but history tells us and the people who experienced it tell us that this was a period of immense trauma—we as a culture decided we were wealthy enough and strong enough to make sure that never happened again to our seniors. So we put in place the Social Security system and the Medicare system as an effort to try to make sure seniors could live their final days of their retirement in dignity, financially and in health care.

These systems have been extraordinarily good systems for our Nation. But now as this generation heads into retirement, these systems are going to come under immense pressure. The whole concept of both of these systems was that there would be a pyramid where you would have a large number of people working and a smaller number of people retired, like a pyramid. So that the large number of people working could be paying into the retirement system and benefiting those people in retirement. So the pyramid would work as long as there was a larger working population than retired population.

The practical effect of the baby boom generation, the demographic effect, is that when we hit the retirement system, we go from a pyramid to basically a rectangle where essentially you will have about as many people working as retired.

For example, in 1950 there were 12.5 people working for every 1 person retired. This year, there is something like 3.3, 3.5 people working for every 1 person retired. By the time we hit 2030, there are going to be 2 people working for every 1 person retired. The number of people retired today is 40 million. The number of people who will be retired in the year 2030 will be 70 million, a 75 percent increase. So the system, which was structured to be a pyramid and has worked very well as a pyramid, simply won't work effectively as a rectangle. You can't have about as many people working, paying retirement benefits, as you have people taking those benefits because the practical effect of that is you would have to dramatically increase the taxes on working Americans in order to support nonworking retired Americans to a point where working Americans' lifestyles would be significantly reduced.

The debate today has to be put in the context of two fundamental issues: One, how do we benefit senior citizens with a reasonable drug program that is going to give them adequate drug care, adequate prescription drug opportunities; but, two—and we can't forget this issue in addressing the question—how do we make sure that in doing that, we don't set up a situation where the next generation of young people—these folks who are working as our pages, people who are in high school today, people who are in college today, people in their twenties today—don't end up with a tax burden that is so large that we significantly reduce the quality of their life because we have decided this year to give seniors a benefit which we cannot afford 5 or 10 years from now because there will be so many seniors who are retiring.

We have to keep in mind, as we go through this reform effort and the addition of a prescription drug benefit to Medicare, those two groups—seniors and young people who will have to pay the taxes, our children and grandchildren, in order to support that program.

This brings us to the question of what type of program should we have which can accomplish that. To begin with, we have to put in place a Medicare Program which is cost sensitive, which has in place marketplace forces which allow us to maintain a reasonable cost so that we don't have a growth rate in Medicare that is so great that it simply overwhelms the ability of working Americans to pay the taxes to support it.

We know, for example, we already have a $13.3 trillion unfunded liability in Medicare. We know, for example, that under the present Medicare system, the costs of Medicare are exceeding the income of Medicare by about 71 percent and that by 2026 the Medicare system will be insolvent under the present structure, insolvent because it has this huge unfunded liability as a result of the huge demographic group, the postwar baby boom generation, entering the system.

These are facts that cannot be changed. The people are alive, the baby boom generation exists, and we will retire. We will, therefore, be on the Medicare system and on the Social Security system.

We have to find some way to address the Medicare system in a manner which will allow us to make it affordable as we move into the outyears. This means putting some cost sensitivity into its structure. If we are going to add a new benefit to Medicare, we have to be sensitive that it does not at the same time create a massive new unfunded liability.

If, for example, we simply put on to the Medicare system a $330 billion new drug benefit, which was the proposal last year from someone—that was the number; today it is $400 billion—that $330 billion drug benefit over 10 years translates into a $4.6 trillion add-on in unfunded liability in the system, which just means you have to raise taxes by that much on working Americans, on our children and their children, in order to pay for it. So we have to be thoughtful about how we do this. As a parent and hopefully a future grandparent, I don't want to reduce the lifestyle of my children and their children and their ability to participate in the American dream simply to support me when I am retired.

What does this bill do? This bill has two fundamental problems, both of which go to the issue. First, it adds a $400 billion drug benefit, but it does it in a way that essentially says: We are going to take a lot of people who are already paying for their benefit, middle-income Americans, Americans who have worked and have obtained a retirement benefit, which includes a drug benefit, and we are going to move them from the private sector on to the public sector. We are essentially going to nationalize the drug delivery system for everybody who is over 65, whether they want it or not. That policy has some fundamental flaws.

What do we need as a drug benefit? What we need is to make sure that people who cannot afford to buy drugs today, people who are making the difficult decision between purchasing a meal or maintaining their residence and buying the drugs they need to be healthy, those folks who have to make that type of choice, that they have support, that they have a drug assistance program that helps them buy pharmaceuticals and assists them in a way that allows them to live a decent lifestyle without having to make terrible choices between the basics of life, such as food and housing versus their medical care.

We do need a drug benefit that does that, that takes care of the low-income individual who is not covered today by a drug benefit. And we need a drug benefit that says you don't have to spend your life savings in order to pay for your drugs. You don't have to wipe yourself out financially in order to be able to care for yourself physically as a result of your needs to purchase pharmaceuticals. So we need catastrophic coverage, where over a certain level you basically have an insurance program that comes in and pays your costs. But this bill doesn't do that.

What this bill does, as I mentioned, is it says to everyone that you shall have drug coverage, and it takes literally 40 percent of the seniors, as a conservative estimate, who presently have some sort of private coverage program and moves them onto the public coverage system. As a practical matter, in

doing that, it spends a lot of money but, more importantly, it creates a lot of outyear liability because it essentially says the Federal Government shall have a nationalized drug system for everybody over 65 which will be paid for by earning Americans who are in their twenties and thirties and trying to raise families. Whether or not they are wealthy, they are going to have this sort of drug benefit. That really doesn't make a whole lot of sense, in my opinion.

It would make much more sense if the drug benefit in the bill said something to the effect of, if you are a low-income individual and you don't qualify for a State program, which already gives you a drug benefit—which is Medicaid, basically—and your income is, say, under 200 percent of poverty—I'll just pick that as a number because I think that is a reasonable number—then you shall receive assistance in purchasing your prescription drugs. There are about 4 million to 5 million people in that category. There are 40 million seniors. In the category between those covered by Medicaid and those at 200 percent of poverty, there are approximately 4 million to 5 million people. The cost of doing that part of the drug benefit to make sure you had a reasonable drug benefit—and essentially those low-income seniors have the support they need to pay for their drugs—can be $135 billion to $185 billion, depending how you score it. But it would not be $400 billion.

So you could set up a reasonable program targeted at low-income seniors to make sure they had fair and reasonable coverage, with the support of the Government. Other seniors who are over that income level should have the protection of a catastrophic program. But they should not have the protection of a public program because they already have it.

It has been estimated that 75 percent of the seniors in the country today already have some form of drug coverage. Why should the Federal Government come in and replace that? Why should the Federal Government come in and say to General Motors, which negotiated a contract with its employees that when they retire they would get a health care package that gave them drug coverage—why should you, a person working at a restaurant in Claremont, NH, in your twenties, trying to raise two kids and send them to school—why should your Medicare and health insurance tax be taken to pay for a drug benefit for somebody who retired from General Motors, who already has a benefit under the terms of the agreement they negotiated with General Motors? All you are essentially doing is saying, if you do that, that some poor guy or woman who is working hard to make ends meet in Claremont, NH, in a restaurant is going to bear the burden of what General Motors should be bearing for its retirees. You are replacing the obligation of General Motors with the obligation of some poor guy or woman in their twenties or thirties who is trying to raise a family and is working in a restaurant, and they have two kids going to school. They have to buy a Chevrolet, which is a pretty expensive experience. They should not have to pay for the health care of the person who made that Chevrolet. But that is what this bill essentially does.

The bill basically frees up, within 5 years—not immediately because there are contracts in place—certainly by the time the baby boom generation retires, which is 2008, it basically frees up corporate America from any obligation to bear any cost relative to retirement in the area of drugs. Now, there may be some unions that will negotiate a strong contract with their corporations and they will force them to come and do some sort of wraparound. But the core of the drug benefit will always be from here on out, once this bill is passed, that the public sector will bear the burden of all the costs for drugs for all Americans, no matter how wealthy they are, no matter what their income is, whether they had a union contract, agreement, or a Medigap policy that covers the drug costs.

The practical effect of that is going to be that when the baby boom generation—my generation—hits retirement beginning in 2008, we are going to escalate the cost of this benefit radically—radically. So $400 billion is a conservative number for 10 years and, over the life of this program, $4.6 trillion is an incredibly conservative number. This benefit, which is a very legitimate benefit and a very appropriate benefit, should be targeted at people who need it, people who cannot afford it, people who are having to make the tough choices in their life between the food they eat, the housing they have, and the drugs they pay for. Those folks deserve Government support. But Bill Gates, when he retires, does not deserve Government support in the area of purchasing his drugs. Under this bill, he would get it.

So that is the first and most fundamental flaw in this bill. It essentially nationalizes and moves from the private sector literally millions of people who are presently capable of having, and who are in, programs that take care of their drug benefit. It does an aggressive job, I admit, on the low-income person and that should be kept in place. There are a variety of ways to do that. But we should not nationalize the system for everyone.

The second flaw in this bill, the most fundamental flaw, is the issue of how you control the overall cost of Medicare. This is at the essence of the future financial soundness of this country. Today, Medicare consumes about 14 percent of the GDP, if you include retirement benefits, Social Security, Medicare, and Medicaid. If you applied the projections to the Medicare, which are in place, the fact that we have a $13 trillion unfunded liability, and if you apply the unfunded liability projections to Social Security and Medicaid, then you will end up by 2030 having those three—Social Security, Medicare and Medicaid—absorbing 14 percent of the GDP. They do not do that today, obviously. Today, the Federal Government absorbs about 19 percent of the gross domestic product. So you could see that if you project the cost of Medicare and Social Security out to 2030 and you have it using up 14 percent of the gross national product, and today we do all Government spending, all the Government responsibilities, including education, national defense, and all the different issues of core Government needs we manage with 19 percent of the gross national product, we can see that by the time we get to the year 2030, there is not going to be anything left that the Federal Government is going to be able to do other than take care of the retirement accounts. We are not going to be able to do national defense, education, roads, parks—all the important functions to have a strong Government and a good society. They are not going to be affordable unless we are willing to radically increase the taxes on the working Americans of this country who will be our children and our grandchildren.

That is why I say reforming Medicare—and Social Security, for that matter, which I have already worked on extensively—is one of the most fundamental issues we face as a country, getting those costs under control in the outyears.

Does this bill do that? This bill attempts to create a market force in the area of Medicare by setting up something called PPOs, preferred provider groups. The practical effect, though, is there are very few likely scenarios under which the PPOs will be viable, under which private market forces will come into play. We will still have, basically, a price-controlled situation, a single-payer situation.

We cannot reform Medicare unless we bring into Medicare market forces. We cannot control the price and delivery of health care unless we start to put in place some sensitivity to the quality of care that is being delivered in the context of how it is being delivered, when it should be delivered, and the amount that should be delivered. We cannot do that in a single-payer system. We cannot do that in a price-controlled system. We can only do that if we have market forces that are competing and, thus, bringing to the table the essence of competition, which is competing on the basis of price and quality.

This bill in name attempts to do that through the PPO process. It is projected, however, by CBO, the Congressional Budget Office—there are so many initials thrown around; we confuse people—that only 2 percent of the Medicare recipients will take advantage of this market-oriented approach.

The White House and the Office of Management and Budget projects it at

a much higher level. They say 45 percent will take advantage of this program, and that is because they are optimistic, and it is because it is their plan. I think the Congressional Budget Office has taken a much fairer and objective look at this. They have said: What in this plan creates an atmosphere which would cause somebody to leave Medicare and move over to a private provider? There is virtually nothing in this plan that would cause somebody to do that. There is no market force which is allowed to be brought into play to accomplish that because of the way the pricing mechanism is set up under this bill.

The practical effect is that the market has been taken out of—at least in a real sense, not in an illusory sense; it is there as a stated purpose—but as a practical likely effect, it has been taken out of the game. So we are going to move forward into the next generation with the same program that we presently have with a drug benefit on top of it, which drug benefit essentially will cover everyone, no matter what their income levels are, no matter what their benefit structures are. They already exist.

Instead of improving the system, what we are going to end up with is the same old Medicare system, a 1950s car with a brand new paint job on it in the form of the drug benefit but without anything in it that is going to fundamentally improve it as it moves into the next generation and the need to control costs in the next generation.

The practical effect of it will be that the $13.3 trillion unfunded liability that already exists in Medicare will have $4.6 trillion of new unfunded liability put on top of that for the purpose of the drug benefit, which are all massive numbers, but they come down to this: For a child born today—John Jones or Mary Smith—when that child takes his or her first breath, that child gets with that breath a debt of $44,000 to pay for Medicare. That debt is going to have added to it $15,000 after this bill passes to pay for the new Medicare benefit.

Yes, this bill does take care of our seniors and our baby boom generation group who are becoming seniors in a very generous way. One-half of the equation is addressed—seniors. That is always politically very attractive. It polls very well. It gets you through the next election. It makes you a hero with groups of people who are concerned about seniors' rights. But the other half of the equation is our children and our children's children. It leaves them with an extraordinary bill and with no opportunity to affect it.

The great tragedy is this drug benefit gave us, the Congress and the executive branch, the first and best opportunity to substantively reform Medicare using the drug benefit basically as the carrot that brings along the reforms. We could have used this benefit in an extraordinarily constructive way to assure that my generation, the baby boom generation, is not an undue burden on our children and our grandchildren or on that fellow or woman working in a restaurant in Claremont.

Instead, what we have done with this bill is added a drug benefit which will make my generation very happy and seniors who are receiving it today very happy, which will leave in place a Medicare system that has a $13 trillion projected unfunded liability and which will leave with our kids a debt which is both unfair, inappropriate, and, ironically, unnecessary were we approaching this with better policy.

I suppose, in understated terms, I have reservations about this bill.

Mr. President, I yield the floor.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, it is my understanding, under the order now in effect, that a Democrat will be recognized; is that right?

The PRESIDING OFFICER. That is correct.

Mr. REID. Senator KENNEDY is here and ready to speak. Under the previous order, a Democrat is to be recognized to speak now. The Senator has until 11 o'clock if he wants to use that time. At 11 o'clock, the two managers of the bill will be recognized to offer a substitute.

Mr. KENNEDY. We now will be recognized?

Mr. REID. For debate only on the bill.

Mr. CRAIG. Mr. President, will the minority whip yield?

Mr. REID. I will be happy to.

Mr. CRAIG. Will it be possible for me to gain some time following the Senator from Massachusetts?

Mr. REID. Through the Chair, I ask the Senator from Massachusetts, how long does the Senator wish to speak? I say to the Senator from Massachusetts, Senator GREGG spoke for 30 minutes. Under the order, we have the time.

Mr. KENNEDY. We have 9 minutes?

Mr. REID. Senator KENNEDY has until the top of the hour.

Mr. KENNEDY. I want to accommodate my friend. Do I understand the Senator from Michigan intends to offer an amendment this morning?

Mr. REID. Mr. President, the intention, although there is no order in effect, is that at 11 o'clock, the two managers of the bill will be recognized and, at that time, they will offer their substitute. At that time, it will be open to amendment. It has been talked about for the last 2 days that Senator STABENOW will be recognized to offer an amendment.

Mr. KENNEDY. We have, therefore, about 20 minutes between now and 11 o'clock. I will be glad to divide that time.

Mr. CRAIG. I will require more time than that. The Senator, obviously, has the floor, as under the UC, which is fine. I am looking for a window of about 15 or 20 minutes maximum.

Mr. REID. Mr. President, I do not know if the two managers of the bill would be willing to start at 11:15 rather than 11. They are in the cloakroom. While Senator KENNEDY speaks, I will walk back and ask them.

Mr. CRAIG. That would be appreciated.

The PRESIDING OFFICER. The Senator from Massachusetts.

Mr. KENNEDY. Mr. President, I thank the Senator from Idaho as well. As I indicated, I was willing to share the time we had up to 11. As soon as a Member is prepared to offer an amendment, I will yield the floor because I do think we have had a good opportunity to make general comments and opening statements over the period of these last 2 days, and I think the business of the Senate should require that we begin to address some of the areas which need addressing.

I understood my friend and colleague from Michigan will be in the Chamber shortly, and as soon as she is and it is agreeable with the managers, I will yield the floor.

To review very quickly, this is a momentous time. We give credit to the chairman and ranking member of the Finance Committee in moving this process forward in a way which I think can be a building foundation for addressing the critical issue which is on the minds of so many of our seniors, and that is a good, effective, reliable, affordable prescription drug program.

As has been mentioned previously, when we passed the Medicare Program in 1965, it provided for the hospitalization and physician fees, but it did not provide for prescription drugs. Only about 3 percent of all of the private sector insurance programs had a prescription drug program. What we have seen since that time is the extraordinary explosion of prescription drugs which are so necessary to enhance and improve the quality of life for so many of our seniors. They are as indispensable to our seniors as hospitalization and physician fees.

In 1965, we made a commitment and a pledge to our seniors that is really the basis of a program that was developed in the late 1950s. It was an issue that divided the two political parties in the 1960 campaign. President Kennedy felt strongly about developing a Medicare system for our seniors. We had failed to provide national health insurance for all Americans, a goal I am still committed to. It was Harry Truman's goal.

We are always reminded that we in the Senate, Republicans and Democrats, effectively have national health insurance. There is not a single Member of this body who does not take the Federal employees program, rejects that, and takes their own homegrown program. They all take the Federal employees program, which is heavily underwritten by the Federal Government. I do not know of a single program that exists in this country that has the taxpayer underwriting what we in the Congress and the Senate have, including a prescription drug program.

So I am always interested in those who complain about our efforts to try

and pass a good, effective prescription drug program when we have it ourselves. We have looked out after ourselves and we have been so slow in looking out after the needs of our fellow elderly citizens.

I arrived to the Chamber too late to hear my good friend—and he is my good friend—from New Hampshire talk about the indebtedness this bill will provide in terms of the children of this country. This is a $400 billion bill and it is going to mean several thousand dollars of indebtedness to the children who are being born today. Well, that pales in significance when we think that under the Republican administration of the last 2 ½ years we have passed a $2.3 billion tax reduction that is going to mean billions and hundreds of billions of dollars of indebtedness for our children.

This program at least is going to make a difference in terms of the quality of life for seniors who have built this country and sacrificed for their children and fought in the wars and fought to make sure we were going to have economic recovery. It is an investment in them rather than just to the wealthiest individuals. I welcome the opportunity to debate, if we are going to have the chance to do it, which is of greater value to the Nation, which is of greater value to our fellow human beings, these extraordinary tax cuts or the downpayment on the prescription drug program.

The principal reason we have been unable to bring this matter up and develop a bipartisan approach is because of ideology, which has been a part of the Republican commitment over the years, and that is to privatize Social Security and privatize Medicare. They have been opposed to Medicare, opposed to Social Security, from the time immemorial when these programs were passed. We heard the word ''socialism'' talked about all during the debates on the Medicare Program. Every other word was ''socialized medicine.'' We do not hear any of those words anymore. We hear words, as we heard from Newt Gingrich, ''we want to see Medicare wither on the vine.'' But they are opposed to it.

So this issue has been divisive because those of us who have been strongly committed to Medicare refuse to see that it is effectively dismantled by offering a prescription program that would be used to either bribe or coerce seniors out of the Medicare system into a private sector system and then to let the Medicare system wither on the vine. Our elderly people, our seniors, those who have contributed to this country, know their doctor, they know their neighborhood, they know their hospital, and they do not want to be forced out of Medicare into an uncertain system. Many of us in this body are going to resist that and fight that with every fiber in our body.

We have seen an alteration and change, and that is what has been developed in the Senate Finance Committee legislation, which will permit those who are under Medicare to be assured that no matter what part of the country they live in they are going to be able to have access to the prescription drug program that is outlined in this legislation.

For those who want to go into the HMOs, there will be at least the opportunity for those in the private sector who want to risk providing the benefit package that is in here, and want to take the chance, to be able to compete. That is the compromise that has certainly not satisfied everyone—I certainly would not have drafted the bill as it is drafted today—but nonetheless it is the compromise that came out of that committee and which I think Senator GRASSLEY and Senator BAUCUS deserve credit for.

They have established a foundation in which this prescription drug program can be enhanced, strengthened, and built upon, both during the debate over the next 6 days but also in the future years. As long as I am in the Senate and honored to represent the people of Massachusetts, I make the commitment and pledge that I am going to do everything I possibly can to make sure this is the kind of program which is worthy of our senior citizens in the future, but we will have a downpayment in this program with this legislation.

In the past, we reviewed very briefly the need for this program and the costs for this program. I think at the time that we are actually into the amendments, we do not have to go back and speak about the enormous costs our elderly are paying, how their CPI, their adjustment, is not enough to make up for these escalating costs; the fact that these prescription drugs are absolutely indispensable to the lives and well-being of millions of our citizens. We know that is the truth. We know we have an uncertain condition out there in terms of the seniors having access to the drugs. Many of them do not have it. Others are in retirement programs. An increasing number of the retirement programs are dropping individuals. Millions of others have them in Medicaid and that is being cut back in a number of our States, and they are being left out and left behind.

Millions are in HMOs, and almost half of those numbers have been dropped by the HMOs and other conditions have been put on in terms of restricting the amounts that will be expended by the HMOs in the prescription drug program which is disadvantaging these individuals to an enormous degree. Medigap is not picking up the process. The fact remains, our seniors are enormously vulnerable today. Never have they been more vulnerable.

This is against another background that I will just mention very briefly. We have seen in the Congress, in the Senate, over the period of this last 5 years the doubling of the NIH budget. Why was that done? The reason it was done is the recognition that we have had, Republicans and Democrats alike, of the enormous opportunities for breakthroughs, in prescription drugs primarily, and in new technologies to deal with the challenges in health care, mixing technologies and mixing prescription drugs to make further advances—which is certainly the goal of Dr. Sahni at the NIH.

These are very bold and challenging new initiatives in which they are involved. We have seen the mapping of the human genome, with all that means, in the predictability of how genes are going to function and so averting dangers that presents to patients in the future, anticipating that and developing medical technologies that can address that so we can prevent individuals from developing, in this instance I am talking about, several different types of cancers. The list goes on.

We have the most extraordinary opportunity now for breakthroughs in prescription drugs. Now that we have doubled the NIH budget, we have to ask ourselves what is the sense of making these breakthroughs and spending billions and billions of dollars if we are not going to get them out of the laboratory and into the homes of those who need them?

This bill is that downpayment that ensures the drugs get out of the laboratory and to those who need them. That is why it is so important we take action. We are seeing such progress. I see in my own State of Massachusetts—we have more biotech companies in our State than all of Western Europe. I am always amazed at the continued dreams in these research labs in terms of potential breakthroughs and the progress that is being made. It is beyond the possible imagination of so many of us, to think someday we might really conquer cancer, we might really conquer Alzheimer's, we might really conquer diabetes or other diseases. There are dreamers who believe it will be done, and in the none-too-distant future.

We want to put in place a process, a procedure, a delivery system which is affordable, dependable, reliable, so those breakthroughs can get out and get to them. That is what this bill does.

I will just review this because these issues were raised. One of the features, which is not a major feature but which I find has not been mentioned in most of the news reports, is that in January of next year 5 million seniors will receive a card—some might have to pay $25 for it but no more than $25—that will guarantee them $600 worth of prescription drugs. If they do not use all $600, if they use just $400, they can carry that over to next year. That is a real downpayment of this legislation. Five million people are going to receive that. Although the Medicare program will take 3 years to get implemented, this prescription drug card will soon provide needed relief to millions of seniors. That is an indicator to at least 5 million of our seniors, that help is coming, help is on its way.

Let me give three quick examples of an average senior citizen with an income of $15,000. That is the average senior citizen, if they have drug costs at the national average of $2,300. This is the group this legislation perhaps helps the least. We take great care of the 40 percent of the senior citizens with lowest incomes and we take care of those with catastrophic expenses. This is the group we hope to provide additional assistance. This individual would pay a $420 premium, and they would pay $1,298 for cost sharing, and they would receive $604. That may not sound like much, but that is $604 they do not get today.

Let's take the instance of an individual who has the same income, average income, and has a great deal of medical expenses; $15,000 income and they have $10,000 in expenses. They will end up paying the $4,500 but they get $5,400 in savings under this legislation. That is still a good deal—I'd like it to be better, but at least they will gain significantly from this legislation if they have those kinds of bills.

Let's take the same individual. By and large this is 40 percent of all the senior citizens—not half but not far from it. Let's look at a person just above the poverty line with $9,000 in income and the same $2,300 in drug expenses each year. That works out to about $190 per month.

Under this legislation, at $9,000 income, you would pay $5. That would mean a monthly savings of $185.

If your income is $12,000 and you pay out the $190 per month in expenses today, under this legislation you would pay $10 and would save $180 per month.

If your income is $13,500 and you have $190 in monthly costs, under this legislation you would pay $23 and save $168. That is a major relief for those families who are facing these extraordinary challenges across this country.

I see the ranking members of the Finance Committee now on the floor. Let me wind up.

Mr. President, listen to this: 83 percent of all Medicare beneficiaries are going to receive more out of this legislation than they will pay in. Today, in part B of the Medicare only about 50 percent of seniors get out more than they pay in. Under this legislation it would be 83 percent.

For those who go through what they call the doughnut hole, that is the period of time when they are not getting the full assistance I would like to see, it is important to recognize that two-thirds of those who go into the doughnut hole go out the other end into the catastrophic and get extra help. Only about 8 percent actually remain in that doughnut hole.

We are going to have the opportunity here to try to make some further adjustments to strengthen and improve this legislation.

Finally, let me say in watching what happened over in the House of Representatives, their legislation fails to have the kind of backup this legislation has in the delivery of the Medicare benefit, which is unacceptable. They have what they call a premium support program which effectively would undermine the Medicare system, which is completely unacceptable. The means testing is in there, which would require individuals to submit their tax forms to agencies of the Federal Government and insurance companies. I think that would be very offensive.

There are many different aspects of that legislation that are enormously troubling. But that is not this bill. That is not this bill.

So, again, I commend Senator GRASSLEY and Senator BAUCUS and our Republican leader, Senator FRIST, for all they have done working this through. I look forward to the opportunity to address these amendments.

I see the hour of 11 has arrived.

Mr. REID. Mr. President, even though there may not be a unanimous consent request that has been ordered, I ask that the two managers be recognized now; that following whatever they decide to do the Senator from Idaho be recognized to speak for up to 15 minutes; and following the statement of the Senator from Idaho that Senator STABENOW be recognized to offer an amendment. We talked about her amendment for a couple of days.

I ask all this in the form of a unanimous consent request.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

The PRESIDING OFFICER. The Senator from Iowa is recognized.

Mr. GRASSLEY. Mr. President, I am going to offer a modification in just a minute. We are going to wait for our staff to come and present the exact language which we will use in the unanimous consent request.

Before we do that, I have not had the opportunity to express my appreciation to the entire Senate for Senator BAUCUS's cooperation in bringing the bill here, and for everything we have done in order to bring a bipartisan bill here which was voted out of a committee on a 16–5 vote.

In other speeches, I have talked about people who have been working on this issue, such as Senator BREAUX with the Breaux Commission. I have talked about the tripartisan people who worked over the last 2 years to bring a bill before the Senate last year, all of which set the stage for some of the subject matter we have before us. Senator BAUCUS and I hope we will have a continuation of the bipartisanship that has been expressed so far in that vote.

But I haven't had a chance to tell the Senate of my appreciation to Senator BAUCUS in working both at the staff level and his staff—meaning the Finance Committee staff on the Democratic side, and the Finance Committee staff on the Republican side—doing a lot of nitty-gritty work to bring things together with a consensus that can be arrived at at the staff level, but, more importantly, a lot of the things Senator BAUCUS and I had to work out.

When it was all said and done, it was a very pleasant experience. I don't say that because of the relationship Senator BAUCUS and I have, but it is because of a continuation of the tradition of the Senate Finance Committee to do most of its business—albeit not all of its business—in a bipartisan way.

We would not have an issue before us like this—and a lot of other issues that have come out of the Senate Finance Committee—without that sort of cooperation.

I think this deserves a little more special attention of bipartisanship and Senator BAUCUS's cooperation. This is the first major expansion of Medicare in 35 years. This is something that candidates of both political parties have talked about the necessity of doing—providing prescription drugs for seniors.

There is something which is very much of an issue to Montana and to Iowa and to a lot of other States we call rural States. There is an inequity issue within Medicare reimbursement.

Working very closely with Senator BAUCUS last year to establish a Baucus-Grassley bill on Medicare rural equity, then moving this year to adopt the one earlier on a tax bill and duplicating that effort in this prescription drug bill was all done in a bipartisan way. You can only say it so many times, but I don't think you can say it enough either, because people think the Senate is always a highly partisan body. Sometimes we are too highly partisan. Sometimes it is OK to be partisan, I believe, in our system of government. But really nothing gets done in the Senate if there isn't some bipartisan cooperation. Obviously, I take this opportunity to thank Senator BAUCUS for that cooperation.

We still have not had that agreement presented to us yet. I am going to ask Senator BAUCUS if we should let Senator CRAIG go ahead and speak for his 15 minutes before we lay down our amendment.

Mr. BAUCUS. Mr. President, first I very much appreciate the kind words by the chairman of the committee. It is wonderful working with the Senator from Iowa. He is a good man.

With respect to the point made by the chairman, I agree. I think it makes sense at this time, since we are still trying to get papers ready, for the Senator from Idaho to proceed.

Mr. GRASSLEY. Mr. President, we will let the Senator from Idaho finish before we proceed with our unanimous consent.

The PRESIDING OFFICER. The Senator from Idaho.

Mr. CRAIG. Mr. President, I want to thank the Chairman of the Finance Committee and the ranking member for the work they have done on the Finance Committee on S. 1, the Medicare legislation.

The legislation before us today is a praiseworthy document, in that it is a

step forward toward the fundamental goals of providing prescription drug relief for America's seniors and strengthening the Medicare program. This is certainly not to suggest that this legislation is without flaws, but it does begin the process of improving Medicare for our children and our grandchildren down the road and in what we hope will be the right direction.

To paraphrase the words of a rather historic person, Benjamin Franklin, ''Is the sun rising, or is the sun setting'' on the promise of creating a federally funded but also privately competitive Medicare system that can succeed, both in holding down costs and in providing adequate coverage?

Only the future will tell whether what we have before us is the case of a sun rising on a new day in health care or simply a dramatic shift and a sun setting.

What I think is happening here today is the beginning of a very important debate for the remainder of this week and next week. I hope that passage of this legislation will prove to be a major step forward.

As chairman of the Special Committee on Aging, I have convened a variety of hearings over the last several months to carefully examine the difficulties of all of the issues that are going to be talked about here this week, including the long-term demographic pressures facing Medicare, the value of integrating competitive alternatives into the program, and the promise of making care coordination part of a strengthened and improved Medicare prescription drug coverage.

All of these are important. But there is no question that prescription drug coverage is the political engine that drives this debate, but it is just one of several grave challenges we face as we take up this important legislation.

There is no question that drug coverage for America's seniors is long overdue, especially for those in the greatest of need. Except for Medicare, virtually every health care insurance plan in America today covers prescription drugs. Medicare today is trapped in a 1960s model of health care delivery, and lags decades behind what the private sector has to offer.

This bill would address this problem. Beginning immediately, America's seniors would receive a drug discount card enabling them to purchase drugs at a significant discount. More importantly, in 2006 seniors would be able to enroll in federally subsidized Medicare drug coverage for a premium of about $35 a month—coverage that would be of greater per-dollar value than that currently offered through Medicare supplemental, Medigap, or wraparound plans.

I am especially pleased that this legislation devotes the greatest share of its drug assistance to seniors of low and modest income—most especially seniors below 160 percent of poverty. These seniors—those with annual incomes below about $13,500 for an individual, and about $18,200 for a couple—would receive special assistance of about 80 to 90 percent for their drug costs, depending on income.

The truth is, the proportion of seniors who truly cannot afford prescription drugs is relatively small—perhaps 25 percent. It is on these seniors in the greatest of need that our help should be focused.

Mr. President, even more important than drug coverage is the urgent need to begin putting Medicare on a more modern and secure footing as the 77-million-strong baby boomer generation moves even closer to retirement age. According to the Medicare Trustees, Medicare costs, even without any drug benefit, will more than triple over the next 75 years, placing a tremendous burden on future generations.

Despite this looming challenge, Medicare today remains clogged by rigid bureaucracy and complex regulations regulations that are already beginning to drive doctors and other health care providers out of this program, leaving our seniors, in many instances, without access to the health care they need.

Medicare, as we know it today, is micromanaged to the tiniest of details for medical payments and procedures, including the pricing and regulation of more than 7,000 medical procedures and over 500 hospital procedures. Why are we so intent on micromanaging the system? Medicare regulations now total more than 110,000 pages of rules and regulations.

Perhaps it is not surprising, then, that doctors and hospitals report having to spend half an hour to an hour in paperwork for every hour spent in patient care. In other words, there is often more intensity on doing the paperwork right than there is on good health care procedures for the patient and all because of a Federal system that is so heavily micromanaged. And of course, the risks to providers are high if they fail to perform the required regulatory tasks in the most minute of ways.

Even more distressing, the heavily bureaucratic Medicare Program has ultimately failed to keep up with the kinds of medical and health care coverage innovations most of the rest of us take for granted. For example, the current Medicare Program only covers a handful of preventive screenings and tests and in most cases will not even pay for a standard physical.

Medicare also lags far behind the private sector in its use of care coordination and disease management systems under which a patient's care is coordinated and optimized, promoting better health outcomes and fewer days of hospitalization.

For certain chronic conditions, such as diabetes and congestive heart failure, as many as 83 to 97 percent of America's health care plans now offer such care coordination. Medicare, meanwhile, has only barely begun to experiment with demonstration projects in this area and some prominent experts, such as former CBO Director Dan Crippen, doubt that care management can ever work effectively in Medicare as we know it today.

The bill before us seeks to bring Medicare into the 21st century, not just by providing prescription drug coverage, but also by offering seniors the choice to enroll in federally supervised but privately operated health care plans the same kind of choices and coverage currently enjoyed by millions of other Americans under age 65. Ideally, these plans could include preferred provider organizations, fee-for-service plans, HMOs, and even medical savings accounts.

The current Medicare system forces seniors to hunt for and purchase supplemental plans for many of the things that Medicare does not cover. By contrast, the new Medicare Advantage plans would give seniors one-stop shopping for comprehensive and integrated coverage including prescription drugs, preventive care, care coordination, and protection against high catastrophic medical bills, benefits which are largely unheard of in the traditional Medicare plan of today.

Importantly, these new choices would be entirely voluntary. Seniors who want to keep their current coverage and stay in traditional Medicare would be free to do so. Also, the new prescription drug program would be offered in both the traditional program and in the new Medicare Advantage plans. No senior would see any reduction in Medicare benefits under this bill. No benefits would be taken away—none.

I am also extremely pleased this bill includes a significant and necessary package of improvements in rural health care and reimbursement. Among other changes, this legislation would improve certain categories of rural payment and would make needed rule changes to assist critical access hospitals and other rural providers.

For far too long, doctors and hospitals in Idaho and other rural States have suffered under payment classifications and reimbursement levels that put them at a significant disadvantage and that make the already difficult job of providing health care in rural America even more daunting.

The underlying framework of this bill is a sound one, and it follows the basic principles laid out by President Bush earlier this year—namely, to strengthen traditional Medicare and keep it as an alternative for those seniors who want it, but also to provide a new foundation for the future, one built on choices, competition, and innovation.

This said, however, I am gravely troubled by certain aspects of this bill's current design—particularly the fact that we have not incorporated in it enough competitive alternatives.

First, I believe it is a mistake to offer exactly equivalent drug benefits in the older, more traditional program

and in the new Medicare Advantage plans—and thereby not create a strong competitive advantage for the Medicare Advantage programs. This is an important issue in causing seniors to make selections toward the marketplace and toward a variety of alternatives—rather than to be fearfully hunkered down, if you will, in the old program. If we truly believe, as I do, that structured competition, rather than a perpetuation of top-down bureaucratic health care, is the better future for Medicare, our legislation should reflect this commitment.

Second, this bill unwisely imposes a ceiling, or benchmark, on the amount the Federal Government will pay the new Medicare Advantage plans. What we want is a variety of robust competitive alternatives in the marketplace, and capping or creating a ceiling may threaten that goal.

Third, the legislation creates an unnecessarily heavy-handed and restrictive bidding system for the Medicare Advantage Program. Under this program, HHS would choose only three winning plans for each of ten national regions. Far preferable would be a system like the Federal Health Benefits Program, under which any plan meeting basic federal standards would be permitted to compete. It should be the marketplace, not HHS bureaucrats, who decide which plans succeed or fail.

Fourth, I am concerned by this legislation's overall high level of complexity and prescriptiveness—prescriptiveness that threatens to add appreciably to the 110,000 pages of regulation already in place. Shame on us if we do that. This bill, which I suspect weighs a few pounds, has hundreds and hundreds of pages. I hope that, for every page of legislation we do not also see 25 or 30 pages of ensuing regulation. If that is the case, we will have created the opposite of what we should intend—namely walking away from the bureaucracy and into the marketplace, into the opportunity of choice, and into a much freer environment—one that providers want to join, and one that provides optimum health care for the senior of today.

Over the course of the next week and a half, hopefully, amendments will take us toward simplicity instead of toward the kind of micromanagement we have seen in the past. History should not repeat itself here, and I think all of us should be concerned that it might. This is because we have the great tendency to err on the side of the bureaucracy and the side of regulation, when, in fact, the marketplace—as shown by the hearings I have held—can, in fact, be the greater arbiter of health care when effective competition is provided.

These concerns are by no means exhaustive. Like many of my colleagues, I am also concerned about the complexity and stability of the proposed system for providing drug coverage in the traditional Medicare program, and I worry about the possibility that some employers may react to the new Federal drug coverage by cutting back or dropping benefits they currently provide to their retirees.

Finally, I want to caution my colleagues, in no uncertain terms, that neither this bill nor any of the alternative Democratic proposals offers a magic bullet for Medicare's future. The financial and demographic outlook for Medicare is sobering in the extreme, and nothing can change the fact that hard choices lie ahead, regardless of what we do this year. This legislation could improve our prospects, but it is, at best, only a first step.

Majority Leader FRIST, Senator GRASSLEY, and others on the Finance Committee deserve tremendous credit for bringing us to where we are today, as does President Bush for making prescription drugs and Medicare reform a top priority this year.

The coming weeks will be critical ones. I hope we can succeed in producing a bill worthy of this historic opportunity.

Mr. President, I again thank the chairman and the ranking member. I also thank Senator FRIST, our leader, for insisting that this issue get to the floor for the kind of debate I trust we will have—and for working with the House toward putting on our President's desk something that we have long promised America's seniors: That those who are truly needy will have access to prescription drugs and all seniors will have access to a modernized Medicare Program.

I yield the floor.

The PRESIDING OFFICER (Mr. GRAHAM of South Carolina). The Senator from Nevada.

Mr. REID. Mr. 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.

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MODIFICATION TO COMMITTEE AMENDMENT

Mr. GRASSLEY. Mr. President, with the authority of the majority of the Finance Committee, I now modify my committee substitute and the modification is at the desk.

The PRESIDING OFFICER. The amendment is so modified.

The committee amendment, as modified, is as follows:

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

(a) SHORT TITLE.—This Act may be cited as the ''Prescription Drug and Medicare Improvement Act of 2003''.

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

(c) BIPA; SECRETARY.—In this Act:

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

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

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

(a) ESTABLISHMENT.—Title XVIII (42 U.S.C. 1395 et seq.) is amended by redesignating part D as part E and by inserting after part C the following new part:

''PART D—VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

''DEFINITIONS; TREATMENT OF REFERENCES TO PROVISIONS IN MEDICAREADVANTAGE PROGRAM

''SEC. 1860D. (a) DEFINITIONS.—In this part:

''(1) ADMINISTRATOR.—The term 'Administrator' means the Administrator of the Center for Medicare Choices as established under section 1808.

''(2) COVERED DRUG.—

''(A) IN GENERAL.—Except as provided in subparagraphs (B), (C), and (D), the term 'covered drug' means—

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

''(ii) a biological product described in clauses (i) through (iii) of subparagraph (B) of such section; or

''(iii) insulin described in subparagraph (C) of such section;

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

''(B) EXCLUSIONS.—

''(i) IN GENERAL.—The term 'covered drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

''(ii) AVOIDANCE OF DUPLICATE COVERAGE.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered if payment for such drug is available under part A or B, but shall be so considered if such payment is not available under part A or B or because benefits under such parts have been exhausted.

''(C) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered drug under this part shall not be so considered under a plan if the plan excludes the drug under a formulary and such exclusion is not successfully resolved under subsection (d) or (e)(2) of section 1860D–5.

''(D) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—A Medicare Prescription Drug plan or a MedicareAdvantage plan may exclude from qualified prescription drug coverage any covered drug—

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

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

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860D–5(e).

''(3) ELIGIBLE BENEFICIARY.—The term 'eligible beneficiary' means an individual who is entitled to, or enrolled for, benefits under part A and enrolled under part B (other than a dual eligible individual, as defined in section 1860D–19(a)(4)(E)).

''(4) ELIGIBLE ENTITY.—The term 'eligible entity' means any risk-bearing entity that the Administrator determines to be appropriate to provide eligible beneficiaries with the benefits under a Medicare Prescription Drug plan, including—

''(A) a pharmaceutical benefit management company;

''(B) a wholesale or retail pharmacist delivery system;

''(C) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

''(D) any other risk-bearing entity; or

''(E) any combination of the entities described in subparagraphs (A) through (D).

''(5) INITIAL COVERAGE LIMIT.—The term 'initial coverage limit' means the limit as established under section 1860D–6(c)(3), or, in the case of coverage that is not standard prescription drug coverage, the comparable limit (if any) established under the coverage.

''(6) MEDICAREADVANTAGE ORGANIZATION; MEDICAREADVANTAGE PLAN.—The terms 'MedicareAdvantage organization' and 'MedicareAdvantage plan' have the meanings given such terms in subsections (a)(1) and (b)(1), respectively, of section 1859 (relating to definitions relating to MedicareAdvantage organizations).

''(7) MEDICARE PRESCRIPTION DRUG PLAN.—The term 'Medicare Prescription Drug plan' means prescription drug coverage that is offered under a policy, contract, or plan—

''(A) that has been approved under section 1860D–13; and

''(B) by an eligible entity pursuant to, and in accordance with, a contract between the Administrator and the entity under section 1860D–7(b).

''(8) PRESCRIPTION DRUG ACCOUNT.—The term 'Prescription Drug Account' means the Prescription Drug Account (as established under section 1860D–25) in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(9) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' means the coverage described in section 1860D–6(a)(1).

''(10) STANDARD PRESCRIPTION DRUG COVERAGE.—The term 'standard prescription drug coverage' means the coverage described in section 1860D–6(c).

''(b) APPLICATION OF MEDICAREADVANTAGE PROVISIONS UNDER THIS PART.—For purposes of applying provisions of part C under this part with respect to a Medicare Prescription Drug plan and an eligible entity, unless otherwise provided in this part such provisions shall be applied as if—

''(1) any reference to a MedicareAdvantage plan included a reference to a Medicare Prescription Drug plan;

''(2) any reference to a provider-sponsored organization included a reference to an eligible entity;

''(3) any reference to a contract under section 1857 included a reference to a contract under section 1860D–7(b); and

''(4) any reference to part C included a reference to this part.

''Subpart 1—Establishment of Voluntary Prescription Drug Delivery Program

''ESTABLISHMENT OF VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM

''SEC. 1860D–1. (a) PROVISION OF BENEFIT.—

''(1) IN GENERAL.—The Administrator shall provide for and administer a voluntary prescription drug delivery program under which each eligible beneficiary enrolled under this part shall be provided with access to qualified prescription drug coverage as follows:

''(A) MEDICAREADVANTAGE ENROLLEES RECEIVE COVERAGE THROUGH MEDICAREADVANTAGE PLAN.—

''(i) IN GENERAL.—Except as provided in clause (ii), an eligible beneficiary who is enrolled under this part and enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization shall receive coverage of benefits under this part through such plan.

''(ii) EXCEPTION FOR ENROLLEES IN MEDICAREADVANTAGE MSA PLANS.—An eligible beneficiary who is enrolled under this part and enrolled in an MSA plan under part C shall receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides. For purposes of this part, the term 'MSA plan' has the meaning given such term in section 1859(b)(3).

''(iii) EXCEPTION FOR ENROLLEES IN MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—An eligible beneficiary who is enrolled under this part and enrolled in a private fee-for-service plan under part C shall—

''(i) receive benefits under this part through such plan if the plan provides qualified prescription drug coverage; and

''(ii) if the plan does not provide qualified prescription drug coverage, receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan

that is offered in the geographic area in which the beneficiary resides. For purposes of this part, the term 'private fee-for-service plan' has the meaning given such term in section 1859(b)(2).

''(B) FEE-FOR-SERVICE ENROLLEES RECEIVE COVERAGE THROUGH A MEDICARE PRESCRIPTION DRUG PLAN.—An eligible beneficiary who is enrolled under this part but is not enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) shall receive coverage of benefits under this part through enrollment in a Medicare Prescription Drug plan that is offered in the geographic area in which the beneficiary resides.

''(2) VOLUNTARY NATURE OF PROGRAM.—Nothing in this part shall be construed as requiring an eligible beneficiary to enroll in the program under this part.

''(3) SCOPE OF BENEFITS.—Pursuant to section 1860D–6(b)(3)(C), the program established under this part shall provide for coverage of all therapeutic categories and classes of covered drugs (although not necessarily for all drugs within such categories and classes).

''(4) PROGRAM TO BEGIN IN 2006.—The Administrator shall establish the program under this part in a manner so that benefits are first provided beginning on January 1, 2006.

''(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG COVERAGE.—In the case of an eligible beneficiary who has creditable prescription drug coverage (as defined in section 1860D–2(b)(1)(F)), such beneficiary—

''(1) may continue to receive such coverage and not enroll under this part; and

''(2) pursuant to section 1860D–2(b)(1)(C), is permitted to subsequently enroll under this part without any penalty and obtain access to qualified prescription drug coverage in the manner described in subsection (a) if the beneficiary involuntarily loses such coverage.

''(c) FINANCING.—The costs of providing benefits under this part shall be payable from the Prescription Drug Account.

''ENROLLMENT UNDER PROGRAM

''SEC. 1860D–2. (a) ESTABLISHMENT OF ENROLLMENT PROCESS.—

''(1) PROCESS SIMILAR TO PART B ENROLLMENT.—The Administrator shall establish a process through which an eligible beneficiary (including an eligible beneficiary enrolled in a MedicareAdvantage plan offered by a MedicareAdvantage organization) may make an election to enroll under this part. Such process shall be similar to the process for enrollment in part B under section 1837, including the deeming provisions of such section.

''(2) CONDITION OF ENROLLMENT.—An eligible beneficiary must be enrolled under this part in order to be eligible to receive access to qualified prescription drug coverage.

''(b) SPECIAL ENROLLMENT PROCEDURES.—

''(1) LATE ENROLLMENT PENALTY.—

''(A) INCREASE IN MONTHLY BENEFICIARY OBLIGATION.—Subject to the succeeding provisions of this paragraph, in the case of an eligible beneficiary whose coverage period under this part began pursuant to an enrollment after the beneficiary's initial enrollment period under part B (determined pursuant to section 1837(d)) and not pursuant to the open enrollment period described in paragraph (2), the Administrator shall establish procedures for increasing the amount of the monthly beneficiary obligation under section 1860D–17 applicable to such beneficiary by an amount that the Administrator determines is actuarially sound for each full 12-month period (in the same continuous period of eligibility) in which the eligible beneficiary could have been enrolled under this part but was not so enrolled.

''(B) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under subparagraph (A), there shall be taken into account—

''(i) the months which elapsed between the close of the eligible beneficiary's initial enrollment period and the close of the enrollment period in which the beneficiary enrolled; and

''(ii) in the case of an eligible beneficiary who reenrolls under this part, the months which elapsed between the date of termination of a previous coverage period and the close of the enrollment period in which the beneficiary reenrolled.

''(C) PERIODS NOT TAKEN INTO ACCOUNT.—

''(i) IN GENERAL.—For purposes of calculating any 12-month period under subparagraph (A), subject to clause (ii), there shall not be taken into account months for which the eligible beneficiary can demonstrate that the beneficiary had creditable prescription drug coverage (as defined in subparagraph (F)).

''(ii) BENEFICIARY MUST INVOLUNTARILY LOSE COVERAGE.—Clause (i) shall only apply with respect to coverage—

''(I) in the case of coverage described in clause (ii) of subparagraph (F), if the plan terminates, ceases to provide, or reduces the value of the prescription drug coverage under such plan to below the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f));

''(II) in the case of coverage described in clause (i), (iii), or (iv) of subparagraph (F), if the beneficiary is involuntarily disenrolled or becomes ineligible for such coverage; or

''(III) in the case of a beneficiary with coverage described in clause (v) of subparagraph (F), if the issuer of the policy terminates coverage under the policy.

''(D) PERIODS TREATED SEPARATELY.—Any increase in an eligible beneficiary's monthly beneficiary obligation under subparagraph (A) with respect to a particular continuous period of eligibility shall not be applicable with respect to any other continuous period of eligibility which the beneficiary may have.

''(E) CONTINUOUS PERIOD OF ELIGIBILITY.—

''(i) IN GENERAL.—Subject to clause (ii), for purposes of this paragraph, an eligible beneficiary's 'continuous period of eligibility' is the period that begins with the first day on which the beneficiary is eligible to enroll under section 1836 and ends with the beneficiary's death.

''(ii) SEPARATE PERIOD.—Any period during all of which an eligible beneficiary satisfied paragraph (1) of section 1836 and which terminated in or before the month preceding the month in which the beneficiary attained age 65 shall be a separate 'continuous period of eligibility' with respect to the beneficiary (and each such period which terminates shall be deemed not to have existed for purposes of subsequently applying this paragraph).

''(F) CREDITABLE PRESCRIPTION DRUG COVERAGE DEFINED.—Subject to subparagraph (G), for purposes of this part, the term 'creditable prescription drug coverage' means any of the following:

''(i) DRUG-ONLY COVERAGE UNDER MEDICAID.—Coverage of covered outpatient drugs (as defined in section 1927) under title XIX or a waiver under 1115 that is provided to an individual who is not a dual eligible individual (as defined in section 1860D–19(a)(4)(E)).

''(ii) PRESCRIPTION DRUG COVERAGE UNDER A GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under chapter 89 of title 5, United States Code (commonly known as the Federal employees health benefits program), and a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)).

''(iii) STATE PHARMACEUTICAL ASSISTANCE PROGRAM.—Coverage of prescription drugs under a State pharmaceutical assistance program.

''(iv) VETERANS' COVERAGE OF PRESCRIPTION DRUGS.—Coverage of prescription drugs for veterans, and survivors and dependents of veterans, under chapter 17 of title 38, United States Code.

''(v) PRESCRIPTION DRUG COVERAGE UNDER MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs (whether or not such coverage conforms to the standards for packages of benefits under section 1882(p)(1)).

''(G) REQUIREMENT FOR CREDITABLE COVERAGE.—Coverage described in clauses (i) through (v) of subparagraph (F) shall not be considered to be creditable coverage under this part unless the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)).

''(H) DISCLOSURE.—

''(i) IN GENERAL.—Each entity that offers coverage of the type described in clause (ii) (iii), (iv), or (v) of subparagraph (F) shall provide for disclosure, consistent with standards established by the Administrator, of whether the coverage provides coverage of the cost of prescription drugs the actuarial value of which (as defined by the Administrator) to the beneficiary equals or exceeds the actuarial value of standard prescription drug coverage (as determined under section 1860D–6(f)).

''(ii) WAIVER OF LIMITATIONS.—An individual may apply to the Administrator to waive the application of subparagraph (G) if the individual establishes that the individual was not adequately informed that the coverage the beneficiary was enrolled in did not provide the level of benefits required in order for the coverage to be considered creditable coverage under subparagraph (F).

''(2) INITIAL ELECTION PERIODS.—

''(A) OPEN ENROLLMENT PERIOD FOR CURRENT BENEFICIARIES IN WHICH LATE ENROLLMENT PROCEDURES DO NOT APPLY.—In the case of an individual who is an eligible beneficiary as of November 1, 2005, there shall be an open enrollment period of 6 months beginning on that date under which such beneficiary may enroll under this part without the application of the late enrollment procedures established under paragraph (1)(A).

''(B) INDIVIDUAL COVERED IN FUTURE.—In the case of an individual who becomes an eligible beneficiary after such date, there shall be an initial election period which is the same as the initial enrollment period under section 1837(d).

''(3) SPECIAL ENROLLMENT PERIOD FOR BENEFICIARIES WHO INVOLUNTARILY LOSE CREDITABLE PRESCRIPTION DRUG COVERAGE.—

''(A) ESTABLISHMENT.—The Administrator shall establish a special open enrollment period (as described in subparagraph (B)) for an eligible beneficiary that loses creditable prescription drug coverage.

''(B) SPECIAL OPEN ENROLLMENT PERIOD.—The special open enrollment period described in this subparagraph is the 63-day period that begins on—

''(i) in the case of a beneficiary with coverage described in clause (ii) of paragraph (1)(F), the later of the date on which the plan terminates, ceases to provide, or substantially reduces (as defined by the Administrator) the value of the prescription drug coverage under such plan or the date the beneficiary is provided with notice of such termination or reduction;

''(ii) in the case of a beneficiary with coverage described in clause (i), (iii), or (iv) of paragraph (1)(F), the later of the date on which the beneficiary is involuntarily disenrolled or becomes ineligible for such coverage or the date the beneficiary is provided with notice of such loss of eligibility; or

''(iii) in the case of a beneficiary with coverage described in clause (v) of paragraph (1)(F), the latter of the date on which the issuer of the policy terminates coverage under the policy or the date the beneficiary is provided with notice of such termination.

''(c) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as provided in paragraph (2) and subject to paragraph (3), an eligible beneficiary's coverage under the program under this part shall be effective for the period provided in section 1838, as if that section applied to the program under this part.

''(2) OPEN AND SPECIAL ENROLLMENT.—

''(A) OPEN ENROLLMENT.—An eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(2) shall be entitled to the benefits under this part beginning on January 1, 2006.

''(B) SPECIAL ENROLLMENT.—Subject to paragraph (3), an eligible beneficiary who enrolls under the program under this part pursuant to subsection (b)(3) shall be entitled to the benefits under this part beginning on the first day of the month following the month in which such enrollment occurs.

''(3) LIMITATION.—Coverage under this part shall not begin prior to January 1, 2006.

''(d) TERMINATION.—

''(1) IN GENERAL.—The causes of termination specified in section 1838 shall apply to this part in the same manner as such causes apply to part B.

''(2) COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PART A OR B.—

''(A) IN GENERAL.—In addition to the causes of termination specified in paragraph (1), the Administrator shall terminate an individual's coverage under this part if the individual is no longer enrolled in both parts A and B.

''(B) EFFECTIVE DATE.—The termination described in subparagraph (A) shall be effective on the effective date of termination of coverage under part A or (if earlier) under part B.

''(3) PROCEDURES REGARDING TERMINATION OF A BENEFICIARY UNDER A PLAN.—The Administrator shall establish procedures for determining the status of an eligible beneficiary's enrollment under this part if the beneficiary's enrollment in a Medicare Prescription Drug plan offered by an eligible entity under this part is terminated by the entity for cause (pursuant to procedures established by the Administrator under section 1860D–3(a)(1)).

''ELECTION OF A MEDICARE PRESCRIPTION DRUG PLAN

''SEC. 1860D–3. (a) IN GENERAL.—

''(1) PROCESS.—

''(A) ELECTION.—

''(i) IN GENERAL.—The Administrator shall establish a process through which an eligible beneficiary who is enrolled under this part but not enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) offered by a MedicareAdvantage organization—

''(I) shall make an election to enroll in any Medicare Prescription Drug plan that is offered by an eligible entity and that serves the geographic area in which the beneficiary resides; and

''(II) may make an annual election to change the election under this clause.

''(ii) CLARIFICATION REGARDING ENROLLMENT.—The process established under clause (i) shall include, in the case of an eligible beneficiary who is enrolled under this part but who has failed to make an election of a Medicare Prescription Drug plan in an area, for the enrollment in any Medicare Prescription Drug plan that has been designated by the Administrator in the area. The Administrator shall establish a process for designating a plan or plans in order to carry out the preceding sentence.

''(B) REQUIREMENTS FOR PROCESS.—In establishing the process under subparagraph (A), the Administrator shall—

''(i) use rules similar to the rules for enrollment, disenrollment, and termination of enrollment with a MedicareAdvantage plan under section 1851, including—

''(I) the establishment of special election periods under subsection (e)(4) of such section; and

''(II) the application of the guaranteed issue and renewal provisions of section 1851(g) (other than clause (i) and the second sentence of clause (ii) of paragraph (3)(C), relating to default enrollment); and

''(ii) coordinate enrollments, disenrollments, and terminations of enrollment under part C with enrollments, disenrollments, and terminations of enrollment under this part.

''(2) FIRST ENROLLMENT PERIOD FOR PLAN ENROLLMENT.—The process developed under paragraph (1) shall ensure that eligible beneficiaries who enroll under this part during the open enrollment period under section 1860D–2(b)(2) are permitted to elect an eligible entity prior to January 1, 2006, in order to ensure that coverage under this part is effective as of such date.

''(b) ENROLLMENT IN A MEDICAREADVANTAGE PLAN.—

''(1) IN GENERAL.—An eligible beneficiary who is enrolled under this part and enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage) offered by a MedicareAdvantage organization shall receive access to such coverage under this part through such plan.

''(2) RULES.—Enrollment in a MedicareAdvantage plan is subject to the rules for enrollment in such plan under section 1851.

''(c) INFORMATION TO ENTITIES TO FACILITATE ENROLLMENT.—Notwithstanding any other provision of law, the Administrator may provide to each eligible entity with a contract under this part such information about eligible beneficiaries as the Administrator determines to be necessary to facilitate efficient enrollment by such beneficiaries with such entities. The Administrator may provide such information only so long as and to the extent necessary to carry out such objective.

''PROVIDING INFORMATION TO BENEFICIARIES

''SEC. 1860D–4. (a) ACTIVITIES.—

''(1) IN GENERAL.—The Administrator shall conduct activities that are designed to broadly disseminate information to eligible beneficiaries (and prospective eligible beneficiaries) regarding the coverage provided under this part.

''(2) SPECIAL RULE FOR FIRST ENROLLMENT UNDER THE PROGRAM.—The activities described in paragraph (1) shall ensure that eligible beneficiaries are provided with such information at least 30 days prior to the first enrollment period described in section 1860D–3(a)(2).

''(b) REQUIREMENTS.—

''(1) IN GENERAL.—The activities described in subsection (a) shall—

''(A) be similar to the activities performed by the Administrator under section 1851(d);

''(B) be coordinated with the activities performed by—

''(i) the Administrator under such section; and

''(ii) the Secretary under section 1804; and

''(C) provide for the dissemination of information comparing the plans offered by eligible entities under this part that are available to eligible beneficiaries residing in an area.

''(2) COMPARATIVE INFORMATION.—The comparative information described in paragraph (1)(C) shall include a comparison of the following:

''(A) BENEFITS.—The benefits provided under the plan and the formularies and grievance and appeals processes under the plan.

''(B) MONTHLY BENEFICIARY OBLIGATION.—The monthly beneficiary obligation under the plan.

''(C) QUALITY AND PERFORMANCE.—The quality and performance of the eligible entity offering the plan.

''(D) BENEFICIARY COST-SHARING.—The cost-sharing required of eligible beneficiaries under the plan.

''(E) CONSUMER SATISFACTION SURVEYS.—The results of consumer satisfaction surveys regarding the plan and the eligible entity offering such plan (conducted pursuant to section 1860D–5(h).

''(F) ADDITIONAL INFORMATION.—Such additional information as the Administrator may prescribe.

''BENEFICIARY PROTECTIONS

''SEC. 1860D–5. (a) DISSEMINATION OF INFORMATION.—

''(1) GENERAL INFORMATION.—An eligible entity offering a Medicare Prescription Drug plan shall disclose, in a clear, accurate, and standardized form to each enrollee at the time of enrollment, and at least annually thereafter, the information described in section 1852(c)(1) relating to such plan. Such information includes the following:

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

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

''(C) Copayments, coinsurance, and deductible requirements.

''(D) Grievance and appeals processes.

The information described in the preceding sentence shall also be made available on request to prospective enrollees during open enrollment periods.

''(2) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll in a Medicare Prescription Drug plan, the eligible entity offering such plan shall provide information similar (as determined by the Administrator) to the information described in subparagraphs (A), (B), and (C) of section 1852(c)(2) to such individual.

''(3) RESPONSE TO BENEFICIARY QUESTIONS.—An eligible entity offering a Medicare Prescription Drug plan shall have a mechanism for providing on a timely basis specific information to enrollees upon request, including information on the coverage of specific drugs and changes in its formulary.

''(4) CLAIMS INFORMATION.—An eligible entity offering a Medicare Prescription Drug plan must furnish to enrolled individuals in a form easily understandable to such individuals—

''(A) an explanation of benefits (in accordance with section 1806(a) or in a comparable manner); and

''(B) when prescription drug benefits are provided under this part, a notice of the benefits in relation to the initial coverage limit and annual out-of-pocket limit for the current year (except that such notice need not be provided more often than monthly).

''(5) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—The provisions of section 1851(h) shall apply to marketing material and application forms under this part in the same manner as such provisions apply to marketing material and application forms under part C.

''(b) ACCESS TO COVERED DRUGS.—

''(1) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—An eligible entity offering a Medicare Prescription Drug plan shall have in place procedures to ensure that beneficiaries are not charged more than the negotiated price of a covered drug. Such procedures shall include the issuance of a card (or other technology) that may be used by an enrolled beneficiary for the purchase of prescription drugs for which coverage is not otherwise provided under the Medicare Prescription Drug plan.

''(2) ASSURING PHARMACY ACCESS.—

''(A) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Administrator and including adequate emergency access) for enrolled beneficiaries, in accordance with standards established by the Administrator under section 1860D–7(g) that ensure such convenient access. Such standards shall take into account reasonable distances to pharmacy services in both urban and rural areas.

''(B) USE OF POINT-OF-SERVICE SYSTEM.—An eligible entity offering a Medicare Prescription Drug plan shall establish an optional point-of-service method of operation under which—

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

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

The additional copayments so charged shall not count toward the application of section 1860D–6(c).

''(3) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If an eligible entity offering a Medicare Prescription Drug plan uses a formulary, the following requirements must be met:

''(A) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

''(i) IN GENERAL.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary.

''(ii) COMPOSITION.—A pharmacy and therapeutic committee shall include at least 1 academic expert, at least 1 practicing physician, and at least 1 practicing pharmacist, all of whom have expertise in the care of elderly or disabled persons, and a majority of the members of such committee shall consist of individuals who are a practicing physician or a practicing pharmacist (or both).

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

''(C) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES AND CLASSES.—

''(i) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered drugs (as defined by the Administrator), although not necessarily for all drugs within such categories and classes.

''(ii) REQUIREMENT.—In defining therapeutic categories and classes of covered drugs pursuant to clause (i), the Administrator shall use—

''(I) the compendia referred to section 1927(g)(1)(B)(i); and

''(II) other recognized sources of drug classifications and categorizations determined appropriate by the Administrator.

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

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

''(F) APPEALS AND EXCEPTIONS TO APPLICATION.—The eligible entity must have, as part of the appeals process under subsection (e), a process for timely appeals for denials of coverage based on such application of the formulary.

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

''(1) IN GENERAL.—An eligible entity shall have in place the following with respect to covered drugs:

''(A) A cost-effective drug utilization management program, including incentives to reduce costs when appropriate.

''(B) Quality assurance measures to reduce medical errors and adverse drug interactions and to improve medication use, which—

''(i) shall include a medication therapy management program described in paragraph (2); and

''(ii) may include beneficiary education programs, counseling, medication refill reminders, and special packaging.

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

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

''(2) MEDICATION THERAPY MANAGEMENT PROGRAM.—

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

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

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

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

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

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

''(D) CONSIDERATIONS IN PHARMACY FEES.—The eligible entity offering a Medicare Prescription Drug plan shall take into account, in establishing fees for pharmacists and others providing services under the medication therapy management program, the resources and time used in implementing the program.

''(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—The eligible entity offering a Medicare Prescription Drug plan shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest cost generic drug covered under the plan that is therapeutically equivalent and bioequivalent.

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

''(1) IN GENERAL.—An eligible entity shall provide meaningful procedures for hearing and resolving grievances between the eligible entity (including any entity or individual through which the eligible entity provides covered benefits) and enrollees with Medicare Prescription Drug plans of the eligible entity under this part in accordance with section 1852(f).

''(2) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—The requirements of paragraphs (1) through (3) of section 1852(g) shall apply to an eligible entity with respect to covered benefits under the Medicare Prescription Drug plan it offers under this part in the same manner as such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

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

''(e) APPEALS.—

''(1) IN GENERAL.—Subject to paragraph (2), the requirements of paragraphs (4) and (5) of section 1852(g) shall apply to an eligible entity with respect to drugs not included on any formulary in a manner that is similar (as determined by the Administrator) to the manner that such requirements apply to a MedicareAdvantage organization with respect to benefits it offers under a MedicareAdvantage plan under part C.

''(2) FORMULARY DETERMINATIONS.—An individual who is enrolled in a Medicare Prescription Drug plan offered by an eligible entity may appeal to obtain coverage for a covered drug that is not on a formulary of the entity under the terms applicable for a formulary drug if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the individual or has adverse effects for the individual.

''(f) PRIVACY, CONFIDENTIALITY, AND ACCURACY OF ENROLLEE RECORDS.—Insofar as an eligible entity maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in the Medicare Prescription Drug plan offered by the entity, the entity shall have in place procedures to—

''(1) safeguard the privacy of any individually identifiable beneficiary information in a manner consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated

under section 264(c) of the Health Insurance Portability and Accountability Act of 1996;

''(2) maintain such records and information in a manner that is accurate and timely;

''(3) ensure timely access by such beneficiaries to such records and information; and

''(4) otherwise comply with applicable laws relating to patient privacy and confidentiality.

''(g) UNIFORM MONTHLY PLAN PREMIUM.—An eligible entity shall ensure that the monthly plan premium for a Medicare Prescription Drug plan charged under this part is the same for all eligible beneficiaries enrolled in the plan.

''(h) CONSUMER SATISFACTION SURVEYS.—An eligible entity shall conduct consumer satisfaction surveys with respect to the plan and the entity. The Administrator shall establish uniform requirements for such surveys.

''PRESCRIPTION DRUG BENEFITS

''SEC. 1860D–6. (a) REQUIREMENTS.—

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

''(A) STANDARD PRESCRIPTION DRUG COVERAGE WITH ACCESS TO NEGOTIATED PRICES.—Standard prescription drug coverage (as defined in subsection (c)) and access to negotiated prices under subsection (e).

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

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

''(A) IN GENERAL.—Subject to subparagraph (B) and section 1860D–13(c)(2), nothing in this part shall be construed as preventing qualified prescription drug coverage from including coverage of covered drugs that exceeds the coverage required under paragraph (1).

''(B) REQUIREMENT.—An eligible entity may not offer a Medicare Prescription Drug plan that provides additional benefits pursuant to subparagraph (A) in an area unless the eligible entity offering such plan also offers a Medicare Prescription Drug plan in the area that only provides the coverage of prescription drugs that is required under paragraph (1).

''(3) COST CONTROL MECHANISMS.—In providing qualified prescription drug coverage, the entity offering the Medicare Prescription Drug plan or the MedicareAdvantage plan may use a variety of cost control mechanisms, including the use of formularies, tiered copayments, selective contracting with providers of prescription drugs, and mail order pharmacies.

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

''(c) STANDARD PRESCRIPTION DRUG COVERAGE.—For purposes of this part and part C, the term 'standard prescription drug coverage' means coverage of covered drugs that meets the following requirements:

''(1) DEDUCTIBLE.—

''(A) IN GENERAL.—The coverage has an annual deductible—

''(i) for 2006, that is equal to $275; or

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

''(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

''(2) LIMITS ON COST-SHARING.—The coverage has cost-sharing (for costs above the annual deductible specified in paragraph (1) and up to the initial coverage limit under paragraph (3)) that is equal to 50 percent or that is actuarially consistent (using processes established under subsection (f)) with an average expected payment of 50 percent of such costs.

''(3) INITIAL COVERAGE LIMIT.—

''(A) IN GENERAL.—Subject to paragraph (4), the coverage has an initial coverage limit on the maximum costs that may be recognized for payment purposes (including the annual deductible)—

''(i) for 2006, that is equal to $4,500; or

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

''(B) ROUNDING.—Any amount determined under subparagraph (A)(ii) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

''(4) LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARY.—

''(A) IN GENERAL.—The coverage provides benefits with cost-sharing that is equal to 10 percent after the individual has incurred costs (as described in subparagraph (C)) for covered drugs in a year equal to the annual out-of-pocket limit specified in subparagraph (B).

''(B) ANNUAL OUT-OF-POCKET LIMIT.—

''(i) IN GENERAL.—For purposes of this part, the 'annual out-of-pocket limit' specified in this subparagraph—

''(I) for 2006, is equal to $3,700; or

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

''(ii) ROUNDING.—Any amount determined under clause (i)(II) that is not a multiple of $1 shall be rounded to the nearest multiple of $1.

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

''(i) incurred costs shall only include costs incurred, with respect to covered drugs, for the annual deductible (described in paragraph (1)), cost-sharing (described in paragraph (2)), and amounts for which benefits are not provided because of the application of the initial coverage limit described in paragraph (3) (including costs incurred for covered drugs described in section 1860D(a)(2)(C)); and

''(ii) such costs shall be treated as incurred 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–19, 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 for such costs.

''(D) INFORMATION REGARDING THIRD-PARTY REIMBURSEMENT.—In order to ensure compliance with the requirements of subparagraph (C)(ii), the Administrator is authorized to establish procedures, in coordination with the Secretary of Treasury and the Secretary of Labor, for determining whether costs for individuals are being reimbursed through insurance or otherwise, a group health plan, or other third-party payment arrangement, and for alerting the entities in which such individuals are enrolled about such reimbursement arrangements. An entity with a contract under this part may also periodically ask individuals enrolled in a plan offered by the entity whether the individuals have or expect to receive such third-party reimbursement. A material misrepresentation of the information described in the preceding sentence by an individual (as defined in standards set by the Administrator and determined through a process established by the Administrator) shall constitute grounds for termination of enrollment under section 1860D–2(d).

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

''(d) ALTERNATIVE COVERAGE REQUIREMENTS.—A Medicare Prescription Drug plan or MedicareAdvantage plan may provide a different prescription drug benefit design from the standard prescription drug coverage described in subsection (c) so long as the Administrator determines (based on an actuarial analysis by the Administrator) that the following requirements are met and the plan applies for, and receives, the approval of the Administrator for such benefit design:

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

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

''(B) ASSURING EQUIVALENT UNSUBSIDIZED VALUE OF COVERAGE.—The unsubsidized value of the coverage is at least equal to the unsubsidized value of standard prescription drug coverage. For purposes of this subparagraph, the unsubsidized value of coverage is the amount by which the actuarial value of the coverage (as determined under subsection (f)) exceeds the actuarial value of the amounts associated with the application of section 1860D–17(c) and reinsurance payments under section 1860D–20 with respect to such coverage.

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

''(i) such initial coverage limit minus the deductible under subsection (c)(1); and

''(ii) the percentage specified in subsection (c)(2).

Benefits other than qualified prescription drug coverage shall not be taken into account for purposes of this paragraph.

''(2) DEDUCTIBLE AND LIMITATION ON OUT-OF-POCKET EXPENDITURES BY BENEFICIARIES MAY NOT VARY.—The coverage may not vary the deductible under subsection (c)(1) for the year or the limitation on out-of-pocket expenditures by beneficiaries described in subsection (c)(4) for the year.

''(e) ACCESS TO NEGOTIATED PRICES.—

''(1) ACCESS.—

''(A) IN GENERAL.—Under qualified prescription drug coverage offered by an eligible entity or a MedicareAdvantage organization, the entity or organization shall provide beneficiaries with access to negotiated prices used for payment for covered drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of the deductible, any cost-sharing, or an initial coverage limit (described in subsection (c)(3)). For purposes of this part, the term 'negotiated prices' includes all discounts, direct

or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations.

''(B) MEDICAID RELATED PROVISIONS.—Insofar as a State elects to provide medical assistance under title XIX for a drug based on the prices negotiated under a Medicare Prescription Drug plan under this part, the requirements of section 1927 shall not apply to such drugs. The prices negotiated under a Medicare Prescription Drug plan with respect to covered drugs, under a MedicareAdvantage plan with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)) with respect to such drugs, on behalf of eligible beneficiaries, shall (notwithstanding any other provision of law) not be taken into account for the purposes of establishing the best price under section 1927(c)(1)(C).

''(2) CARDS OR OTHER TECHNOLOGY.—

''(A) IN GENERAL.—In providing the access under paragraph (1), the eligible entity or MedicareAdvantage organization shall issue a card or use other technology pursuant to section 1860D–5(b)(1).

''(B) NATIONAL STANDARDS.—

''(i) DEVELOPMENT.—The Administrator shall provide for the development of national standards relating to a standardized format for the card or other technology required under subparagraph (A). Such standards shall be compatible with parts C and D of title XI and may be based on standards developed by an appropriate standard setting organization.

''(ii) CONSULTATION.—In developing the standards under clause (i), the Administrator shall consult with the National Council for Prescription Drug Programs and other standard-setting organizations determined appropriate by the Administrator.

''(iii) IMPLEMENTATION.—The Administrator shall implement the standards developed under clause (i) by January 1, 2008.

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

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

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

''(i) an actuarial valuation of standard prescription drug coverage and of the reinsurance payments under section 1860D–20;

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

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

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

Such processes shall take into account any effect that providing actuarially equivalent prescription drug coverage rather than standard prescription drug coverage has on drug utilization.

''(2) USE OF OUTSIDE ACTUARIES.—Under the processes under paragraph (1)(A), eligible entities and MedicareAdvantage organizations may use actuarial opinions certified by independent, qualified actuaries to establish actuarial values, but the Administrator shall determine whether such actuarial values meet the requirements under subsection (c)(1).

''REQUIREMENTS FOR ENTITIES OFFERING MEDICARE PRESCRIPTION DRUG PLANS; ESTABLISHMENT OF STANDARDS

''SEC. 1860D–7. (a) GENERAL REQUIREMENTS.—An eligible entity offering a Medicare Prescription Drug plan shall meet the following requirements:

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

''(2) ASSUMPTION OF FINANCIAL RISK.—

''(A) IN GENERAL.—Subject to subparagraph (B) and subsections (d)(2) and (e) of section 1860D–13, to the extent that the entity is at risk pursuant to such section 1860D–16, the entity assumes financial risk on a prospective basis for the benefits that it offers under a Medicare Prescription Drug plan and that is not covered under section 1860D–20.

''(B) REINSURANCE PERMITTED.—To the extent that the entity is at risk pursuant to section 1860D–16, the entity may obtain insurance or make other arrangements for the cost of coverage provided to any enrolled member under this part.

''(3) SOLVENCY FOR UNLICENSED ENTITIES.—In the case of an eligible entity that is not described in paragraph (1) and for which a waiver has been approved under subsection (c), such entity shall meet solvency standards established by the Administrator under subsection (d).

''(b) CONTRACT REQUIREMENTS.—The Administrator shall not permit an eligible beneficiary to elect a Medicare Prescription Drug plan offered by an eligible entity under this part, and the entity shall not be eligible for payments under section 1860D–16 or 1860D–20, unless the Administrator has entered into a contract under this subsection with the entity with respect to the offering of such plan. Such a contract with an entity may cover more than 1 Medicare Prescription Drug plan. Such contract shall provide that the entity agrees to comply with the applicable requirements and standards of this part and the terms and conditions of payment as provided for in this part.

''(c) WAIVER OF CERTAIN REQUIREMENTS IN ORDER TO ENSURE BENEFICIARY CHOICE.—

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

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

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

''(4) REFERENCES TO CERTAIN PROVISIONS.—For purposes of this subsection, in applying the provisions of section 1855(a)(2) under this subsection to Medicare Prescription Drug plans and eligible entities—

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

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

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

''(1) ESTABLISHMENT AND PUBLICATION.—The Administrator, in consultation with the National Association of Insurance Commissioners, shall establish and publish, by not later than January 1, 2005, financial solvency and capital adequacy standards for entities described in paragraph (2).

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

''(e) LICENSURE DOES NOT SUBSTITUTE FOR OR CONSTITUTE CERTIFICATION.—The fact that an entity is licensed in accordance with subsection (a)(1) or has a waiver application approved under subsection (c) does not deem the eligible entity to meet other requirements imposed under this part for an eligible entity.

''(f) INCORPORATION OF CERTAIN MEDICAREADVANTAGE CONTRACT REQUIREMENTS.—The following provisions of section 1857 shall apply, subject to subsection (c)(4), to contracts under this section in the same manner as they apply to contracts under section 1857(a):

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

''(2) INTERMEDIATE SANCTIONS.—Section 1857(g), except that in applying such section—

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

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

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

''(g) OTHER STANDARDS.—The Administrator shall establish by regulation other standards (not described in subsection (d)) for eligible entities and Medicare Prescription Drug plans consistent with, and to carry out, this part. The Administrator shall publish such regulations by January 1, 2005.

''(h) PERIODIC REVIEW AND REVISION OF STANDARDS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Administrator shall periodically review the standards established under this section and, based on such review, may revise such standards if the Administrator determines such revision to be appropriate.

''(2) PROHIBITION OF MIDYEAR IMPLEMENTATION OF SIGNIFICANT NEW REGULATORY REQUIREMENTS.—The Administrator may not implement, other than at the beginning of a calendar year, regulations under this section that impose new, significant regulatory requirements on an eligible entity or a Medicare Prescription Drug plan.

''(h) RELATION TO STATE LAWS.—

''(1) IN GENERAL.—The standards established under this part shall supersede any State law or regulation (including standards described in paragraph (2)) with respect to Medicare Prescription Drug plans which are offered by eligible entities under this part—

''(A) to the extent such law or regulation is inconsistent with such standards; and

''(B) in the same manner as such laws and regulations are superseded under section 1856(b)(3).

''(2) STANDARDS SPECIFICALLY SUPERSEDED.—State standards relating to the following are superseded under this section:

''(A) Benefit requirements, including requirements relating to cost-sharing and the structure of formularies.

''(B) Premiums.

''(C) Requirements relating to inclusion or treatment of providers.

''(D) Coverage determinations (including related appeals and grievance processes).

''(E) Requirements relating to marketing materials and summaries and schedules of

benefits regarding a Medicare Prescription Drug plan.

''(3) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to—

''(A) monthly beneficiary obligations paid to the Administrator for Medicare Prescription Drug plans under this part; or

''(B) any payments made by the Administrator under this part to an eligible entity offering such a plan.

''Subpart 2—Prescription Drug Delivery System

''ESTABLISHMENT OF SERVICE AREAS

''SEC. 1860D–10. (a) ESTABLISHMENT.—

''(1) INITIAL ESTABLISHMENT.—Not later than April 15, 2005, the Administrator shall establish and publish the service areas in which Medicare Prescription Drug plans may offer benefits under this part.

''(2) PERIODIC REVIEW AND REVISION OF SERVICE AREAS.—The Administrator shall periodically review the service areas applicable under this section and, based on such review, may revise such service areas if the Administrator determines such revision to be appropriate.

''(b) REQUIREMENTS FOR ESTABLISHMENT OF SERVICE AREAS.—

''(1) IN GENERAL.—The Administrator shall establish the service areas under subsection (a) in a manner that—

''(A) maximizes the availability of Medicare Prescription Drug plans to eligible beneficiaries; and

''(B) minimizes the ability of eligible entities offering such plans to favorably select eligible beneficiaries.

''(2) ADDITIONAL REQUIREMENTS.—The Administrator shall establish the service areas under subsection (a) consistent with the following requirements:

''(A) There shall be at least 10 service areas.

''(B) Each service area must include at least 1 State.

''(C) The Administrator may not divide States so that portions of the State are in different service areas.

''(D) To the extent possible, the Administrator shall include multistate metropolitan statistical areas in a single service area. The Administrator may divide metropolitan statistical areas where it is necessary to establish service areas of such size and geography as to maximize the participation of Medicare Prescription Drug plans.

''(3) MAY CONFORM TO MEDICAREADVANTAGE PREFERRED PROVIDER REGIONS.—The Administrator may conform the service areas established under this section to the preferred provider regions established under section 1858(a)(3).

''PUBLICATION OF RISK ADJUSTERS

''SEC. 1860D–11. (a) PUBLICATION.—Not later than April 15 of each year (beginning in 2005), the Administrator shall publish the risk adjusters established under subsection (b) to be used in computing—

''(1) the amount of payment to Medicare Prescription Drug plans in the subsequent year under section 1860D–16(a), insofar as it is attributable to standard prescription drug coverage (or actuarially equivalent prescription drug coverage); and

''(2) the amount of payment to MedicareAdvantage plans in the subsequent year under section 1858A(c), insofar as it is attributable to standard prescription drug coverage (or actuarially equivalent prescription drug coverage).

''(b) ESTABLISHMENT OF RISK ADJUSTERS.—

''(1) IN GENERAL.—Subject to paragraph (2), the Administrator shall establish an appropriate methodology for adjusting the amount of payment to plans referred to in subsection (a) to take into account variation in costs based on the differences in actuarial risk of different enrollees being served. Any such risk adjustment shall be designed in a manner as to not result in a change in the aggregate payments described in paragraphs (1) and (2) of subsection (a).

''(2) CONSIDERATIONS.—In establishing the methodology under paragraph (1), the Administrator may take into account the similar methodologies used under section 1853(a)(3) to adjust payments to MedicareAdvantage organizations.

''(3) DATA COLLECTION.—In order to carry out this subsection, the Administrator shall require—

''(A) eligible entities to submit data regarding drug claims that can be linked at the beneficiary level to part A and part B data and such other information as the Administrator determines necessary; and

''(B) MedicareAdvantage organizations (except MSA plans or a private fee-for-service plan that does not provide qualified prescription drug coverage) to submit data regarding drug claims that can be linked to other data that such organizations are required to submit to the Administrator and such other information as the Administrator determines necessary.

''SUBMISSION OF BIDS FOR PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

''SEC. 1860D–12. (a) SUBMISSION.—

''(1) IN GENERAL.—Each eligible entity that intends to offer a Medicare Prescription Drug plan in an area in a year (beginning with 2006) shall submit to the Administrator, at such time in the previous year and in such manner as the Administrator may specify, such information as the Administrator may require, including the information described in subsection (b).

''(2) ANNUAL SUBMISSION.—An eligible entity shall submit the information required under paragraph (1) with respect to a Medicare Prescription Drug plan that the entity intends to offer on an annual basis.

''(b) INFORMATION DESCRIBED.—The information described in this subsection includes information on each of the following:

''(1) The benefits under the plan (as required under section 1860D–6).

''(2) The actuarial value of the qualified prescription drug coverage.

''(3) The amount of the monthly plan premium under the plan, including an actuarial certification of—

''(A) the actuarial basis for such monthly plan premium;

''(B) the portion of such monthly plan premium attributable to standard prescription drug coverage or actuarially equivalent prescription drug coverage and, if applicable, to benefits that are in addition to such coverage; and

''(C) the reduction in such monthly plan premium resulting from the payments provided under section 1860D–20.

''(4) The service area for the plan.

''(5) Whether the entity plans to use any funds in the plan stabilization reserve fund in the Prescription Drug Account that are available to the entity to stabilize or reduce the monthly plan premium submitted under paragraph (3), and if so, the amount in such reserve fund that is to be used.

''(6) Such other information as the Administrator may require to carry out this part.

''(c) OPTIONS REGARDING SERVICE AREAS.—

''(1) IN GENERAL.—The service area of a Medicare Prescription Drug plan shall be either—

''(A) the entire area of 1 of the service areas established by the Administrator under section 1860D–10; or

''(B) the entire area covered by the medicare program.

''(2) RULE OF CONSTRUCTION.—Nothing in this part shall be construed as prohibiting an eligible entity from submitting separate bids in multiple service areas as long as each bid is for a single service area.

''APPROVAL OF PROPOSED MEDICARE PRESCRIPTION DRUG PLANS

''SEC. 1860D–13. (a) APPROVAL.—

''(1) IN GENERAL.—The Administrator shall review the information filed under section 1860D–12 and shall approve or disapprove the Medicare Prescription Drug plan.

''(2) REQUIREMENTS FOR APPROVAL.—The Administrator may not approve a Medicare Prescription Drug plan unless the following requirements are met:

''(A) COMPLIANCE WITH REQUIREMENTS.—The plan and the entity offering the plan comply with the requirements under this part.

''(B) APPLICATION OF FEHBP STANDARD.—(i) The portion of the monthly plan premium submitted under section 1860D–12(b) that is attributable to standard prescription drug coverage reasonably and equitably reflects the actuarial value of the standard prescription drug coverage less the actuarial value of the reinsurance payments under section 1860D–20 and the amount of any funds in the plan stabilization reserve fund in the Prescription Drug Account used to stabilize or reduce the monthly plan premium.

''(ii) If the plan provides additional prescription drug coverage pursuant to section 1860D–6(a)(2), the monthly plan premium reasonably and equitably reflects the actuarial value of the coverage provided less the actuarial value of the reinsurance payments under section 1860D–20 and the amount of any funds in the plan stabilization reserve fund in the Prescription Drug Account used to stabilize or reduce the monthly plan premium.

''(b) NEGOTIATION.—In exercising the authority under subsection (a), the Administrator shall have the authority to—

''(1) negotiate the terms and conditions of the proposed monthly plan premiums submitted and other terms and conditions of a proposed plan; and

''(2) disapprove, or limit enrollment in, a proposed plan based on—

''(A) the costs to beneficiaries under the plan;

''(B) the quality of the coverage and benefits under the plan;

''(C) the adequacy of the network under the plan; or

''(D) other factors determined appropriate by the Administrator.

''(c) SPECIAL RULES FOR APPROVAL.—The Administrator may approve a Medicare Prescription Drug plan submitted under section 1860D–12 only if the benefits under such plan—

''(1) include the required benefits under section 1860D–6(a)(1); and

''(2) are not designed in such a manner that the Administrator finds is likely to result in favorable selection of eligible beneficiaries.

''(d) ACCESS TO COMPETITIVE COVERAGE.—

''(1) NUMBER OF CONTRACTS.—The Administrator, consistent with the requirements of this part and the goal of containing costs under this title, shall, with respect to a year, approve at least 2 contracts to offer a Medicare Prescription Drug plan in each service area (established under section 1860D–10) for the year.

''(2) AUTHORITY TO REDUCE RISK TO ENSURE ACCESS.—

''(A) IN GENERAL.—Subject to subparagraph (B), if the Administrator determines, with respect to an area, that the access required under paragraph (1) is not going to be provided in the area during the subsequent year, the Administrator shall—

''(i) adjust the percents specified in paragraphs (2) and (4) of section 1860D–16(b) in an area in a year; or

''(ii) increase the percent specified in section 1860D–20(c)(1) in an area in a year.

The administrator shall exercise the authority under the preceding sentence only so long as (and to the extent) necessary to assure the access guaranteed under paragraph (1).

''(B) REQUIREMENTS FOR USE OF AUTHORITY.—In exercising authority under subparagraph (A), the Administrator—

''(i) shall not provide for the full underwriting of financial risk for any eligible entity;

''(ii) shall not provide for any underwriting of financial risk for a public eligible entity with respect to the offering of a nationwide Medicare Prescription Drug plan; and

''(iii) shall seek to maximize the assumption of financial risk by eligible entities to ensure fair competition among Medicare Prescription Drug plans.

''(C) REQUIREMENT TO ACCEPT 2 FULL-RISK QUALIFIED BIDS BEFORE EXERCISING AUTHORITY.—The Administrator may not exercise the authority under subparagraph (A) with respect to an area and year if 2 or more qualified bids are submitted by eligible entities to offer a Medicare Prescription Drug plan in the area for the year under paragraph (1) before the application of subparagraph (A).

''(D) REPORTS.—The Administrator, in each annual report to Congress under section 1808(c)(1)(D), shall include information on the exercise of authority under subparagraph (A). The Administrator also shall include such recommendations as may be appropriate to limit the exercise of such authority.

''(e) GUARANTEED ACCESS.—

''(1) ACCESS.—In order to assure access to qualified prescription drug coverage in an area, the Administrator shall take the following steps:

''(A) DETERMINATION.—Not later than September 1 of each year (beginning in 2005) and for each area (established under section 1860D–10), the Administrator shall make a determination as to whether the access required under subsection (d)(1) is going to be provided in the area during the subsequent year. Such determination shall be made after the Administrator has exercised the authority under subsection (d)(2).

''(B) CONTRACT WITH AN ENTITY TO PROVIDE COVERAGE IN AN AREA.—Subject to paragraph (3), if the Administrator makes a determination under subparagraph (A) that the access required under subsection (d)(1) is not going to be provided in an area during the subsequent year, the Administrator shall enter into a contract with an entity to provide eligible beneficiaries enrolled under this part (and not, except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage enrolled in a MedicareAdvantage plan) and residing in the area with standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)) during the subsequent year. An entity may be awarded a contract for more than 1 of the areas for which the Administrator is required to enter into a contract under this paragraph but the Administrator may enter into only 1 such contract in each such area. An entity with a contract under this part shall meet the requirements described in section 1860D–5 and such other requirements determined appropriate by the Administrator.

''(C) REQUIREMENT TO ACCEPT 2 REDUCED-RISK QUALIFIED BIDS BEFORE ENTERING INTO CONTRACT.—The Administrator may not enter into a contract under subparagraph (B) with respect to an area and year if 2 or more qualified bids are submitted by eligible entities to offer a Medicare Prescription Drug plan in the area for the year after the Administrator has exercised the authority under subsection (d)(2) in the area for the year.

''(D) ENTITY REQUIRED TO MEET BENEFICIARY PROTECTION AND OTHER REQUIREMENTS.—An entity with a contract under subparagraph (B) shall meet the requirements described in section 1860D–5 and such other requirements determined appropriate by the Administrator.

''(E) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into a contract under subparagraph (B).

''(2) MONTHLY BENEFICIARY OBLIGATION FOR ENROLLMENT.—

''(A) IN GENERAL.—In the case of an eligible beneficiary receiving access to qualified prescription drug coverage through enrollment with an entity with a contract under paragraph (1)(B), the monthly beneficiary obligation of such beneficiary for such enrollment shall be an amount equal to the applicable percent (as determined under section 1860D–17(c)) of the monthly national average premium (as computed under section 1860D–15) for the area for the year, as adjusted using the geographic adjuster under subparagraph (B).

''(B) ESTABLISHMENT OF GEOGRAPHIC ADJUSTER.—The Administrator shall establish an appropriate methodology for adjusting the monthly beneficiary obligation (as computed under subparagraph (A)) for the year in an area to take into account differences in drug prices among areas. In establishing such methodology, the Administrator may take into account differences in drug utilization between eligible beneficiaries in an area and eligible beneficiaries in other areas and the results of the ongoing study required under section 106 of the Prescription Drug and Medicare Improvement Act of 2003. Any such adjustment shall be applied in a manner so as to not result in a change in the aggregate payments made under this part that would have been made if the Administrator had not applied such adjustment.

''(3) PAYMENTS UNDER THE CONTRACT.—

''(A) IN GENERAL.—A contract entered into under paragraph (1)(B) shall provide for—

''(i) payment for the negotiated costs of covered drugs provided to eligible beneficiaries enrolled with the entity; and

''(ii) payment of prescription management fees that are tied to performance requirements established by the Administrator for the management, administration, and delivery of the benefits under the contract.

''(B) PERFORMANCE REQUIREMENTS.—The performance requirements established by the Administrator pursuant to subparagraph (A)(ii) shall include the following:

''(i) The entity contains costs to the Prescription Drug Account and to eligible beneficiaries enrolled under this part and with the entity.

''(ii) The entity provides such beneficiaries with quality clinical care.

''(iii) The entity provides such beneficiaries with quality services.

''(C) ENTITY ONLY AT RISK TO THE EXTENT OF THE FEES TIED TO PERFORMANCE REQUIREMENTS.—An entity with a contract under paragraph (1)(B) shall only be at risk for the provision of benefits under the contract to the extent that the management fees paid to the entity are tied to performance requirements under subparagraph (A)(ii).

''(4) ELIGIBLE ENTITY THAT SUBMITTED A BID FOR THE AREA NOT ELIGIBLE TO BE AWARDED THE CONTRACT.—An eligible entity that submitted a bid to offer a Medicare Prescription Drug plan for an area for a year under section 1860D–12, including a bid submitted after the Administrator has exercised the authority under subsection (d)(2), may not be awarded a contract under paragraph (1)(B) for that area and year. The previous sentence shall apply to an entity that was awarded a contract under paragraph (1)(B) for the area in the previous year and submitted such a bid under section 1860D–12 for the year.

''(5) TERM OF CONTRACT.—A contract entered into under paragraph (1)(B) shall be for a 1-year period. Such contract may provide for renewal at the discretion of the Administrator if the Administrator is required to enter into a contract under such paragraph with respect to the area covered by such contract for the subsequent year.

''(6) ENTITY NOT PERMITTED TO MARKET OR BRAND THE CONTRACT.—An entity with a contract under paragraph (1)(B) may not engage in any marketing or branding of such contract.

''(7) RULES FOR AREAS WHERE ONLY 1 COMPETITIVELY BID PLAN WAS APPROVED.—In the case of an area where (before the application of this subsection) only 1 Medicare Prescription Drug plan was approved for a year—

''(A) the plan may (at the option of the plan) be offered in the area for the year (under rules applicable to such plans under this part and not under this subsection);

''(B) eligible beneficiaries described in paragraph (1)(B) may receive access to qualified prescription drug coverage through enrollment in the plan or with an entity with a contract under paragraph (1)(B); and

''(C) for purposes of applying section 1860D–3(a)(1)(A)(ii), such plan shall be the plan designated in the area under such section.

''(f) TWO-YEAR CONTRACTS.—Except for a contract entered into under subsection (e)(1)(B), a contract approved under this part (including a contract under) shall be for a 2-year period.

''COMPUTATION OF MONTHLY STANDARD PRESCRIPTION DRUG COVERAGE PREMIUMS

''SEC. 1860D–14. (a) IN GENERAL.—For each year (beginning with 2006), the Administrator shall compute a monthly standard prescription drug coverage premium for each Medicare Prescription Drug plan approved under section 1860D–13 and for each MedicareAdvantage plan.

''(b) REQUIREMENTS.—The monthly standard prescription drug coverage premium for a plan for a year shall be equal to—

''(1) in the case of a plan offered by an eligible entity or MedicareAdvantage organization that provides standard prescription drug coverage or an actuarially equivalent prescription drug coverage and does not provide additional prescription drug coverage pursuant to section 1860D–6(a)(2), the monthly plan premium approved for the plan under section 1860D–13 for the year; and

''(2) in the case of a plan offered by an eligible entity or MedicareAdvantage organization that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2)—

''(A) an amount that reflects only the actuarial value of the standard prescription drug coverage offered under the plan; or

''(B) if determined appropriate by the Administrator, the monthly plan premium approved under section 1860D–13 for the year for the Medicare Prescription Drug plan (or, if applicable, the MedicareAdvantage plan) that, as required under section 1860D–6(a)(2)(B) for a Medicare Prescription Drug plans and a MedicareAdvantage plan—

''(i) is offered by such entity or organization in the same area as the plan; and

''(ii) does not provide additional prescription drug coverage pursuant to such section.

''COMPUTATION OF MONTHLY NATIONAL AVERAGE PREMIUM

''SEC. 1860D–15. (a) COMPUTATION.—

''(1) IN GENERAL.—For each year (beginning with 2006) the Administrator shall compute a monthly national average premium equal to the average of the monthly standard prescription drug coverage premium for each Medicare Prescription Drug plan and each MedicareAdvantage plan (as computed under section 1860D–14). Such premium may be adjusted pursuant to any methodology determined under subsection (b), as determined appropriate by the Administrator.

''(2) WEIGHTED AVERAGE.—The monthly national average premium computed under paragraph (1) shall be a weighted average, with the weight for each plan being equal to the average number of beneficiaries enrolled under such plan in the previous year.

''(b) GEOGRAPHIC ADJUSTMENT.—The Administrator shall establish an appropriate methodology for adjusting the monthly national average premium (as computed under subsection (a)) for the year in an area to take into account differences in prices for covered drugs among different areas. In establishing such methodology, the Administrator may take into account differences in drug utilization between eligible beneficiaries in that area and other eligible beneficiaries and the results of the ongoing study required under section 106 of the Prescription Drug and Medicare Improvement Act of 2003. Any such adjustment shall be applied in a manner as to not result in a change in aggregate payments made under this part than would have been made if the Administrator had not applied such adjustment.

''(c) SPECIAL RULE FOR 2006.—For purposes of applying this section for 2006, the Administrator shall establish procedures for determining the weighted average under subsection (a)(2) for 2005.

''PAYMENTS TO ELIGIBLE ENTITIES

''SEC. 1860D–16. (a) PAYMENT OF MONTHLY PLAN PREMIUMS.—For each year (beginning with 2006), the Administrator shall pay to each entity offering a Medicare Prescription Drug plan in which an eligible beneficiary is enrolled an amount equal to the full amount of the monthly plan premium approved for the plan under section 1860D–13 on behalf of each eligible beneficiary enrolled in such plan for the year, as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

''(b) PORTION OF TOTAL PAYMENTS OF MONTHLY PLAN PREMIUMS SUBJECT TO RISK.—

''(1) NOTIFICATION OF SPENDING UNDER THE PLAN.—

''(A) IN GENERAL.—For each year (beginning in 2007), the eligible entity offering a Medicare Prescription Drug plan shall notify the Administrator of the following:

''(i) TOTAL ACTUAL COSTS.—The total amount of costs that the entity incurred in providing standard prescription drug coverage (or prescription drug coverage that is actuarially equivalent pursuant to section 1860D–6(a)(1)(B)) for all enrollees under the plan in the previous year.

''(ii) ACTUAL COSTS FOR SPECIFIC DRUGS.—With respect to the total amount under clause (i) for the year, a breakdown of—

''(I) each covered drug that constitutes a portion of such amount;

''(II) the negotiated price for the eligible entity for each such drug;

''(III) the number of prescriptions; and

''(IV) the average beneficiary coinsurance rate for a each covered drug that constitutes a portion of such amount.

''(B) CERTAIN EXPENSES NOT INCLUDED.—The amounts under clauses (i) and (ii)(II) of subparagraph (A) may not include—

''(i) administrative expenses incurred in providing the coverage described in subparagraph (A)(i);

''(ii) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2); or

''(iii) amounts expended for which the entity is subsequently provided with reinsurance payments under section 1860D–20.

''(2) ADJUSTMENT OF PAYMENT.—

''(A) NO ADJUSTMENT IF ALLOWABLE COSTS WITHIN RISK CORRIDOR.—If the allowable costs (specified in paragraph (3)) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (4)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (4)(A)(i)) for the plan for the year, then no additional payments shall be made by the Administrator and no payments shall be made by (or collected from) the eligible entity offering the plan.

''(B) INCREASE IN PAYMENT IF ALLOWABLE COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—

''(i) IN GENERAL.—If the allowable costs for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Administrator shall increase the total of the monthly payments made to the entity offering the plan for the year under subsection (a) by an amount equal to the sum of—

''(I) the applicable percent (as defined in subparagraph (D)) of such allowable costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (4)(A)(iv)); and

''(II) 90 percent of such allowable costs which are more than such second threshold upper limit of the risk corridor.

''(ii) SPECIAL TRANSITIONAL CORRIDOR FOR 2006 AND 2007.—If the Administrator determines with respect to 2006 or 2007 that at least 60 percent of Medicare Prescription Drug plans and MedicareAdvantage Plans (excluding MSA plans or private fee-for-service plans that do not provide qualified prescription drug coverage) have allowable costs for the plan for the year that are more than the first threshold upper limit of the risk corridor for the plan for the year and that such plans represent at least 60 percent of eligible beneficiaries enrolled under this part, clause (i)(I) shall be applied by substituting '90 percent' for 'applicable percent'.

''(C) PLAN PAYMENT IF ALLOWABLE COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the allowable costs for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the entity offering the plan shall a make a payment to the Administrator of an amount (or the Administrator shall otherwise recover from the plan an amount) equal to—

''(i) the applicable percent (as so defined) of such allowable costs which are less than such first threshold lower limit of the risk corridor and not less than the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (4)(A)(ii)); and

''(ii) 90 percent of such allowable costs which are less than such second threshold lower limit of the risk corridor.

''(D) APPLICABLE PERCENT DEFINED.—For purposes of this paragraph, the term 'applicable percent' means—

''(i) for 2006 and 2007, 75 percent; and

''(ii) for 2008 and subsequent years, 50 percent.

''(3) ESTABLISHMENT OF ALLOWABLE COSTS.—

''(A) IN GENERAL.—For each year, the Administrator shall establish the allowable costs for each Medicare Prescription Drug plan for the year. The allowable costs for a plan for a year shall be equal to the amount described in paragraph (1)(A)(i) for the plan for the year, adjusted under subparagraph (B)(ii).

''(B) REPRICING OF COSTS.—

''(i) CALCULATION OF AVERAGE PLAN COST.—Utilizing the information obtained under paragraph (1)(A)(ii) and section 1860D–20(b)(1)(B), for each year (beginning with 2006), the Administrator shall establish an average negotiated price with respect to all Medicare Prescription Drug plans for each covered drug.

''(ii) ADJUSTMENT IF ACTUAL COSTS EXCEED AVERAGE COSTS.—With respect to a Medicare Prescription Drug plan for a year, the Administrator shall reduce the amount described in paragraph (1)(A)(i) for the plan for the year to the extent such amount is based on costs of specific covered drugs furnished under the plan in the year (as specified under paragraph (1)(A)(ii)) for which the negotiated prices are greater than the average negotiated price for the covered drug for the year (as determined under clause (i)).

''(4) ESTABLISHMENT OF RISK CORRIDORS.—

''(A) IN GENERAL.—For each year (beginning with 2006), the Administrator shall establish a risk corridor for each Medicare Prescription Drug plan. The risk corridor for a plan for a year shall be equal to a range as follows:

''(i) FIRST THRESHOLD LOWER LIMIT.—The first threshold lower limit of such corridor shall be equal to—

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to the first threshold risk percentage for the plan (as determined under subparagraph (C)(i)) of such target amount.

''(ii) SECOND THRESHOLD LOWER LIMIT.—The second threshold lower limit of such corridor shall be equal to—

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to the second threshold risk percentage for the plan (as determined under subparagraph (C)(ii)) of such target amount.

''(iii) FIRST THRESHOLD UPPER LIMIT.—The first threshold upper limit of such corridor shall be equal to the sum of—

''(I) such target amount; and

''(II) the amount described in clause (i)(II).

''(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

''(I) such target amount; and

''(II) the amount described in clause (ii)(II).

''(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a Medicare Prescription Drug plan offered by an eligible entity in a year—

''(i) in the case of a plan offered by an eligible entity that provides standard prescription drug coverage or actuarially equivalent prescription drug coverage and does not provide additional prescription drug coverage pursuant to section 1860D–6(a)(2), an amount equal to the total of the monthly plan premiums paid to such entity for such plan for the year pursuant to subsection (a), reduced by the percentage specified in subparagraph (D); and

''(ii) in the case of a plan offered by an eligible entity that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2), an amount equal to the total of the monthly plan premiums paid to such entity for such plan for the year pursuant to subsection (a) that are related to standard prescription drug coverage (determined using the rules under section 1860D–14(b)), reduced by the percentage specified in subparagraph (D).

''(C) FIRST AND SECOND THRESHOLD RISK PERCENTAGE DEFINED.—

''(i) FIRST THRESHOLD RISK PERCENTAGE.—Subject to clause (iii), for purposes of this section, the first threshold risk percentage is—

''(I) for 2006 and 2007, and 2.5 percent;

''(II) for 2008 through 2011, 5 percent; and

''(III) for 2012 and subsequent years, a percentage established by the Administrator, but in no case less than 5 percent.

''(ii) SECOND THRESHOLD RISK PERCENTAGE.—Subject to clause (iii), for purposes of this section, the second threshold risk percentage is—

''(I) for 2006 and 2007, 5.0 percent;

''(II) for 2008 through 2011, 10 percent

''(III) for 2012 and subsequent years, a percentage established by the Administrator that is greater than the percent established for the year under clause (i)(III), but in no case less than 10 percent.

''(iii) REDUCTION OF RISK PERCENTAGE TO ENSURE 2 PLANS IN AN AREA.—Pursuant to paragraph (2) of section 1860D–13(d), the Administrator may reduce the applicable first or second threshold risk percentage in an area in a year in order to ensure the access to plans required under paragraph (1) of such section.

''(D) TARGET AMOUNT NOT TO INCLUDE ADMINISTRATIVE EXPENSES NEGOTIATED BETWEEN THE ADMINISTRATOR AND THE ENTITY OFFERING THE PLAN.—For each year (beginning in 2006), the Administrator and the entity offering a Medicare Prescription Drug plan shall negotiate, as part of the negotiation process described in section 1860D–13(b) during the previous year, the percentage of the payments to the entity under subsection (a) with respect to the plan that are attributable and reasonably incurred for administrative expenses for providing standard prescription drug coverage or actuarially equivalent prescription drug coverage in the year.

''(5) PLANS AT RISK FOR ENTIRE AMOUNT OF ADDITIONAL PRESCRIPTION DRUG COVERAGE.—An eligible entity that offers a Medicare Prescription Drug plan that provides additional prescription drug coverage pursuant to section 1860D–6(a)(2) shall be at full financial risk for the provision of such additional coverage.

''(6) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the beneficiary obligation under section 1860D–17 for the year in which such change in payments is made.

''(7) DISCLOSURE OF INFORMATION.—

''(A) IN GENERAL.—Each contract under this part shall provide that—

''(i) the entity offering a Medicare Prescription Drug plan shall provide the Administrator with such information as the Administrator determines is necessary to carry out this section; and

''(ii) the Administrator shall have the right to inspect and audit any books and records of the eligible entity that pertain to the information regarding costs provided to the Administrator under paragraph (1).

''(B) RESTRICTION ON USE OF INFORMATION.—Information disclosed or obtained pursuant to the provisions of this section may be used by officers and employees of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

''(c) STABILIZATION RESERVE FUND.—

''(1) ESTABLISHMENT.—

''(A) IN GENERAL.—There is established, within the Prescription Drug Account, a stabilization reserve fund in which the Administrator shall deposit amounts on behalf of eligible entities in accordance with paragraph (2) and such amounts shall be made available by the Secretary for the use of eligible entities in contract year 2008 and subsequent contract years in accordance with paragraph (3).

''(B) REVERSION OF UNUSED AMOUNTS.—Any amount in the stabilization reserve fund established under subparagraph (A) that is not expended by an eligible entity in accordance with paragraph (3) or that was deposited for the use of an eligible entity that no longer has a contract under this part shall revert for the use of the Prescription Drug Account.

''(2) DEPOSIT OF AMOUNTS FOR 5 YEARS.—

''(A) IN GENERAL.—If the target amount for a Medicare Prescription Drug plan for 2006, 2007, 2008, 2009, or 2010 (as determined under subsection (b)(4)(B)) exceeds the applicable costs for the plan for the year by more than 3 percent, then—

''(i) the entity offering the plan shall make a payment to the Administrator of an amount (or the Administrator shall otherwise recover from the plan an amount) equal to the portion of such excess that is in excess of 3 percent of the target amount; and

''(ii) the Administrator shall deposit an amount equal to the amount collected or otherwise recovered under clause (i) in the stabilization reserve fund on behalf of the eligible entity offering such plan.

''(B) APPLICABLE COSTS.—For purposes of subparagraph (A), the term 'applicable costs' means, with respect to a Medicare Prescription Drug plan and year, an amount equal the sum of—

''(i) the allowable costs for the plan and year (as determined under subsection (b)(3)(A); and

''(ii) the total amount by which monthly payments to the plan were reduced (or otherwise recovered from the plan) for the year under subsection (b)(2)(C).

''(3) USE OF RESERVE FUND TO STABILIZE OR REDUCE MONTHLY PLAN PREMIUMS.—

''(A) IN GENERAL.—For any contract year beginning after 2007, an eligible entity offering a Medicare Prescription Drug plan may use funds in the stabilization reserve fund in the Prescription Drug Account that were deposited in such fund on behalf of the entity to stabilize or reduce monthly plan premiums submitted under section 1860D–12(b)(3).

''(B) PROCEDURES.—The Administrator shall establish procedures for—

''(i) reducing monthly plan premiums submitted under section 1860D–12(b)(3) pursuant to subparagraph (A); and

''(ii) making payments from the plan stabilization reserve fund in the Prescription Drug Account to eligible entities that inform the Secretary under section 1860D–12(b)(5) of the entity's intent to use funds in such reserve fund to reduce such premiums.

''(d) PORTION OF PAYMENTS OF MONTHLY PLAN PREMIUMS ATTRIBUTABLE TO ADMINISTRATIVE EXPENSES TIED TO PERFORMANCE REQUIREMENTS.—

''(1) IN GENERAL.—The Administrator shall establish procedures to adjust the portion of the payments made to an entity under subsection (a) that are attributable to administrative expenses (as determined pursuant to subsection (b)(4)(D)) to ensure that the entity meets the performance requirements described in clauses (ii) and (iii) of section 1860D–13(e)(4)(B).

''(2) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the beneficiary obligation under section 1860D–17 for the year in which such change in payments is made.

''(e) PAYMENT TERMS.—

''(1) ADMINISTRATOR PAYMENTS.—Payments to an entity offering a Medicare Prescription Drug plan under this section shall be made in a manner determined by the Administrator and based upon the manner in which payments are made under section 1853(a) (relating to payments to MedicareAdvantage organizations).

''(2) PLAN PAYMENTS.—The Administrator shall establish a process for collecting (or other otherwise recovering) amounts that an entity offering a Medicare Prescription Drug plan is required to make to the Administrator under this section.

''(f) PAYMENTS TO MEDICAREADVANTAGE PLANS.—For provisions related to payments to MedicareAdvantage organizations offering MedicareAdvantage plans for qualified prescription drug coverage made available under the plan, see section 1858A(c).

''(g) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to the benefits provided under this part.

''COMPUTATION OF MONTHLY BENEFICIARY OBLIGATION

''SEC. 1860D–17. (a) BENEFICIARIES ENROLLED IN A MEDICARE PRESCRIPTION DRUG PLAN.—In the case of an eligible beneficiary enrolled under this part and in a Medicare Prescription Drug plan, the monthly beneficiary obligation for enrollment in such plan in a year shall be determined as follows:

''(1) MONTHLY PLAN PREMIUM EQUALS MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year is equal to the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to the applicable percent (as determined in subsection (c)) of the amount of such monthly national average premium.

''(2) MONTHLY PLAN PREMIUM LESS THAN MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for the Medicare Prescription Drug plan for the year is less than the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to—

''(A) the applicable percent of the amount of such monthly national average premium; minus

''(B) the amount by which such monthly national average premium exceeds the amount of the monthly plan premium approved by the Administrator for the plan.

''(3) MONTHLY PLAN PREMIUM EXCEEDS MONTHLY NATIONAL AVERAGE PREMIUM.—If the amount of the monthly plan premium approved by the Administrator under section 1860D–13 for a Medicare Prescription Drug plan for the year exceeds the monthly national average premium (as computed under section 1860D–15) for the area for the year, the monthly beneficiary obligation of the eligible beneficiary in that year shall be an amount equal to the sum of—

''(A) the applicable percent of the amount of such monthly national average premium; plus

''(B) the amount by which the monthly plan premium approved by the Administrator for the plan exceeds the amount of such monthly national average premium.

''(b) BENEFICIARIES ENROLLED IN A MEDICAREADVANTAGE PLAN.—In the case of an eligible beneficiary that is enrolled in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), the Medicare monthly beneficiary obligation for qualified prescription drug coverage shall be determined pursuant to section 1858A(d).

''(c) APPLICABLE PERCENT.—For purposes of this section, except as provided in section

1860D–19 (relating to premium subsidies for low-income individuals), the applicable percent for any year is the percentage equal to a fraction—

''(1) the numerator of which is 30 percent; and

''(2) the denominator of which is 100 percent minus a percentage equal to—

''(A) the total reinsurance payments which the Administrator estimates will be made under section 1860D–20 to qualifying entities described in subsection (e)(3) of such section during the year; divided by

''(B) the sum of—

''(i) the amount estimated under subparagraph (A) for the year; and

''(ii) the total payments which the Administrator estimates will be made under sections 1860D–16 and 1858A(c) during the year that relate to standard prescription drug coverage (or actuarially equivalent prescription drug coverage).

''COLLECTION OF MONTHLY BENEFICIARY OBLIGATION

''SEC. 1860D–18. (a) COLLECTION OF AMOUNT IN SAME MANNER AS PART B PREMIUM.—

''(1) IN GENERAL.—Subject to paragraph (2), the amount of the monthly beneficiary obligation (determined under section 1860D–17) applicable to an eligible beneficiary under this part (after application of any increase under section 1860D–2(b)(1)(A)) shall be collected and credited to the Prescription Drug Account in the same manner as the monthly premium determined under section 1839 is collected and credited to the Federal Supplementary Medical Insurance Trust Fund under section 1840.

''(2) PROCEDURES FOR SPONSOR TO PAY OBLIGATION ON BEHALF OF RETIREE.—The Administrator shall establish procedures under which an eligible beneficiary enrolled in a Medicare Prescription Drug plan may elect to have the sponsor (as defined in paragraph (5) of section 1860D–20(e)) of employment-based retiree health coverage (as defined in paragraph (4)(B) of such section) in which the beneficiary is enrolled pay the amount of the monthly beneficiary obligation applicable to the beneficiary under this part directly to the Administrator.

''(b) INFORMATION NECESSARY FOR COLLECTION.—In order to carry out subsection (a), the Administrator shall transmit to the Commissioner of Social Security—

''(1) by the beginning of each year, the name, social security account number, monthly beneficiary obligation owed by each individual enrolled in a Medicare Prescription Drug plan for each month during the year, and other information determined appropriate by the Administrator; and

''(2) periodically throughout the year, information to update the information previously transmitted under this paragraph for the year.

''(c) COLLECTION FOR BENEFICIARIES ENROLLED IN A MEDICAREADVANTAGE PLAN.—For provisions related to the collection of the monthly beneficiary obligation for qualified prescription drug coverage under a MedicareAdvantage plan, see section 1858A(e).

''PREMIUM AND COST-SHARING SUBSIDIES FOR LOW-INCOME INDIVIDUALS

''SEC. 1860D–19. (a) AMOUNT OF SUBSIDIES.—

''(1) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR QUALIFIED MEDICARE BENEFICIARIES.—In the case of a qualified medicare beneficiary (as defined in paragraph (4)(A))—

''(A) section 1860D–17 shall be applied—

''(i) in subsection (c), by substituting '0 percent' for the applicable percent that would otherwise apply under such subsection; and

''(ii) in subsection (a)(3)(B), by substituting 'the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides' for 'the amount of such monthly national average premium', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year;

''(B) the annual deductible applicable under section 1860D–6(c)(1) in a year shall be reduced to $0;

''(C) section 1860D–6(c)(2) shall be applied by substituting '2.5 percent' for '50 percent' each place it appears;

''(D) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 5.0 percent; and

''(E) section 1860D–6(c)(4)(A) shall be applied by substituting '2.5 percent' for '10 percent'.

In no case may the application of subparagraph (A) result in a monthly beneficiary obligation that is below 0.

''(2) FULL PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR SPECIFIED LOW INCOME MEDICARE BENEFICIARIES AND QUALIFYING INDIVIDUALS.—In the case of a specified low income medicare beneficiary (as defined in paragraph (4)(B)) or a qualifying individual (as defined in paragraph (4)(C))—

''(A) section 1860D–17 shall be applied—

''(i) in subsection (c), by substituting '0 percent' for the applicable percent that would otherwise apply under such subsection; and

''(ii) in subsection (a)(3)(B), by substituting 'the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides' for 'the amount of such monthly national average premium', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year;

''(B) the annual deductible applicable under section 1860D–6(c)(1) in a year shall be reduced to $0;

''(C) section 1860D–6(c)(2) shall be applied by substituting '5.0 percent' for '50 percent' each place it appears;

''(D) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 10.0 percent; and

''(E) section 1860D–6(c)(4)(A) shall be applied by substituting '2.5 percent' for '10 percent'.

In no case may the application of subparagraph (A) result in a monthly beneficiary obligation that is below 0.

''(3) SLIDING SCALE PREMIUM SUBSIDY AND REDUCTION OF COST-SHARING FOR SUBSIDY-ELIGIBLE INDIVIDUALS.—

''(A) IN GENERAL.—In the case of a subsidy-eligible individual (as defined in paragraph (4)(D))—

''(i) section 1860D–17 shall be applied—

''(I) in subsection (c), by substituting 'subsidy percent' for the applicable percentage that would otherwise apply under such subsection; and

''(II) in subparagraphs (A) and (B) of subsection (a)(3), by substituting 'the amount of the monthly plan premium for the Medicare Prescription Drug plan with the lowest monthly plan premium in the area that the beneficiary resides' for 'the amount of such monthly national average premium', but only if there is no Medicare Prescription Drug plan offered in the area in which the individual resides that has a monthly plan premium for the year that is equal to or less than the monthly national average premium (as computed under section 1860D–15) for the area for the year; and

''(ii) the annual deductible applicable under section 1860D–6(c)(1)—

''(I) for 2006, shall be reduced to $50; and

''(II) for a subsequent year, shall be reduced to the amount specified under this clause for the previous year increased by the percentage specified in section 1860D–6(c)(5) for the year involved;

''(iii) section 1860D–6(c)(2) shall be applied by substituting '10.0 percent' for '50 percent' each place it appears;

''(iv) such individual shall be responsible for cost-sharing for the cost of any covered drug provided in the year (after the individual has reached the initial coverage limit described in section 1860D–6(c)(3) and before the individual has reached the annual out-of-pocket limit under section 1860D–6(c)(4)(A)), that is equal to 20.0 percent; and

''(v) such individual shall be responsible for the cost-sharing described in section 1860D–6(c)(4)(A).

In no case may the application of clause (i) result in a monthly beneficiary obligation that is below 0.

''(B) SUBSIDY PERCENT DEFINED.—For purposes of subparagraph (A)(i), the term 'subsidy percent' means, with respect to a State, a percent determined on a linear sliding scale ranging from—

''(i) 0 percent with respect to a subsidy-eligible individual residing in the State whose income does not exceed 135 percent of the poverty line; to

''(ii) the highest percentage that would otherwise apply under section 1860D–17 in the service area in which the subsidy-eligible individual resides, in the case of a subsidy-eligible individual residing in the State whose income equals 160 percent of the poverty line.

''(4) DEFINITIONS.—In this part:

''(A) QUALIFIED MEDICARE BENEFICIARY.—Subject to subparagraph (H), the term 'qualified medicare beneficiary' means an individual who—

''(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan;

''(ii) is described in section 1905(p)(1); and

''(iii) is not—

''(I) a specified low-income medicare beneficiary;

''(II) a qualifying individual; or

''(III) a dual eligible individual.

''(B) SPECIFIED LOW INCOME MEDICARE BENEFICIARY.—Subject to subparagraph (H), the term 'specified low income medicare beneficiary' means an individual who—

''(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan;

''(ii) is described in section 1902(a)(10)(E)(iii); and

''(iii) is not—

''(I) a qualified medicare beneficiary;

''(II) a qualifying individual; or

''(III) a dual eligible individual.

''(C) QUALIFYING INDIVIDUAL.—Subject to subparagraph (H), the term 'qualifying individual' means an individual who—

''(i) is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan;

''(ii) is described in section 1902(a)(10)(E)(iv) (without regard to any termination of the application of such section under title XIX); and

''(iii) is not—

''(I) a qualified medicare beneficiary;

''(II) a specified low-income medicare beneficiary; or

''(III) a dual eligible individual.

''(D) SUBSIDY-ELIGIBLE INDIVIDUAL.—Subject to subparagraph (H), the term 'subsidy-eligible individual' means an individual—

''(i) who is enrolled under this part, including an individual who is enrolled under a MedicareAdvantage plan;

''(ii) whose income is less than 160 percent of the poverty line; and

''(iii) who is not—

''(I) a qualified medicare beneficiary;

''(II) a specified low-income medicare beneficiary;

''(III) a qualifying individual; or

''(IV) a dual eligible individual.

''(E) DUAL ELIGIBLE INDIVIDUAL.—

''(i) IN GENERAL.—The term 'dual eligible individual' means an individual who is—

''(I) enrolled under title XIX or under a waiver under section 1115 of the requirements of such title for medical assistance that is not less than the medical assistance provided to an individual described in section 1902(a)(10)(A)(i) and includes covered outpatient drugs (as such term is defined for purposes of section 1927); and

''(II) entitled to benefits under part A and enrolled under part B.

''(ii) INCLUSION OF MEDICALLY NEEDY.—Such term includes an individual described in section 1902(a)(10)(C).

''(F) POVERTY LINE.—The term 'poverty line' has the meaning given such term in section 673(2) of the Community Services Block Grant Act (42 U.S.C. 9902(2)), including any revision required by such section.

''(G) ELIGIBILITY DETERMINATIONS.—Beginning on November 1, 2005, the determination of whether an individual residing in a State is an individual described in subparagraph (A), (B), (C), (D), or (E) and, for purposes of paragraph (3), the amount of an individual's income, shall be determined under the State medicaid plan for the State under section 1935(a). In the case of a State that does not operate such a medicaid plan (either under title XIX or under a statewide waiver granted under section 1115), such determination shall be made under arrangements made by the Administrator.

''(H) NONAPPLICATION TO DUAL ELIGIBLE INDIVIDUALS AND TERRITORIAL RESIDENTS.—In the case of an individual who is a dual eligible individual or an individual who is not a resident of the 50 States or the District of Columbia—

''(i) the subsidies provided under this section shall not apply; and

''(ii) such individuals may be provided with medical assistance for covered outpatient drugs (as such term is defined for purposes of section 1927) in accordance with section 1935 under the State medicaid program under title XIX.

''(b) RULES IN APPLYING COST-SHARING SUBSIDIES.—Nothing in this section shall be construed as preventing an eligible entity offering a Medicare Prescription Drug plan or a MedicareAdvantage organization offering a MedicareAdvantage plan from waiving or reducing the amount of the deductible or other cost-sharing otherwise applicable pursuant to section 1860D–6(a)(2).

''(c) ADMINISTRATION OF SUBSIDY PROGRAM.—The Administrator shall establish a process whereby, in the case of an individual eligible for a cost-sharing subsidy under subsection (a) who is enrolled in a Medicare Prescription Drug plan or a MedicareAdvantage plan—

''(1) the Administrator provides for a notification of the eligible entity or MedicareAdvantage organization involved that the individual is eligible for a cost-sharing subsidy and the amount of the subsidy under such subsection;

''(2) the entity or organization involved reduces the cost-sharing otherwise imposed by the amount of the applicable subsidy and submits to the Administrator information on the amount of such reduction; and

''(3) the Administrator periodically and on a timely basis reimburses the entity or organization for the amount of such reductions.

The reimbursement under paragraph (3) may be computed on a capitated basis, taking into account the actuarial value of the subsidies and with appropriate adjustments to reflect differences in the risks actually involved.

''(d) RELATION TO MEDICAID PROGRAM.—For provisions providing for eligibility determinations and additional Federal payments for expenditures related to providing prescription drug coverage for dual eligible individuals and territorial residents under the medicaid program, see section 1935.

''REINSURANCE PAYMENTS FOR EXPENSES INCURRED IN PROVIDING PRESCRIPTION DRUG COVERAGE ABOVE THE ANNUAL OUT-OF-POCKET THRESHOLD

''SEC. 1860D–20. (a) REINSURANCE PAYMENTS.—

''(1) IN GENERAL.—Subject to section 1860D–21(b), the Administrator shall provide in accordance with this section for payment to a qualifying entity of the reinsurance payment amount (as specified in subsection (c)(1)) for costs incurred by the entity in providing prescription drug coverage for a qualifying covered individual after the individual has reached the annual out-of-pocket threshold specified in section 1860D–6(c)(4)(B) for the year.

''(2) BUDGET AUTHORITY.—This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Administrator to provide for the payment of amounts provided under this section.

''(b) NOTIFICATION OF SPENDING UNDER THE PLAN FOR COSTS INCURRED IN PROVIDING PRESCRIPTION DRUG COVERAGE ABOVE THE ANNUAL OUT-OF-POCKET THRESHOLD.—

''(1) IN GENERAL.—Each qualifying entity shall notify the Administrator of the following with respect to a qualifying covered individual for a coverage year:

''(A) TOTAL ACTUAL COSTS.—The total amount (if any) of costs that the qualifying entity incurred in providing prescription drug coverage for the individual in the year after the individual had reached the annual out-of-pocket threshold specified in section 1860D–6(c)(4)(B) for the year.

''(B) ACTUAL COSTS FOR SPECIFIC DRUGS.—With respect to the total amount under subparagraph (A) for the year, a breakdown of—

''(i) each covered drug that constitutes a portion of such amount;

''(ii) the negotiated price for the qualifying entity for each such drug;

''(iii) the number of prescriptions; and

''(iv) the average beneficiary coinsurance rate for a each covered drug that constitutes a portion of such amount.

''(2) CERTAIN EXPENSES NOT INCLUDED.—The amounts under subparagraphs (A) and (B)(ii) of paragraph (1) may not include—

''(A) administrative expenses incurred in providing the coverage described in paragraph (1)(A); or

''(B) amounts expended on providing additional prescription drug coverage pursuant to section 1860D–6(a)(2).

''(3) RESTRICTION ON USE OF INFORMATION.—The restriction specified in section 1860D–16(b)(7)(B) shall apply to information disclosed or obtained pursuant to the provisions of this section.

''(c) REINSURANCE PAYMENT AMOUNT.—

''(1) IN GENERAL.—The reinsurance payment amount under this subsection for a qualifying covered individual for a coverage year is an amount equal to 80 percent of the allowable costs (as specified in paragraph (2)) incurred by the qualifying entity with respect to the individual and year.

''(2) ALLOWABLE COSTS.—

''(A) IN GENERAL.—In the case of a qualifying entity that has incurred costs described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year, the Administrator shall establish the allowable costs for the individual and year. Such allowable costs shall be equal to the amount described in such subsection for the individual and year, adjusted under subparagraph (B).

''(B) REPRICING OF COSTS IF ACTUAL COSTS EXCEED AVERAGE COSTS.—The Administrator shall reduce the amount described in subsection (b)(1)(A) with respect to a qualifying covered individual for a coverage year to the extent such amount is based on costs of specific covered drugs furnished under the plan in the year (as specified under subsection (b)(1)(B)) that are greater than the average cost for the covered drug for the year (as determined under section 1860D–16(b)(3)(A)).

''(d) PAYMENT METHODS.—

''(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

''(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

''(e) DEFINITIONS.—In this section:

''(1) COVERAGE YEAR.—The term 'coverage year' means a calendar year in which covered drugs are dispensed if a claim for payment is made under the plan for such drugs, regardless of when the claim is paid.

''(2) QUALIFYING COVERED INDIVIDUAL.—The term 'qualifying covered individual' means an individual who—

''(A) is enrolled in this part and in a Medicare Prescription Drug plan;

''(B) is enrolled in this part and in a MedicareAdvantage plan (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage); or

''(C) is eligible for, but not enrolled in, the program under this part, and is covered under a qualified retiree prescription drug plan.

''(3) QUALIFYING ENTITY.—The term 'qualifying entity' means any of the following that has entered into an agreement with the Administrator to provide the Administrator with such information as may be required to carry out this section:

''(A) An eligible entity offering a Medicare Prescription Drug plan under this part.

''(B) A MedicareAdvantage organization offering a MedicareAdvantage plan under part C (except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage).

''(C) The sponsor of a qualified retiree prescription drug plan.

''(4) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—

''(A) IN GENERAL.—The term 'qualified retiree prescription drug plan' means employment-based retiree health coverage if, with respect to a qualifying covered individual

who is covered under the plan, the following requirements are met:

''(i) ASSURANCE.—The sponsor of the plan shall annually attest, and provide such assurances as the Administrator may require, that the coverage meets or exceeds the requirements for qualified prescription drug coverage.

''(ii) DISCLOSURE OF INFORMATION.—The sponsor complies with the requirements described in clauses (i) and (ii) of section 1860D–16(b)(7)(A).

''(B) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance or other coverage, whether provided by voluntary insurance coverage or pursuant to statutory or contractual obligation, of health care costs for retired individuals (or for such individuals and their spouses and dependents) based on their status as former employees or labor union members.

''(5) SPONSOR.—The term 'sponsor' means a plan sponsor, as defined in section 3(16)(B) of the Employee Retirement Income Security Act of 1974.

''DIRECT SUBSIDY FOR SPONSOR OF A QUALIFIED RETIREE PRESCRIPTION DRUG PLAN FOR PLAN ENROLLEES ELIGIBLE FOR, BUT NOT ENROLLED IN, THIS PART

''SEC. 1860D–21. (a) DIRECT SUBSIDY.—

''(1) IN GENERAL.—The Administrator shall provide for the payment to a sponsor of a qualified retiree prescription drug plan (as defined in section 1860D–20(e)(4)) for each qualifying covered individual (described in subparagraph (C) of section 1860D–20(e)(2)) enrolled in the plan for each month for which such individual is so enrolled.

''(2) AMOUNT OF PAYMENT.—

''(A) IN GENERAL.—The amount of the payment under paragraph (1) shall be an amount equal to the direct subsidy percent determined for the year of the monthly national average premium for the area for the year (determined under section 1860D–15), as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

''(B) DIRECT SUBSIDY PERCENT.—For purposes of subparagraph (A), the term 'direct subsidy percent' means the percentage equal to—

''(i) 100 percent; minus

''(ii) the applicable percent for the year (as determined under section 1860D–17(c).

''(b) PAYMENT METHODS.—

''(1) IN GENERAL.—Payments under this section shall be based on such a method as the Administrator determines. The Administrator may establish a payment method by which interim payments of amounts under this section are made during a year based on the Administrator's best estimate of amounts that will be payable after obtaining all of the information.

''(2) SOURCE OF PAYMENTS.—Payments under this section shall be made from the Prescription Drug Account.

''Subpart 3—Miscellaneous Provisions

''PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

''SEC. 1860D–25. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is created within the Federal Supplementary Medical Insurance Trust Fund established by section 1841 an account to be known as the 'Prescription Drug Account' (in this section referred to as the 'Account').

''(2) FUNDS.—The Account shall consist of such gifts and bequests as may be made as provided in section 201(i)(1), and such amounts as may be deposited in, or appropriated to, the Account as provided in this part.

''(3) SEPARATE FROM REST OF TRUST FUND.—Funds provided under this part to the Account shall be kept separate from all other funds within the Federal Supplementary Medical Insurance Trust Fund.

''(b) PAYMENTS FROM ACCOUNT.—

''(1) IN GENERAL.—The Managing Trustee shall pay from time to time from the Account such amounts as the Secretary certifies are necessary to make payments to operate the program under this part, including—

''(A) payments to eligible entities under section 1860D–16;

''(B) payments under 1860D–19 for low-income subsidy payments for cost-sharing;

''(C) reinsurance payments under section 1860D–20;

''(D) payments to sponsors of qualified retiree prescription drug plans under section 1860D–21;

''(E) payments to MedicareAdvantage organizations for the provision of qualified prescription drug coverage under section 1858A(c); and

''(F) payments with respect to administrative expenses under this part in accordance with section 201(g).

''(2) TREATMENT IN RELATION TO PART B PREMIUM.—Amounts payable from the Account shall not be taken into account in computing actuarial rates or premium amounts under section 1839.

''(c) APPROPRIATIONS TO COVER BENEFITS AND ADMINISTRATIVE COSTS.—There are appropriated to the Account in a fiscal year, out of any moneys in the Treasury not otherwise appropriated, an amount equal to the payments and transfers made from the Account in the year.

''OTHER RELATED PROVISIONS

''SEC. 1860D–26. (a) RESTRICTION ON ENROLLMENT IN A MEDICARE PRESCRIPTION DRUG PLAN OFFERED BY A SPONSOR OF EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—

''(1) IN GENERAL.—In the case of a Medicare Prescription Drug plan offered by an eligible entity that is a sponsor (as defined in paragraph (5) of section 1860D–20(e)) of employment-based retiree health coverage (as defined in paragraph (4)(B) of such section), notwithstanding any other provision of this part and in accordance with regulations of the Administrator, the entity offering the plan may restrict the enrollment of eligible beneficiaries enrolled under this part to eligible beneficiaries who are enrolled in such coverage.

''(2) LIMITATION.—The sponsor of the employment-based retiree health coverage described in paragraph (1) may not offer enrollment in the Medicare Prescription Drug plan described in such paragraph based on the health status of eligible beneficiaries enrolled for such coverage.

''(b) COORDINATION WITH STATE PHARMACEUTICAL ASSISTANCE PROGRAMS.—

''(1) IN GENERAL.—An eligible entity offering a Medicare Prescription Drug plan, or a MedicareAdvantage organization offering a MedicareAdvantage plan (other than an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage), may enter into an agreement with a State pharmaceutical assistance program described in paragraph (2) to coordinate the coverage provided under the plan with the assistance provided under the State pharmaceutical assistance program.

''(2) STATE PHARMACEUTICAL ASSISTANCE PROGRAM DESCRIBED.—For purposes of paragraph (1), a State pharmaceutical assistance program described in this paragraph is a program that has been established pursuant to a waiver under section 1115 or otherwise.

''(c) REGULATIONS TO CARRY OUT THIS PART.—

''(1) AUTHORITY FOR INTERIM FINAL REGULATIONS.—The Secretary may promulgate initial regulations implementing this part in interim final form without prior opportunity for public comment.

''(2) FINAL REGULATIONS.—A final regulation reflecting public comments must be published within 1 year of the interim final regulation promulgated under paragraph (1).''.

(b) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 (42 U.S.C. 1395t) is amended—

(1) in the last sentence of subsection (a)—

(A) by striking ''and'' before ''such amounts''; and

(B) by inserting before the period the following: '', and such amounts as may be deposited in, or appropriated to, the Prescription Drug Account established by section 1860D–25'';

(2) in subsection (g), by inserting after ''by this part,'' the following: ''the payments provided for under part D (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),'';

(3) in subsection (h), by inserting after ''1840(d)'' the following: ''and sections 1860D–18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund)''; and

(4) in subsection (i), by inserting after ''section 1840(b)(1)'' the following: '', sections 1860D–18 and 1858A(e) (in which case the payments shall be made from the Prescription Drug Account in the Trust Fund),''.

(c) CONFORMING REFERENCES TO PREVIOUS PART D.—Any reference in law (in effect before the date of enactment of this Act) to part D of title XVIII of the Social Security Act is deemed a reference to part F of such title (as in effect after such date).

(d) SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of the enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this Act.

SEC. 102. STUDY AND REPORT ON PERMITTING PART B ONLY INDIVIDUALS TO ENROLL IN MEDICARE VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.

(a) STUDY.—The Administrator of the Center for Medicare Choices (as established under section 1808 of the Social Security Act, as added by section 301(a)) shall conduct a study on the need for rules relating to permitting individuals who are enrolled under part B of title XVIII of the Social Security Act but are not entitled to benefits under part A of such title to buy into the medicare voluntary prescription drug delivery program under part D of such title (as so added).

(b) REPORT.—Not later than January 1, 2005, the Administrator of the Center for Medicare Choices shall submit a report to Congress on the study conducted under subsection (a), together with any recommendations for legislation that the Administrator determines to be appropriate as a result of such study.

SEC. 103. RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.

(a) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—Section 1882 (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) RULES RELATING TO MEDIGAP POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE.—

''(1) PROHIBITION ON SALE, ISSUANCE, AND RENEWAL OF POLICIES THAT PROVIDE PRESCRIPTION DRUG COVERAGE TO PART D ENROLLEES.—

''(A) IN GENERAL.—Notwithstanding any other provision of law, on or after January 1, 2006, no medicare supplemental policy that provides coverage of expenses for prescription drugs may be sold, issued, or renewed under this section to an individual who is enrolled under part D.

''(B) PENALTIES.—The penalties described in subsection (d)(3)(A)(ii) shall apply with respect to a violation of subparagraph (A).

''(2) ISSUANCE OF SUBSTITUTE POLICIES IF THE POLICYHOLDER OBTAINS PRESCRIPTION DRUG COVERAGE UNDER PART D.—

''(A) IN GENERAL.—The issuer of a medicare supplemental policy—

''(i) may not deny or condition the issuance or effectiveness of a medicare supplemental policy that has a benefit package classified as 'A', 'B', 'C', 'D', 'E', 'F' (including the benefit package classified as 'F' with a high deductible feature, as described in subsection (p)(11)), or 'G' (under the standards established under subsection (p)(2)) and that is offered and is available for issuance to new enrollees by such issuer;

''(ii) may not discriminate in the pricing of such policy, because of health status, claims experience, receipt of health care, or medical condition; and

''(iii) may not impose an exclusion of benefits based on a pre-existing condition under such policy,

in the case of an individual described in subparagraph (B) who seeks to enroll under the policy during the open enrollment period established under section 1860D–2(b)(2) and who submits evidence that they meet the requirements under subparagraph (B) along with the application for such medicare supplemental policy.

''(B) INDIVIDUAL DESCRIBED.—An individual described in this subparagraph is an individual who—

''(i) enrolls in the medicare prescription drug delivery program under part D; and

''(ii) at the time of such enrollment was enrolled and terminates enrollment in a medicare supplemental policy which has a benefit package classified as 'H', 'I', or 'J' (including the benefit package classified as 'J' with a high deductible feature, as described in section 1882(p)(11)) under the standards referred to in subparagraph (A)(i) or terminates enrollment in a policy to which such standards do not apply but which provides benefits for prescription drugs.

''(C) ENFORCEMENT.—The provisions of subparagraph (A) shall be enforced as though they were included in subsection (s).

''(3) NOTICE REQUIRED TO BE PROVIDED TO CURRENT POLICYHOLDERS WITH PRESCRIPTION DRUG COVERAGE.—No medicare supplemental policy of an issuer shall be deemed to meet the standards in subsection (c) unless the issuer provides written notice during the 60-day period immediately preceding the period established for the open enrollment period established under section 1860D–2(b)(2), to each individual who is a policyholder or certificate holder of a medicare supplemental policy issued by that issuer that provides some coverage of expenses for prescription drugs (at the most recent available address of that individual) of—

''(A) the ability to enroll in a new medicare supplemental policy pursuant to paragraph (2); and

''(B) the fact that, so long as such individual retains coverage under such policy, the individual shall be ineligible for coverage of prescription drugs under part D.''.

(b) RULE OF CONSTRUCTION.—

(1) IN GENERAL.—Nothing in this Act shall be construed to require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) to participate as an eligible entity under part D of such Act, as added by section 101, as a condition for issuing such policy.

(2) PROHIBITION ON STATE REQUIREMENT.—A State may not require an issuer of a medicare supplemental policy under section 1882 of the Social Security Act (42 U.S.C. 1395rr) to participate as an eligible entity under part D of such Act, as added by section 101, as a condition for issuing such policy.

SEC. 104. MEDICAID AND OTHER AMENDMENTS RELATED TO LOW-INCOME BENEFICIARIES.

(a) DETERMINATIONS OF ELIGIBILITY FOR LOW-INCOME SUBSIDIES.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

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

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

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

''(66) provide for making eligibility determinations under section 1935(a).''.

(b) NEW SECTION.—

(1) IN GENERAL.—Title XIX (42 U.S.C. 1396 et seq.) is amended—

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

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

''SPECIAL PROVISIONS RELATING TO MEDICARE PRESCRIPTION DRUG BENEFIT

''SEC. 1935. (a) REQUIREMENT FOR MAKING ELIGIBILITY DETERMINATIONS FOR LOW-INCOME SUBSIDIES.—As a condition of its State plan under this title under section 1902(a)(66) and receipt of any Federal financial assistance under section 1903(a), a State shall satisfy the following:

''(1) DETERMINATION OF ELIGIBILITY FOR TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE CARD PROGRAM FOR ELIGIBLE LOW-INCOME BENEFICIARIES.—For purposes of section 1807A, submit to the Secretary an eligibility plan under which the State—

''(A) establishes eligibility standards consistent with the provisions of that section;

''(B) establishes procedures for providing presumptive eligibility for eligible low-income beneficiaries (as defined in section 1807A(i)(2)) under that section in a manner that is similar to the manner in which presumptive eligibility is provided to children and pregnant women under this title;

''(C) makes determinations of eligibility and income for purposes of identifying eligible low-income beneficiaries (as so defined) under that section; and

''(D) communicates to the Secretary determinations of eligibility or discontinuation of eligibility under that section for purposes of notifying prescription drug card sponsors under that section of the identity of eligible medicare low-income beneficiaries.

''(2) DETERMINATION OF ELIGIBILITY FOR PREMIUM AND COST-SHARING SUBSIDIES UNDER PART D OF TITLE XVIII FOR LOW-INCOME INDIVIDUALS.—Beginning November 1, 2005, for purposes of section 1860D–19—

''(A) make determinations of eligibility for premium and cost-sharing subsidies under and in accordance with such section;

''(B) establish procedures for providing presumptive eligibility for individuals eligible for subsidies under that section in a manner that is similar to the manner in which presumptive eligibility is provided to children and pregnant women under this title;

''(C) inform the Administrator of the Center for Medicare Choices of such determinations in cases in which such eligibility is established; and

''(D) otherwise provide such Administrator with such information as may be required to carry out part D of title XVIII (including section 1860D–19).

''(3) AGREEMENT TO ESTABLISH INFORMATION AND ENROLLMENT SITES AT SOCIAL SECURITY FIELD OFFICES.—Enter into an agreement with the Commissioner of Social Security to use all Social Security field offices located in the State as information and enrollment sites for making the eligibility determinations required under paragraphs (1) and (2).

''(b) FEDERAL SUBSIDY OF ADMINISTRATIVE COSTS.—

''(1) ENHANCED MATCH FOR ELIGIBILITY DETERMINATIONS.—Subject to paragraphs (2) and (4), with respect to calendar quarters beginning on or after January 1, 2004, the amounts expended by a State in carrying out subsection (a) are expenditures reimbursable under section 1903(a)(7) except that, in applying such section with respect to such expenditures incurred for—

''(A) such calendar quarters occurring in fiscal year 2004 or 2005, '75 percent' shall be substituted for '50 per centum';

''(B) calendar quarters occurring in fiscal year 2006, '70 percent' shall be substituted for '50 per centum';

''(C) calendar quarters occurring in fiscal year 2007, '65 percent' shall be substituted for '50 per centum'; and

''(D) calendar quarters occurring in fiscal year 2008 or any fiscal year thereafter, '60 percent' shall be substituted for '50 per centum'.

''(2) 100 PERCENT MATCH FOR ELIGIBILITY DETERMINATIONS FOR SUBSIDY-ELIGIBLE INDIVIDUALS.—In the case of amounts expended by a State on or after November 1, 2005, to determine whether an individual is a subsidy-eligible individual for purposes of section 1860D–19, such expenditures shall be reimbursed under section 1903(a)(7) by substituting '100 percent' for '50 per centum'.

''(3) ENHANCED MATCH FOR UPDATES OR IMPROVEMENTS TO ELIGIBILITY DETERMINATION SYSTEMS.—With respect to calendar quarters occurring in fiscal year 2004, 2005, or 2006, the Secretary, in addition to amounts otherwise paid under section 1903(a), shall pay to each State which has a plan approved under this title, for each such quarter an amount equal to 90 percent of so much of the sums expended during such quarter as are attributable to the design, development, acquisition, or installation of improved eligibility determination systems (including hardware and software for such systems) in order to carry out the requirements of subsection (a) and section 1807A(h)(1). No payment shall be made to a State under the preceding sentence unless the State's improved eligibility determination system—

''(A) satisfies such standards for improvement as the Secretary may establish; and

''(B) complies, and is compatible, with the standards established under part C of title XI and any regulations promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. 1320d–2 note).

''(4) COORDINATION.—The State shall provide the Secretary with such information as may be necessary to properly allocate expenditures described in paragraph (1), (2), or (3) that may otherwise be made for similar eligibility determinations or expenditures.

''(c) FEDERAL PAYMENT OF MEDICARE PART B PREMIUM FOR STATES PROVIDING PRESCRIPTION DRUG COVERAGE FOR DUAL ELIGIBLE INDIVIDUALS.—

''(1) IN GENERAL.—Subject to paragraph (4), in the case of a State that provides medical assistance for covered drugs (as such term is defined in section 1860D(a)(2)) to dual eligible individuals under this title that satisfies the minimum standards described in paragraph (2), the Secretary shall be responsible in accordance with section 1841(f)(2) for paying 100 percent of the medicare cost-sharing described in section 1905(p)(3)(A)(ii) (relating to premiums under section 1839) for individuals—

''(A) who are dual eligible individuals or qualified medicare beneficiaries; and

''(B) whose family income is at least 74 percent, but not more than 100 percent, of the poverty line (as defined in section 2110(c)(5)) applicable to a family of the size involved.

''(2) MINIMUM STANDARDS DESCRIBED.—For purposes of paragraph (1), the minimum standards described in this paragraph are the following:

''(A) In providing medical assistance for dual eligible individuals for such covered drugs, the State satisfies the requirements of this title (including limitations on cost-sharing imposed under section 1916) applicable to the provision of medical assistance for prescribed drugs to dual eligible individuals.

''(B) In providing medical assistance for dual eligible individuals for such covered drugs, the State provides such individuals with beneficiary protections that the Secretary determines are equivalent to the beneficiary protections applicable under section 1860D–5 to eligible entities offering a Medicare Prescription Drug plan under part D of title XVIII.

''(C) In providing medical assistance for dual eligible individuals for such covered drugs, the State does not impose a limitation on the number of prescriptions an individual may have filled.

''(3) NONAPPLICATION.—Section 1927(d)(2)(E) shall not apply to a State for purposes of providing medical assistance for covered drugs (as such term is defined in section 1860D(a)(2)) to dual eligible individuals that satisfies the minimum standards described in paragraph (2).

''(4) LIMITATION.—Paragraph (1) shall not apply to any State before January 1, 2006.

''(d) FEDERAL PAYMENT OF MEDICARE PART A COST-SHARING FOR CERTAIN STATES.—

''(1) IN GENERAL.—Subject to paragraph (2), in the case of a State that, as of the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, provides medical assistance for individuals described in section 1902(a)(10)(A)(ii))(X), the Secretary shall be responsible in accordance with section 1817(g)(2), for paying 100 percent of the medicare cost-sharing described in subparagraphs (B) and (C) of section 1905(p)(3) (relating to coinsurance and deductibles established under title XVIII) for the individuals provided medical assistance under section 1902(a)(10)(A)(ii)(X), but only—

''(A) with respect to such medicare cost-sharing that is incurred under part A of title XVIII; and

''(B) for so long as the State elects to provide medical assistance under section 1902(a)(10)(A)(ii)(X).

''(2) LIMITATION.—Paragraph (1) shall not apply to any State before January 1, 2006.

''(e) TREATMENT OF TERRITORIES.—

''(1) IN GENERAL.—In the case of a State, other than the 50 States and the District of Columbia—

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

''(B) if the State establishes a plan described in paragraph (2), the amount otherwise determined under section 1108(f) (as increased under section 1108(g)) for the State shall be further increased by the amount specified in paragraph (3).

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

''(A) provides medical assistance with respect to the provision of covered drugs (as defined in section 1860D(a)(2)) to individuals described in subparagraph (A), (B), (C), or (D) of section 1860D–19(a)(3); and

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

''(3) INCREASED AMOUNT.—

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

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

''(ii) the amount specified in section 1108(g)(1) for that State, divided by the sum of the amounts specified in such section for all such States.

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

''(i) the last 3 quarters of fiscal year 2006, is equal to $22,500,000;

''(ii) fiscal year 2007, is equal to $30,000,000; and

''(iii) any subsequent fiscal year, is equal to the aggregate amount specified in this subparagraph for the previous fiscal year increased by the annual percentage increase specified in section 1860D–6(c)(5) for the calendar year beginning in such fiscal year.

''(4) NONAPPLICATION.—Section 1927(d)(2)(E) shall not apply to a State described in paragraph (1) for purposes of providing medical assistance described in paragraph (2)(A).

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

''(f) DEFINITIONS.—For purposes of this section, the terms 'qualified medicare beneficiary', 'subsidy-eligible individual', and 'dual eligible individual' have the meanings given such terms in subparagraphs (A), (D), and (E), respectively, of section 1860D–19(a)(4).''.

(2) CONFORMING AMENDMENT.—Section 1108(f) (42 U.S.C. 1308(f)) is amended by inserting ''and section 1935(e)(1)(B)'' after ''Subject to subsection (g)''.

(3) TRANSFER OF FEDERALLY ASSUMED PORTIONS OF MEDICARE COST-SHARING.—

(A) TRANSFER OF ASSUMPTION OF PART B PREMIUM FOR STATES PROVIDING PRESCRIPTION DRUG COVERAGE FOR DUAL ELIGIBLE INDIVIDUALS TO THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841(f) (42 U.S.C. 1395t(f)) is amended—

(i) by inserting ''(1)'' after ''(f)''; and

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

''(2) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Treasury amounts which the Secretary of Health and Human Services shall have certified are equivalent to the amounts determined under section 1935(c)(1) with respect to all States for a fiscal year.''.

(B) TRANSFER OF ASSUMPTION OF PART A COST-SHARING FOR CERTAIN STATES.—Section 1817(g) (42 U.S.C. 1395i(g)) is amended—

(i) by inserting ''(1)'' after ''(g)''; and

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

''(2) There shall be transferred periodically (but not less often than once each fiscal year) to the Trust Fund from the Treasury amounts which the Secretary of Health and Human Services shall have certified are equivalent to the amounts determined under section 1935(d)(1) with respect to certain States for a fiscal year.''.

(4) AMENDMENT TO BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)), as amended by section 111(b), is amended—

(A) by striking ''and'' at the end of subclause (IV);

(B) by striking the period at the end of subclause (V) and inserting ''; and''; and

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

''(VI) any prices charged which are negotiated under a Medicare Prescription Drug plan under part D of title XVIII with respect to covered drugs, under a MedicareAdvantage plan under part C of such title with respect to such drugs, or under a qualified retiree prescription drug plan (as defined in section 1860D–20(f)(1)) with respect to such drugs, on behalf of eligible beneficiaries (as defined in section 1860D(a)(3).''.

(c) EXTENSION OF MEDICARE COST-SHARING FOR PART B PREMIUM FOR QUALIFYING INDIVIDUALS THROUGH 2008.—

(1) IN GENERAL.—Section 1902(a)(10)(E)(iv) (42 U.S.C. 1396a(a)(10)(E)(iv)) is amended to read as follows:

''(iv) subject to sections 1933 and 1905(p)(4), for making medical assistance available (but only for premiums payable with respect to months during the period beginning with January 1998, and ending with December 2008) for medicare cost-sharing described in section 1905(p)(3)(A)(ii) for individuals who would be qualified medicare beneficiaries described in section 1905(p)(1) but for the fact that their income exceeds the income level established by the State under section 1905(p)(2) and is at least 120 percent, but less than 135 percent, of the official poverty line (referred to in such section) for a family of the size involved and who are not otherwise eligible for medical assistance under the State plan;''.

(2) TOTAL AMOUNT AVAILABLE FOR ALLOCATION.—Section 1933(c) (42 U.S.C. 1396u–3(c)) is amended—

(A) in paragraph (1)—

(i) in subparagraph (D), by striking ''and'' at the end;

(ii) in subparagraph (E)—

(I) by striking ''fiscal year 2002'' and inserting ''each of fiscal years 2002 through 2008''; and

(II) by striking the period and inserting ''; and''; and

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

''(F) the first quarter of fiscal year 2009, $100,000,000.''; and

(B) in paragraph (2)(A), by striking ''the sum of'' and all that follows through ''1902(a)(10)(E)(iv)(II) in the State; to'' and inserting ''twice the total number of individuals described in section 1902(a)(10)(E)(iv) in the State; to''.

(d) OUTREACH BY THE COMMISSIONER OF SOCIAL SECURITY.—Section 1144 (42 U.S.C. 1320b–14) is amended—

(1) in the section heading, by inserting ''AND SUBSIDIES FOR LOW-INCOME INDIVIDUALS UNDER TITLE XVIII'' after ''COST-SHARING'';

(2) in subsection (a)—

(A) in paragraph (1)—

(i) in subparagraph (A), by inserting ''for the transitional prescription drug assistance card program under section 1807A, or for premium and cost-sharing subsidies under section 1860D–19'' before the semicolon; and

(ii) in subparagraph (B), by inserting '', program, and subsidies'' after ''medical assistance''; and

(B) in paragraph (2)—

(i) in the matter preceding subparagraph (A), by inserting '', the transitional prescription drug assistance card program under section 1807A, or premium and cost-sharing subsidies under section 1860D–19'' after ''assistance''; and

(ii) in subparagraph (A), by striking ''such eligibility'' and inserting ''eligibility for medicare cost-sharing under the medicaid program''; and

(3) in subsection (b)—

(A) in paragraph (1)(A), by inserting '', for the transitional prescription drug assistance card program under section 1807A, or for premium and cost-sharing subsidies for low-income individuals under section 1860D–19'' after ''1933''; and

(B) in paragraph (2), by inserting '', program, and subsidies'' after ''medical assistance''.

(e) REPORT REGARDING VOLUNTARY ENROLLMENT OF DUAL ELIGIBLE INDIVIDUALS IN PART D.—Not later than January 1, 2005, the Secretary shall submit a report to Congress that contains such recommendations for legislation as the Secretary determines are necessary in order to establish a voluntary option for dual eligible individuals (as defined in 1860D–19(a)(4)(E) of the Social Security Act (as added by section 101)) to enroll under part D of title XVIII of such Act for prescription drug coverage.

SEC. 105. EXPANSION OF MEMBERSHIP AND DUTIES OF MEDICARE PAYMENT ADVISORY COMMISSION (MEDPAC).

(a) EXPANSION OF MEMBERSHIP.—

(1) IN GENERAL.—Section 1805(c) (42 U.S.C. 1395b–6(c)) is amended—

(A) in paragraph (1), by striking ''17'' and inserting ''19''; and

(B) in paragraph (2)(B), by inserting ''experts in the area of pharmacology and prescription drug benefit programs,'' after ''other health professionals,''.

(2) INITIAL TERMS OF ADDITIONAL MEMBERS.—

(A) IN GENERAL.—For purposes of staggering the initial terms of members of the Medicare Payment Advisory Commission under section 1805(c)(3) of the Social Security Act (42 U.S.C. 1395b–6(c)(3)), the initial terms of the 2 additional members of the Commission provided for by the amendment under paragraph (1)(A) are as follows:

(i) One member shall be appointed for 1 year.

(ii) One member shall be appointed for 2 years.

(B) COMMENCEMENT OF TERMS.—Such terms shall begin on January 1, 2005.

(b) EXPANSION OF DUTIES.—Section 1805(b)(2) (42 U.S.C. 1395b–6(b)(2)) is amended by adding at the end the following new subparagraph:

''(D) VOLUNTARY PRESCRIPTION DRUG DELIVERY PROGRAM.—Specifically, the Commission shall review, with respect to the voluntary prescription drug delivery program under part D, competition among eligible entities offering Medicare Prescription Drug plans and beneficiary access to such plans and covered drugs, particularly in rural areas.''.

SEC. 106. STUDY REGARDING VARIATIONS IN SPENDING AND DRUG UTILIZATION.

(a) STUDY.—The Secretary shall study on an ongoing basis variations in spending and drug utilization under part D of title XVIII of the Social Security Act for covered drugs to determine the impact of such variations on premiums imposed by eligible entities offering Medicare Prescription Drug plans under that part. In conducting such study, the Secretary shall examine the impact of geographic adjustments of the monthly national average premium under section 1860D–15 of such Act on—

(1) maximization of competition under part D of title XVIII of such Act; and

(2) the ability of eligible entities offering Medicare Prescription Drug plans to contain costs for covered drugs.

(b) REPORT.—Beginning with 2007, the Secretary shall submit annual reports to Congress on the study required under subsection (a).

Subtitle B—Medicare Prescription Drug Discount Card and Transitional Assistance for Low-Income Beneficiaries

SEC. 111. MEDICARE PRESCRIPTION DRUG DISCOUNT CARD AND TRANSITIONAL ASSISTANCE FOR LOW-INCOME BENEFICIARIES.

(a) IN GENERAL.—Title XVIII is amended by inserting after section 1806 the following new sections:

''MEDICARE PRESCRIPTION DRUG DISCOUNT CARD ENDORSEMENT PROGRAM

''SEC. 1807. (a) ESTABLISHMENT.—There is established a medicare prescription drug discount card endorsement program under which the Secretary shall—

''(1) endorse prescription drug discount card programs offered by prescription drug card sponsors that meet the requirements of this section; and

''(2) make available to eligible beneficiaries information regarding such endorsed programs.

''(b) ELIGIBILITY, ELECTION OF PROGRAM, AND ENROLLMENT FEES.—

''(1) ELIGIBILITY AND ELECTION OF PROGRAM.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall establish procedures—

''(i) for identifying eligible beneficiaries; and

''(ii) under which such beneficiaries may make an election to enroll in any prescription drug discount card program endorsed under this section and disenroll from such a program.

''(B) LIMITATION.—An eligible beneficiary may not be enrolled in more than 1 prescription drug discount card program at any time.

''(2) ENROLLMENT FEES.—

''(A) IN GENERAL.—A prescription drug card sponsor may charge an annual enrollment fee to each eligible beneficiary enrolled in a prescription drug discount card program offered by such sponsor.

''(B) AMOUNT.—No enrollment fee charged under subparagraph (A) may exceed $25.

''(C) UNIFORM ENROLLMENT FEE.—A prescription drug card sponsor shall ensure that the enrollment fee for a prescription drug discount card program endorsed under this section is the same for all eligible medicare beneficiaries enrolled in the program.

''(D) COLLECTION.—Any enrollment fee shall be collected by the prescription drug card sponsor.

''(c) PROVIDING INFORMATION TO ELIGIBLE BENEFICIARIES.—

''(1) PROMOTION OF INFORMED CHOICE.—

''(A) BY THE SECRETARY.—In order to promote informed choice among endorsed prescription drug discount card programs, the Secretary shall provide for the dissemination of information which compares the costs and benefits of such programs. Such dissemination shall be coordinated with the dissemination of educational information on other medicare options.

''(B) BY PRESCRIPTION DRUG CARD SPONSORS.—Each prescription drug card sponsor shall make available to each eligible beneficiary (through the Internet and otherwise) information—

''(i) that the Secretary identifies as being necessary to promote informed choice among endorsed prescription drug discount card programs by eligible beneficiaries, including information on enrollment fees, negotiated prices for prescription drugs charged to beneficiaries, and services relating to prescription drugs offered under the program;

''(ii) on how any formulary used by such sponsor functions.

''(2) USE OF MEDICARE TOLL-FREE NUMBER.—The Secretary shall provide through the 1–800–MEDICARE toll free telephone number for the receipt and response to inquiries and complaints concerning the medicare prescription drug discount card endorsement program established under this section and prescription drug discount card programs endorsed under such program.

''(d) BENEFICIARY PROTECTIONS.—

''(1) IN GENERAL.—Each prescription drug discount card program endorsed under this section shall meet such requirements as the Secretary identifies to protect and promote the interest of eligible beneficiaries, including requirements that—

''(A) relate to appeals by eligible beneficiaries and marketing practices; and

''(B) ensure that beneficiaries are not charged more than the lower of the negotiated retail price or the usual and customary price.

''(2) ENSURING PHARMACY ACCESS.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall secure the participation in its network of a sufficient number of pharmacies that dispense (other than by mail order) drugs directly to patients to ensure convenient access (as determined by the Secretary and including adequate emergency access) for enrolled beneficiaries. Such standards shall take into account reasonable distances to pharmacy services in both urban and rural areas.

''(3) QUALITY ASSURANCE.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall have in place adequate procedures for assuring that quality service is provided to eligible beneficiaries enrolled in a prescription drug discount card program offered by such sponsor.

''(4) CONFIDENTIALITY OF ENROLLEE RECORDS.—Insofar as a prescription drug card sponsor maintains individually identifiable medical records or other health information regarding eligible beneficiaries enrolled in a prescription drug discount card program endorsed under this section, the prescription drug card sponsor shall have in place procedures to safeguard the privacy of any individually identifiable beneficiary information in a manner that the Secretary determines is consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996.

''(5) NO OTHER FEES.—A prescription drug card sponsor may not charge any fee to an eligible beneficiary under a prescription drug discount card program endorsed under this section other than an enrollment fee charged under subsection (b)(2)(A).

''(6) PRICES.—

''(A) AVOIDANCE OF HIGH PRICED DRUGS.—A prescription drug card sponsor may not recommend switching an eligible beneficiary to a drug with a higher negotiated price absent a recommendation by a licensed health professional that there is a clinical indication with respect to the patient for such a switch.

''(B) PRICE STABILITY.—Negotiated prices charged for prescription drugs covered under a prescription drug discount card program endorsed under this section may not change more frequently than once every 60 days.

''(e) PRESCRIPTION DRUG BENEFITS.—

''(1) IN GENERAL.—Each prescription drug card sponsor may only provide benefits that relate to prescription drugs (as defined in subsection (i)(2)) under a prescription drug discount card program endorsed under this section.

''(2) SAVINGS TO ELIGIBLE BENEFICIARIES.—

''(A) IN GENERAL.—Subject to subparagraph (D), each prescription drug card sponsor shall provide eligible beneficiaries who enroll in a prescription drug discount card program offered by such sponsor that is endorsed under this section with access to negotiated prices used by the sponsor with respect to prescription drugs dispensed to eligible beneficiaries.

''(B) INAPPLICABILITY OF MEDICAID BEST PRICE RULES.—The requirements of section 1927 relating to manufacturer best price shall

not apply to the negotiated prices for prescription drugs made available under a prescription drug discount card program endorsed under this section.

''(C) GUARANTEED ACCESS TO NEGOTIATED PRICES.—The Secretary, in consultation with the Inspector General of the Department of Health and Human Services, shall establish procedures to ensure that eligible beneficiaries have access to the negotiated prices for prescription drugs provided under subparagraph (A).

''(D) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug discount card program if the program excludes the drug under a formulary.

''(3) BENEFICIARY SERVICES.—Each prescription drug discount card program endorsed under this section shall provide pharmaceutical support services, such as education, counseling, and services to prevent adverse drug interactions.

''(4) DISCOUNT CARDS.—Each prescription drug card sponsor shall issue a card to eligible beneficiaries enrolled in a prescription drug discount card program offered by such sponsor that the beneficiary may use to obtain benefits under the program.

''(f) SUBMISSION OF APPLICATIONS FOR ENDORSEMENT AND APPROVAL.—

''(1) SUBMISSION OF APPLICATIONS FOR ENDORSEMENT.—Each prescription drug card sponsor that seeks endorsement of a prescription drug discount card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, such information as the Secretary may require.

''(2) APPROVAL.—The Secretary shall review the information submitted under paragraph (1) and shall determine whether to endorse the prescription drug discount card program to which such information relates. The Secretary may not approve a program unless the program and prescription drug card sponsor offering the program comply with the requirements under this section.

''(g) REQUIREMENTS ON DEVELOPMENT AND APPLICATION OF FORMULARIES.—If a prescription drug card sponsor offering a prescription drug discount card program uses a formulary, the following requirements must be met:

''(1) PHARMACY AND THERAPEUTIC (P&T) COMMITTEE.—

''(A) IN GENERAL.—The eligible entity must establish a pharmacy and therapeutic committee that develops and reviews the formulary.

''(B) COMPOSITION.—A pharmacy and therapeutic committee shall include at least 1 academic expert, at least 1 practicing physician, and at least 1 practicing pharmacist, all of whom have expertise in the care of elderly or disabled persons, and a majority of the members of such committee shall consist of individuals who are a practicing physician or a practicing pharmacist (or both).

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

''(3) INCLUSION OF DRUGS IN ALL THERAPEUTIC CATEGORIES AND CLASSES.—

''(A) IN GENERAL.—The formulary must include drugs within each therapeutic category and class of covered outpatient drugs (as defined by the Secretary), although not necessarily for all drugs within such categories and classes.

''(B) REQUIREMENT.—In defining therapeutic categories and classes of covered outpatient drugs pursuant to subparagraph (A), the Secretary shall use the compendia referred to section 1927(g)(1)(B)(i) or other recognized sources for categorizing drug therapeutic categories and classes.

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

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

''(h) FRAUD AND ABUSE PREVENTION.—

''(1) IN GENERAL.—The Secretary shall provide appropriate oversight to ensure compliance of endorsed programs with the requirements of this section, including verification of the negotiated prices and services provided.

''(2) DISQUALIFICATION FOR ABUSIVE PRACTICES.—The Secretary may implement intermediate sanctions and may revoke the endorsement of a program that the Secretary determines no longer meets the requirements of this section or that has engaged in false or misleading marketing practices.

''(3) AUTHORITY WITH RESPECT TO CIVIL MONEY PENALTIES.—The Secretary may impose a civil money penalty in an amount not to exceed $10,000 for any violation of this section. The provisions of section 1128A (other than subsections (a) and (b)) shall apply to a civil money penalty under the previous sentence in the same manner as such provisions apply to a penalty or proceeding under section 1128A(a).

''(4) REPORTING TO SECRETARY.—Each prescription drug card sponsor offering a prescription drug discount card program endorsed under this section shall report information relating to program performance, use of prescription drugs by eligible beneficiaries enrolled in the program, financial information of the sponsor, and such other information as the Secretary may specify. The Secretary may not disclose any proprietary data reported under this paragraph.

''(5) DRUG UTILIZATION REVIEW.—The Secretary may use claims data from parts A and B for purposes of conducting a drug utilization review program.

''(i) DEFINITIONS.—In this section:

''(1) ELIGIBLE BENEFICIARY.—

''(A) IN GENERAL.—The term 'eligible beneficiary' means an individual who—

''(i) is entitled to, or enrolled for, benefits under part A and enrolled under part B; and

''(ii) is not a dual eligible individual (as defined in subparagraph (B)).

''(B) DUAL ELIGIBLE INDIVIDUAL.—

''(i) IN GENERAL.—The term 'dual eligible individual' means an individual who is—

''(I) enrolled under title XIX or under a waiver under section 1115 of the requirements of such title for medical assistance that is not less than the medical assistance provided to an individual described in section 1902(a)(10)(A)(i) and includes covered outpatient drugs (as such term is defined for purposes of section 1927); and

''(II) entitled to benefits under part A and enrolled under part B.

''(ii) INCLUSION OF MEDICALLY NEEDY.—Such term includes an individual described in section 1902(a)(10)(C).

''(2) PRESCRIPTION DRUG.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), the term 'prescription drug' means—

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

''(ii) a biological product or insulin described in subparagraph (B) or (C) of such section,

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

''(B) EXCLUSIONS.—The term 'prescription drug' does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents), or under section 1927(d)(3).

''(3) NEGOTIATED PRICE.—The term 'negotiated price' includes all discounts, direct or indirect subsidies, rebates, price concessions, and direct or indirect remunerations.

''(4) PRESCRIPTION DRUG CARD SPONSOR.—The term 'prescription drug card sponsor' means any entity with demonstrated experience and expertise in operating a prescription drug discount card program, an insurance program that provides coverage for prescription drugs, or a similar program that the Secretary determines to be appropriate to provide eligible beneficiaries with the benefits under a prescription drug discount card program endorsed by the Secretary under this section, including—

''(A) a pharmaceutical benefit management company;

''(B) a wholesale or retail pharmacist delivery system;

''(C) an insurer (including an insurer that offers medicare supplemental policies under section 1882);

''(D) any other entity; or

''(E) any combination of the entities described in subparagraphs (A) through (D).

''TRANSITIONAL PRESCRIPTION DRUG ASSISTANCE CARD PROGRAM FOR ELIGIBLE LOW-INCOME BENEFICIARIES

''SEC. 1807A. (a) ESTABLISHMENT.—

''(1) IN GENERAL.—There is established a program under which the Secretary shall award contracts to prescription drug card sponsors offering a prescription drug discount card that has been endorsed by the Secretary under section 1807 under which such sponsors shall offer a prescription drug assistance card program to eligible low-income beneficiaries in accordance with the requirements of this section.

''(2) APPLICATION OF DISCOUNT CARD PROVISIONS.—Except as otherwise provided in this section, the provisions of section 1807 shall apply to the program established under this section.

''(b) ELIGIBILITY, ELECTION OF PROGRAM, AND ENROLLMENT FEES.—

''(1) ELIGIBILITY AND ELECTION OF PROGRAM.—

''(A) IN GENERAL.—Subject to the succeeding provisions of this paragraph, the enrollment procedures established under section 1807(b)(1)(A)(ii) shall apply for purposes of this section.

''(B) ENROLLMENT OF ANY ELIGIBLE LOW-INCOME BENEFICIARY.—Each prescription drug card sponsor offering a prescription drug assistance card program under this section shall permit any eligible low-income beneficiary to enroll in such program if it serves the geographic area in which the beneficiary resides.

''(C) SIMULTANEOUS ENROLLMENT IN PRESCRIPTION DRUG DISCOUNT CARD PROGRAM.—An eligible low-income beneficiary who enrolls in a prescription drug assistance card program offered by a prescription drug card

sponsor under this section shall be simultaneously enrolled in a prescription drug discount card program offered by such sponsor.

''(2) WAIVER OF ENROLLMENT FEES.—

''(A) IN GENERAL.—A prescription drug card sponsor may not charge an enrollment fee to any eligible low-income beneficiary enrolled in a prescription drug discount card program offered by such sponsor.

''(B) PAYMENT BY SECRETARY.—Under a contract awarded under subsection (f)(2), the Secretary shall pay to each prescription drug card sponsor an amount equal to any enrollment fee charged under section 1807(b)(2)(A) on behalf of each eligible low-income beneficiary enrolled in a prescription drug discount card program under paragraph (1)(C) offered by such sponsor.

''(c) ADDITIONAL BENEFICIARY PROTECTIONS.—

''(1) PROVIDING INFORMATION TO ELIGIBLE LOW-INCOME BENEFICIARIES.—In addition to the information provided to eligible beneficiaries under section 1807(c), the prescription drug card sponsor shall—

''(A) periodically notify each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor of the amount of coverage for prescription drugs remaining under subsection (d)(2)(A); and

''(B) notify each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor of the grievance and appeals processes under the program.

''(2) CONVENIENT ACCESS IN LONG-TERM CARE FACILITIES.—For purposes of determining whether convenient access has been provided under section 1807(d)(2) with respect to eligible low-income beneficiaries enrolled in a prescription drug assistance card program, the Secretary may only make a determination that such access has been provided if an appropriate arrangement is in place for eligible low-income beneficiaries who are in a long-term care facility (as defined by the Secretary) to receive prescription drug benefits under the program.

''(3) COORDINATION OF BENEFITS.—

''(A) IN GENERAL.—The Secretary shall establish procedures under which eligible low-income beneficiaries who are enrolled for coverage described in subparagraph (B) and enrolled in a prescription drug assistance card program have access to the prescription drug benefits available under such program.

''(B) COVERAGE DESCRIBED.—Coverage described in this subparagraph is as follows:

''(i) Coverage of prescription drugs under a State pharmaceutical assistance program.

''(ii) Enrollment in a Medicare+Choice plan under part C.

''(4) GRIEVANCE MECHANISM.—Each prescription drug card sponsor with a contract under this section shall provide in accordance with section 1852(f) meaningful procedures for hearing and resolving grievances between the prescription drug card sponsor (including any entity or individual through which the prescription drug card sponsor provides covered benefits) and enrollees in a prescription drug assistance card program offered by such sponsor.

''(5) APPLICATION OF COVERAGE DETERMINATION AND RECONSIDERATION PROVISIONS.—

''(A) IN GENERAL.—The requirements of paragraphs (1) through (3) of section 1852(g) shall apply with respect to covered benefits under a prescription drug assistance card program under this section in the same manner as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(B) REQUEST FOR REVIEW OF TIERED FORMULARY DETERMINATIONS.—In the case of a prescription drug assistance card program offered by a prescription drug card sponsor that provides for tiered pricing for drugs included within a formulary and provides lower prices for preferred drugs included within the formulary, an eligible low-income beneficiary who is enrolled in the program may request coverage of a nonpreferred drug under the terms applicable for preferred drugs if the prescribing physician determines that the preferred drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

''(C) FORMULARY DETERMINATIONS.—An eligible low-income beneficiary who is enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor may appeal to obtain coverage for a covered drug that is not on a formulary of the entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

''(6) APPEALS.—

''(A) IN GENERAL.—Subject to subparagraph (B), a prescription drug card sponsor shall meet the requirements of paragraphs (4) and (5) of section 1852(g) with respect to drugs not included on any formulary in a similar manner (as determined by the Secretary) as such requirements apply to a Medicare+Choice organization with respect to benefits it offers under a Medicare+Choice plan under part C.

''(B) FORMULARY DETERMINATIONS.—An eligible low-income beneficiary who is enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor may appeal to obtain coverage for a covered drug that is not on a formulary of the entity if the prescribing physician determines that the formulary drug for treatment of the same condition is not as effective for the eligible low-income beneficiary or has adverse effects for the eligible low-income beneficiary.

''(C) APPEALS AND EXCEPTIONS TO APPLICATION.—The prescription drug card sponsor must have, as part of the appeals process under this paragraph, a process for timely appeals for denials of coverage based on the application of the formulary.

''(d) PRESCRIPTION DRUG BENEFITS.—

''(1) IN GENERAL.—Subject to paragraph (5), all the benefits available under a prescription drug discount card program offered by a prescription drug card sponsor and endorsed under section 1807 shall be available to eligible low-income beneficiaries enrolled in a prescription drug assistance card program offered by such sponsor.

''(2) ASSISTANCE FOR ELIGIBLE LOW-INCOME BENEFICIARIES.—

''(A) $600 ANNUAL ASSISTANCE.—Subject to subparagraphs (B) and (C) and paragraph (5), each prescription drug card sponsor with a contract under this section shall provide coverage for the first $600 of expenses for prescription drugs incurred during each calendar year by an eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor.

''(B) COINSURANCE.—

''(i) IN GENERAL.—The prescription drug card sponsor shall determine an amount of coinsurance to collect from each eligible low-income beneficiary enrolled in a prescription drug assistance card program offered by such sponsor for which coverage is available under subparagraph (A).

''(ii) AMOUNT.—The amount of coinsurance collected under clause (i) shall be at least 10 percent of the negotiated price of each prescription drug dispensed to an eligible low-income beneficiary.

''(iii) CONSTRUCTION.—Amounts collected under clause (i) shall not be counted against the total amount of coverage available under subparagraph (A).

''(C) REDUCTION FOR LATE ENROLLMENT.—For each month during a calendar quarter in which an eligible low-income beneficiary is not enrolled in a prescription drug assistance card program offered by a prescription drug card sponsor with a contract under this section, the amount of assistance available under subparagraph (A) shall be reduced by $50.

''(D) CREDITING OF UNUSED BENEFITS TOWARD FUTURE YEARS.—The dollar amount of coverage described in subparagraph (A) shall be increased by any amount of coverage described in such subparagraph that was not used during the previous calendar year.

''(E) WAIVER TO ENSURE PROVISION OF BENEFIT.—The Secretary may waive such requirements of this section and section 1807 as may be necessary to ensure that each eligible low-income beneficiaries has access to the assistance described in subparagraph (A).

''(3) ADDITIONAL DISCOUNTS.—A prescription drug card sponsor with a contract under this section shall provide each eligible low-income beneficiary enrolled in a prescription drug assistance program offered by the sponsor with access to negotiated prices that reflect a minimum average discount of at least 20 percent of the average wholesale price for prescription drugs covered under that program.

''(4) ASSISTANCE CARDS.—Each prescription drug card sponsor shall permit eligible low-income beneficiaries enrolled in a prescription drug assistance card program offered by such sponsor to use the discount card issued under section 1807(e)(4) to obtain benefits under the program.

''(5) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an eligible low-income beneficiary that would otherwise be a covered drug under this section shall not be so considered under a prescription drug assistance card program if the program excludes the drug under a formulary and such exclusion is not successfully resolved under paragraph (4), (5), or (6) of subsection (c).

''(e) REQUIREMENTS FOR PRESCRIPTION DRUG CARD SPONSORS THAT OFFER PRESCRIPTION DRUG ASSISTANCE CARD PROGRAMS.—

''(1) IN GENERAL.—Each prescription drug card sponsor shall—

''(A) process claims made by eligible low-income beneficiaries;

''(B) negotiate with brand name and generic prescription drug manufacturers and others for low prices on prescription drugs;

''(C) track individual beneficiary expenditures in a format and periodicity specified by the Secretary; and

''(D) perform such other functions as the Secretary may assign.

''(2) DATA EXCHANGES.—Each prescription drug card sponsor shall receive data exchanges in a format specified by the Secretary and shall maintain real-time beneficiary files.

''(3) PUBLIC DISCLOSURE OF PHARMACEUTICAL PRICES FOR EQUIVALENT DRUGS.—The prescription drug card sponsor offering the prescription drug assistance card program shall provide that each pharmacy or other dispenser that arranges for the dispensing of a covered drug shall inform the eligible low-income beneficiary at the time of purchase of the drug of any differential between the price of the prescribed drug to the enrollee and the price of the lowest priced generic drug covered under the plan that is therapeutically equivalent and bioequivalent and available at such pharmacy or other dispenser.

''(f) SUBMISSION OF BIDS AND AWARDING OF CONTRACTS.—

''(1) SUBMISSION OF BIDS.—Each prescription drug card sponsor that seeks to offer a prescription drug assistance card program under this section shall submit to the Secretary, at such time and in such manner as the Secretary may specify, such information as the Secretary may require.

''(2) AWARDING OF CONTRACTS.—The Secretary shall review the information submitted under paragraph (1) and shall determine whether to award a contract to the prescription drug card sponsor offering the program to which such information relates. The Secretary may not approve a program unless the program and prescription drug card sponsor offering the program comply with the requirements under this section.

''(3) NUMBER OF CONTRACTS.—There shall be no limit on the number of prescription drug card sponsors that may be awarded contracts under paragraph (2).

''(4) CONTRACT PROVISIONS.—

''(A) DURATION.—A contract awarded under paragraph (2) shall be for the lifetime of the program under this section.

''(B) WITHDRAWAL.—A prescription drug card sponsor that desires to terminate the contract awarded under paragraph (2) may terminate such contract without penalty if such sponsor gives notice—

''(i) to the Secretary 90 days prior to the termination of such contract; and

''(ii) to each eligible low-income beneficiary that is enrolled in a prescription drug assistance card program offered by such sponsor 60 days prior to such termination.

''(C) SERVICE AREA.—The service area under the contract shall be the same as the area served by the prescription drug card sponsor under section 1807.

''(5) SIMULTANEOUS APPROVAL OF DISCOUNT CARD AND ASSISTANCE PROGRAMS.—A prescription drug card sponsor may submit an application for endorsement under section 1807 as part of the bid submitted under paragraph (1) and the Secretary may approve such application at the same time as the Secretary awards a contract under this section.

''(g) PAYMENTS TO PRESCRIPTION DRUG CARD SPONSORS.—

''(1) IN GENERAL.—The Secretary shall pay to each prescription drug card sponsor offering a prescription drug assistance card program in which an eligible low-income beneficiary is enrolled an amount equal to the amount agreed to by the Secretary and the sponsor in the contract awarded under subsection (f)(2).

''(2) PAYMENT FROM PART B TRUST FUND.—The costs of providing benefits under this section shall be payable from the Federal Supplementary Medical Insurance Trust Fund established under section 1841.

''(h) ELIGIBILITY DETERMINATIONS MADE BY STATES; PRESUMPTIVE ELIGIBILITY.—States shall perform the functions described in section 1935(a)(1).

''(i) APPROPRIATIONS.—There are appropriated from the Federal Supplementary Medical Insurance Trust Fund established under section 1841 such sums as may be necessary to carry out the program under this section.

''(j) DEFINITIONS.—In this section:

''(1) ELIGIBLE BENEFICIARY; NEGOTIATED PRICE; PRESCRIPTION DRUG.—The terms 'eligible beneficiary', 'negotiated price', and 'prescription drug' have the meanings given those terms in section 1807(i).

''(2) ELIGIBLE LOW-INCOME BENEFICIARY.—The term 'eligible low-income beneficiary' means an individual who—

''(A) is an eligible beneficiary (as defined in section 1807(i)); and

''(B) is described in clause (iii) or (iv) of section 1902(a)(10)(E) or in section 1905(p)(1).

''(3) PRESCRIPTION DRUG CARD SPONSOR.—The term 'prescription drug card sponsor' has the meaning given that term in section 1807(i), except that such sponsor shall also be an entity that the Secretary determines is—

''(A) is appropriate to provide eligible low-income beneficiaries with the benefits under a prescription drug assistance card program under this section; and

''(B) is able to manage the monetary assistance made available under subsection (d)(2);

''(C) agrees to submit to audits by the Secretary; and

''(D) provides such other assurances as the Secretary may require.

''(4) STATE.—The term 'State' has the meaning given such term for purposes of title XIX.''.

(b) EXCLUSION OF PRICES FROM DETERMINATION OF BEST PRICE.—Section 1927(c)(1)(C)(i) (42 U.S.C. 1396r–8(c)(1)(C)(i)) is amended—

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

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

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

''(V) any negotiated prices charged under the medicare prescription drug discount card endorsement program under section 1807 or under the transitional prescription drug assistance card program for eligible low-income beneficiaries under section 1807A.''.

(c) EXCLUSION OF PRESCRIPTION DRUG ASSISTANCE CARD COSTS FROM DETERMINATION OF PART B MONTHLY PREMIUM.—Section 1839(g) of the Social Security Act (42 U.S.C. 1395r(g)) is amended—

(1) by striking ''attributable to the application of section'' and inserting ''attributable to—

''(1) the application of section'';

(2) by striking the period and inserting ''; and''; and

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

''(2) the prescription drug assistance card program under section 1807A.''.

(d) REGULATIONS.—

(1) AUTHORITY FOR INTERIM FINAL REGULATIONS.—The Secretary may promulgate initial regulations implementing sections 1807 and 1807A of the Social Security Act (as added by this section) in interim final form without prior opportunity for public comment.

(2) FINAL REGULATIONS.—A final regulation reflecting public comments must be published within 1 year of the interim final regulation promulgated under paragraph (1).

(3) EXEMPTION FROM THE PAPERWORK REDUCTION ACT.—The promulgation of the regulations under this subsection and the administration the programs established by sections 1807 and 1807A of the Social Security Act (as added by this section) shall be made without regard to chapter 35 of title 44, United States Code (commonly known as the ''Paperwork Reduction Act'').

(e) IMPLEMENTATION; TRANSITION.—

(1) IMPLEMENTATION.—The Secretary shall implement the amendments made by this section in a manner that discounts are available to eligible beneficiaries under section 1807 of the Social Security Act and assistance is available to eligible low-income beneficiaries under section 1807A of such Act not later than January 1, 2004.

(2) TRANSITION.—The Secretary shall provide for an appropriate transition and discontinuation of the programs under section 1807 and 1807A of the Social Security Act. Such transition and discontinuation shall ensure that such programs continue to operate until the date on which the first enrollment period under part D ends.

Subtitle C—Standards for Electronic Prescribing

SEC. 121. STANDARDS FOR ELECTRONIC PRESCRIBING.

Title XI (42 U.S.C. 1301 et seq.) is amended by adding at the end the following new part:

''PART D—ELECTRONIC PRESCRIBING

''STANDARDS FOR ELECTRONIC PRESCRIBING

''SEC. 1180. (a) STANDARDS.—

''(1) DEVELOPMENT AND ADOPTION.—

''(A) IN GENERAL.—The Secretary shall develop or adopt standards for transactions and data elements for such transactions (in this section referred to as 'standards') to enable the electronic transmission of medication history, eligibility, benefit, and other prescription information.

''(B) CONSULTATION.—In developing and adopting the standards under subparagraph (A), the Secretary shall consult with representatives of physicians, hospitals, pharmacists, standard setting organizations, pharmacy benefit managers, beneficiary information exchange networks, technology experts, and representatives of the Departments of Veterans Affairs and Defense and other interested parties.

''(2) OBJECTIVE.—Any standards developed or adopted under this part shall be consistent with the objectives of improving—

''(A) patient safety; and

''(B) the quality of care provided to patients.

''(3) REQUIREMENTS.—Any standards developed or adopted under this part shall comply with the following:

''(A) ELECTRONIC TRANSMITTAL OF PRESCRIPTIONS.—

''(i) IN GENERAL.—Except as provided in clause (ii), the standards require that prescriptions be written and transmitted electronically.

''(ii) EXCEPTIONS.—The standards shall not require a prescription to be written and transmitted electronically—

''(I) in emergency cases and other exceptional circumstances recognized by the Administrator; or

''(II) if the patient requests that the prescription not be transmitted electronically.

If a patient makes a request under subclause (II), no additional charges may be imposed on the patient for making such request.

''(B) PATIENT-SPECIFIC MEDICATION HISTORY, ELIGIBILITY, BENEFIT, AND OTHER PRESCRIPTION INFORMATION.—

''(i) IN GENERAL.—The standards shall accommodate electronic transmittal of patient-specific medication history, eligibility, benefit, and other prescription information among prescribing and dispensing professionals at the point of care.

''(ii) REQUIRED INFORMATION.—The information described in clause (i) shall include the following:

''(I) Information (to the extent available and feasible) on the drugs being prescribed for that patient and other information relating to the medication history of the patient that may be relevant to the appropriate prescription for that patient.

''(II) Cost-effective alternatives (if any) to the drug prescribed.

''(III) Information on eligibility and benefits, including the drugs included in the applicable formulary and any requirements for prior authorization.

''(IV) Information on potential interactions with drugs listed on the medication history, graded by severity of the potential interaction.

''(V) Other information to improve the quality of patient care and to reduce medical errors.

''(C) UNDUE BURDEN.—The standards shall be designed so that, to the extent practicable, the standards do not impose an

undue administrative burden on the practice of medicine, pharmacy, or other health professions.

''(D) COMPATIBILITY WITH ADMINISTRATIVE SIMPLIFICATION AND PRIVACY LAWS.—The standards shall be—

''(i) consistent with the Federal regulations (concerning the privacy of individually identifiable health information) promulgated under section 264(c) of the Health Insurance Portability and Accountability Act of 1996; and

''(ii) compatible with the standards adopted under part C.

''(4) TRANSFER OF INFORMATION.—The Secretary shall develop and adopt standards for transferring among prescribing and insurance entities and other necessary entities appropriate standard data elements needed for the electronic exchange of medication history, eligibility, benefit, and other prescription drug information and other health information determined appropriate in compliance with the standards adopted or modified under this part.

''(b) TIMETABLE FOR ADOPTION OF STANDARDS.—

''(1) IN GENERAL.—The Secretary shall adopt the standards under this part by January 1, 2006.

''(2) ADDITIONS AND MODIFICATIONS TO STANDARDS.—The Secretary shall, in consultation with appropriate representatives of interested parties, review the standards developed or adopted under this part and adopt modifications to the standards (including additions to the standards), as determined appropriate. Any addition or modification to such standards shall be completed in a manner which minimizes the disruption and cost of compliance.

''(c) COMPLIANCE WITH STANDARDS.—

''(1) REQUIREMENT FOR ALL INDIVIDUALS AND ENTITIES THAT TRANSMIT OR RECEIVE PRESCRIPTIONS ELECTRONICALLY.—

''(A) IN GENERAL.—Individuals or entities that transmit or receive electronic medication history, eligibility, benefit and prescription information, shall comply with the standards adopted or modified under this part.

''(B) RELATION TO STATE LAWS.—The standards adopted or modified under this part shall supersede any State law or regulations pertaining to the electronic transmission of medication history, eligibility, benefit and prescription information.

''(2) TIMETABLE FOR COMPLIANCE.—

''(A) INITIAL COMPLIANCE.—

''(i) IN GENERAL.—Not later than 24 months after the date on which an initial standard is adopted under this part, each individual or entity to whom the standard applies shall comply with the standard.

''(ii) SPECIAL RULE FOR SMALL HEALTH PLANS.—In the case of a small health plan, as defined by the Secretary for purposes of section 1175(b)(1)(B), clause (i) shall be applied by substituting '36 months' for '24 months'.

''(d) CONSULTATION WITH ATTORNEY GENERAL.—The Secretary shall consult with the Attorney General before developing, adopting, or modifying a standard under this part to ensure that the standard accommodates secure electronic transmission of prescriptions for controlled substances in a manner that minimizes the possibility of violations under the Comprehensive Drug Abuse Prevention and Control Act of 1970 and related Federal laws.

''GRANTS TO HEALTH CARE PROVIDERS TO IMPLEMENT ELECTRONIC PRESCRIPTION PROGRAMS

''SEC. 1180A. (a) IN GENERAL.—The Secretary is authorized to make grants to health care providers for the purpose of assisting such entities to implement electronic prescription programs that comply with the standards adopted or modified under this part.

''(b) APPLICATION.—No grant may be made under this section except pursuant to a grant application that is submitted in a time, manner, and form approved by the Secretary.

''(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated for each of fiscal years 2006, 2007, and 2008, such sums as may be necessary to carry out this section.''.

Subtitle D—Other Provisions

SEC. 131. ADDITIONAL REQUIREMENTS FOR ANNUAL FINANCIAL REPORT AND OVERSIGHT ON MEDICARE PROGRAM.

(a) IN GENERAL.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(l) COMBINED REPORT ON OPERATION AND STATUS OF THE TRUST FUND AND THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND (INCLUDING THE PRESCRIPTION DRUG ACCOUNT).—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 and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 (including the Prescription Drug Account within such Trust Fund), in this subsection referred to as the 'Trust Funds'. Such report shall include the following information:

''(1) OVERALL SPENDING FROM THE GENERAL FUND OF THE TREASURY.—A statement of total amounts obligated during the preceding fiscal year from the General Revenues of the Treasury to the Trust Funds, separately stated in terms of the total amount and in terms of the percentage such amount bears to all other amounts obligated from such General Revenues during such fiscal year, for each of the following amounts:

''(A) MEDICARE BENEFITS.—The amount expended for payment of benefits covered under this title.

''(B) ADMINISTRATIVE AND OTHER EXPENSES.—The amount expended for payments not related to the benefits described in subparagraph (A).

''(2) HISTORICAL OVERVIEW OF SPENDING.—From the date of the inception of the program of insurance under this title through the fiscal year involved, a statement of the total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph.

''(3) 10-YEAR AND 50-YEAR PROJECTIONS.—An estimate of total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph, 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 50-year period beginning with the succeeding fiscal year.

''(4) RELATION TO OTHER MEASURES OF GROWTH.—A comparison of the rate of growth of the total amounts referred to in paragraph (1), separately stated for the amounts described in subparagraphs (A) and (B) of such paragraph, to the rate of growth for the same period in—

''(A) the gross domestic product;

''(B) health insurance costs in the private sector;

''(C) employment-based health insurance costs in the public and private sectors; and

''(D) other areas as determined appropriate by the Board of Trustees.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply with respect to fiscal years beginning on or after the date of enactment of this Act.

(c) CONGRESSIONAL HEARINGS.—It is the sense of Congress that the committees of jurisdiction of Congress shall hold hearings on the reports submitted under section 1817(l) of the Social Security Act (as added by subsection (a)).

SEC. 132. TRUSTEES' REPORT ON MEDICARE'S UNFUNDED OBLIGATIONS.

(a) REPORT.—The report submitted under sections 1817(b)(2) and 1841(b)(2) of the Social Security Act (42 U.S.C. 1395i(b)(2) and 1395t(b)(2)) during 2004 shall include an analysis of the total amount of the unfunded obligations of the Medicare program under title XVIII of the Social Security Act.

(b) MATTERS ANALYZED.—The analysis described in subsection (A) shall compare the long-term obligations of the Medicare program to the dedicated funding sources for that program (other than general revenue transfers), including the combined obligations of the Federal Hospital Insurance Trust Fund established under section 1817 of such Act (42 U.S.C. 1395i) and the Federal Supplementary Medical Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t).

TITLE II—MEDICAREADVANTAGE

Subtitle A—MedicareAdvantage Competition

SEC. 201. ELIGIBILITY, ELECTION, AND ENROLLMENT.

Section 1851 (42 U.S.C. 1395w–21) is amended to read as follows:

''ELIGIBILITY, ELECTION, AND ENROLLMENT

''SEC. 1851. (a) CHOICE OF MEDICARE BENEFITS THROUGH MEDICAREADVANTAGE PLANS.—

''(1) IN GENERAL.—Subject to the provisions of this section, each MedicareAdvantage eligible individual (as defined in paragraph (3)) is entitled to elect to receive benefits under this title—

''(A) through—

''(i) the original Medicare fee-for-service program under parts A and B; and

''(ii) the voluntary prescription drug delivery program under part D; or

''(B) through enrollment in a MedicareAdvantage plan under this part.

''(2) TYPES OF MEDICAREADVANTAGE PLANS THAT MAY BE AVAILABLE.—A MedicareAdvantage plan may be any of the following types of plans of health insurance:

''(A) COORDINATED CARE PLANS.—Coordinated care plans which provide health care services, including health maintenance organization plans (with or without point of service options) and plans offered by provider-sponsored organizations (as defined in section 1855(d)).

''(B) COMBINATION OF MSA PLAN AND CONTRIBUTIONS TO MEDICAREADVANTAGE MSA.—An MSA plan, as defined in section 1859(b)(3), and a contribution into a MedicareAdvantage medical savings account (MSA).

''(C) PRIVATE FEE-FOR-SERVICE PLANS.—A MedicareAdvantage private fee-for-service plan, as defined in section 1859(b)(2).

''(3) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.—

''(A) IN GENERAL.—Subject to subparagraph (B), in this title, the term 'MedicareAdvantage eligible individual' means an individual who is entitled to (or enrolled for) benefits under part A, enrolled under part B, and enrolled under part D.

''(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—Such term shall not include an individual medically determined to have end-stage renal disease, except that—

''(i) an individual who develops end-stage renal disease while enrolled in a Medicare+Choice or a MedicareAdvantage plan may continue to be enrolled in that plan; and

''(ii) in the case of such an individual who is enrolled in a Medicare+Choice plan or a MedicareAdvantage plan under clause (i) (or subsequently under this clause), if the enrollment is discontinued under circumstances described in section 1851(e)(4)(A), then the individual will be treated as a 'MedicareAdvantage eligible individual' for purposes of electing to continue enrollment in another MedicareAdvantage plan.

''(b) SPECIAL RULES.—

''(1) RESIDENCE REQUIREMENT.—

''(A) IN GENERAL.—Except as the Secretary may otherwise provide and except as provided in subparagraph (C), an individual is eligible to elect a MedicareAdvantage plan offered by a MedicareAdvantage organization only if the plan serves the geographic area in which the individual resides.

''(B) CONTINUATION OF ENROLLMENT PERMITTED.—Pursuant to rules specified by the Secretary, the Secretary shall provide that a plan may offer to all individuals residing in a geographic area the option to continue enrollment in the plan, notwithstanding that the individual no longer resides in the service area of the plan, so long as the plan provides that individuals exercising this option have, as part of the basic benefits described in section 1852(a)(1)(A), reasonable access within that geographic area to the full range of basic benefits, subject to reasonable cost-sharing liability in obtaining such benefits.

''(C) CONTINUATION OF ENROLLMENT PERMITTED WHERE SERVICE CHANGED.—Notwithstanding subparagraph (A) and in addition to subparagraph (B), if a MedicareAdvantage organization eliminates from its service area a MedicareAdvantage payment area that was previously within its service area, the organization may elect to offer individuals residing in all or portions of the affected area who would otherwise be ineligible to continue enrollment the option to continue enrollment in a MedicareAdvantage plan it offers so long as—

''(i) the enrollee agrees to receive the full range of basic benefits (excluding emergency and urgently needed care) exclusively at facilities designated by the organization within the plan service area; and

''(ii) there is no other MedicareAdvantage plan offered in the area in which the enrollee resides at the time of the organization's election.

''(2) SPECIAL RULE FOR CERTAIN INDIVIDUALS COVERED UNDER FEHBP OR ELIGIBLE FOR VETERANS OR MILITARY HEALTH BENEFITS.—

''(A) FEHBP.—An individual who is enrolled in a health benefit plan under chapter 89 of title 5, United States Code, is not eligible to enroll in an MSA plan until such time as the Director of the Office of Management and Budget certifies to the Secretary that the Office of Personnel Management has adopted policies which will ensure that the enrollment of such individuals in such plans will not result in increased expenditures for the Federal Government for health benefit plans under such chapter.

''(B) VA AND DOD.—The Secretary may apply rules similar to the rules described in subparagraph (A) in the case of individuals who are eligible for health care benefits under chapter 55 of title 10, United States Code, or under chapter 17 of title 38 of such Code.

''(3) LIMITATION ON ELIGIBILITY OF QUALIFIED MEDICARE BENEFICIARIES AND OTHER MEDICAID BENEFICIARIES TO ENROLL IN AN MSA PLAN.—An individual who is a qualified medicare beneficiary (as defined in section 1905(p)(1)), a qualified disabled and working individual (described in section 1905(s)), an individual described in section 1902(a)(10)(E)(iii), or otherwise entitled to medicare cost-sharing under a State plan under title XIX is not eligible to enroll in an MSA plan.

''(4) COVERAGE UNDER MSA PLANS ON A DEMONSTRATION BASIS.—

''(A) IN GENERAL.—An individual is not eligible to enroll in an MSA plan under this part—

''(i) on or after January 1, 2004, unless the enrollment is the continuation of such an enrollment in effect as of such date; or

''(ii) as of any date if the number of such individuals so enrolled as of such date has reached 390,000.

Under rules established by the Secretary, an individual is not eligible to enroll (or continue enrollment) in an MSA plan for a year unless the individual provides assurances satisfactory to the Secretary that the individual will reside in the United States for at least 183 days during the year.

''(B) EVALUATION.—The Secretary shall regularly evaluate the impact of permitting enrollment in MSA plans under this part on selection (including adverse selection), use of preventive care, access to care, and the financial status of the Trust Funds under this title.

''(C) REPORTS.—The Secretary shall submit to Congress periodic reports on the numbers of individuals enrolled in such plans and on the evaluation being conducted under subparagraph (B).

''(c) PROCESS FOR EXERCISING CHOICE.—

''(1) IN GENERAL.—The Secretary shall establish a process through which elections described in subsection (a) are made and changed, including the form and manner in which such elections are made and changed. Such elections shall be made or changed only during coverage election periods specified under subsection (e) and shall become effective as provided in subsection (f).

''(2) COORDINATION THROUGH MEDICAREADVANTAGE ORGANIZATIONS.—

''(A) ENROLLMENT.—Such process shall permit an individual who wishes to elect a MedicareAdvantage plan offered by a MedicareAdvantage organization to make such election through the filing of an appropriate election form with the organization.

''(B) DISENROLLMENT.—Such process shall permit an individual, who has elected a MedicareAdvantage plan offered by a MedicareAdvantage organization and who wishes to terminate such election, to terminate such election through the filing of an appropriate election form with the organization.

''(3) DEFAULT.—

''(A) INITIAL ELECTION.—

''(i) IN GENERAL.—Subject to clause (ii), an individual who fails to make an election during an initial election period under subsection (e)(1) is deemed to have chosen the original medicare fee-for-service program option.

''(ii) SEAMLESS CONTINUATION OF COVERAGE.—The Secretary may establish procedures under which an individual who is enrolled in a Medicare+Choice plan or another health plan (other than a MedicareAdvantage plan) offered by a MedicareAdvantage organization at the time of the initial election period and who fails to elect to receive coverage other than through the organization is deemed to have elected the MedicareAdvantage plan offered by the organization (or, if the organization offers more than 1 such plan, such plan or plans as the Secretary identifies under such procedures).

''(B) CONTINUING PERIODS.—An individual who has made (or is deemed to have made) an election under this section is considered to have continued to make such election until such time as—

''(i) the individual changes the election under this section; or

''(ii) the MedicareAdvantage plan with respect to which such election is in effect is discontinued or, subject to subsection (b)(1)(B), no longer serves the area in which the individual resides.

''(d) PROVIDING INFORMATION TO PROMOTE INFORMED CHOICE.—

''(1) IN GENERAL.—The Secretary shall provide for activities under this subsection to broadly disseminate information to medicare beneficiaries (and prospective medicare beneficiaries) on the coverage options provided under this section in order to promote an active, informed selection among such options.

''(2) PROVISION OF NOTICE.—

''(A) OPEN SEASON NOTIFICATION.—At least 15 days before the beginning of each annual, coordinated election period (as defined in subsection (e)(3)(B)), the Secretary shall mail to each MedicareAdvantage eligible individual residing in an area the following:

''(i) GENERAL INFORMATION.—The general information described in paragraph (3).

''(ii) LIST OF PLANS AND COMPARISON OF PLAN OPTIONS.—A list identifying the MedicareAdvantage plans that are (or will be) available to residents of the area and information described in paragraph (4) concerning such plans. Such information shall be presented in a comparative form.

''(iii) ADDITIONAL INFORMATION.—Any other information that the Secretary determines will assist the individual in making the election under this section.

The mailing of such information shall be coordinated, to the extent practicable, with the mailing of any annual notice under section 1804.

''(B) NOTIFICATION TO NEWLY ELIGIBLE MEDICAREADVANTAGE ELIGIBLE INDIVIDUALS.—To the extent practicable, the Secretary shall, not later than 30 days before the beginning of the initial MedicareAdvantage enrollment period for an individual described in subsection (e)(1), mail to the individual the information described in subparagraph (A).

''(C) FORM.—The information disseminated under this paragraph shall be written and formatted using language that is easily understandable by medicare beneficiaries.

''(D) PERIODIC UPDATING.—The information described in subparagraph (A) shall be updated on at least an annual basis to reflect changes in the availability of MedicareAdvantage plans, the benefits under such plans, and the MedicareAdvantage monthly basic beneficiary premium, MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, and MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage for such plans.

''(3) GENERAL INFORMATION.—General information under this paragraph, with respect to coverage under this part during a year, shall include the following:

''(A) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—A general description of the benefits covered under parts A and B of the original medicare fee-for-service program, including—

''(i) covered items and services;

''(ii) beneficiary cost-sharing, such as deductibles, coinsurance, and copayment amounts; and

''(iii) any beneficiary liability for balance billing.

''(B) CATASTROPHIC COVERAGE AND COMBINED DEDUCTIBLE.—A description of the catastrophic coverage and unified deductible applicable under the plan.

''(C) OUTPATIENT PRESCRIPTION DRUG COVERAGE BENEFITS.—The information required under section 1860D–4 with respect to coverage for prescription drugs under the plan.

''(D) ELECTION PROCEDURES.—Information and instructions on how to exercise election options under this section.

''(E) RIGHTS.—A general description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program (including such rights under part D) and the MedicareAdvantage program and the right to be protected against discrimination based on health status-related factors under section 1852(b).

''(F) INFORMATION ON MEDIGAP AND MEDICARE SELECT.—A general description of the benefits, enrollment rights, and other requirements applicable to medicare supplemental policies under section 1882 and provisions relating to medicare select policies described in section 1882(t).

''(G) POTENTIAL FOR CONTRACT TERMINATION.—The fact that a MedicareAdvantage organization may terminate its contract, refuse to renew its contract, or reduce the service area included in its contract, under this part, and the effect of such a termination, nonrenewal, or service area reduction may have on individuals enrolled with the MedicareAdvantage plan under this part.

''(4) INFORMATION COMPARING PLAN OPTIONS.—Information under this paragraph, with respect to a MedicareAdvantage plan for a year, shall include the following:

''(A) BENEFITS.—The benefits covered under the plan, including the following:

''(i) Covered items and services beyond those provided under the original medicare fee-for-service program option.

''(ii) Beneficiary cost-sharing for any items and services described in clause (i) and paragraph (3)(A)(i), including information on the unified deductible under section 1852(a)(1)(C).

''(iii) The maximum limitations on out-of-pocket expenses under section 1852(a)(1)(C).

''(iv) In the case of an MSA plan, differences in cost-sharing, premiums, and balance billing under such a plan compared to under other MedicareAdvantage plans.

''(v) In the case of a MedicareAdvantage private fee-for-service plan, differences in cost-sharing, premiums, and balance billing under such a plan compared to under other MedicareAdvantage plans.

''(vi) The extent to which an enrollee may obtain benefits through out-of-network health care providers.

''(vii) The extent to which an enrollee may select among in-network providers and the types of providers participating in the plan's network.

''(viii) The organization's coverage of emergency and urgently needed care.

''(ix) The comparative information described in section 1860D–4(b)(2) relating to prescription drug coverage under the plan.

''(B) PREMIUMS.—

''(i) IN GENERAL.—The MedicareAdvantage monthly basic beneficiary premium and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, if any, for the plan or, in the case of an MSA plan, the MedicareAdvantage monthly MSA premium.

''(ii) REDUCTIONS.—The reduction in part B premiums, if any.

''(iii) NATURE OF THE PREMIUM FOR ENHANCED MEDICAL BENEFITS.—Whether the MedicareAdvantage monthly premium for enhanced benefits is optional or mandatory.

''(C) SERVICE AREA.—The service area of the plan.

''(D) QUALITY AND PERFORMANCE.—Plan quality and performance indicators for the benefits under the plan (and how such indicators compare to quality and performance indicators under the original medicare fee-for-service program under parts A and B and under the voluntary prescription drug delivery program under part D in the area involved), including—

''(i) disenrollment rates for medicare enrollees electing to receive benefits through the plan for the previous 2 years (excluding disenrollment due to death or moving outside the plan's service area);

''(ii) information on medicare enrollee satisfaction;

''(iii) information on health outcomes; and

''(iv) the recent record regarding compliance of the plan with requirements of this part (as determined by the Secretary).

''(5) MAINTAINING A TOLL-FREE NUMBER AND INTERNET SITE.—The Secretary shall maintain a toll-free number for inquiries regarding MedicareAdvantage options and the operation of this part in all areas in which MedicareAdvantage plans are offered and an Internet site through which individuals may electronically obtain information on such options and MedicareAdvantage plans.

''(6) USE OF NON-FEDERAL ENTITIES.—The Secretary may enter into contracts with non-Federal entities to carry out activities under this subsection.

''(7) PROVISION OF INFORMATION.—A MedicareAdvantage organization shall provide the Secretary with such information on the organization and each MedicareAdvantage plan it offers as may be required for the preparation of the information referred to in paragraph (2)(A).

''(e) COVERAGE ELECTION PERIODS.—

''(1) INITIAL CHOICE UPON ELIGIBILITY TO MAKE ELECTION IF MEDICAREADVANTAGE PLANS AVAILABLE TO INDIVIDUAL.—If, at the time an individual first becomes eligible to elect to receive benefits under part B or D (whichever is later), there is 1 or more MedicareAdvantage plans offered in the area in which the individual resides, the individual shall make the election under this section during a period specified by the Secretary such that if the individual elects a MedicareAdvantage plan during the period, coverage under the plan becomes effective as of the first date on which the individual may receive such coverage.

''(2) OPEN ENROLLMENT AND DISENROLLMENT OPPORTUNITIES.—Subject to paragraph (5), the following rules shall apply:

''(A) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005.—At any time during the period beginning January 1, 1998, and ending on December 31, 2005, a Medicare+Choice eligible individual may change the election under subsection (a)(1).

''(B) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 6 MONTHS DURING 2006.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), at any time during the first 6 months of 2006, or, if the individual first becomes a MedicareAdvantage eligible individual during 2006, during the first 6 months during 2006 in which the individual is a MedicareAdvantage eligible individual, a MedicareAdvantage eligible individual may change the election under subsection (a)(1).

''(ii) LIMITATION OF 1 CHANGE.—An individual may exercise the right under clause (i) only once. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under the first sentence of paragraph (4).

''(C) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT FOR FIRST 3 MONTHS IN SUBSEQUENT YEARS.—

''(i) IN GENERAL.—Subject to clause (ii) and subparagraph (D), at any time during the first 3 months of 2007 and each subsequent year, or, if the individual first becomes a MedicareAdvantage eligible individual during 2007 or any subsequent year, during the first 3 months of such year in which the individual is a MedicareAdvantage eligible individual, a MedicareAdvantage eligible individual may change the election under subsection (a)(1).

''(ii) LIMITATION OF 1 CHANGE DURING OPEN ENROLLMENT PERIOD EACH YEAR.—An individual may exercise the right under clause (i) only once during the applicable 3-month period described in such clause in each year. The limitation under this clause shall not apply to changes in elections effected during an annual, coordinated election period under paragraph (3) or during a special enrollment period under paragraph (4).

''(D) CONTINUOUS OPEN ENROLLMENT FOR INSTITUTIONALIZED INDIVIDUALS.—At any time during 2006 or any subsequent year, in the case of a MedicareAdvantage eligible individual who is institutionalized (as defined by the Secretary), the individual may elect under subsection (a)(1)—

''(i) to enroll in a MedicareAdvantage plan; or

''(ii) to change the MedicareAdvantage plan in which the individual is enrolled.

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—

''(A) IN GENERAL.—Subject to paragraph (5), each individual who is eligible to make an election under this section may change such election during an annual, coordinated election period.

''(B) ANNUAL, COORDINATED ELECTION PERIOD.—For purposes of this section, the term 'annual, coordinated election period' means, with respect to a year before 2003 and after 2006, the month of November before such year and with respect to 2003, 2004, 2005, and 2006, the period beginning on November 15 and ending on December 31 of the year before such year.

''(C) MEDICAREADVANTAGE HEALTH INFORMATION FAIRS.—During the fall season of each year (beginning with 2006), in conjunction with the annual coordinated election period defined in subparagraph (B), the Secretary shall provide for a nationally coordinated educational and publicity campaign to inform MedicareAdvantage eligible individuals about MedicareAdvantage plans and the election process provided under this section.

''(D) SPECIAL INFORMATION CAMPAIGN IN 2005.—During the period beginning on November 15, 2005, and ending on December 31, 2005, the Secretary shall provide for an educational and publicity campaign to inform MedicareAdvantage eligible individuals about the availability of MedicareAdvantage plans, and eligible organizations with risk-sharing contracts under section 1876, offered in different areas and the election process provided under this section.

''(4) SPECIAL ELECTION PERIODS.—Effective on and after January 1, 2006, an individual may discontinue an election of a MedicareAdvantage plan offered by a MedicareAdvantage organization other than during an annual, coordinated election period and make a new election under this section if—

''(A)(i) the certification of the organization or plan under this part has been terminated, or the organization or plan has notified the individual of an impending termination of such certification; or

''(ii) the organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides, or has notified the individual of an impending termination or discontinuation of such plan;

''(B) the individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances (specified by the Secretary, but not including termination of the individual's enrollment on the basis described in clause (i) or (ii) of subsection (g)(3)(B));

''(C) the individual demonstrates (in accordance with guidelines established by the Secretary) that—

''(i) the organization offering the plan substantially violated a material provision of the organization's contract under this part in relation to the individual (including the failure to provide an enrollee on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered care in accordance with applicable quality standards); or

''(ii) the organization (or an agent or other entity acting on the organization's behalf) materially misrepresented the plan's provisions in marketing the plan to the individual; or

''(D) the individual meets such other exceptional conditions as the Secretary may provide.

Effective on and after January 1, 2006, an individual who, upon first becoming eligible for benefits under part A at age 65, enrolls in a MedicareAdvantage plan under this part, the individual may discontinue the election of such plan, and elect coverage under the original fee-for-service plan, at any time during the 12-month period beginning on the effective date of such enrollment.

''(5) SPECIAL RULES FOR MSA PLANS.—Notwithstanding the preceding provisions of this subsection, an individual—

''(A) may elect an MSA plan only during—

''(i) an initial open enrollment period described in paragraph (1);

''(ii) an annual, coordinated election period described in paragraph (3)(B); or

''(iii) the month of November 1998;

''(B) subject to subparagraph (C), may not discontinue an election of an MSA plan except during the periods described in clause (ii) or (iii) of subparagraph (A) and under the first sentence of paragraph (4); and

''(C) who elects an MSA plan during an annual, coordinated election period, and who never previously had elected such a plan, may revoke such election, in a manner determined by the Secretary, by not later than December 15 following the date of the election.

''(6) OPEN ENROLLMENT PERIODS.—Subject to paragraph (5), a MedicareAdvantage organization—

''(A) shall accept elections or changes to elections during the initial enrollment periods described in paragraph (1), during the period beginning on November 15, 2005, and ending on December 31, 2005, and during the annual, coordinated election period under paragraph (3) for each subsequent year, and during special election periods described in the first sentence of paragraph (4); and

''(B) may accept other changes to elections at such other times as the organization provides.

''(f) EFFECTIVENESS OF ELECTIONS AND CHANGES OF ELECTIONS.—

''(1) DURING INITIAL COVERAGE ELECTION PERIOD.—An election of coverage made during the initial coverage election period under subsection (e)(1)(A) shall take effect upon the date the individual becomes entitled to (or enrolled for) benefits under part A, enrolled under part B, and enrolled under part D, except as the Secretary may provide (consistent with sections 1838 and 1860D–2)) in order to prevent retroactive coverage.

''(2) DURING CONTINUOUS OPEN ENROLLMENT PERIODS.—An election or change of coverage made under subsection (e)(2) shall take effect with the first day of the first calendar month following the date on which the election or change is made.

''(3) ANNUAL, COORDINATED ELECTION PERIOD.—An election or change of coverage made during an annual, coordinated election period (as defined in subsection (e)(3)(B)) in a year shall take effect as of the first day of the following year.

''(4) OTHER PERIODS.—An election or change of coverage made during any other period under subsection (e)(4) shall take effect in such manner as the Secretary provides in a manner consistent (to the extent practicable) with protecting continuity of health benefit coverage.

''(g) GUARANTEED ISSUE AND RENEWAL.—

''(1) IN GENERAL.—Except as provided in this subsection, a MedicareAdvantage organization shall provide that at any time during which elections are accepted under this section with respect to a MedicareAdvantage plan offered by the organization, the organization will accept without restrictions individuals who are eligible to make such election.

''(2) PRIORITY.—If the Secretary determines that a MedicareAdvantage organization, in relation to a MedicareAdvantage plan it offers, has a capacity limit and the number of MedicareAdvantage eligible individuals who elect the plan under this section exceeds the capacity limit, the organization may limit the election of individuals of the plan under this section but only if priority in election is provided—

''(A) first to such individuals as have elected the plan at the time of the determination; and

''(B) then to other such individuals in such a manner that does not discriminate, on a basis described in section 1852(b), among the individuals (who seek to elect the plan).

The preceding sentence shall not apply if it would result in the enrollment of enrollees substantially nonrepresentative, as determined in accordance with regulations of the Secretary, of the medicare population in the service area of the plan.

''(3) LIMITATION ON TERMINATION OF ELECTION.—

''(A) IN GENERAL.—Subject to subparagraph (B), a MedicareAdvantage organization may not for any reason terminate the election of any individual under this section for a MedicareAdvantage plan it offers.

''(B) BASIS FOR TERMINATION OF ELECTION.—A MedicareAdvantage organization may terminate an individual's election under this section with respect to a MedicareAdvantage plan it offers if—

''(i) any MedicareAdvantage monthly basic beneficiary premium, MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, or MedicareAdvantage monthly beneficiary premium for required or optional enhanced medical benefits required with respect to such plan are not paid on a timely basis (consistent with standards under section 1856 that provide for a grace period for late payment of such premiums);

''(ii) the individual has engaged in disruptive behavior (as specified in such standards); or

''(iii) the plan is terminated with respect to all individuals under this part in the area in which the individual resides.

''(C) CONSEQUENCE OF TERMINATION.—

''(i) TERMINATIONS FOR CAUSE.—Any individual whose election is terminated under clause (i) or (ii) of subparagraph (B) is deemed to have elected to receive benefits under the original medicare fee-for-service program option.

''(ii) TERMINATION BASED ON PLAN TERMINATION OR SERVICE AREA REDUCTION.—Any individual whose election is terminated under subparagraph (B)(iii) shall have a special election period under subsection (e)(4)(A) in which to change coverage to coverage under another MedicareAdvantage plan. Such an individual who fails to make an election during such period is deemed to have chosen to change coverage to the original medicare fee-for-service program option.

''(D) ORGANIZATION OBLIGATION WITH RESPECT TO ELECTION FORMS.—Pursuant to a contract under section 1857858., each MedicareAdvantage organization receiving an election form under subsection (c)(2) shall transmit to the Secretary (at such time and in such manner as the Secretary may specify) a copy of such form or such other information respecting the election as the Secretary may specify.

''(h) APPROVAL OF MARKETING MATERIAL AND APPLICATION FORMS.—

''(1) SUBMISSION.—No marketing material or application form may be distributed by a MedicareAdvantage organization to (or for the use of) MedicareAdvantage eligible individuals unless—

''(A) at least 45 days (or 10 days in the case described in paragraph (5)) before the date of distribution the organization has submitted the material or form to the Secretary for review; and

''(B) the Secretary has not disapproved the distribution of such material or form.

''(2) REVIEW.—The standards established under section 1856 shall include guidelines for the review of any material or form submitted and under such guidelines the Secretary shall disapprove (or later require the correction of) such material or form if the material or form is materially inaccurate or misleading or otherwise makes a material misrepresentation.

''(3) DEEMED APPROVAL (1-STOP SHOPPING).—In the case of material or form that is submitted under paragraph (1)(A) to the Secretary or a regional office of the Department of Health and Human Services and the Secretary or the office has not disapproved the distribution of marketing material or form under paragraph (1)(B) with respect to a MedicareAdvantage plan in an area, the Secretary is deemed not to have disapproved such distribution in all other areas covered by the plan and organization except with regard to that portion of such material or form that is specific only to an area involved.

''(4) PROHIBITION OF CERTAIN MARKETING PRACTICES.—Each MedicareAdvantage organization shall conform to fair marketing standards, in relation to MedicareAdvantage plans offered under this part, included in the standards established under section 1856. Such standards—

''(A) shall not permit a MedicareAdvantage organization to provide for cash or other monetary rebates as an inducement for enrollment or otherwise (other than as an additional benefit described in section 1854(g)(1)(C)(i)); and

''(B) may include a prohibition against a MedicareAdvantage organization (or agent of such an organization) completing any portion of any election form used to carry out elections under this section on behalf of any individual.

''(5) SPECIAL TREATMENT OF MARKETING MATERIAL FOLLOWING MODEL MARKETING LANGUAGE.—In the case of marketing material of an organization that uses, without modification, proposed model language specified by the Secretary, the period specified in paragraph (1)(A) shall be reduced from 45 days to 10 days.

''(i) EFFECT OF ELECTION OF MEDICAREADVANTAGE PLAN OPTION.—

''(1) PAYMENTS TO ORGANIZATIONS.—Subject to sections 1852(a)(5), 1853(h), 1853(i), 1886(d)(11), and 1886(h)(3)(D), payments under a contract with a MedicareAdvantage organization under section 1853(a) with respect to an individual electing a MedicareAdvantage plan offered by the organization shall be instead of the amounts which (in the absence of the contract) would otherwise be payable

under parts A, B, and D for items and services furnished to the individual.

''(2) ONLY ORGANIZATION ENTITLED TO PAYMENT.—Subject to sections 1853(f), 1853(h), 1853(i), 1857(f)(2), 1886(d)(11), and 1886(h)(3)(D), only the MedicareAdvantage organization shall be entitled to receive payments from the Secretary under this title for services furnished to the individual.''.

SEC. 202. BENEFITS AND BENEFICIARY PROTECTIONS.

Section 1852 (42 U.S.C. 1395w–22) is amended to read as follows:

''BENEFITS AND BENEFICIARY PROTECTIONS

''SEC. 1852. (a) BASIC BENEFITS.—

''(1) IN GENERAL.—Except as provided in section 1859(b)(3) for MSA plans, each MedicareAdvantage plan shall provide to members enrolled under this part, through providers and other persons that meet the applicable requirements of this title and part A of title XI—

''(A) those items and services (other than hospice care) for which benefits are available under parts A and B to individuals residing in the area served by the plan;

''(B) except as provided in paragraph (2)(D), qualified prescription drug coverage under part D to individuals residing in the area served by the plan;

''(C) a maximum limitation on out-of-pocket expenses and a unified deductible; and

''(D) additional benefits required under section 1854(d)(1).

''(2) SATISFACTION OF REQUIREMENT.—

''(A) IN GENERAL.—A MedicareAdvantage plan (other than an MSA plan) offered by a MedicareAdvantage organization satisfies paragraph (1)(A), with respect to benefits for items and services furnished other than through a provider or other person that has a contract with the organization offering the plan, if the plan provides payment in an amount so that—

''(i) the sum of such payment amount and any cost-sharing provided for under the plan; is equal to at least

''(ii) the total dollar amount of payment for such items and services as would otherwise be authorized under parts A and B (including any balance billing permitted under such parts).

''(B) REFERENCE TO RELATED PROVISIONS.—For provisions relating to—

''(i) limitations on balance billing against MedicareAdvantage organizations for non-contract providers, see sections 1852(k) and 1866(a)(1)(O); and

''(ii) limiting actuarial value of enrollee liability for covered benefits, see section 1854(f).

''(C) ELECTION OF UNIFORM COVERAGE POLICY.—In the case of a MedicareAdvantage organization that offers a MedicareAdvantage plan in an area in which more than 1 local coverage policy is applied with respect to different parts of the area, the organization may elect to have the local coverage policy for the part of the area that is most beneficial to MedicareAdvantage enrollees (as identified by the Secretary) apply with respect to all MedicareAdvantage enrollees enrolled in the plan.

''(D) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE PLANS.—

''(i) IN GENERAL.—A private fee-for-service plan may elect not to provide qualified prescription drug coverage under part D to individuals residing in the area served by the plan.

''(ii) AVAILABILITY OF DRUG COVERAGE FOR ENROLLEES.—If a beneficiary enrolls in a plan making the election described in clause (i), the beneficiary may enroll for drug coverage under part D with an eligible entity under such part.

''(3) ENHANCED MEDICAL BENEFITS.—

''(A) BENEFITS INCLUDED SUBJECT TO SECRETARY'S APPROVAL.—Each MedicareAdvantage organization may provide to individuals enrolled under this part, other than under an MSA plan (without affording those individuals an option to decline the coverage), enhanced medical benefits that the Secretary may approve. The Secretary shall approve any such enhanced medical benefits unless the Secretary determines that including such enhanced medical benefits would substantially discourage enrollment by MedicareAdvantage eligible individuals with the organization.

''(B) AT ENROLLEES' OPTION.—A MedicareAdvantage organization may not provide, under an MSA plan, enhanced medical benefits that cover the deductible described in section 1859(b)(2)(B). In applying the previous sentence, health benefits described in section 1882(u)(2)(B) shall not be treated as covering such deductible.

''(C) APPLICATION TO MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—Nothing in this paragraph shall be construed as preventing a MedicareAdvantage private fee-for-service plan from offering enhanced medical benefits that include payment for some or all of the balance billing amounts permitted consistent with section 1852(k) and coverage of additional services that the plan finds to be medically necessary.

''(D) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—Notwithstanding the preceding provisions of this paragraph, the Secretary may not approve any enhanced medical benefit that provides for the coverage of any prescription drug (other than that relating to prescription drugs covered under the original medicare fee-for-service program option).

''(4) ORGANIZATION AS SECONDARY PAYER.—Notwithstanding any other provision of law, a MedicareAdvantage organization may (in the case of the provision of items and services to an individual under a MedicareAdvantage plan under circumstances in which payment under this title is made secondary pursuant to section 1862(b)(2)) charge or authorize the provider of such services to charge, in accordance with the charges allowed under a law, plan, or policy described in such section—

''(A) the insurance carrier, employer, or other entity which under such law, plan, or policy is to pay for the provision of such services; or

''(B) such individual to the extent that the individual has been paid under such law, plan, or policy for such services.

''(5) NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If there is a national coverage determination or legislative change in benefits required to be provided under this part made in the period beginning on the date of an announcement under section 1853(b) and ending on the date of the next announcement under such section and the Secretary projects that the determination will result in a significant change in the costs to a MedicareAdvantage organization of providing the benefits that are the subject of such national coverage determination and that such change in costs was not incorporated in the determination of the benchmark amount announced under section 1853(b)(1)(A) at the beginning of such period, then, unless otherwise required by law—

''(A) such determination or legislative change in benefits shall not apply to contracts under this part until the first contract year that begins after the end of such period; and

''(B) if such coverage determination or legislative change provides for coverage of additional benefits or coverage under additional circumstances, section 1851(i)(1) shall not apply to payment for such additional benefits or benefits provided under such additional circumstances until the first contract year that begins after the end of such period.

The projection under the previous sentence shall be based on an analysis by the Secretary of the actuarial costs associated with the coverage determination or legislative change in benefits.

''(6) AUTHORITY TO PROHIBIT RISK SELECTION.—The Secretary shall have the authority to disapprove any MedicareAdvantage plan that the Secretary determines is designed to attract a population that is healthier than the average population residing in the service area of the plan.

''(7) UNIFIED DEDUCTIBLE DEFINED.—In this part, the term 'unified deductible' means an annual deductible amount that is applied in lieu of the inpatient hospital deductible under section 1813(b)(1) and the deductible under section 1833(b). Nothing in this part shall be construed as preventing a MedicareAdvantage organization from requiring coinsurance or a copayment for inpatient hospital services after the unified deductible is satisfied, subject to the limitation on enrollee liability under section 1854(f).

''(b) ANTIDISCRIMINATION.—

''(1) BENEFICIARIES.—

''(A) IN GENERAL.—A MedicareAdvantage organization may not deny, limit, or condition the coverage or provision of benefits under this part, for individuals permitted to be enrolled with the organization under this part, based on any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(B) CONSTRUCTION.—Except as provided under section 1851(a)(3)(B), subparagraph (A) shall not be construed as requiring a MedicareAdvantage organization to enroll individuals who are determined to have end-stage renal disease.

''(2) PROVIDERS.—A MedicareAdvantage organization shall not discriminate with respect to participation, reimbursement, or indemnification as to any provider who is acting within the scope of the provider's license or certification under applicable State law, solely on the basis of such license or certification. This paragraph shall not be construed to prohibit a plan from including providers only to the extent necessary to meet the needs of the plan's enrollees or from establishing any measure designed to maintain quality and control costs consistent with the responsibilities of the plan.

''(c) DISCLOSURE REQUIREMENTS.—

''(1) DETAILED DESCRIPTION OF PLAN PROVISIONS.—A MedicareAdvantage organization shall disclose, in clear, accurate, and standardized form to each enrollee with a MedicareAdvantage plan offered by the organization under this part at the time of enrollment and at least annually thereafter, the following information regarding such plan:

''(A) SERVICE AREA.—The plan's service area.

''(B) BENEFITS.—Benefits offered under the plan, including information described section 1852(a)(1) (relating to benefits under the original Medicare fee-for-service program option, the maximum limitation in out-of-pocket expenses and the unified deductible, and qualified prescription drug coverage under part D, respectively) and exclusions from coverage and, if it is an MSA plan, a comparison of benefits under such a plan with benefits under other MedicareAdvantage plans.

''(C) ACCESS.—The number, mix, and distribution of plan providers, out-of-network coverage (if any) provided by the plan, and

any point-of-service option (including the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits for such option).

''(D) OUT-OF-AREA COVERAGE.—Out-of-area coverage provided by the plan.

''(E) EMERGENCY COVERAGE.—Coverage of emergency services, including—

''(i) the appropriate use of emergency services, including use of the 911 telephone system or its local equivalent in emergency situations and an explanation of what constitutes an emergency situation;

''(ii) the process and procedures of the plan for obtaining emergency services; and

''(iii) the locations of—

''(I) emergency departments; and

''(II) other settings, in which plan physicians and hospitals provide emergency services and post-stabilization care.

''(F) ENHANCED MEDICAL BENEFITS.—Enhanced medical benefits available from the organization offering the plan, including—

''(i) whether the enhanced medical benefits are optional;

''(ii) the enhanced medical benefits covered; and

''(iii) the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits.

''(G) PRIOR AUTHORIZATION RULES.—Rules regarding prior authorization or other review requirements that could result in nonpayment.

''(H) PLAN GRIEVANCE AND APPEALS PROCEDURES.—All plan appeal or grievance rights and procedures.

''(I) QUALITY ASSURANCE PROGRAM.—A description of the organization's quality assurance program under subsection (e).

''(2) DISCLOSURE UPON REQUEST.—Upon request of a MedicareAdvantage eligible individual, a MedicareAdvantage organization must provide the following information to such individual:

''(A) The general coverage information and general comparative plan information made available under clauses (i) and (ii) of section 1851(d)(2)(A).

''(B) Information on procedures used by the organization to control utilization of services and expenditures.

''(C) Information on the number of grievances, reconsiderations, and appeals and on the disposition in the aggregate of such matters.

''(D) An overall summary description as to the method of compensation of participating physicians.

''(E) The information described in subparagraphs (A) through (C) in relation to the qualified prescription drug coverage provided by the organization.

''(d) ACCESS TO SERVICES.—

''(1) IN GENERAL.—A MedicareAdvantage organization offering a MedicareAdvantage plan may select the providers from whom the benefits under the plan are provided so long as—

''(A) the organization makes such benefits available and accessible to each individual electing the plan within the plan service area with reasonable promptness and in a manner which assures continuity in the provision of benefits;

''(B) when medically necessary the organization makes such benefits available and accessible 24 hours a day and 7 days a week;

''(C) the plan provides for reimbursement with respect to services which are covered under subparagraphs (A) and (B) and which are provided to such an individual other than through the organization, if—

''(i) the services were not emergency services (as defined in paragraph (3)), but—

''(I) the services were medically necessary and immediately required because of an unforeseen illness, injury, or condition; and

''(II) it was not reasonable given the circumstances to obtain the services through the organization;

''(ii) the services were renal dialysis services and were provided other than through the organization because the individual was temporarily out of the plan's service area; or

''(iii) the services are maintenance care or post-stabilization care covered under the guidelines established under paragraph (2);

''(D) the organization provides access to appropriate providers, including credentialed specialists, for medically necessary treatment and services; and

''(E) coverage is provided for emergency services (as defined in paragraph (3)) without regard to prior authorization or the emergency care provider's contractual relationship with the organization.

''(2) GUIDELINES RESPECTING COORDINATION OF POST-STABILIZATION CARE.—A MedicareAdvantage plan shall comply with such guidelines as the Secretary may prescribe relating to promoting efficient and timely coordination of appropriate maintenance and post-stabilization care of an enrollee after the enrollee has been determined to be stable under section 1867.

''(3) DEFINITION OF EMERGENCY SERVICES.—In this subsection—

''(A) IN GENERAL.—The term 'emergency services' means, with respect to an individual enrolled with an organization, covered inpatient and outpatient services that—

''(i) are furnished by a provider that is qualified to furnish such services under this title; and

''(ii) are needed to evaluate or stabilize an emergency medical condition (as defined in subparagraph (B)).

''(B) EMERGENCY MEDICAL CONDITION BASED ON PRUDENT LAYPERSON.—The term 'emergency medical condition' means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in—

''(i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy;

''(ii) serious impairment to bodily functions; or

''(iii) serious dysfunction of any bodily organ or part.

''(4) ASSURING ACCESS TO SERVICES IN MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—In addition to any other requirements under this part, in the case of a MedicareAdvantage private fee-for-service plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan. The Secretary shall find that an organization has met such requirement with respect to any category of health care professional or provider if, with respect to that category of provider—

''(A) the plan has established payment rates for covered services furnished by that category of provider that are not less than the payment rates provided for under part A, B, or D for such services; or

''(B) the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan,

or a combination of both. The previous sentence shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.

''(e) QUALITY ASSURANCE PROGRAM.—

''(1) IN GENERAL.—Each MedicareAdvantage organization must have arrangements, consistent with any regulation, for an ongoing quality assurance program for health care services it provides to individuals enrolled with MedicareAdvantage plans of the organization.

''(2) ELEMENTS OF PROGRAM.—

''(A) IN GENERAL.—The quality assurance program of an organization with respect to a MedicareAdvantage plan (other than a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan) it offers shall—

''(i) stress health outcomes and provide for the collection, analysis, and reporting of data (in accordance with a quality measurement system that the Secretary recognizes) that will permit measurement of outcomes and other indices of the quality of MedicareAdvantage plans and organizations;

''(ii) monitor and evaluate high volume and high risk services and the care of acute and chronic conditions;

''(iii) provide access to disease management and chronic care services;

''(iv) provide access to preventive benefits and information for enrollees on such benefits;

''(v) evaluate the continuity and coordination of care that enrollees receive;

''(vi) be evaluated on an ongoing basis as to its effectiveness;

''(vii) include measures of consumer satisfaction;

''(viii) provide the Secretary with such access to information collected as may be appropriate to monitor and ensure the quality of care provided under this part;

''(ix) provide review by physicians and other health care professionals of the process followed in the provision of such health care services;

''(x) provide for the establishment of written protocols for utilization review, based on current standards of medical practice;

''(xi) have mechanisms to detect both underutilization and overutilization of services;

''(xii) after identifying areas for improvement, establish or alter practice parameters;

''(xiii) take action to improve quality and assesses the effectiveness of such action through systematic followup; and

''(xiv) make available information on quality and outcomes measures to facilitate beneficiary comparison and choice of health coverage options (in such form and on such quality and outcomes measures as the Secretary determines to be appropriate).

Such program shall include a separate focus (with respect to all the elements described in this subparagraph) on racial and ethnic minorities.

''(B) ELEMENTS OF PROGRAM FOR ORGANIZATIONS OFFERING MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS, AND NONNETWORK MSA PLANS.—The quality assurance program of an organization with respect to a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan it offers shall—

''(i) meet the requirements of clauses (i) through (viii) of subparagraph (A);

''(ii) insofar as it provides for the establishment of written protocols for utilization review, base such protocols on current standards of medical practice; and

''(iii) have mechanisms to evaluate utilization of services and inform providers and enrollees of the results of such evaluation.

Such program shall include a separate focus (with respect to all the elements described in this subparagraph) on racial and ethnic minorities.

''(C) DEFINITION OF NONNETWORK MSA PLAN.—In this subsection, the term 'nonnetwork MSA plan' means an MSA plan offered by a MedicareAdvantage organization that does not provide benefits required to be provided by this part, in whole or in part, through a defined set of providers under contract, or under another arrangement, with the organization.

''(3) EXTERNAL REVIEW.—

''(A) IN GENERAL.—Each MedicareAdvantage organization shall, for each MedicareAdvantage plan it operates, have an agreement with an independent quality review and improvement organization approved by the Secretary to perform functions of the type described in paragraphs (4)(B) and (14) of section 1154(a) with respect to services furnished by MedicareAdvantage plans for which payment is made under this title. The previous sentence shall not apply to a MedicareAdvantage private fee-for-service plan or a nonnetwork MSA plan that does not employ utilization review.

''(B) NONDUPLICATION OF ACCREDITATION.—Except in the case of the review of quality complaints, and consistent with subparagraph (C), the Secretary shall ensure that the external review activities conducted under subparagraph (A) are not duplicative of review activities conducted as part of the accreditation process.

''(C) WAIVER AUTHORITY.—The Secretary may waive the requirement described in subparagraph (A) in the case of an organization if the Secretary determines that the organization has consistently maintained an excellent record of quality assurance and compliance with other requirements under this part.

''(4) TREATMENT OF ACCREDITATION.—

''(A) IN GENERAL.—The Secretary shall provide that a MedicareAdvantage organization is deemed to meet all the requirements described in any specific clause of subparagraph (B) if the organization is accredited (and periodically reaccredited) by a private accrediting organization under a process that the Secretary has determined assures that the accrediting organization applies and enforces standards that meet or exceed the standards established under section 1856 to carry out the requirements in such clause.

''(B) REQUIREMENTS DESCRIBED.—The provisions described in this subparagraph are the following:

''(i) Paragraphs (1) and (2) of this subsection (relating to quality assurance programs).

''(ii) Subsection (b) (relating to antidiscrimination).

''(iii) Subsection (d) (relating to access to services).

''(iv) Subsection (h) (relating to confidentiality and accuracy of enrollee records).

''(v) Subsection (i) (relating to information on advance directives).

''(vi) Subsection (j) (relating to provider participation rules).

''(C) TIMELY ACTION ON APPLICATIONS.—The Secretary shall determine, within 210 days after the date the Secretary receives an application by a private accrediting organization and using the criteria specified in section 1865(b)(2), whether the process of the private accrediting organization meets the requirements with respect to any specific clause in subparagraph (B) with respect to which the application is made. The Secretary may not deny such an application on the basis that it seeks to meet the requirements with respect to only one, or more than one, such specific clause.

''(D) CONSTRUCTION.—Nothing in this paragraph shall be construed as limiting the authority of the Secretary under section 1857, including the authority to terminate contracts with MedicareAdvantage organizations under subsection (c)(2) of such section.

''(5) REPORT TO CONGRESS.—

''(A) IN GENERAL.—The Secretary shall submit to Congress a biennial report regarding how quality assurance programs conducted under this subsection focus on racial and ethnic minorities.

''(B) CONTENTS OF REPORT.—Each such report shall include the following:

''(i) A description of the means by which such programs focus on such racial and ethnic minorities.

''(ii) An evaluation of the impact of such programs on eliminating health disparities and on improving health outcomes, continuity and coordination of care, management of chronic conditions, and consumer satisfaction.

''(iii) Recommendations on ways to reduce clinical outcome disparities among racial and ethnic minorities.

''(f) GRIEVANCE MECHANISM.—Each MedicareAdvantage organization must provide meaningful procedures for hearing and resolving grievances between the organization (including any entity or individual through which the organization provides health care services) and enrollees with MedicareAdvantage plans of the organization under this part.

''(g) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—

''(1) DETERMINATIONS BY ORGANIZATION.—

''(A) IN GENERAL.—A MedicareAdvantage organization shall have a procedure for making determinations regarding whether an individual enrolled with the plan of the organization under this part is entitled to receive a health service under this section and the amount (if any) that the individual is required to pay with respect to such service. Subject to paragraph (3), such procedures shall provide for such determination to be made on a timely basis.

''(B) EXPLANATION OF DETERMINATION.—Such a determination that denies coverage, in whole or in part, shall be in writing and shall include a statement in understandable language of the reasons for the denial and a description of the reconsideration and appeals processes.

''(2) RECONSIDERATIONS.—

''(A) IN GENERAL.—The organization shall provide for reconsideration of a determination described in paragraph (1)(B) upon request by the enrollee involved. The reconsideration shall be within a time period specified by the Secretary, but shall be made, subject to paragraph (3), not later than 60 days after the date of the receipt of the request for reconsideration.

''(B) PHYSICIAN DECISION ON CERTAIN RECONSIDERATIONS.—A reconsideration relating to a determination to deny coverage based on a lack of medical necessity shall be made only by a physician with appropriate expertise in the field of medicine which necessitates treatment who is other than a physician involved in the initial determination.

''(3) EXPEDITED DETERMINATIONS AND RECONSIDERATIONS.—

''(A) RECEIPT OF REQUESTS.—

''(i) ENROLLEE REQUESTS.—An enrollee in a MedicareAdvantage plan may request, either in writing or orally, an expedited determination under paragraph (1) or an expedited reconsideration under paragraph (2) by the MedicareAdvantage organization.

''(ii) PHYSICIAN REQUESTS.—A physician, regardless whether the physician is affiliated with the organization or not, may request, either in writing or orally, such an expedited determination or reconsideration.

''(B) ORGANIZATION PROCEDURES.—

''(i) IN GENERAL.—The MedicareAdvantage organization shall maintain procedures for expediting organization determinations and reconsiderations when, upon request of an enrollee, the organization determines that the application of the normal timeframe for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

''(ii) EXPEDITION REQUIRED FOR PHYSICIAN REQUESTS.—In the case of a request for an expedited determination or reconsideration made under subparagraph (A)(ii), the organization shall expedite the determination or reconsideration if the request indicates that the application of the normal timeframe for making a determination (or a reconsideration involving a determination) could seriously jeopardize the life or health of the enrollee or the enrollee's ability to regain maximum function.

''(iii) TIMELY RESPONSE.—In cases described in clauses (i) and (ii), the organization shall notify the enrollee (and the physician involved, as appropriate) of the determination or reconsideration under time limitations established by the Secretary, but not later than 72 hours of the time of receipt of the request for the determination or reconsideration (or receipt of the information necessary to make the determination or reconsideration), or such longer period as the Secretary may permit in specified cases.

''(4) INDEPENDENT REVIEW OF CERTAIN COVERAGE DENIALS.—The Secretary shall contract with an independent, outside entity to review and resolve in a timely manner reconsiderations that affirm denial of coverage, in whole or in part. The provisions of section 1869(c)(5) shall apply to independent outside entities under contract with the Secretary under this paragraph.

''(5) APPEALS.—An enrollee with a MedicareAdvantage plan of a MedicareAdvantage organization under this part who is dissatisfied by reason of the enrollee's failure to receive any health service to which the enrollee believes the enrollee is entitled and at no greater charge than the enrollee believes the enrollee is required to pay is entitled, if the amount in controversy is $100 or more, to a hearing before the Secretary to the same extent as is provided in section 205(b), and in any such hearing the Secretary shall make the organization a party. If the amount in controversy is $1,000 or more, the individual or organization shall, upon notifying the other party, be entitled to judicial review of the Secretary's final decision as provided in section 205(g), and both the individual and the organization shall be entitled to be parties to that judicial review. In applying subsections (b) and (g) of section 205 as provided in this paragraph, and in applying section 205(l) thereto, any reference therein to the Commissioner of Social Security or the Social Security Administration shall be considered a reference to the Secretary or the Department of Health and Human Services, respectively.

''(h) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—Insofar as a MedicareAdvantage organization maintains medical records or other health information regarding enrollees under this part, the MedicareAdvantage organization shall establish procedures—

''(1) to safeguard the privacy of any individually identifiable enrollee information;

''(2) to maintain such records and information in a manner that is accurate and timely; and

''(3) to assure timely access of enrollees to such records and information.

''(i) INFORMATION ON ADVANCE DIRECTIVES.—Each MedicareAdvantage organization shall meet the requirement of section

1866(f) (relating to maintaining written policies and procedures respecting advance directives).

''(j) RULES REGARDING PROVIDER PARTICIPATION.—

''(1) PROCEDURES.—Insofar as a MedicareAdvantage organization offers benefits under a MedicareAdvantage plan through agreements with physicians, the organization shall establish reasonable procedures relating to the participation (under an agreement between a physician and the organization) of physicians under such a plan. Such procedures shall include—

''(A) providing notice of the rules regarding participation;

''(B) providing written notice of participation decisions that are adverse to physicians; and

''(C) providing a process within the organization for appealing such adverse decisions, including the presentation of information and views of the physician regarding such decision.

''(2) CONSULTATION IN MEDICAL POLICIES.—A MedicareAdvantage organization shall consult with physicians who have entered into participation agreements with the organization regarding the organization's medical policy, quality, and medical management procedures.

''(3) PROHIBITING INTERFERENCE WITH PROVIDER ADVICE TO ENROLLEES.—

''(A) IN GENERAL.—Subject to subparagraphs (B) and (C), a MedicareAdvantage organization (in relation to an individual enrolled under a MedicareAdvantage plan offered by the organization under this part) shall not prohibit or otherwise restrict a covered health care professional (as defined in subparagraph (D)) from advising such an individual who is a patient of the professional about the health status of the individual or medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice.

''(B) CONSCIENCE PROTECTION.—Subparagraph (A) shall not be construed as requiring a MedicareAdvantage plan to provide, reimburse for, or provide coverage of a counseling or referral service if the MedicareAdvantage organization offering the plan—

''(i) objects to the provision of such service on moral or religious grounds; and

''(ii) in the manner and through the written instrumentalities such MedicareAdvantage organization deems appropriate, makes available information on its policies regarding such service to prospective enrollees before or during enrollment and to enrollees within 90 days after the date that the organization or plan adopts a change in policy regarding such a counseling or referral service.

''(C) CONSTRUCTION.—Nothing in subparagraph (B) shall be construed to affect disclosure requirements under State law or under the Employee Retirement Income Security Act of 1974.

''(D) HEALTH CARE PROFESSIONAL DEFINED.—For purposes of this paragraph, the term 'health care professional' means a physician (as defined in section 1861(r)) or other health care professional if coverage for the professional's services is provided under the MedicareAdvantage plan for the services of the professional. Such term includes a podiatrist, optometrist, chiropractor, psychologist, dentist, licensed pharmacist, physician assistant, physical or occupational therapist and therapy assistant, speech-language pathologist, audiologist, registered or licensed practical nurse (including nurse practitioner, clinical nurse specialist, certified registered nurse anesthetist, and certified nurse-midwife), licensed certified social worker, registered respiratory therapist, and certified respiratory therapy technician.

''(4) LIMITATIONS ON PHYSICIAN INCENTIVE PLANS.—

''(A) IN GENERAL.—No MedicareAdvantage organization may operate any physician incentive plan (as defined in subparagraph (B)) unless the following requirements are met:

''(i) No specific payment is made directly or indirectly under the plan to a physician or physician group as an inducement to reduce or limit medically necessary services provided with respect to a specific individual enrolled with the organization.

''(ii) If the plan places a physician or physician group at substantial financial risk (as determined by the Secretary) for services not provided by the physician or physician group, the organization—

''(I) provides stop-loss protection for the physician or group that is adequate and appropriate, based on standards developed by the Secretary that take into account the number of physicians placed at such substantial financial risk in the group or under the plan and the number of individuals enrolled with the organization who receive services from the physician or group; and

''(II) conducts periodic surveys of both individuals enrolled and individuals previously enrolled with the organization to determine the degree of access of such individuals to services provided by the organization and satisfaction with the quality of such services.

''(iii) The organization provides the Secretary with descriptive information regarding the plan, sufficient to permit the Secretary to determine whether the plan is in compliance with the requirements of this subparagraph.

''(B) PHYSICIAN INCENTIVE PLAN DEFINED.—In this paragraph, the term 'physician incentive plan' means any compensation arrangement between a MedicareAdvantage organization and a physician or physician group that may directly or indirectly have the effect of reducing or limiting services provided with respect to individuals enrolled with the organization under this part.

''(5) LIMITATION ON PROVIDER INDEMNIFICATION.—A MedicareAdvantage organization may not provide (directly or indirectly) for a health care professional, provider of services, or other entity providing health care services (or group of such professionals, providers, or entities) to indemnify the organization against any liability resulting from a civil action brought for any damage caused to an enrollee with a MedicareAdvantage plan of the organization under this part by the organization's denial of medically necessary care.

''(6) SPECIAL RULES FOR MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—For purposes of applying this part (including subsection (k)(1)) and section 1866(a)(1)(O), a hospital (or other provider of services), a physician or other health care professional, or other entity furnishing health care services is treated as having an agreement or contract in effect with a MedicareAdvantage organization (with respect to an individual enrolled in a MedicareAdvantage private fee-for-service plan it offers), if—

''(A) the provider, professional, or other entity furnishes services that are covered under the plan to such an enrollee; and

''(B) before providing such services, the provider, professional, or other entity —

''(i) has been informed of the individual's enrollment under the plan; and

''(ii) either—

''(I) has been informed of the terms and conditions of payment for such services under the plan; or

''(II) is given a reasonable opportunity to obtain information concerning such terms and conditions,

in a manner reasonably designed to effect informed agreement by a provider.

The previous sentence shall only apply in the absence of an explicit agreement between such a provider, professional, or other entity and the MedicareAdvantage organization.

''(k) TREATMENT OF SERVICES FURNISHED BY CERTAIN PROVIDERS.—

''(1) IN GENERAL.—Except as provided in paragraph (2), a physician or other entity (other than a provider of services) that does not have a contract establishing payment amounts for services furnished to an individual enrolled under this part with a MedicareAdvantage organization described in section 1851(a)(2)(A) shall accept as payment in full for covered services under this title that are furnished to such an individual the amounts that the physician or other entity could collect if the individual were not so enrolled. Any penalty or other provision of law that applies to such a payment with respect to an individual entitled to benefits under this title (but not enrolled with a MedicareAdvantage organization under this part) also applies with respect to an individual so enrolled.

''(2) APPLICATION TO MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS.—

''(A) BALANCE BILLING LIMITS UNDER MEDICAREADVANTAGE PRIVATE FEE-FOR-SERVICE PLANS IN CASE OF CONTRACT PROVIDERS.—

''(i) IN GENERAL.—In the case of an individual enrolled in a MedicareAdvantage private fee-for-service plan under this part, a physician, provider of services, or other entity that has a contract (including through the operation of subsection (j)(6)) establishing a payment rate for services furnished to the enrollee shall accept as payment in full for covered services under this title that are furnished to such an individual an amount not to exceed (including any deductibles, coinsurance, copayments, or balance billing otherwise permitted under the plan) an amount equal to 115 percent of such payment rate.

''(ii) PROCEDURES TO ENFORCE LIMITS.—The MedicareAdvantage organization that offers such a plan shall establish procedures, similar to the procedures described in section 1848(g)(1)(A), in order to carry out clause (i).

''(iii) ASSURING ENFORCEMENT.—If the MedicareAdvantage organization fails to establish and enforce procedures required under clause (ii), the organization is subject to intermediate sanctions under section 1857(g).

''(B) ENROLLEE LIABILITY FOR NONCONTRACT PROVIDERS.—For provisions—

''(i) establishing a minimum payment rate in the case of noncontract providers under a MedicareAdvantage private fee-for-service plan, see section 1852(a)(2); or

''(ii) limiting enrollee liability in the case of covered services furnished by such providers, see paragraph (1) and section 1866(a)(1)(O).

''(C) INFORMATION ON BENEFICIARY LIABILITY.—

''(i) IN GENERAL.—Each MedicareAdvantage organization that offers a MedicareAdvantage private fee-for-service plan shall provide that enrollees under the plan who are furnished services for which payment is sought under the plan are provided an appropriate explanation of benefits (consistent with that provided under parts A, B, and D, and, if applicable, under medicare supplemental policies) that includes a clear statement of the amount of the enrollee's liability (including any liability for balance billing consistent with this subsection) with respect to payments for such services.

''(ii) ADVANCE NOTICE BEFORE RECEIPT OF INPATIENT HOSPITAL SERVICES AND CERTAIN OTHER SERVICES.—In addition, such organization shall, in its terms and conditions of payments to hospitals for inpatient hospital services and for other services identified by the Secretary for which the amount of the balance billing under subparagraph (A) could be substantial, require the hospital to provide to the enrollee, before furnishing such services and if the hospital imposes balance billing under subparagraph (A)—

''(I) notice of the fact that balance billing is permitted under such subparagraph for such services; and

''(II) a good faith estimate of the likely amount of such balance billing (if any), with respect to such services, based upon the presenting condition of the enrollee.

''(l) RETURN TO HOME SKILLED NURSING FACILITIES FOR COVERED POST-HOSPITAL EXTENDED CARE SERVICES.—

''(1) ENSURING RETURN TO HOME SNF.—

''(A) IN GENERAL.—In providing coverage of post-hospital extended care services, a MedicareAdvantage plan shall provide for such coverage through a home skilled nursing facility if the following conditions are met:

''(i) ENROLLEE ELECTION.—The enrollee elects to receive such coverage through such facility.

''(ii) SNF AGREEMENT.—The facility has a contract with the MedicareAdvantage organization for the provision of such services, or the facility agrees to accept substantially similar payment under the same terms and conditions that apply to similarly situated skilled nursing facilities that are under contract with the MedicareAdvantage organization for the provision of such services and through which the enrollee would otherwise receive such services.

''(B) MANNER OF PAYMENT TO HOME SNF.—The organization shall provide payment to the home skilled nursing facility consistent with the contract or the agreement described in subparagraph (A)(ii), as the case may be.

''(2) NO LESS FAVORABLE COVERAGE.—The coverage provided under paragraph (1) (including scope of services, cost-sharing, and other criteria of coverage) shall be no less favorable to the enrollee than the coverage that would be provided to the enrollee with respect to a skilled nursing facility the post-hospital extended care services of which are otherwise covered under the MedicareAdvantage plan.

''(3) RULE OF CONSTRUCTION.—Nothing in this subsection shall be construed to do the following:

''(A) To require coverage through a skilled nursing facility that is not otherwise qualified to provide benefits under part A for medicare beneficiaries not enrolled in a MedicareAdvantage plan.

''(B) To prevent a skilled nursing facility from refusing to accept, or imposing conditions upon the acceptance of, an enrollee for the receipt of post-hospital extended care services.

''(4) DEFINITIONS.—In this subsection:

''(A) HOME SKILLED NURSING FACILITY.—The term 'home skilled nursing facility' means, with respect to an enrollee who is entitled to receive post-hospital extended care services under a MedicareAdvantage plan, any of the following skilled nursing facilities:

''(i) SNF RESIDENCE AT TIME OF ADMISSION.—The skilled nursing facility in which the enrollee resided at the time of admission to the hospital preceding the receipt of such post-hospital extended care services.

''(ii) SNF IN CONTINUING CARE RETIREMENT COMMUNITY.—A skilled nursing facility that is providing such services through a continuing care retirement community (as defined in subparagraph (B)) which provided residence to the enrollee at the time of such admission.

''(iii) SNF RESIDENCE OF SPOUSE AT TIME OF DISCHARGE.—The skilled nursing facility in which the spouse of the enrollee is residing at the time of discharge from such hospital.

''(B) CONTINUING CARE RETIREMENT COMMUNITY.—The term 'continuing care retirement community' means, with respect to an enrollee in a MedicareAdvantage plan, an arrangement under which housing and health-related services are provided (or arranged) through an organization for the enrollee under an agreement that is effective for the life of the enrollee or for a specified period.''.

SEC. 203. PAYMENTS TO MEDICAREADVANTAGE ORGANIZATIONS.

Section 1853 (42 U.S.C. 1395w–23) is amended to read as follows:

''PAYMENTS TO MEDICAREADVANTAGE ORGANIZATIONS

''SEC. 1853. (a) PAYMENTS TO ORGANIZATIONS.—

''(1) MONTHLY PAYMENTS.—

''(A) IN GENERAL.—Under a contract under section 1857 and subject to subsections (f), (h), and (j) and section 1859(e)(4), the Secretary shall make, to each MedicareAdvantage organization, with respect to coverage of an individual for a month under this part in a MedicareAdvantage payment area, separate monthly payments with respect to—

''(i) benefits under the original medicare fee-for-service program under parts A and B in accordance with subsection (d); and

''(ii) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

''(B) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment to a MedicareAdvantage organization with respect to classes of individuals determined to have end-stage renal disease and enrolled in a MedicareAdvantage plan of the organization. Such rates of payment shall be actuarially equivalent to rates paid to other enrollees in the MedicareAdvantage payment area (or such other area as specified by the Secretary). In accordance with regulations, the Secretary shall provide for the application of the seventh sentence of section 1881(b)(7) to payments under this section covering the provision of renal dialysis treatment in the same manner as such sentence applies to composite rate payments described in such sentence. In establishing such rates, the Secretary shall provide for appropriate adjustments to increase each rate to reflect the demonstration rate (including the risk adjustment methodology associated with such rate) of the social health maintenance organization end-stage renal disease capitation demonstrations (established by section 2355 of the Deficit Reduction Act of 1984, as amended by section 13567(b) of the Omnibus Budget Reconciliation Act of 1993), and shall compute such rates by taking into account such factors as renal treatment modality, age, and the underlying cause of the end-stage renal disease.

''(2) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—

''(A) IN GENERAL.—The amount of payment under this subsection may be retroactively adjusted to take into account any difference between the actual number of individuals enrolled with an organization under this part and the number of such individuals estimated to be so enrolled in determining the amount of the advance payment.

''(B) SPECIAL RULE FOR CERTAIN ENROLLEES.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary may make retroactive adjustments under subparagraph (A) to take into account individuals enrolled during the period beginning on the date on which the individual enrolls with a MedicareAdvantage organization under a plan operated, sponsored, or contributed to by the individual's employer or former employer (or the employer or former employer of the individual's spouse) and ending on the date on which the individual is enrolled in the organization under this part, except that for purposes of making such retroactive adjustments under this subparagraph, such period may not exceed 90 days.

''(ii) EXCEPTION.—No adjustment may be made under clause (i) with respect to any individual who does not certify that the organization provided the individual with the disclosure statement described in section 1852(c) at the time the individual enrolled with the organization.

''(C) EQUALIZATION OF FEDERAL CONTRIBUTION.—In applying subparagraph (A), the Secretary shall ensure that the payment to the MedicareAdvantage organization for each individual enrolled with the organization shall equal the MedicareAdvantage benchmark amount for the payment area in which that individual resides (as determined under paragraph (4)), as adjusted—

''(i) by multiplying the benchmark amount for that payment area by the ratio of—

''(I) the payment amount determined under subsection (d)(4); to

''(II) the weighted service area benchmark amount determined under subsection (d)(2); and

''(ii) using such risk adjustment factor as specified by the Secretary under subsection (b)(1)(B).

''(3) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—

''(A) APPLICATION OF METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in subparagraph (B) to 100 percent of the amount of payments to plans under subsection (d)(4)(B).

''(B) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY DESCRIBED.—The comprehensive risk adjustment methodology described in this subparagraph is the risk adjustment methodology that would apply with respect to MedicareAdvantage plans offered by MedicareAdvantage organizations in 2005, except that if such methodology does not apply to groups of beneficiaries who are aged or disabled and groups of beneficiaries who have end-stage renal disease, the Secretary shall revise such methodology to apply to such groups.

''(C) UNIFORM APPLICATION TO ALL TYPES OF PLANS.—Subject to section 1859(e)(4), the comprehensive risk adjustment methodology established under this paragraph shall be applied uniformly without regard to the type of plan.

''(D) DATA COLLECTION.—In order to carry out this paragraph, the Secretary shall require MedicareAdvantage organizations to submit such data and other information as the Secretary deems necessary.

''(E) IMPROVEMENT OF PAYMENT ACCURACY.—Notwithstanding any other provision of this paragraph, the Secretary may revise the comprehensive risk adjustment methodology described in subparagraph (B) from time to time to improve payment accuracy.

''(4) ANNUAL CALCULATION OF BENCHMARK AMOUNTS.—For each year, the Secretary shall calculate a benchmark amount for each MedicareAdvantage payment area for each month for such year with respect to coverage of the benefits available under the original medicare fee-for-service program option equal to the greater of the following amounts (adjusted as appropriate for the application of the risk adjustment methodology under paragraph (3)):

''(A) MINIMUM AMOUNT.—1/12 of the annual Medicare+Choice capitation rate determined under subsection (c)(1)(B) for the payment area for the year.

''(B) LOCAL FEE-FOR-SERVICE RATE.—The local fee-for-service rate for such area for the year (as calculated under paragraph (5)).

''(5) ANNUAL CALCULATION OF LOCAL FEE-FOR-SERVICE RATES.—

''(A) IN GENERAL.—Subject to subparagraph (B), the term 'local fee-for-service rate' means the amount of payment for a month in a MedicareAdvantage payment area for benefits under this title and associated claims processing costs for an individual who has elected to receive benefits under the original medicare fee-for-service program option and not enrolled in a MedicareAdvantage plan under this part. The Secretary shall annually calculate such amount in a manner similar to the manner in which the Secretary calculated the adjusted average per capita cost under section 1876.

''(B) REMOVAL OF MEDICAL EDUCATION COSTS FROM CALCULATION OF LOCAL FEE-FOR-SERVICE RATE.—

''(i) IN GENERAL.—In calculating the local fee-for-service rate under subparagraph (A) for a year, the amount of payment described in such subparagraph shall be adjusted to exclude from such payment the payment adjustments described in clause (ii).

''(ii) PAYMENT ADJUSTMENTS DESCRIBED.—

''(I) IN GENERAL.—Subject to subclause (II), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates are payable during the year—

''(aa) for the indirect costs of medical education under section 1886(d)(5)(B); and

''(bb) for direct graduate medical education costs under section 1886(h).

''(II) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that the amount of the local fee-for-service rates reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

''(b) ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.—

''(1) ANNUAL ANNOUNCEMENT.—Beginning in 2005, at the same time as the Secretary publishes the risk adjusters under section 1860D–11, the Secretary shall annually announce (in a manner intended to provide notice to interested parties) the following payment factors:

''(A) The benchmark amount for each MedicareAdvantage payment area (as calculated under subsection (a)(4)) for the year.

''(B) The factors to be used for adjusting payments under the comprehensive risk adjustment methodology described in subsection (a)(3)(B) with respect to each MedicareAdvantage payment area for the year.

''(2) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under paragraph (1) for a year, the Secretary shall—

''(A) provide for notice to MedicareAdvantage organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement; and

''(B) provide such organizations with an opportunity to comment on such proposed changes.

''(3) EXPLANATION OF ASSUMPTIONS.—In each announcement made under paragraph (1), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that MedicareAdvantage organizations can compute each payment factor described in paragraph (1).

''(c) CALCULATION OF ANNUAL MEDICARE+CHOICE CAPITATION RATES.—

''(1) IN GENERAL.—For purposes of making payments under this part for years before 2006 and for purposes of calculating the annual Medicare+Choice capitation rates under paragraph (7) beginning with such year, subject to paragraph (6)(C), each annual Medicare+Choice capitation rate, for a Medicare+Choice payment area before 2006 or a MedicareAdvantage payment area beginning with such year for a contract year consisting of a calendar year, is equal to the largest of the amounts specified in the following subparagraph (A), (B), or (C):

''(A) BLENDED CAPITATION RATE.—The sum of—

''(i) the area-specific percentage (as specified under paragraph (2) for the year) of the annual area-specific Medicare+Choice capitation rate for the MedicareAdvantage payment area, as determined under paragraph (3) for the year; and

''(ii) the national percentage (as specified under paragraph (2) for the year) of the input-price-adjusted annual national Medicare+Choice capitation rate, as determined under paragraph (4) for the year,

multiplied by the budget neutrality adjustment factor determined under paragraph (5).

''(B) MINIMUM AMOUNT.—12 multiplied by the following amount:

''(i) For 1998, $367 (but not to exceed, in the case of an area outside the 50 States and the District of Columbia, 150 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area).

''(ii) For 1999 and 2000, the minimum amount determined under clause (i) or this clause, respectively, for the preceding year, increased by the national per capita Medicare+Choice growth percentage described in paragraph (6)(A) applicable to 1999 or 2000, respectively.

''(iii)(I) Subject to subclause (II), for 2001, for any area in a Metropolitan Statistical Area with a population of more than 250,000, $525, and for any other area $475.

''(II) In the case of an area outside the 50 States and the District of Columbia, the amount specified in this clause shall not exceed 120 percent of the amount determined under clause (ii) for such area for 2000.

''(iv) For 2002 through 2013, the minimum amount specified in this clause (or clause (iii)) for the preceding year increased by the national per capita Medicare+Choice growth percentage, described in paragraph (6)(A) for that succeeding year.

''(v) For 2014 and each succeeding year, the minimum amount specified in this clause (or clause (iv)) for the preceding year increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

''(C) MINIMUM PERCENTAGE INCREASE.—

''(i) For 1998, 102 percent of the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the Medicare+Choice payment area.

''(ii) For 1999 and 2000, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(iii) For 2001, 103 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for 2000.

''(iv) For 2002 and each succeeding year, 102 percent of the annual Medicare+Choice capitation rate under this paragraph for the area for the previous year.

''(2) AREA-SPECIFIC AND NATIONAL PERCENTAGES.—For purposes of paragraph (1)(A)—

''(A) for 1998, the 'area-specific percentage' is 90 percent and the 'national percentage' is 10 percent;

''(B) for 1999, the 'area-specific percentage' is 82 percent and the 'national percentage' is 18 percent;

''(C) for 2000, the 'area-specific percentage' is 74 percent and the 'national percentage' is 26 percent;

''(D) for 2001, the 'area-specific percentage' is 66 percent and the 'national percentage' is 34 percent;

''(E) for 2002, the 'area-specific percentage' is 58 percent and the 'national percentage' is 42 percent; and

''(F) for a year after 2002, the 'area-specific percentage' is 50 percent and the 'national percentage' is 50 percent.

''(3) ANNUAL AREA-SPECIFIC MEDICARE+CHOICE CAPITATION RATE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A), subject to subparagraph (B), the annual area-specific Medicare+Choice capitation rate for a Medicare+Choice payment area—

''(i) for 1998 is, subject to subparagraph (D), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) for the area, increased by the national per capita Medicare+Choice growth percentage for 1998 (described in paragraph (6)(A)); or

''(ii) for a subsequent year is the annual area-specific Medicare+Choice capitation rate for the previous year determined under this paragraph for the area, increased by the national per capita Medicare+Choice growth percentage for such subsequent year.

''(B) REMOVAL OF MEDICAL EDUCATION FROM CALCULATION OF ADJUSTED AVERAGE PER CAPITA COST.—

''(i) IN GENERAL.—In determining the area-specific Medicare+Choice capitation rate under subparagraph (A) for a year (beginning with 1998), the annual per capita rate of payment for 1997 determined under section 1876(a)(1)(C) shall be adjusted to exclude from the rate the applicable percent (specified in clause (ii)) of the payment adjustments described in subparagraph (C).

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

''(I) 1998 is 20 percent;

''(II) 1999 is 40 percent;

''(III) 2000 is 60 percent;

''(IV) 2001 is 80 percent; and

''(V) a succeeding year is 100 percent.

''(C) PAYMENT ADJUSTMENT.—

''(i) IN GENERAL.—Subject to clause (ii), the payment adjustments described in this subparagraph are payment adjustments which the Secretary estimates were payable during 1997—

''(I) for the indirect costs of medical education under section 1886(d)(5)(B); and

''(II) for direct graduate medical education costs under section 1886(h).

''(ii) TREATMENT OF PAYMENTS COVERED UNDER STATE HOSPITAL REIMBURSEMENT SYSTEM.—To the extent that the Secretary estimates that an annual per capita rate of payment for 1997 described in clause (i) reflects payments to hospitals reimbursed under section 1814(b)(3), the Secretary shall estimate a payment adjustment that is comparable to the payment adjustment that would have been made under clause (i) if the hospitals had not been reimbursed under such section.

''(D) TREATMENT OF AREAS WITH HIGHLY VARIABLE PAYMENT RATES.—In the case of a Medicare+Choice payment area for which the annual per capita rate of payment determined under section 1876(a)(1)(C) for 1997 varies by more than 20 percent from such rate for 1996, for purposes of this subsection the Secretary may substitute for such rate for

1997 a rate that is more representative of the costs of the enrollees in the area.

''(4) INPUT-PRICE-ADJUSTED ANNUAL NATIONAL MEDICARE+CHOICE CAPITATION RATE.—

''(A) IN GENERAL.—For purposes of paragraph (1)(A), the input-price-adjusted annual national Medicare+Choice capitation rate for a Medicare+Choice payment area for a year is equal to the sum, for all the types of medicare services (as classified by the Secretary), of the product (for each such type of service) of—

''(i) the national standardized annual Medicare+Choice capitation rate (determined under subparagraph (B)) for the year;

''(ii) the proportion of such rate for the year which is attributable to such type of services; and

''(iii) an index that reflects (for that year and that type of services) the relative input price of such services in the area compared to the national average input price of such services.

In applying clause (iii), the Secretary may, subject to subparagraph (C), apply those indices under this title that are used in applying (or updating) national payment rates for specific areas and localities.

''(B) NATIONAL STANDARDIZED ANNUAL MEDICARE+CHOICE CAPITATION RATE.—In subparagraph (A)(i), the 'national standardized annual Medicare+Choice capitation rate' for a year is equal to—

''(i) the sum (for all Medicare+Choice payment areas) of the product of—

''(I) the annual area-specific Medicare+Choice capitation rate for that year for the area under paragraph (3); and

''(II) the average number of medicare beneficiaries residing in that area in the year, multiplied by the average of the risk factor weights used to adjust payments under subsection (a)(1)(A) for such beneficiaries in such area; divided by

''(ii) the sum of the products described in clause (i)(II) for all areas for that year.

''(5) PAYMENT ADJUSTMENT BUDGET NEUTRALITY FACTOR.—For purposes of paragraph (1)(A), for each year, the Secretary shall determine a budget neutrality adjustment factor so that the aggregate of the payments under this part (other than those attributable to subsections (a)(3)(C)(iii) and (i)) shall equal the aggregate payments that would have been made under this part if payment were based entirely on area-specific capitation rates.

''(6) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE DEFINED.—

''(A) IN GENERAL.—In this part, the 'national per capita Medicare+Choice growth percentage' for a year is the percentage determined by the Secretary, by March 1st before the beginning of the year involved, to reflect the Secretary's estimate of the projected per capita rate of growth in expenditures under this title for an individual entitled to (or enrolled for) benefits under part A and enrolled under part B, reduced by the number of percentage points specified in subparagraph (B) for the year. Separate determinations may be made for aged enrollees, disabled enrollees, and enrollees with end-stage renal disease.

''(B) ADJUSTMENT.—The number of percentage points specified in this subparagraph is—

''(i) for 1998, 0.8 percentage points;

''(ii) for 1999, 0.5 percentage points;

''(iii) for 2000, 0.5 percentage points;

''(iv) for 2001, 0.5 percentage points;

''(v) for 2002, 0.3 percentage points; and

''(vi) for a year after 2002, 0 percentage points.

''(C) ADJUSTMENT FOR OVER OR UNDER PROJECTION OF NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—Beginning with rates calculated for 1999, before computing rates for a year as described in paragraph (1), the Secretary shall adjust all area-specific and national Medicare+Choice capitation rates (and beginning in 2000, the minimum amount) for the previous year for the differences between the projections of the national per capita Medicare+Choice growth percentage for that year and previous years and the current estimate of such percentage for such years.

''(7) TRANSITION TO MEDICAREADVANTAGE COMPETITION.—

''(A) IN GENERAL.—For each year (beginning with 2006) payments to MedicareAdvantage plans shall not be computed under this subsection, but instead shall be based on the payment amount determined under subsection (d).

''(B) CONTINUED CALCULATION OF CAPITATION RATES.—For each year (beginning with 2006) the Secretary shall calculate and publish the annual Medicare+Choice capitation rates under this subsection and shall use the annual Medicare+Choice capitation rate determined under subsection (c)(1) for purposes of determining the benchmark amount under subsection (a)(4).

''(d) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT.—

''(1) REVIEW OF PLAN BIDS.—The Secretary shall review each plan bid submitted under section 1854(a) for the coverage of benefits under the original medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part an are based on the assumptions described in section 1854(a)(2)(A)(iii).

''(2) DETERMINATION OF WEIGHTED SERVICE AREA BENCHMARK AMOUNTS.—The Secretary shall calculate a weighted service area benchmark amount for the benefits under the original medicare fee-for-service program option for each plan equal to the weighted average of the benchmark amounts for benefits under such original medicare fee-for-service program option for the payment areas included in the service area of the plan using the assumptions described in section 1854(a)(2)(A)(iii).

''(3) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under paragraph (1)) and the weighted service area benchmark amount (as determined under paragraph (2)) for purposes of determining—

''(A) the payment amount under paragraph (4); and

''(B) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

''(4) DETERMINATION OF PAYMENT AMOUNT FOR ORIGINAL MEDICARE FEE-FOR-SERVICE BENEFITS.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall determine the payment amount for MedicareAdvantage plans for the benefits under the original medicare fee-for-service program option as follows:

''(i) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the weighted service area benchmark amount, the amount of each monthly payment to a MedicareAdvantage organization with respect to each individual enrolled in a plan shall be the weighted service area benchmark amount.

''(ii) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the weighted service area benchmark amount, the amount of each monthly payment to a MedicareAdvantage organization with respect to each individual enrolled in a plan shall be the weighted service area benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

''(B) APPLICATION OF COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall adjust the amounts determined under subparagraph (A) using the comprehensive risk adjustment methodology applicable under subsection (a)(3).

''(6) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—If the Secretary makes a determination with respect to coverage under this title or there is a change in benefits required to be provided under this part that the Secretary projects will result in a significant increase in the costs to MedicareAdvantage organizations of providing benefits under contracts under this part (for periods after any period described in section 1852(a)(5)), the Secretary shall appropriately adjust the benchmark amounts or payment amounts (as determined by the Secretary). Such projection and adjustment shall be based on an analysis by the Secretary of the actuarial costs associated with the new benefits.

''(7) BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION DEFINED.—For purposes of this part, the term 'benefits under the original medicare fee-for-service program option' means those items and services (other than hospice care) for which benefits are available under parts A and B to individuals entitled to, or enrolled for, benefits under part A and enrolled under part B, with cost-sharing for those services as required under parts A and B or an actuarially equivalent level of cost-sharing as determined in this part.

''(e) MEDICAREADVANTAGE PAYMENT AREA DEFINED.—

''(1) IN GENERAL.—In this part, except as provided in paragraph (3), the term 'MedicareAdvantage payment area' means a county, or equivalent area specified by the Secretary.

''(2) RULE FOR ESRD BENEFICIARIES.—In the case of individuals who are determined to have end stage renal disease, the MedicareAdvantage payment area shall be a State or such other payment area as the Secretary specifies.

''(3) GEOGRAPHIC ADJUSTMENT.—

''(A) IN GENERAL.—Upon written request of the chief executive officer of a State for a contract year (beginning after 2005) made by not later than February 1 of the previous year, the Secretary shall make a geographic adjustment to a MedicareAdvantage payment area in the State otherwise determined under paragraph (1)—

''(i) to a single statewide MedicareAdvantage payment area;

''(ii) to the metropolitan based system described in subparagraph (C); or

''(iii) to consolidating into a single MedicareAdvantage payment area noncontiguous counties (or equivalent areas described in paragraph (1)) within a State.

Such adjustment shall be effective for payments for months beginning with January of the year following the year in which the request is received.

''(B) BUDGET NEUTRALITY ADJUSTMENT.—In the case of a State requesting an adjustment under this paragraph, the Secretary shall initially (and annually thereafter) adjust the payment rates otherwise established under this section for MedicareAdvantage payment areas in the State in a manner so that the aggregate of the payments under this section in the State shall not exceed the aggregate payments that would have been made under this section for MedicareAdvantage payment areas in the State in the absence of the adjustment under this paragraph.

''(C) METROPOLITAN BASED SYSTEM.—The metropolitan based system described in this subparagraph is one in which—

''(i) all the portions of each metropolitan statistical area in the State or in the case of a consolidated metropolitan statistical area,

all of the portions of each primary metropolitan statistical area within the consolidated area within the State, are treated as a single MedicareAdvantage payment area; and

''(ii) all areas in the State that do not fall within a metropolitan statistical area are treated as a single MedicareAdvantage payment area.

''(D) AREAS.—In subparagraph (C), the terms 'metropolitan statistical area', 'consolidated metropolitan statistical area', and 'primary metropolitan statistical area' mean any area designated as such by the Secretary of Commerce.

''(f) SPECIAL RULES FOR INDIVIDUALS ELECTING MSA PLANS.—

''(1) IN GENERAL.—If the amount of the MedicareAdvantage monthly MSA premium (as defined in section 1854(b)(2)(D)) for an MSA plan for a year is less than 1/12 of the annual Medicare+Choice capitation rate applied under this section for the area and year involved, the Secretary shall deposit an amount equal to 100 percent of such difference in a MedicareAdvantage MSA established (and, if applicable, designated) by the individual under paragraph (2).

''(2) ESTABLISHMENT AND DESIGNATION OF MEDICAREADVANTAGE MEDICAL SAVINGS ACCOUNT AS REQUIREMENT FOR PAYMENT OF CONTRIBUTION.—In the case of an individual who has elected coverage under an MSA plan, no payment shall be made under paragraph (1) on behalf of an individual for a month unless the individual—

''(A) has established before the beginning of the month (or by such other deadline as the Secretary may specify) a MedicareAdvantage MSA (as defined in section 138(b)(2) of the Internal Revenue Code of 1986); and

''(B) if the individual has established more than 1 such MedicareAdvantage MSA, has designated 1 of such accounts as the individual's MedicareAdvantage MSA for purposes of this part.

Under rules under this section, such an individual may change the designation of such account under subparagraph (B) for purposes of this part.

''(3) LUMP-SUM DEPOSIT OF MEDICAL SAVINGS ACCOUNT CONTRIBUTION.—In the case of an individual electing an MSA plan effective beginning with a month in a year, the amount of the contribution to the MedicareAdvantage MSA on behalf of the individual for that month and all successive months in the year shall be deposited during that first month. In the case of a termination of such an election as of a month before the end of a year, the Secretary shall provide for a procedure for the recovery of deposits attributable to the remaining months in the year.

''(g) PAYMENTS FROM TRUST FUNDS.—Except as provided in section 1858A(c) (relating to payments for qualified prescription drug coverage), the payment to a MedicareAdvantage organization under this section for individuals enrolled under this part with the organization and payments to a MedicareAdvantage MSA under subsection (e)(1) shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in such proportion as the Secretary determines reflects the relative weight that benefits under part A and under part B represents of the actuarial value of the total benefits under this title. Monthly payments otherwise payable under this section for October 2000 shall be paid on the first business day of such month. Monthly payments otherwise payable under this section for October 2001 shall be paid on the last business day of September 2001. Monthly payments otherwise payable under this section for October 2006 shall be paid on the first business day of October 2006.

''(h) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—In the case of an individual who is receiving inpatient hospital services from a subsection (d) hospital (as defined in section 1886(d)(1)(B)) as of the effective date of the individual's—

''(1) election under this part of a MedicareAdvantage plan offered by a MedicareAdvantage organization—

''(A) payment for such services until the date of the individual's discharge shall be made under this title through the MedicareAdvantage plan or the original medicare fee-for-service program option (as the case may be) elected before the election with such organization,

''(B) the elected organization shall not be financially responsible for payment for such services until the date after the date of the individual's discharge; and

''(C) the organization shall nonetheless be paid the full amount otherwise payable to the organization under this part; or

''(2) termination of election with respect to a MedicareAdvantage organization under this part—

''(A) the organization shall be financially responsible for payment for such services after such date and until the date of the individual's discharge;

''(B) payment for such services during the stay shall not be made under section 1886(d) or by any succeeding MedicareAdvantage organization; and

''(C) the terminated organization shall not receive any payment with respect to the individual under this part during the period the individual is not enrolled.

''(i) SPECIAL RULE FOR HOSPICE CARE.—

''(1) INFORMATION.—A contract under this part shall require the MedicareAdvantage organization to inform each individual enrolled under this part with a MedicareAdvantage plan offered by the organization about the availability of hospice care if—

''(A) a hospice program participating under this title is located within the organization's service area; or

''(B) it is common practice to refer patients to hospice programs outside such service area.

''(2) PAYMENT.—If an individual who is enrolled with a MedicareAdvantage organization under this part makes an election under section 1812(d)(1) to receive hospice care from a particular hospice program—

''(A) payment for the hospice care furnished to the individual shall be made to the hospice program elected by the individual by the Secretary;

''(B) payment for other services for which the individual is eligible notwithstanding the individual's election of hospice care under section 1812(d)(1), including services not related to the individual's terminal illness, shall be made by the Secretary to the MedicareAdvantage organization or the provider or supplier of the service instead of payments calculated under subsection (a); and

''(C) the Secretary shall continue to make monthly payments to the MedicareAdvantage organization in an amount equal to the value of the additional benefits required under section 1854(f)(1)(A).''.

SEC. 204. SUBMISSION OF BIDS; PREMIUMS.

Section 1854 (42 U.S.C. 1395w–24) is amended to read as follows:

''SUBMISSION OF BIDS; PREMIUMS

''SEC. 1854. (a) SUBMISSION OF BIDS BY MEDICAREADVANTAGE ORGANIZATIONS.—

''(1) IN GENERAL.—Not later than the second Monday in September and except as provided in paragraph (3), each MedicareAdvantage organization shall submit to the Secretary, in such form and manner as the Secretary may specify, for each MedicareAdvantage plan that the organization intends to offer in a service area in the following year—

''(A) notice of such intent and information on the service area of the plan;

''(B) the plan type for each plan;

''(C) if the MedicareAdvantage plan is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in paragraph (2) with respect to each payment area;

''(D) the enrollment capacity (if any) in relation to the plan and each payment area;

''(E) the expected mix, by health status, of enrolled individuals; and

''(F) such other information as the Secretary may specify.

''(2) INFORMATION REQUIRED FOR COORDINATED CARE PLANS AND PRIVATE FEE-FOR-SERVICE PLANS.—For a MedicareAdvantage plan that is a coordinated care plan (as described in section 1851(a)(2)(A)) or a private fee-for-service plan (as described in section 1851(a)(2)(C)), the information described in this paragraph is as follows:

''(A) INFORMATION REQUIRED WITH RESPECT TO BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—Information relating to the coverage of benefits under the original medicare fee-for-service program option as follows:

''(i) The plan bid, which shall consist of a dollar amount that represents the total amount that the plan is willing to accept (not taking into account the application of the comprehensive risk adjustment methodology under section 1853(a)(3)) for providing coverage of the benefits under the original medicare fee-for-service program option to an individual enrolled in the plan that resides in the service area of the plan for a month.

''(ii) For the enhanced medical benefits package offered—

''(I) the adjusted community rate (as defined in subsection (g)(3)) of the package;

''(II) the portion of the actuarial value of such benefits package (if any) that will be applied toward satisfying the requirement for additional benefits under subsection (g);

''(III) the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (as defined in subsection (b)(2)(C));

''(IV) a description of any cost-sharing;

''(V) a description of whether the amount of the unified deductible has been lowered or the maximum limitations on out-of-pocket expenses have been decreased (relative to the levels used in calculating the plan bid);

''(VI) such other information as the Secretary considers necessary.

''(iii) The assumptions that the MedicareAdvantage organization used in preparing the plan bid with respect to numbers, in each payment area, of enrolled individuals and the mix, by health status, of such individuals.

''(B) INFORMATION REQUIRED WITH RESPECT TO PART D.—The information required to be submitted by an eligible entity under section 1860D–12, including the monthly premiums for standard coverage and any other qualified prescription drug coverage available to individuals enrolled under part D.

''(C) DETERMINING PLAN COSTS INCLUDED IN PLAN BID.—For purposes of submitting its plan bid under subparagraph (A)(i) a MedicareAdvantage plan offered by a MedicareAdvantage organization satisfies subparagraphs (A) and (C) of section 1852(a)(1) if the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled

in such plan under this part with respect to benefits under the original medicare fee-for-service program option on which that bid is based (ignoring any reduction in cost-sharing offered by such plan as enhanced medical benefits under paragraph (2)(A)(ii) or required under clause (ii) or (iii) of subsection (g)(1)(C)) equals the amount specified in subsection (f)(1)(B).

''(3) REQUIREMENTS FOR MSA PLANS.—For an MSA plan described in section 1851(a)(2)(B), the information described in this paragraph is the information that such a plan would have been required to submit under this part if the Prescription Drug and Medicare Improvements Act of 2003 had not been enacted.

''(4) REVIEW.—

''(A) IN GENERAL.—Subject to subparagraph (B), the Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this subsection and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the MedicareAdvantage organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

''(B) MSA EXCEPTION.—The Secretary shall not review, approve, or disapprove the amounts submitted under paragraph (3).

''(C) CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—Under the authority under subparagraph (A), the Secretary may disapprove the bid if the Secretary determines that the deductibles, coinsurance, or copayments applicable under the plan discourage access to covered services or are likely to result in favorable selection of MedicareAdvantage eligible individuals.

''(5) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under paragraph (1) for a MedicareAdvantage plan must reasonably and equitably reflect the cost of benefits provided under that plan.

''(b) MONTHLY PREMIUMS CHARGED.—

''(1) IN GENERAL.—

''(A) COORDINATED CARE AND PRIVATE FEE-FOR-SERVICE PLANS.—The monthly amount of the premium charged to an individual enrolled in a MedicareAdvantage plan (other than an MSA plan) offered by a MedicareAdvantage organization shall be equal to the sum of the following:

''(i) The MedicareAdvantage monthly basic beneficiary premium (if any).

''(ii) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (if any).

''(iii) The MedicareAdvantage monthly obligation for qualified prescription drug coverage (if any).

''(B) MSA PLANS.—The rules under this section that would have applied with respect to an MSA plan if the Prescription Drug and Medicare Improvements Act of 2003 had not been enacted shall continue to apply to MSA plans after the date of enactment of such Act.

''(2) PREMIUM TERMINOLOGY.—For purposes of this part:

''(A) MEDICAREADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM.—The term 'MedicareAdvantage monthly basic beneficiary premium' means, with respect to a MedicareAdvantage plan, the amount required to be charged under subsection (d)(2) for the plan.

''(B) MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage' means, with respect to a MedicareAdvantage plan, the amount determined under section 1858A(d).

''(C) MEDICAREADVANTAGE MONTHLY BENEFICIARY PREMIUM FOR ENHANCED MEDICAL BENEFITS.—The term 'MedicareAdvantage monthly beneficiary premium for enhanced medical benefits' means, with respect to a MedicareAdvantage plan, the amount required to be charged under subsection (f)(2) for the plan, or, in the case of an MSA plan, the amount filed under subsection (a)(3).

''(D) MEDICAREADVANTAGE MONTHLY MSA PREMIUM.—The term 'MedicareAdvantage monthly MSA premium' means, with respect to a MedicareAdvantage plan, the amount of such premium filed under subsection (a)(3) for the plan.

''(c) UNIFORM PREMIUM.—The MedicareAdvantage monthly basic beneficiary premium, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, and the MedicareAdvantage monthly MSA premium charged under subsection (b) of a MedicareAdvantage organization under this part may not vary among individuals enrolled in the plan.

''(d) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—

''(1) BIDS BELOW THE BENCHMARK.—If the Secretary determines under section 1853(d)(3) that the weighted service area benchmark amount exceeds the plan bid, the Secretary shall require the plan to provide additional benefits in accordance with subsection (g).

''(2) BIDS ABOVE THE BENCHMARK.—If the Secretary determines under section 1853(d)(3) that the plan bid exceeds the weighted service area benchmark amount (determined under section 1853(d)(2)), the amount of such excess shall be the MedicareAdvantage monthly basic beneficiary premium (as defined in section 1854(b)(2)(A)).

''(e) TERMS AND CONDITIONS OF IMPOSING PREMIUMS.—Each MedicareAdvantage organization shall permit the payment of any MedicareAdvantage monthly basic premium, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage, and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits on a monthly basis, may terminate election of individuals for a MedicareAdvantage plan for failure to make premium payments only in accordance with section 1851(g)(3)(B)(i), and may not provide for cash or other monetary rebates as an inducement for enrollment or otherwise (other than as an additional benefit described in subsection (g)(1)(C)(i)).

''(f) LIMITATION ON ENROLLEE LIABILITY.—

''(1) FOR BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM OPTION.—The sum of—

''(A) the MedicareAdvantage monthly basic beneficiary premium (multiplied by 12) and the actuarial value of the deductibles, coinsurance, and copayments (determined on the same basis as used in determining the plan's bid under paragraph (2)(C)) applicable on average to individuals enrolled under this part with a MedicareAdvantage plan described in subparagraph (A) or (C) of section 1851(a)(2) of an organization with respect to required benefits described in section 1852(a)(1)(A); must equal

''(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals who have elected to receive benefits under the original medicare fee-for-service program option if such individuals were not members of a MedicareAdvantage organization for the year (adjusted as determined appropriate by the Secretary to account for geographic differences and for plan cost and utilization differences).

''(2) FOR ENHANCED MEDICAL BENEFITS.—If the MedicareAdvantage organization provides to its members enrolled under this part in a MedicareAdvantage plan described in subparagraph (A) or (C) of section 1851(a)(2) with respect to enhanced medical benefits relating to benefits under the original medicare fee-for-service program option, the sum of the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits (multiplied by 12) charged and the actuarial value of its deductibles, coinsurance, and copayments charged with respect to such benefits for a year must equal the adjusted community rate (as defined in subsection (g)(3)) for such benefits for the year minus the actuarial value of any additional benefits pursuant to clause (ii), (iii), or (iv) of subsection (g)(2)(C) that the plan specified under subsection (a)(2)(i)(II).

''(3) DETERMINATION ON OTHER BASIS.—If the Secretary determines that adequate data are not available to determine the actuarial value under paragraph (1)(A) or (2), the Secretary may determine such amount with respect to all individuals in the same geographic area, the State, or in the United States, eligible to enroll in the MedicareAdvantage plan involved under this part or on the basis of other appropriate data.

''(4) SPECIAL RULE FOR PRIVATE FEE-FOR-SERVICE PLANS.—With respect to a MedicareAdvantage private fee-for-service plan (other than a plan that is an MSA plan), in no event may—

''(A) the actuarial value of the deductibles, coinsurance, and copayments applicable on average to individuals enrolled under this part with such a plan of an organization with respect to required benefits described in subparagraphs (A), (C), and (D) of section 1852(a)(1); exceed

''(B) the actuarial value of the deductibles, coinsurance, and copayments that would be applicable on average to individuals entitled to (or enrolled for) benefits under part A and enrolled under part B if they were not members of a MedicareAdvantage organization for the year.

''(g) REQUIREMENT FOR ADDITIONAL BENEFITS.—

''(1) REQUIREMENT.—

''(A) IN GENERAL.—Each MedicareAdvantage organization (in relation to a MedicareAdvantage plan, other than an MSA plan, it offers) shall provide that if there is an excess amount (as defined in subparagraph (B)) for the plan for a contract year, subject to the succeeding provisions of this subsection, the organization shall provide to individuals such additional benefits described in subparagraph (C) as the organization may specify in a value which the Secretary determines is at least equal to the adjusted excess amount (as defined in subparagraph (D)).

''(B) EXCESS AMOUNT.—For purposes of this paragraph, the term 'excess amount' means, for an organization for a plan, is 100 percent of the amount (if any) by which the weighted service area benchmark amount (determined under section 1853(d)(2)) exceeds the plan bid (as adjusted under section 1853(d)(1)).

''(C) ADDITIONAL BENEFITS DESCRIBED.—The additional benefits described in this subparagraph are as follows:

''(i) Subject to subparagraph (F), a monthly part B premium reduction for individuals enrolled in the plan.

''(ii) Lowering the amount of the unified deductible and decreasing the maximum limitations on out-of-pocket expenses for individuals enrolled in the plan.

''(iii) A reduction in the actuarial value of plan cost-sharing for plan enrollees.

''(iv) Subject to subparagraph (E), such additional benefits as the organization may specify.

''(v) Contributing to the stabilization fund under paragraph (2).

''(vi) Any combination of the reductions and benefits described in clauses (i) through (v).

''(D) ADJUSTED EXCESS AMOUNT.—For purposes of this paragraph, the term 'adjusted excess amount' means, for an organization for a plan, is the excess amount reduced to reflect any amount withheld and reserved for the organization for the year under paragraph (2).

''(E) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—An organization may not specify any additional benefit that provides for the coverage of any prescription drug (other than that relating to prescription drugs covered under the original medicare fee-for-service program option).

''(F) PREMIUM REDUCTIONS.—

''(i) IN GENERAL.—Subject to clause (ii), as part of providing any additional benefits required under subparagraph (A), a MedicareAdvantage organization may elect a reduction in its payments under section 1853(a)(1)(A)(i) with respect to a MedicareAdvantage plan and the Secretary shall apply such reduction to reduce the premium under section 1839 of each enrollee in such plan as provided in section 1840(i).

''(ii) AMOUNT OF REDUCTION.—The amount of the reduction under clause (i) with respect to any enrollee in a MedicareAdvantage plan—

''(I) may not exceed 125 percent of the premium described under section 1839(a)(3); and

''(II) shall apply uniformly to each enrollee of the MedicareAdvantage plan to which such reduction applies.

''(G) UNIFORM APPLICATION.—This paragraph shall be applied uniformly for all enrollees for a plan.

''(H) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing a MedicareAdvantage organization from providing enhanced medical benefits (described in section 1852(a)(3)) that are in addition to the health care benefits otherwise required to be provided under this paragraph and from imposing a premium for such enhanced medical benefits.

''(2) STABILIZATION FUND.—A MedicareAdvantage organization may provide that a part of the value of an excess amount described in paragraph (1) be withheld and reserved in the Federal Hospital Insurance Trust Fund and in the Federal Supplementary Medical Insurance Trust Fund (in such proportions as the Secretary determines to be appropriate) by the Secretary for subsequent annual contract periods, to the extent required to prevent undue fluctuations in the additional benefits offered in those subsequent periods by the organization in accordance with such paragraph. Any of such value of the amount reserved which is not provided as additional benefits described in paragraph (1)(A) to individuals electing the MedicareAdvantage plan of the organization in accordance with such paragraph prior to the end of such periods, shall revert for the use of such Trust Funds.

''(3) ADJUSTED COMMUNITY RATE.—For purposes of this subsection, subject to paragraph (4), the term 'adjusted community rate' for a service or services means, at the election of a MedicareAdvantage organization, either—

''(A) the rate of payment for that service or services which the Secretary annually determines would apply to an individual electing a MedicareAdvantage plan under this part if the rate of payment were determined under a 'community rating system' (as defined in section 1302(8) of the Public Health Service Act, other than subparagraph (C)); or

''(B) such portion of the weighted aggregate premium, which the Secretary annually estimates would apply to such an individual, as the Secretary annually estimates is attributable to that service or services,

but adjusted for differences between the utilization characteristics of the individuals electing coverage under this part and the utilization characteristics of the other enrollees with the plan (or, if the Secretary finds that adequate data are not available to adjust for those differences, the differences between the utilization characteristics of individuals selecting other MedicareAdvantage coverage, or MedicareAdvantage eligible individuals in the area, in the State, or in the United States, eligible to elect MedicareAdvantage coverage under this part and the utilization characteristics of the rest of the population in the area, in the State, or in the United States, respectively).

''(4) DETERMINATION BASED ON INSUFFICIENT DATA.—For purposes of this subsection, if the Secretary finds that there is insufficient enrollment experience to determine the average amount of payments to be made under this part at the beginning of a contract period or to determine (in the case of a newly operated provider-sponsored organization or other new organization) the adjusted community rate for the organization, the Secretary may determine such an average based on the enrollment experience of other contracts entered into under this part and may determine such a rate using data in the general commercial marketplace.

''(h) PROHIBITION OF STATE IMPOSITION OF PREMIUM TAXES.—No State may impose a premium tax or similar tax with respect to payments to MedicareAdvantage organizations under section 1853.

''(i) PERMITTING USE OF SEGMENTS OF SERVICE AREAS.—The Secretary shall permit a MedicareAdvantage organization to elect to apply the provisions of this section uniformly to separate segments of a service area (rather than uniformly to an entire service area) as long as such segments are composed of 1 or more MedicareAdvantage payment areas.''.

(b) STUDY AND REPORT ON CLARIFICATION OF AUTHORITY REGARDING DISAPPROVAL OF UNREASONABLE BENEFICIARY COST-SHARING.—

(1) STUDY.—The Secretary, in consultation with beneficiaries, consumer groups, employers, and Medicare+Choice organizations, shall conduct a study to determine the extent to which the cost-sharing structures under Medicare+Choice plans under part C of title XVIII of the Social Security Act discourage access to covered services or discriminate based on the health status of Medicare+Choice eligible individuals (as defined in section 1851(a)(3) of the Social Security Act (42 U.S.C. 1395w–21(a)(3))).

(2) REPORT.—Not later than December 31, 2004, the Secretary shall submit a report to Congress on the study conducted under paragraph (1) together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

SEC. 205. SPECIAL RULES FOR PRESCRIPTION DRUG BENEFITS.

Part C of title XVIII (42 U.S.C. 1395w–21 et seq.) is amended by inserting after section 1857 the following new section:

''SPECIAL RULES FOR PRESCRIPTION DRUG BENEFITS

''SEC. 1858A. (a) AVAILABILITY.—

''(1) PLANS REQUIRED TO PROVIDE QUALIFIED PRESCRIPTION DRUG COVERAGE TO ENROLLEES.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), on and after January 1, 2006, a MedicareAdvantage organization offering a MedicareAdvantage plan (except for an MSA plan) shall make available qualified prescription drug coverage that meets the requirements for such coverage under this part and part D to each enrollee of the plan.

''(B) PRIVATE FEE-FOR-SERVICE PLANS MAY, BUT ARE NOT REQUIRED TO, PROVIDE QUALIFIED PRESCRIPTION DRUG COVERAGE.—Pursuant to section 1852(a)(2)(D), a private fee-for-service plan may elect not to provide qualified prescription drug coverage under part D to individuals residing in the area served by the plan.

''(2) REFERENCE TO PROVISION PERMITTING ADDITIONAL PRESCRIPTION DRUG COVERAGE.—For the provisions of part D, made applicable to this part pursuant to paragraph (1), that permit a plan to make available qualified prescription drug coverage that includes coverage of covered drugs that exceeds the coverage required under paragraph (1) of section 1860D–6 in an area, but only if the MedicareAdvantage organization offering the plan also offers a MedicareAdvantage plan in the area that only provides the coverage that is required under such paragraph (1), see paragraph (2) of such section.

''(3) RULE FOR APPROVAL OF MEDICAL AND PRESCRIPTION DRUG BENEFITS.—Pursuant to sections 1854(g)(1)(F) and 1852(a)(3)(D), a MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage may not make available coverage of any prescription drugs (other than that relating to prescription drugs covered under the original medicare fee-for-service program option) to an enrollee as an additional benefit or as an enhanced medical benefit.

''(b) COMPLIANCE WITH ADDITIONAL BENEFICIARY PROTECTIONS.—With respect to the offering of qualified prescription drug coverage by a MedicareAdvantage organization under a MedicareAdvantage plan, the organization and plan shall meet the requirements of section 1860D–5, including requirements relating to information dissemination and grievance and appeals, and such other requirements under part D that the Secretary determines appropriate in the same manner as such requirements apply to an eligible entity and a Medicare Prescription Drug plan under part D. The Secretary shall waive such requirements to the extent the Secretary determines that such requirements duplicate requirements otherwise applicable to the organization or the plan under this part.

''(c) PAYMENTS FOR PRESCRIPTION DRUGS.—

''(1) PAYMENT OF FULL AMOUNT OF PREMIUM TO ORGANIZATIONS FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—

''(A) IN GENERAL.—For each year (beginning with 2006), the Secretary shall pay to each MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage, an amount equal to the full amount of the monthly premium submitted under section 1854(a)(2)(B) for the year, as adjusted using the risk adjusters that apply to the standard prescription drug coverage published under section 1860D–11.

''(B) APPLICATION OF PART D RISK CORRIDOR, STABILIZATION RESERVE FUND, AND ADMINISTRATIVE EXPENSES PROVISIONS.—The provisions of subsections (b), (c), and (d) of section 1860D–16 shall apply to a MedicareAdvantage organization offering a MedicareAdvantage plan that provides qualified prescription drug coverage and payments made to such organization under subparagraph (A) in the same manner as such provisions apply to an eligible entity offering a Medicare Prescription Drug plan and payments made to such entity under subsection (a) of section 1860D–16.

''(2) PAYMENT FROM PRESCRIPTION DRUG ACCOUNT.—Payment made to MedicareAdvantage organizations under this subsection shall be made from the Prescription Drug Account in the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''(d) COMPUTATION OF MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—In the case of a MedicareAdvantage eligible individual receiving qualified prescription drug coverage under a MedicareAdvantage plan during a year after 2005, the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage of such individual in the year shall be determined in the same manner as the monthly beneficiary obligation is determined under section 1860D–17 for eligible beneficiaries enrolled in a Medicare Prescription Drug plan, except that, for purposes of this subparagraph, any reference to the monthly plan premium approved by the Secretary under section 1860D–13 shall be treated as a reference to the monthly premium for qualified prescription drug coverage submitted by the MedicareAdvantage organization offering the plan under section 1854(a)(2)(A) and approved by the Secretary.

''(e) COLLECTION OF MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE.—The provisions of section 1860D–18, including subsection (b) of such section, shall apply to the amount of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage (as determined under subsection (d)) required to be paid by a MedicareAdvantage eligible individual enrolled in a MedicareAdvantage plan in the same manner as such provisions apply to the amount of the monthly beneficiary obligation required to be paid by an eligible beneficiary enrolled in a Medicare Prescription Drug plan under part D.

''(f) AVAILABILITY OF PREMIUM SUBSIDY AND COST-SHARING REDUCTIONS FOR LOW-INCOME ENROLLEES AND REINSURANCE PAYMENTS.—For provisions—

''(1) providing premium subsidies and cost-sharing reductions for low-income individuals receiving qualified prescription drug coverage through a MedicareAdvantage plan, see section 1860D–19; and

''(2) providing a MedicareAdvantage organization with reinsurance payments for certain expenses incurred in providing qualified prescription drug coverage through a MedicareAdvantage plan, see section 1860D–20.''.

(b) TREATMENT OF REDUCTION FOR PURPOSES OF DETERMINING GOVERNMENT CONTRIBUTION UNDER PART B.—Section 1844(c) (42 U.S.C. 1395w) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(d)(1)(A)(i)''.

SEC. 206. FACILITATING EMPLOYER PARTICIPATION.

Section 1858(h) (as added by section 211) is amended by inserting ''(including subsection (i) of such section)'' after ''section 1857''.

SEC. 207. ADMINISTRATION BY THE CENTER FOR MEDICARE CHOICES.

On and after January 1, 2006, the MedicareAdvantage program under part C of title XVIII of the Social Security Act shall be administered by the Center for Medicare Choices established under section 1808 such title (as added by section 301), and each reference to the Secretary made in such part shall be deemed to be a reference to the Administrator of the Center for Medicare Choices.

SEC. 208. CONFORMING AMENDMENTS.

(a) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR MEDICAREADVANTAGE ORGANIZATIONS; PROVIDER-SPONSORED ORGANIZATIONS.—Section 1855 (42 U.S.C. 1395w–25) is amended—

(1) in subsection (b), in the matter preceding paragraph (1), by inserting ''subparagraphs (A), (B), and (D) of'' before ''section 1852(A)(1)''; and

(2) by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

(b) ESTABLISHMENT OF PSO STANDARDS.—Section 1856 (42 U.S.C. 1395w–26) is amended by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

(c) CONTRACTS WITH MEDICAREADVANTAGE ORGANIZATIONS.—Section 1857 (42 U.S.C. 1395w–27) is amended—

(1) in subsection (g)(1)—

(A) in subparagraph (B), by striking ''amount of the Medicare+Choice monthly basic and supplemental beneficiary premiums'' and inserting ''amounts of the MedicareAdvantage monthly basic premium and MedicareAdvantage monthly beneficiary premium for enhanced medical benefits'';

(B) in subparagraph (F), by striking ''or'' after the semicolon at the end;

(C) in subparagraph (G), by adding ''or'' after the semicolon at the end; and

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

''(H)(i) charges any individual an amount in excess of the MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage under section 1858A(d);

''(ii) provides coverage for prescription drugs that is not qualified prescription drug coverage;

''(iii) offers prescription drug coverage, but does not make standard prescription drug coverage available; or

''(iv) provides coverage for prescription drugs (other than that relating to prescription drugs covered under the original medicare fee-for-service program option described in section 1851(a)(1)(A)(i)) as an enhanced medical benefit under section 1852(a)(3)(D) or as an additional benefit under section 1854(g)(1)(F),''; and

(2) by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

(d) DEFINITIONS; MISCELLANEOUS PROVISIONS.—Section 1859 (42 U.S.C. 1395w–28) is amended—

(1) by striking subsection (c) and inserting the following new subsection:

''(c) OTHER REFERENCES TO OTHER TERMS.—

''(1) ENHANCED MEDICAL BENEFITS.—The term 'enhanced medical benefits' is defined in section 1852(a)(3)(E).

''(2) MEDICAREADVANTAGE ELIGIBLE INDIVIDUAL.—The term 'MedicareAdvantage eligible individual' is defined in section 1851(a)(3).

''(3) MEDICAREADVANTAGE PAYMENT AREA.—The term 'MedicareAdvantage payment area' is defined in section 1853(d).

''(4) NATIONAL PER CAPITA MEDICARE+CHOICE GROWTH PERCENTAGE.—The 'national per capita Medicare+Choice growth percentage' is defined in section 1853(c)(6).

''(5) MEDICAREADVANTAGE MONTHLY BASIC BENEFICIARY PREMIUM; MEDICAREADVANTAGE MONTHLY BENEFICIARY OBLIGATION FOR QUALIFIED PRESCRIPTION DRUG COVERAGE; MEDICAREADVANTAGE MONTHLY BENEFICIARY PREMIUM FOR ENHANCED MEDICAL BENEFITS.—The terms 'MedicareAdvantage monthly basic beneficiary premium', 'MedicareAdvantage monthly beneficiary obligation for qualified prescription drug coverage', and 'MedicareAdvantage monthly beneficiary premium for enhanced medical benefits' are defined in section 1854(b)(2).

''(6) QUALIFIED PRESCRIPTION DRUG COVERAGE.—The term 'qualified prescription drug coverage' has the meaning given such term in section 1860D(9).

''(7) STANDARD PRESCRIPTION DRUG COVERAGE.—The term 'standard prescription drug coverage' has the meaning given such term in section 1860D(10).''; and

(2) by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

(e) CONFORMING AMENDMENTS EFFECTIVE BEFORE 2006.—

(1) EXTENSION OF MSAS.—Section 1851(b)(4) (42 U.S.C. 1395w–21(b)(4)) is amended by striking ''January 1, 2003'' and inserting ''January 1, 2004''.

(2) CONTINUOUS OPEN ENROLLMENT AND DISENROLLMENT THROUGH 2005.—Section 1851(e) of the Social Security Act (42 U.S.C. 1395w–21(e)) is amended—

(A) in paragraph (2)(A), by striking ''THROUGH 2004'' and ''December 31,2004'' and inserting ''THROUGH 2005'' and ''December 31, 2005'', respectively;

(B) in the heading of paragraph (2)(B), by striking ''DURING 2005'' and inserting ''DURING 2006'';

(C) in paragraphs (2)(B)(i) and (2)(C)(i), by striking ''2005'' and inserting ''2006'' each place it appears;

(D) in paragraph (2)(D), by striking ''2004'' and inserting ''2005''; and

(E) in paragraph (4), by striking ''2005'' and inserting ''2006'' each place it appears.

(3) EFFECTIVE DATE.—The amendments made by this subsection shall take effect on the date of enactment of this Act.

(e) OTHER CONFORMING AMENDMENTS.—

(1) CONFORMING MEDICARE CROSS-REFERENCES.—

(A) Section 1839(a)(2) (42 U.S.C. 1395r(a)(2)) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(g)(1)(C)(i)''.

(B) Section 1840(i) (42 U.S.C. 1395s(i)) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(g)(1)(C)(i)''.

(C) Section 1844(c) (42 U.S.C. 1395w(c)) is amended by striking ''section 1854(f)(1)(E)'' and inserting ''section 1854(g)(1)(C)(i)''.

(D) Section 1876(k)(3)(A) (42 U.S.C. 1395mm(k)(3)(A)) is amended by inserting ''(as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003)'' after section 1853(a).

(F) Section 1876(k)(4) (42 U.S.C. 1395mm(k)(4)(A)) is amended—

(i) in subparagraph (A), by striking ''section 1853(a)(3)(B)'' and inserting ''section 1853(a)(3)(D)''; and

(ii) in subparagraph (B), by striking ''section 1854(g)'' and inserting ''section 1854(h)''.

(G) Section 1876(k)(4)(C) (42 U.S.C. 1395mm(k)(4)(C)) in amended by inserting ''(as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003)'' after ''section 1851(e)(6)''.

(H) Section 1894(d) (42 U.S.C. 1395eee(d)) is amended by adding at the end the following new paragraph:

''(3) APPLICATION OF PROVISIONS.—For purposes of paragraphs (1) and (2), the references to section 1853 and subsection (a)(2) of such section in such paragraphs shall be deemed to be references to those provisions as in effect immediately before the enactment of the Prescription Drug and Medicare Improvements Act of 2003.''.

(2) CONFORMING MEDICARE TERMINOLOGY.—Title XVIII (42 U.S.C. 1395 et seq.), except for part C of such title (42 U.S.C. 1395w–21 et seq.), and title XIX (42 U.S.C. 1396 et seq.) are each amended by striking ''Medicare+Choice'' and inserting ''MedicareAdvantage'' each place it appears.

SEC. 209. EFFECTIVE DATE.

(a) IN GENERAL.—Except as provided in section 208(d)(3) and subsection (b), the amendments made by this title shall apply with respect to plan years beginning on and after January 1, 2006.

(b) MEDICAREADVANTAGE MSA PLANS.—Notwithstanding any provision of this title, the Secretary shall apply the payment and other rules that apply with respect to an MSA plan described in section 1851(a)(2)(B) of the Social Security Act (42 U.S.C. 1395w–21(a)(2)(B)) as if this title had not been enacted.

Subtitle B—Preferred Provider Organizations

SEC. 211. ESTABLISHMENT OF MEDICARE ADVANTAGE PREFERRED PROVIDER PROGRAM OPTION.

(a) ESTABLISHMENT OF PREFERRED PROVIDER PROGRAM OPTION.—Section 1851(a)(2) is amended by adding at the end the following new subparagraph:

''(D) PREFERRED PROVIDER ORGANIZATION PLANS.—A MedicareAdvantage preferred provider organization plan under the program established under section 1858.''.

(b) PROGRAM SPECIFICATIONS.—Part C of title XVIII (42 U.S.C. 1395w–21 et seq.) is amended by inserting after section 1857 the following new section:

''PREFERRED PROVIDER ORGANIZATIONS

''SEC. 1858. (a) ESTABLISHMENT OF PROGRAM.—

''(1) IN GENERAL.—Beginning on January 1, 2006, there is established a preferred provider program under which preferred provider organization plans offered by preferred provider organizations are offered to MedicareAdvantage eligible individuals in preferred provider regions.

''(2) DEFINITIONS.—

''(A) PREFERRED PROVIDER ORGANIZATION.—The term 'preferred provider organization' means an entity with a contract under section 1857 that meets the requirements of this section applicable with respect to preferred provider organizations.

''(B) PREFERRED PROVIDER ORGANIZATION PLAN.—The term 'preferred provider organization plan' means a MedicareAdvantage plan that—

''(i) has a network of providers that have agreed to a contractually specified reimbursement for covered benefits with the organization offering the plan;

''(ii) provides for reimbursement for all covered benefits regardless of whether such benefits are provided within such network of providers; and

''(iii) is offered by a preferred provider organization.

''(C) PREFERRED PROVIDER REGION.—The term 'preferred provider region' means—

''(i) a region established under paragraph (3); and

''(ii) a region that consists of the entire United States.

''(3) PREFERRED PROVIDER REGIONS.—For purposes of this part the Secretary shall establish preferred provider regions as follows:

''(A) There shall be at least 10 regions.

''(B) Each region must include at least 1 State.

''(C) The Secretary may not divide States so that portions of the State are in different regions.

''(D) To the extent possible, the Secretary shall include multistate metropolitan statistical areas in a single region. The Secretary may divide metropolitan statistical areas where it is necessary to establish regions of such size and geography as to maximize the participation of preferred provider organization plans.

''(E) The Secretary may conform the preferred provider regions to the service areas established under section 1860D–10.

''(b) ELIGIBILITY, ELECTION, AND ENROLLMENT; BENEFITS AND BENEFICIARY PROTECTIONS.—

''(1) IN GENERAL.—Except as provided in the succeeding provisions of this subsection, the provisions of sections 1851 and 1852 that apply with respect to coordinated care plans shall apply to preferred provider organization plans offered by a preferred provider organization.

''(2) SERVICE AREA.—The service area of a preferred provider organization plan shall be a preferred provider region.

''(3) AVAILABILITY.—Each preferred provider organization plan must be offered to each MedicareAdvantage eligible individual who resides in the service area of the plan.

''(4) AUTHORITY TO PROHIBIT RISK SELECTION.—The provisions of section 1852(a)(6) shall apply to preferred provider organization plans.

''(5) ASSURING ACCESS TO SERVICES IN PREFERRED PROVIDER ORGANIZATION PLANS.—

''(A) IN GENERAL.—In addition to any other requirements under this section, in the case of a preferred provider organization plan, the organization offering the plan must demonstrate to the Secretary that the organization has sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan.

''(B) DETERMINATION OF SUFFICIENT ACCESS.—The Secretary shall find that an organization has met the requirement under subparagraph (A) with respect to any category of health care professional or provider if, with respect to that category of provider the plan has contracts or agreements with a sufficient number and range of providers within such category to provide covered services under the terms of the plan.

''(C) CONSTRUCTION.—Subparagraph (B) shall not be construed as restricting the persons from whom enrollees under such a plan may obtain covered benefits.

''(c) PAYMENTS TO PREFERRED PROVIDER ORGANIZATIONS.—

''(1) PAYMENTS TO ORGANIZATIONS.—

''(A) MONTHLY PAYMENTS.—

''(i) IN GENERAL.—Under a contract under section 1857 and subject to paragraph (5), subsection (e), and section 1859(e)(4), the Secretary shall make, to each preferred provider organization, with respect to coverage of an individual for a month under this part in a preferred provider region, separate monthly payments with respect to—

''(I) benefits under the original medicare fee-for-service program under parts A and B in accordance with paragraph (4); and

''(II) benefits under the voluntary prescription drug program under part D in accordance with section 1858A and the other provisions of this part.

''(ii) SPECIAL RULE FOR END-STAGE RENAL DISEASE.—The Secretary shall establish separate rates of payment applicable with respect to classes of individuals determined to have end-stage renal disease and enrolled in a preferred provider organization plan under this clause that are similar to the separate rates of payment described in section 1853(a)(1)(B).

''(B) ADJUSTMENT TO REFLECT NUMBER OF ENROLLEES.—The Secretary may retroactively adjust the amount of payment under this paragraph in a manner that is similar to the manner in which payment amounts may be retroactively adjusted under section 1853(a)(2).

''(C) COMPREHENSIVE RISK ADJUSTMENT METHODOLOGY.—The Secretary shall apply the comprehensive risk adjustment methodology described in section 1853(a)(3)(B) to 100 percent of the amount of payments to plans under paragraph (4)(D)(ii).

''(D) ADJUSTMENT FOR SPENDING VARIATIONS WITHIN A REGION.—The Secretary shall establish a methodology for adjusting the amount of payments to plans under paragraph (4)(D)(ii) that achieves the same objective as the adjustment described in paragraph 1853(a)(2)(C).

''(2) ANNUAL CALCULATION OF BENCHMARK AMOUNTS FOR PREFERRED PROVIDER REGIONS.—For each year (beginning in 2006), the Secretary shall calculate a benchmark amount for each preferred provider region for each month for such year with respect to coverage of the benefits available under the original medicare fee-for-service program option equal to the average of each benchmark amount calculated under section 1853(a)(4) for each MedicareAdvantage payment area for the year within such region, weighted by the number of MedicareAdvantage eligible individuals residing in each such payment area for the year.

''(3) ANNUAL ANNOUNCEMENT OF PAYMENT FACTORS.—

''(A) ANNUAL ANNOUNCEMENT.—Beginning in 2005, at the same time as the Secretary publishes the risk adjusters under section 1860D–11, the Secretary shall annually announce (in a manner intended to provide notice to interested parties) the following payment factors:

''(i) The benchmark amount for each preferred provider region (as calculated under paragraph (2)(A)) for the year.

''(ii) The factors to be used for adjusting payments described under—

''(I) the comprehensive risk adjustment methodology described in paragraph (1)(C) with respect to each preferred provider region for the year; and

''(II) the methodology used for adjustment for geographic variations within such region established under paragraph (1)(D).

''(B) ADVANCE NOTICE OF METHODOLOGICAL CHANGES.—At least 45 days before making the announcement under subparagraph (A) for a year, the Secretary shall—

''(i) provide for notice to preferred provider organizations of proposed changes to be made in the methodology from the methodology and assumptions used in the previous announcement; and

''(ii) provide such organizations with an opportunity to comment on such proposed changes.

''(C) EXPLANATION OF ASSUMPTIONS.—In each announcement made under subparagraph (A), the Secretary shall include an explanation of the assumptions and changes in methodology used in the announcement in sufficient detail so that preferred provider organizations can compute each payment factor described in such subparagraph.

''(4) SECRETARY'S DETERMINATION OF PAYMENT AMOUNT FOR BENEFITS UNDER THE ORIGINAL MEDICARE FEE-FOR-SERVICE PROGRAM.—The Secretary shall determine the payment amount for plans as follows:

''(A) REVIEW OF PLAN BIDS.—The Secretary shall review each plan bid submitted under subsection (d)(1) for the coverage of benefits under the original medicare fee-for-service program option to ensure that such bids are consistent with the requirements under this part and are based on the assumptions described in section 1854(a)(2)(A)(iii) that the plan used with respect to numbers of enrolled individuals.

''(B) DETERMINATION OF PREFERRED PROVIDER REGIONAL BENCHMARK AMOUNTS.—The Secretary shall calculate a preferred provider regional benchmark amount for that plan for the benefits under the original medicare fee-for-service program option for each plan equal to the regional benchmark adjusted by using the assumptions described in section 1854(a)(2)(A)(iii) that the plan used

with respect to numbers of enrolled individuals.

''(C) COMPARISON TO BENCHMARK.—The Secretary shall determine the difference between each plan bid (as adjusted under subparagraph (A)) and the preferred provider regional benchmark amount (as determined under subparagraph (B)) for purposes of determining—

''(i) the payment amount under subparagraph (D); and

''(ii) the additional benefits required and MedicareAdvantage monthly basic beneficiary premiums.

''(D) DETERMINATION OF PAYMENT AMOUNT.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary shall determine the payment amount to a preferred provider organization for a preferred provider organization plan as follows:

''(I) BIDS THAT EQUAL OR EXCEED THE BENCHMARK.—In the case of a plan bid that equals or exceeds the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount.

''(II) BIDS BELOW THE BENCHMARK.—In the case of a plan bid that is less than the preferred provider regional benchmark amount, the amount of each monthly payment to the organization with respect to each individual enrolled in a plan shall be the preferred provider regional benchmark amount reduced by the amount of any premium reduction elected by the plan under section 1854(d)(1)(A)(i).

''(ii) APPLICATION OF ADJUSTMENT METHODOLOGIES.—The Secretary shall adjust the amounts determined under subparagraph (A) using the factors described in paragraph (3)(A)(ii).

''(E) FACTORS USED IN ADJUSTING BIDS AND BENCHMARKS FOR PREFERRED PROVIDER ORGANIZATIONS AND IN DETERMINING ENROLLEE PREMIUMS.—Subject to subparagraph (F), in addition to the factors used to adjust payments to plans described in section 1853(d)(6), the Secretary shall use the adjustment for geographic variation within the region established under paragraph (1)(D).

''(F) ADJUSTMENT FOR NATIONAL COVERAGE DETERMINATIONS AND LEGISLATIVE CHANGES IN BENEFITS.—The Secretary shall provide for adjustments for national coverage determinations and legislative changes in benefits applicable with respect to preferred provider organizations in the same manner as the Secretary provides for adjustments under section 1853(d)(7).

''(5) PAYMENTS FROM TRUST FUND.—The payment to a preferred provider organization under this section shall be made from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund in a manner similar to the manner described in section 1853(g).

''(6) SPECIAL RULE FOR CERTAIN INPATIENT HOSPITAL STAYS.—Rules similar to the rules applicable under section 1853(h) shall apply with respect preferred provider organizations.

''(7) SPECIAL RULE FOR HOSPICE CARE.—Rules similar to the rules applicable under section 1853(i) shall apply with respect to preferred provider organizations.

''(d) SUBMISSION OF BIDS BY PPOS; PREMIUMS.—

''(1) SUBMISSION OF BIDS BY PREFERRED PROVIDER ORGANIZATIONS.—

''(A) IN GENERAL.—For the requirements on submissions by MedicareAdvantage preferred provider organization plans, see section 1854(a)(1).

''(B) UNIFORM PREMIUMS.—Each bid amount submitted under subparagraph (A) for a preferred provider organization plan in a preferred provider region may not vary among MedicareAdvantage eligible individuals residing in such preferred provider region.

''(C) APPLICATION OF FEHBP STANDARD; PROHIBITION ON PRICE GOUGING.—Each bid amount submitted under subparagraph (A) for a preferred provider organization plan must reasonably and equitably reflect the cost of benefits provided under that plan.

''(D) REVIEW.—The Secretary shall review the adjusted community rates (as defined in section 1854(g)(3)), the amounts of the MedicareAdvantage monthly basic premium and the MedicareAdvantage monthly beneficiary premium for enhanced medical benefits filed under this paragraph and shall approve or disapprove such rates and amounts so submitted. The Secretary shall review the actuarial assumptions and data used by the preferred provider organization with respect to such rates and amounts so submitted to determine the appropriateness of such assumptions and data.

''(E) AUTHORITY TO LIMIT NUMBER OF PLANS IN A REGION.—If there are bids for more than 3 preferred provider organization plans in a preferred provider region, the Secretary shall accept only the 3 lowest-cost credible bids for that region that meet or exceed the quality and minimum standards applicable under this section.

''(2) MONTHLY PREMIUMS CHARGED.—The amount of the monthly premium charged to an individual enrolled in a preferred provider organization plan offered by a preferred provider organization shall be equal to the sum of the following:

''(A) The MedicareAdvantage monthly basic beneficiary premium, as defined in section 1854(b)(2)(A) (if any).

''(B) The MedicareAdvantage monthly beneficiary premium for enhanced medical benefits, as defined in section 1854(b)(2)(C) (if any).

''(C) The MedicareAdvantage monthly obligation for qualified prescription drug coverage, as defined in section 1854(b)(2)(B) (if any).

''(3) DETERMINATION OF PREMIUM REDUCTIONS, REDUCED COST-SHARING, ADDITIONAL BENEFITS, AND BENEFICIARY PREMIUMS.—The rules for determining premium reductions, reduced cost-sharing, additional benefits, and beneficiary premiums under section 1854(d) shall apply with respect to preferred provider organizations.

''(4) PROHIBITION OF SEGMENTING PREFERRED PROVIDER REGIONS.—The Secretary may not permit a preferred provider organization to elect to apply the provisions of this section uniformly to separate segments of a preferred provider region (rather than uniformly to an entire preferred provider region).

''(e) PORTION OF TOTAL PAYMENTS TO AN ORGANIZATION SUBJECT TO RISK FOR 2 YEARS.—

''(1) NOTIFICATION OF SPENDING UNDER THE PLAN.—

''(A) IN GENERAL.—For 2007 and 2008, the preferred provider organization offering a preferred provider organization plan shall notify the Secretary of the total amount of costs that the organization incurred in providing benefits covered under parts A and B of the original medicare fee-for-service program for all enrollees under the plan in the previous year.

''(B) CERTAIN EXPENSES NOT INCLUDED.—The total amount of costs specified in subparagraph (A) may not include—

''(i) subject to subparagraph (C), administrative expenses incurred in providing the benefits described in such subparagraph; or

''(ii) amounts expended on providing enhanced medical benefits under section 1852(a)(3)(D).

''(C) ESTABLISHMENT OF ALLOWABLE ADMINISTRATIVE EXPENSES.—For purposes of applying subparagraph (B)(i), the administrative expenses incurred in providing benefits described in subparagraph (A) under a preferred provider organization plan may not exceed an amount determined appropriate by the Administrator.

''(2) ADJUSTMENT OF PAYMENT.—

''(A) NO ADJUSTMENT IF COSTS WITHIN RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are not more than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) and are not less than the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)) for the plan for the year, then no additional payments shall be made by the Secretary and no reduced payments shall be made to the preferred provider organization offering the plan.

''(B) INCREASE IN PAYMENT IF COSTS ABOVE UPPER LIMIT OF RISK CORRIDOR.—

''(i) IN GENERAL.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are more than the first threshold upper limit of the risk corridor for the plan for the year, then the Secretary shall increase the total of the monthly payments made to the preferred provider organization offering the plan for the year under subsection (c)(1)(A) by an amount equal to the sum of—

''(I) 50 percent of the amount of such total costs which are more than such first threshold upper limit of the risk corridor and not more than the second threshold upper limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(iv)); and

''(II) 90 percent of the amount of such total costs which are more than such second threshold upper limit of the risk corridor.

''(C) REDUCTION IN PAYMENT IF COSTS BELOW LOWER LIMIT OF RISK CORRIDOR.—If the total amount of costs specified in paragraph (1)(A) for the plan for the year are less than the first threshold lower limit of the risk corridor for the plan for the year, then the Secretary shall reduce the total of the monthly payments made to the preferred provider organization offering the plan for the year under subsection (c)(1)(A) by an amount (or otherwise recover from the plan an amount) equal to—

''(i) 50 percent of the amount of such total costs which are less than such first threshold lower limit of the risk corridor and not less than the second threshold lower limit of the risk corridor for the plan for the year (as specified under paragraph (3)(A)(ii)); and

''(ii) 90 percent of the amount of such total costs which are less than such second threshold lower limit of the risk corridor.

''(3) ESTABLISHMENT OF RISK CORRIDORS.—

''(A) IN GENERAL.—For 2006 and 2007, the Secretary shall establish a risk corridor for each preferred provider organization plan. The risk corridor for a plan for a year shall be equal to a range as follows:

''(i) FIRST THRESHOLD LOWER LIMIT.—The first threshold lower limit of such corridor shall be equal to—

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to 5 percent of such target amount.

''(ii) SECOND THRESHOLD LOWER LIMIT.—The second threshold lower limit of such corridor shall be equal to—

''(I) the target amount described in subparagraph (B) for the plan; minus

''(II) an amount equal to 10 percent of such target amount.

''(iii) FIRST THRESHOLD UPPER LIMIT.—The first threshold upper limit of such corridor shall be equal to the sum of—

''(I) such target amount; and

''(II) the amount described in clause (i)(II).

''(iv) SECOND THRESHOLD UPPER LIMIT.—The second threshold upper limit of such corridor shall be equal to the sum of—

''(I) such target amount; and

''(II) the amount described in clause (ii)(II).

''(B) TARGET AMOUNT DESCRIBED.—The target amount described in this paragraph is, with respect to a preferred provider organization plan offered by a preferred provider organization in a year, an amount equal to the sum of—

''(i) the total monthly payments made to the organization for enrollees in the plan for the year under subsection (c)(1)(A); and

''(ii) the total MedicareAdvantage basic beneficiary premiums collected for such enrollees for the year under subsection (d)(2)(A).

''(4) PLANS AT RISK FOR ENTIRE AMOUNT OF ENHANCED MEDICAL BENEFITS.—A preferred provider organization that offers a preferred provider organization plan that provides enhanced medial benefits under section 1852(a)(3)(D) shall be at full financial risk for the provision of such benefits.

''(5) NO EFFECT ON ELIGIBLE BENEFICIARIES.—No change in payments made by reason of this subsection shall affect the amount of the MedicareAdvantage basic beneficiary premium that a beneficiary is otherwise required to pay under the plan for the year under subsection (d)(2)(A).

''(6) DISCLOSURE OF INFORMATION.—The provisions of section 1860D–16(b)(7), including subparagraph (B) of such section, shall apply to a preferred provider organization and a preferred provider organization plan in the same manner as such provisions apply to an eligible entity and a Medicare Prescription Drug plan under part D.

''(f) ORGANIZATIONAL AND FINANCIAL REQUIREMENTS FOR PREFERRED PROVIDER ORGANIZATIONS.—A preferred provider organization shall be organized and licensed under State law as a risk-bearing entity eligible to offer health insurance or health benefits coverage in each State within the preferred provider region in which it offers a preferred provider organization plan.

''(g) INAPPLICABILITY OF PROVIDER-SPONSORED ORGANIZATION SOLVENCY STANDARDS.—The requirements of section 1856 shall not apply with respect to preferred provider organizations.

''(h) CONTRACTS WITH PREFERRED PROVIDER ORGANIZATIONS.—The provisions of section 1857 shall apply to a preferred provider organization plan offered by a preferred provider organization under this section.''.

(c) PREFERRED PROVIDER TERMINOLOGY DEFINED.—Section 1859(a) is amended by adding at the end the following new paragraph:

''(3) PREFERRED PROVIDER ORGANIZATION; PREFERRED PROVIDER ORGANIZATION PLAN; PREFERRED PROVIDER REGION.—The terms 'preferred provider organization', 'preferred provider organization plan', and 'preferred provider region' have the meaning given such terms in section 1858(a)(2).''.

Subtitle C—Other Managed Care Reforms

SEC. 221. EXTENSION OF REASONABLE COST CONTRACTS.

(a) FIVE-YEAR EXTENSION.—Section 1876(h)(5)(C) (42 U.S.C. 1395mm(h)(5)(C)) is amended by striking ''2004'' and inserting ''2009''.

(b) APPLICATION OF CERTAIN MEDICARE+CHOICE REQUIREMENTS TO COST CONTRACTS EXTENDED OR RENEWED AFTER 2003.—Section 1876(h) (42 U.S.C. 1395mm(h)(5)), as amended by subsection (a), is amended—

(1) by redesignating paragraph (5) as paragraph (6); and

(2) by inserting after paragraph (4) the following new paragraph:

''(5) Any reasonable cost reimbursement contract with an eligible organization under this subsection that is extended or renewed on or after the date of enactment of the Prescription Drug and Medicare Improvements Act of 2003 for plan years beginning on or after January 1, 2004, shall provide that the following provisions of the Medicare+Choice program under part C (and, on and after January 1, 2006, the provisions of the MedicareAdvantage program under such part) shall apply to such organization and such contract in a substantially similar manner as such provisions apply to Medicare+Choice organizations and Medicare+Choice plans (or, on and after January 1, 2006, MedicareAdvantage organizations and MedicareAdvantage plans, respectively) under such part:

''(A) Paragraph (1) of section 1852(e) (relating to the requirement of having an ongoing quality assurance program) and paragraph (2)(B) of such section (relating to the required elements for such a program).

''(B) Section 1852(j)(4) (relating to limitations on physician incentive plans).

''(C) Section 1854(c) (relating to the requirement of uniform premiums among individuals enrolled in the plan).

''(D) Section 1854(g), or, on and after January 1, 2006, section 1854(h) (relating to restrictions on imposition of premium taxes with respect to payments to organizations).

''(E) Section 1856(b) (regarding compliance with the standards established by regulation pursuant to such section, including the provisions of paragraph (3) of such section relating to relation to State laws).

''(F) Section 1852(a)(3)(A) (regarding the authority of organizations to include supplemental health care benefits and, on and after January 1, 2006, enhanced medical benefits under the plan subject to the approval of the Secretary).

''(G) The provisions of part C relating to timelines for benefit filings, contract renewal, and beneficiary notification.

''(H) Section 1854(e), or, on and after January 1, 2006, section 1854(f) (relating to proposed cost-sharing under the contract being subject to review by the Secretary).''.

(c) PERMITTING DEDICATED GROUP PRACTICE HEALTH MAINTENANCE ORGANIZATIONS TO PARTICIPATE IN THE MEDICARE COST CONTRACT PROGRAM.—Section 1876(h)(6) of the Social Security Act (42 U.S.C. 1395mm(h)(6)), as redesignated and amended by subsections (a) and (b), is amended—

(1) in subparagraph (A), by striking ''After the date of the enactment'' and inserting ''Except as provided in subparagraph (C), after the date of the enactment'';

(2) in subparagraph (B), by striking ''subparagraph (C)'' and inserting ''subparagraph (D)'';

(3) by redesignating subparagraph (C) as subparagraph (D); and

(4) by inserting after subparagraph (B), the following new subparagraph:

''(C) Subject to paragraph (5) and subparagraph (D), the Secretary shall approve an application to enter into a reasonable cost contract under this section if—

''(i) the application is submitted to the Secretary by a health maintenance organization (as defined in section 1301(a) of the Public Health Service Act) that, as of January 1, 2004, and except as provided in section 1301(b)(3)(B) of such Act, provides at least 85 percent of the services of a physician which are provided as basic health services through a medical group (or groups), as defined in section 1302(4) of such Act; and

''(ii) the Secretary determines that the organization meets the requirements applicable to such organizations and contracts under this section.''.

SEC. 222. SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.

(a) TREATMENT AS COORDINATED CARE PLAN.—Section 1851(a)(2)(A) (42 U.S.C. 1395w–21(a)(2)(A)) is amended by adding at the end the following new sentence: ''Specialized Medicare+Choice plans for special needs beneficiaries (as defined in section 1859(b)(4)) may be any type of coordinated care plan.''.

(b) SPECIALIZED MEDICARE+CHOICE PLAN FOR SPECIAL NEEDS BENEFICIARIES DEFINED.—Section 1859(b) (42 U.S.C. 1395w–28(b)) is amended by adding at the end the following new paragraph:

''(4) SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—

''(A) IN GENERAL.—The term 'specialized Medicare+Choice plan for special needs beneficiaries' means a Medicare+Choice plan that exclusively serves special needs beneficiaries (as defined in subparagraph (B)).

''(B) SPECIAL NEEDS BENEFICIARY.—The term 'special needs beneficiary' means a Medicare+Choice eligible individual who—

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

''(ii) is entitled to medical assistance under a State plan under title XIX; or

''(iii) meets such requirements as the Secretary may determine would benefit from enrollment in such a specialized Medicare+Choice plan described in subparagraph (A) for individuals with severe or disabling chronic conditions.''.

(c) RESTRICTION ON ENROLLMENT PERMITTED.—Section 1859 (42 U.S.C. 1395w–28) is amended by adding at the end the following new subsection:

''(f) RESTRICTION ON ENROLLMENT FOR SPECIALIZED MEDICARE+CHOICE PLANS FOR SPECIAL NEEDS BENEFICIARIES.—In the case of a specialized Medicare+Choice plan (as defined in subsection (b)(4)), notwithstanding any other provision of this part and in accordance with regulations of the Secretary and for periods before January 1, 2008, the plan may restrict the enrollment of individuals under the plan to individuals who are within 1 or more classes of special needs beneficiaries.''.

(d) REPORT TO CONGRESS.—Not later than December 31, 2006, the Secretary shall submit to Congress a report that assesses the impact of specialized Medicare+Choice plans for special needs beneficiaries on the cost and quality of services provided to enrollees. Such report shall include an assessment of the costs and savings to the medicare program as a result of amendments made by subsections (a), (b), and (c).

(e) EFFECTIVE DATES.—

(1) IN GENERAL.—The amendments made by subsections (a), (b), and (c) shall take effect on the date of enactment of this Act.

(2) DEADLINE FOR ISSUANCE OF REQUIREMENTS FOR SPECIAL NEEDS BENEFICIARIES; TRANSITION.—No later than 1 year after the date of enactment of this Act, the Secretary shall issue final regulations to establish requirements for special needs beneficiaries under section 1859(b)(4)(B)(iii) of the Social Security Act, as added by subsection (b).

SEC. 223. PAYMENT BY PACE PROVIDERS FOR MEDICARE AND MEDICAID SERVICES FURNISHED BY NONCONTRACT PROVIDERS.

(a) MEDICARE SERVICES.—

(1) MEDICARE SERVICES FURNISHED BY PROVIDERS OF SERVICES.—Section 1866(a)(1)(O) (42 U.S.C. 1395cc(a)(1)(O)) is amended—

(A) by striking ''part C or'' and inserting ''part C, with a PACE provider under section 1894 or 1934, or'';

(B) by striking ''(i)'';

(C) by striking ''and (ii)''; and

(D) by striking ''members of the organization'' and inserting ''members of the organization or PACE program eligible individuals enrolled with the PACE provider,''.

(2) MEDICARE SERVICES FURNISHED BY PHYSICIANS AND OTHER ENTITIES.—Section 1894(b) (42 U.S.C. 1395eee(b)) is amended by adding at the end the following new paragraphs:

''(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

''(A) APPLICATION OF MEDICARE+CHOICE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against Medicare+Choice organizations for noncontract physicians and other entities with respect to services covered under this title) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract establishing payment amounts for services furnished to such an individual in the same manner as such section applies to Medicare+Choice organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

''(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under this title furnished by noncontract providers of services, see section 1866(a)(1)(O).

''(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER TITLE XIX BUT NOT UNDER THIS TITLE.—For provisions relating to limitations on payments to providers participating under the State plan under title XIX that do not have a contract with a PACE provider establishing payment amounts for services covered under such plan (but not under this title) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).''.

(b) MEDICAID SERVICES.—

(1) REQUIREMENT UNDER STATE PLAN.—Section 1902(a) (42 U.S.C. 1396a(a)) is amended—

(A) in paragraph (64), by striking ''and'' at the end;

(B) in paragraph (65), by striking the period at the end and inserting ''; and''; and

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

''(66) provide, with respect to services covered under the State plan (but not under title XVIII) that are furnished to a PACE program eligible individual enrolled with a PACE provider by a provider participating under the State plan that does not have a contract with the PACE provider that establishes payment amounts for such services, that such participating provider may not require the PACE provider to pay the participating provider an amount greater than the amount that would otherwise be payable for the service to the participating provider under the State plan for the State where the PACE provider is located (in accordance with regulations issued by the Secretary).''.

(2) REFERENCE IN MEDICAID STATUTE.—Section 1934(b) (42 U.S.C. 1396u–4(b)) is amended by adding at the end the following new paragraphs:

''(3) TREATMENT OF MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—

''(A) APPLICATION OF MEDICARE+CHOICE REQUIREMENT WITH RESPECT TO MEDICARE SERVICES FURNISHED BY NONCONTRACT PHYSICIANS AND OTHER ENTITIES.—Section 1852(k)(1) (relating to limitations on balance billing against Medicare+Choice organizations for noncontract physicians and other entities with respect to services covered under title XVIII) shall apply to PACE providers, PACE program eligible individuals enrolled with such PACE providers, and physicians and other entities that do not have a contract establishing payment amounts for services furnished to such an individual in the same manner as such section applies to Medicare+Choice organizations, individuals enrolled with such organizations, and physicians and other entities referred to in such section.

''(B) REFERENCE TO RELATED PROVISION FOR NONCONTRACT PROVIDERS OF SERVICES.—For the provision relating to limitations on balance billing against PACE providers for services covered under title XVIII furnished by noncontract providers of services, see section 1866(a)(1)(O).

''(4) REFERENCE TO RELATED PROVISION FOR SERVICES COVERED UNDER THIS TITLE BUT NOT UNDER TITLE XVIII.—For provisions relating to limitations on payments to providers participating under the State plan under this title that do not have a contract with a PACE provider establishing payment amounts for services covered under such plan (but not under title XVIII) when such services are furnished to enrollees of that PACE provider, see section 1902(a)(66).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2004.

SEC. 224. INSTITUTE OF MEDICINE EVALUATION AND REPORT ON HEALTH CARE PERFORMANCE MEASURES.

(a) EVALUATION.—

(1) IN GENERAL.—Not later than the date that is 2 months after the date of enactment of this Act, the Secretary of Health and Human Services shall enter into an arrangement under which the Institute of Medicine of the National Academy of Sciences (in this section referred to as the ''Institute'') shall conduct an evaluation of leading health care performance measures and options to implement policies that align performance with payment under the medicare program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(2) SPECIFIC MATTERS EVALUATED.—In conducting the evaluation under paragraph (1), the Institute shall—

(A) catalogue, review, and evaluate the validity of leading health care performance measures;

(B) catalogue and evaluate the success and utility of alternative performance incentive programs in public or private sector settings; and

(C) identify and prioritize options to implement policies that align performance with payment under the medicare program that indicate—

(i) the performance measurement set to be used and how that measurement set will be updated;

(ii) the payment policy that will reward performance; and

(iii) the key implementation issues (such as data and information technology requirements) that must be addressed.

(3) SCOPE OF HEALTH CARE PERFORMANCE MEASURES.—The health care performance measures described in paragraph (2)(A) shall encompass a variety of perspectives, including physicians, hospitals, health plans, purchasers, and consumers.

(4) CONSULTATION WITH MEDPAC.—In evaluating the matters described in paragraph (2)(C), the Institute shall consult with the Medicare Payment Advisory Commission established under section 1805 of the Social Security Act (42 U.S.C. 1395b–6).

(b) REPORT.—Not later than the date that is 18 months after the date of enactment of this Act, the Institute shall submit to the Secretary of Health and Human Services, the Committees on Ways and Means and Energy and Commerce of the House of Representatives, and the Committee on Finance of the Senate a report on the evaluation conducted under subsection (a)(1) describing the findings of such evaluation and recommendations for an overall strategy and approach for aligning payment with performance in the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act, the Medicare+Choice program under part C of such title, and any other programs under such title XVIII.

(c) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated $1,000,000 for purposes of conducting the evaluation and preparing the report required by this section.

SEC. 225. EXPANDING THE WORK OF MEDICARE QUALITY IMPROVEMENT ORGANIZATIONS TO INCLUDE PARTS C AND D.

(a) APPLICATION TO MEDICARE MANAGED CARE AND PRESCRIPTION DRUG COVERAGE.—Section 1154(a)(1) (42 U.S.C. 1320c–3(a)(1)) is amended by inserting '', Medicare+Choice organizations and MedicareAdvantage organizations under part C, and prescription drug card sponsors and eligible entities under part D'' after ''under section 1876''.

(b) PRESCRIPTION DRUG THERAPY QUALITY IMPROVEMENT.—Section 1154(a) (42 U.S.C. 1320c–3(a)) is amended by adding at the end the following new paragraph:

''(17) The organization shall execute its responsibilities under subparagraphs (A) and (B) of paragraph (1) by offering to providers, practitioners, prescription drug card sponsors and eligible entities under part D, and Medicare+Choice and MedicareAdvantage plans under part C quality improvement assistance pertaining to prescription drug therapy. For purposes of this part and title XVIII, the functions described in this paragraph shall be treated as a review function.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply on and after January 1, 2004.

TITLE III—CENTER FOR MEDICARE CHOICES

SEC. 301. ESTABLISHMENT OF THE CENTER FOR MEDICARE CHOICES.

(a) IN GENERAL.—Title XVIII (42 U.S.C. 1395 et seq.), as amended by section 111, is amended by inserting after 1806 the following new section:

''ESTABLISHMENT OF THE CENTER FOR MEDICARE CHOICES

''SEC. 1808. (a) ESTABLISHMENT.—By not later than March 1, 2004, the Secretary shall establish within the Department of Health and Human Services the Center for Medicare Choices, which shall be separate from the Centers for Medicare & Medicaid Services.

''(b) ADMINISTRATOR AND DEPUTY ADMINISTRATOR.—

''(1) ADMINISTRATOR.—

''(A) IN GENERAL.—The Center for Medicare Choices shall be headed by an Administrator (in this section referred to as the 'Administrator') who shall be appointed by the President, by and with the advice and consent of the Senate. The Administrator shall report directly to the Secretary.

''(B) COMPENSATION.—The Administrator shall be paid at the rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of an Administrator's term of office, that Administrator may continue in office until the entry upon office of such a successor. An Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) GENERAL AUTHORITY.—The Administrator shall be responsible for the exercise of all powers and the discharge of all duties of the Center for Medicare Choices, and shall have authority and control over all personnel and activities thereof.

''(E) RULEMAKING AUTHORITY.—The Administrator may prescribe such rules and regulations as the Administrator determines necessary or appropriate to carry out the functions of the Center for Medicare Choices. The regulations prescribed by the Administrator shall be subject to the rulemaking procedures established under section 553 of title 5, United States Code.

''(F) AUTHORITY TO ESTABLISH ORGANIZATIONAL UNITS.—The Administrator may establish, alter, consolidate, or discontinue such organizational units or components within the Center for Medicare Choices as the Administrator considers necessary or appropriate, except that this subparagraph shall not apply with respect to any unit, component, or provision provided for by this section.

''(G) AUTHORITY TO DELEGATE.—The Administrator may assign duties, and delegate, or authorize successive redelegations of, authority to act and to render decisions, to such officers and employees of the Center for Medicare Choices as the Administrator may find necessary. Within the limitations of such delegations, redelegations, or assignments, all official acts and decisions of such officers and employees shall have the same force and effect as though performed or rendered by the Administrator.

''(2) DEPUTY ADMINISTRATOR.—

''(A) IN GENERAL.—There shall be a Deputy Administrator of the Center for Medicare Choices who shall be appointed by the Administrator.

''(B) COMPENSATION.—The Deputy Administrator shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(C) TERM OF OFFICE.—The Deputy Administrator shall be appointed for a term of 5 years. In any case in which a successor does not take office at the end of a Deputy Administrator's term of office, such Deputy Administrator may continue in office until the entry upon office of such a successor. A Deputy Administrator appointed to a term of office after the commencement of such term may serve under such appointment only for the remainder of such term.

''(D) DUTIES.—The Deputy Administrator shall perform such duties and exercise such powers as the Administrator shall from time to time assign or delegate. The Deputy Administrator shall be the Acting Administrator of the Center for Medicare Choices during the absence or disability of the Administrator and, unless the President designates another officer of the Government as Acting Administrator, in the event of a vacancy in the office of the Administrator.

''(3) SECRETARIAL COORDINATION OF PROGRAM ADMINISTRATION.—The Secretary shall ensure appropriate coordination between the Administrator and the Administrator of the Centers for Medicare & Medicaid Services in carrying out the programs under this title.

''(c) DUTIES; ADMINISTRATIVE PROVISIONS.—

''(1) DUTIES.—

''(A) GENERAL DUTIES.—The Administrator shall carry out parts C and D, including—

''(i) negotiating, entering into, and enforcing, contracts with plans for the offering of MedicareAdvantage plans under part C, including the offering of qualified prescription drug coverage under such plans; and

''(ii) negotiating, entering into, and enforcing, contracts with eligible entities for the offering of Medicare Prescription Drug plans under part D.

''(B) OTHER DUTIES.—The Administrator shall carry out any duty provided for under part C or D, including duties relating to—

''(i) reasonable cost contracts with eligible organizations under section 1876(h); and

''(ii) demonstration projects carried out in part or in whole under such parts, including the demonstration project carried out through a MedicareAdvantage (formerly Medicare+Choice) project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of an interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

''(C) NONINTERFERENCE.—In order to promote competition under parts C and D, the Administrator, in carrying out the duties required under this section, may not, to the extent possible, interfere in any way with negotiations between eligible entities, MedicareAdvantage organizations, hospitals, physicians, other entities or individuals furnishing items and services under this title (including contractors for such items and services), and drug manufacturers, wholesalers, or other suppliers of covered drugs

''(D) ANNUAL REPORTS.—Not later than March 31 of each year, the Administrator shall submit to Congress and the President a report on the administration of the voluntary prescription drug delivery program under this part during the previous fiscal year.

''(2) MANAGEMENT STAFF.—

''(A) IN GENERAL.—The Administrator, with the approval of the Secretary, may employ, such management staff as determined appropriate. Any such manager shall be required to have demonstrated, by their education and experience (either in the public or private sector), superior expertise in the following areas:

''(i) The review, negotiation, and administration of health care contracts.

''(ii) The design of health care benefit plans.

''(iii) Actuarial sciences.

''(iv) Compliance with health plan contracts.

''(v) Consumer education and decision making.

''(B) COMPENSATION.—

''(i) IN GENERAL.—Subject to clause (ii), the Administrator shall establish the rate of pay for an individual employed under subparagraph (A).

''(ii) MAXIMUM RATE.—In no case may the rate of compensation determined under clause (i) exceed the highest rate of basic pay for the Senior Executive Service under section 5382(b) of title 5, United States Code.

''(3) REDELEGATION OF CERTAIN FUNCTIONS OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

''(A) IN GENERAL.—The Secretary, the Administrator of the Center for Medicare Choices, and the Administrator of the Centers for Medicare & Medicaid Services shall establish an appropriate transition of responsibility in order to redelegate the administration of part C from the Secretary and the Administrator of the Centers for Medicare & Medicaid Services to the Administrator of the Center for Medicare Choices as is appropriate to carry out the purposes of this section.

''(B) TRANSFER OF DATA AND INFORMATION.—The Secretary shall ensure that the Administrator of the Centers for Medicare & Medicaid Services transfers to the Administrator such information and data in the possession of the Administrator of the Centers for Medicare & Medicaid Services as the Administrator requires to carry out the duties described in paragraph (1).

''(C) CONSTRUCTION.—Insofar as a responsibility of the Secretary or the Administrator of the Centers for Medicare & Medicaid Services is redelegated to the Administrator under this section, any reference to the Secretary or the Administrator of the Centers for Medicare & Medicaid Services in this title or title XI with respect to such responsibility is deemed to be a reference to the Administrator.

''(d) OFFICE OF BENEFICIARY ASSISTANCE.—

''(1) ESTABLISHMENT.—The Secretary shall establish within the Center for Medicare Choices an Office of Beneficiary Assistance to carry out functions relating to medicare beneficiaries under this title, including making determinations of eligibility of individuals for benefits under this title, providing for enrollment of medicare beneficiaries under this title, and the functions described in paragraph (2). The Office shall be a separate operating division within the Center for Medicare Choices.

''(2) DISSEMINATION OF INFORMATION ON BENEFITS AND APPEALS RIGHTS.—

''(A) DISSEMINATION OF BENEFITS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries, by mail, by posting on the Internet site of the Center for Medicare Choices, and through the toll-free telephone number provided for under section 1804(b), information with respect to the following:

''(i) Benefits, and limitations on payment (including cost-sharing, stop-loss provisions, and formulary restrictions) under parts C and D.

''(ii) Benefits, and limitations on payment under parts A, and B, including information on medicare supplemental policies under section 1882.

''(iii) Other areas determined to be appropriate by the Administrator.

Such information shall be presented in a manner so that medicare beneficiaries may compare benefits under parts A, B, and D, and medicare supplemental policies with benefits under MedicareAdvantage plans under part C.

''(B) DISSEMINATION OF APPEALS RIGHTS INFORMATION.—The Office of Beneficiary Assistance shall disseminate to medicare beneficiaries in the manner provided under subparagraph (A) a description of procedural rights (including grievance and appeals procedures) of beneficiaries under the original medicare fee-for-service program under parts A and B, the MedicareAdvantage program under part C, and the voluntary prescription drug delivery program under part D.

''(3) MEDICARE OMBUDSMAN.—

''(A) IN GENERAL.—Within the Office of Beneficiary Assistance, there shall be a Medicare Ombudsman, appointed by the Secretary from among individuals with expertise and experience in the fields of health care and advocacy, to carry out the duties described in subparagraph (B).

''(B) DUTIES.—The Medicare Ombudsman shall—

''(i) receive complaints, grievances, and requests for information submitted by a medicare beneficiary, with respect to any aspect of the medicare program;

''(ii) provide assistance with respect to complaints, grievances, and requests referred to in clause (i), including—

''(I) assistance in collecting relevant information for such beneficiaries, to seek an appeal of a decision or determination made by a fiscal intermediary, carrier, MedicareAdvantage organization, an eligible entity under part D, or the Secretary; and

''(II) assistance to such beneficiaries with any problems arising from disenrollment from a MedicareAdvantage plan under part C or a prescription drug plan under part D; and

''(iii) submit annual reports to Congress, the Secretary, and the Medicare Competitive Policy Advisory Board describing the activities of the Office, and including such recommendations for improvement in the administration of this title as the Ombudsman determines appropriate.

''(C) COORDINATION WITH STATE OMBUDSMAN PROGRAMS AND CONSUMER ORGANIZATIONS.—The Medicare Ombudsman shall, to the extent appropriate, coordinate with State medical Ombudsman programs, and with State- and community-based consumer organizations, to—

''(i) provide information about the medicare program; and

''(ii) conduct outreach to educate medicare beneficiaries with respect to manners in which problems under the medicare program may be resolved or avoided.

''(e) MEDICARE COMPETITIVE POLICY ADVISORY BOARD.—

''(1) ESTABLISHMENT.—There is established within the Center for Medicare Choices the Medicare Competitive Policy Advisory Board (in this section referred to as the 'Board'). The Board shall advise, consult with, and make recommendations to the Administrator with respect to the administration of parts C and D, including the review of payment policies under such parts.

''(2) REPORTS.—

''(A) IN GENERAL.—With respect to matters of the administration of parts C and D, the Board shall submit to Congress and to the Administrator such reports as the Board determines appropriate. Each such report may contain such recommendations as the Board determines appropriate for legislative or administrative changes to improve the administration of such parts, including the stability and solvency of the programs under such parts and the topics described in subparagraph (B). Each such report shall be published in the Federal Register.

''(B) TOPICS DESCRIBED.—Reports required under subparagraph (A) may include the following topics:

''(i) FOSTERING COMPETITION.—Recommendations or proposals to increase competition under parts C and D for services furnished to medicare beneficiaries.

''(ii) EDUCATION AND ENROLLMENT.—Recommendations for the improvement of efforts to provide medicare beneficiaries information and education on the program under this title, and specifically parts C and D, and the program for enrollment under the title.

''(iii) QUALITY.—Recommendations on ways to improve the quality of benefits provided under plans under parts C and D.

''(iv) DISEASE MANAGEMENT PROGRAMS.—Recommendations on the incorporation of disease management programs under parts C and D.

''(v) RURAL ACCESS.—Recommendations to improve competition and access to plans under parts C and D in rural areas.

''(C) MAINTAINING INDEPENDENCE OF BOARD.—The Board shall directly submit to Congress reports required under subparagraph (A). No officer or agency of the United States may require the Board to submit to any officer or agency of the United States for approval, comments, or review, prior to the submission to Congress of such reports.

''(3) DUTY OF ADMINISTRATOR.—With respect to any report submitted by the Board under paragraph (2)(A), not later than 90 days after the report is submitted, the Administrator shall submit to Congress and the President an analysis of recommendations made by the Board in such report. Each such analysis shall be published in the Federal Register.

''(4) MEMBERSHIP.—

''(A) APPOINTMENT.—Subject to the succeeding provisions of this paragraph, the Board shall consist of 7 members to be appointed as follows:

''(i) Three members shall be appointed by the President.

''(ii) Two members shall be appointed by the Speaker of the House of Representatives, with the advice of the chairman and the ranking minority member of the Committees on Ways and Means and on Energy and Commerce of the House of Representatives.

''(iii) Two members shall be appointed by the President pro tempore of the Senate with the advice of the chairman and the ranking minority member of the Committee on Finance of the Senate.

''(B) QUALIFICATIONS.—The members shall be chosen on the basis of their integrity, impartiality, and good judgment, and shall be individuals who are, by reason of their education and experience in health care benefits management, exceptionally qualified to perform the duties of members of the Board.

''(C) PROHIBITION ON INCLUSION OF FEDERAL EMPLOYEES.—No officer or employee of the United States may serve as a member of the Board.

''(5) COMPENSATION.—Members of the Board shall receive, for each day (including travel time) they are engaged in the performance of the functions of the Board, compensation at rates not to exceed the daily equivalent to the annual rate in effect for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

''(6) TERMS OF OFFICE.—

''(A) IN GENERAL.—The term of office of members of the Board shall be 3 years.

''(B) TERMS OF INITIAL APPOINTEES.—As designated by the President at the time of appointment, of the members first appointed—

''(i) one shall be appointed for a term of 1 year;

''(ii) three shall be appointed for terms of 2 years; and

''(iii) three shall be appointed for terms of 3 years.

''(C) REAPPOINTMENTS.—Any person appointed as a member of the Board may not serve for more than 8 years.

''(D) VACANCY.—Any member appointed to fill a vacancy occurring before the expiration of the term for which the member's predecessor was appointed shall be appointed only for the remainder of that term. A member may serve after the expiration of that member's term until a successor has taken office. A vacancy in the Board shall be filled in the manner in which the original appointment was made.

''(7) CHAIR.—The Chair of the Board shall be elected by the members. The term of office of the Chair shall be 3 years.

''(8) MEETINGS.—The Board shall meet at the call of the Chair, but in no event less than 3 times during each fiscal year.

''(9) DIRECTOR AND STAFF.—

''(A) APPOINTMENT OF DIRECTOR.—The Board shall have a Director who shall be appointed by the Chair.

''(B) IN GENERAL.—With the approval of the Board, the Director may appoint such additional personnel as the Director considers appropriate.

''(C) ASSISTANCE FROM THE ADMINISTRATOR.—The Administrator shall make available to the Board such information and other assistance as it may require to carry out its functions.

''(10) CONTRACT AUTHORITY.—The Board may contract with and compensate government and private agencies or persons to carry out its duties under this subsection, without regard to section 3709 of the Revised Statutes (41 U.S.C. 5).

''(f) FUNDING.—There is authorized to be appropriated, in appropriate part from the Federal Hospital Insurance Trust Fund and from the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account), such sums as are necessary to carry out this section.''.

(b) USE OF CENTRAL, TOLL-FREE NUMBER (1–800–MEDICARE).—Section 1804(b) (42 U.S.C. 1395b–2(b)) is amended by adding at the end the following: ''By not later than 1 year after the date of the enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall provide, through the toll-free number 1–800–MEDICARE, for a means by which individuals seeking information about, or assistance with, such programs who phone such toll-free number are transferred (without charge) to appropriate entities for the provision of such information or assistance. Such toll-free number shall be the toll-free number listed for general information and assistance in the annual notice under subsection (a) instead of the listing of numbers of individual contractors.''.

SEC. 302. MISCELLANEOUS ADMINISTRATIVE PROVISIONS.

(a) ADMINISTRATOR AS MEMBER AND CO-SECRETARY OF THE BOARD OF TRUSTEES OF THE MEDICARE TRUST FUNDS.—The fifth sentence of sections 1817(b) and 1841(b) (42 U.S.C. 1395i(b), 1395t(b)) are each amended by striking ''shall serve as the Secretary'' and inserting ''and the Administrator of the Center for Medicare Choices shall serve as the Co-Secretaries''.

(b) INCREASE IN GRADE TO EXECUTIVE LEVEL III FOR THE ADMINISTRATOR OF THE CENTERS FOR MEDICARE & MEDICAID SERVICES.—

(1) IN GENERAL.—Section 5314 of title 5, United States Code, is amended by adding at the end the following:

''Administrator of the Centers for Medicare & Medicaid Services.''.

(2) CONFORMING AMENDMENT.—Section 5315 of such title is amended by striking ''Administrator of the Health Care Financing Administration.''.

(3) EFFECTIVE DATE.—The amendments made by this subsection take effect on March 1, 2004.

TITLE IV—MEDICARE FEE-FOR-SERVICE IMPROVEMENTS

Subtitle A—Provisions Relating to Part A

SEC. 401. EQUALIZING URBAN AND RURAL STANDARDIZED PAYMENT AMOUNTS UNDER THE MEDICARE INPATIENT HOSPITAL PROSPECTIVE PAYMENT SYSTEM.

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

(1) by striking ''(iv) For discharges'' and inserting ''(iv)(I) Subject to the succeeding provisions of this clause, for discharges''; and

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

''(II) For discharges occurring during the last 3 quarters of fiscal year 2004, the operating standardized amount for hospitals located other than in a large urban area shall be increased by ½ of the difference between the operating standardized amount determined under subclause (I) for hospitals located in large urban areas for such fiscal year and such amount determined (without regard to this subclause) for other hospitals for such fiscal year.

''(III) For discharges occurring in a fiscal year beginning with fiscal year 2005, the Secretary shall compute an operating standardized amount for hospitals located in any area within the United States and within each region equal to the operating standardized amount computed for the previous fiscal year under this subparagraph for hospitals located in a large urban area (or, beginning with fiscal year 2006, applicable for all hospitals in the previous fiscal year) increased by the applicable percentage increase under

subsection (b)(3)(B)(i) for the fiscal year involved.''.

(b) CONFORMING AMENDMENTS.—

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

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

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

(C) in clause (i)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2005,'' before ''for hospitals''; and

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

(D) in clause (ii)—

(i) in the matter preceding subclause (I), by inserting ''for fiscal years before fiscal year 2005,'' before ''for hospitals''; and

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

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

''(iii) for a fiscal year beginning after fiscal year 2004, for hospitals located in all areas, to the product of—

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

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

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

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

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

SEC. 402. ADJUSTMENT TO THE MEDICARE INPATIENT HOSPITAL PPS WAGE INDEX TO REVISE THE LABOR-RELATED SHARE OF SUCH INDEX.

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

(1) by striking ''WAGE LEVELS.—The Secretary'' and inserting ''WAGE LEVELS.—

''(i) IN GENERAL.—Except as provided in clause (ii), the Secretary''; and

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

''(ii) ALTERNATIVE PROPORTION TO BE ADJUSTED BEGINNING IN FISCAL YEAR 2005.—

''(I) IN GENERAL.—Except as provided in subclause (II), for discharges occurring on or after October 1, 2004, the Secretary shall substitute '62 percent' for the proportion described in the first sentence of clause (i).

''(II) HOLD HARMLESS FOR CERTAIN HOSPITALS.—If the application of subclause (I) would result in lower payments to a hospital than would otherwise be made, then this subparagraph shall be applied as if this clause had not been enacted.''.

(b) WAIVING BUDGET NEUTRALITY.—Section 1886(d)(3)(E) (42 U.S.C. 1395ww(d)(3)(E)), as amended by subsection (a), is amended by adding at the end of clause (i) the following new sentence: ''The Secretary shall apply the previous sentence for any period as if the amendments made by section 402(a) of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.''.

SEC. 403. MEDICARE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.

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

''(12) PAYMENT ADJUSTMENT FOR LOW-VOLUME HOSPITALS.—

''(A) PAYMENT ADJUSTMENT.—

''(i) IN GENERAL.—Notwithstanding any other provision of this section, for each cost reporting period (beginning with the cost reporting period that begins in fiscal year 2005), the Secretary shall provide for an additional payment amount to each low-volume hospital (as defined in clause (iii)) for discharges occurring during that cost reporting period which is equal to the applicable percentage increase (determined under clause (ii)) in the amount paid to such hospital under this section for such discharges.

''(ii) APPLICABLE PERCENTAGE INCREASE.—The Secretary shall determine a percentage increase applicable under this paragraph that ensures that—

''(I) no percentage increase in payments under this paragraph exceeds 25 percent of the amount of payment that would (but for this paragraph) otherwise be made to a low-volume hospital under this section for each discharge;

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

''(III) the percentage increase in payments to any low-volume hospital due to the application of this paragraph is reduced as the number of discharges per cost reporting period increases.

''(iii) LOW-VOLUME HOSPITAL DEFINED.—For purposes of this paragraph, the term 'low-volume hospital' means, for a cost reporting period, a subsection (d) hospital (as defined in paragraph (1)(B)) other than a critical access hospital (as defined in section 1861(mm)(1)) that—

''(I) the Secretary determines had an average of less than 2,000 discharges (determined with respect to all patients and not just individuals receiving benefits under this title) during the 3 most recent cost reporting periods for which data are available that precede the cost reporting period to which this paragraph applies; and

''(II) is located at least 15 miles from a like hospital (or is deemed by the Secretary to be so located by reason of such factors as the Secretary determines appropriate, including the time required for an individual to travel to the nearest alternative source of appropriate inpatient care (after taking into account the location of such alternative source of inpatient care and any weather or travel conditions that may affect such travel time).

''(B) PROHIBITING CERTAIN REDUCTIONS.—Notwithstanding subsection (e), the Secretary shall not reduce the payment amounts under this section to offset the increase in payments resulting from the application of subparagraph (A).''.

SEC. 404. FAIRNESS IN THE MEDICARE DISPROPORTIONATE SHARE HOSPITAL (DSH) ADJUSTMENT FOR RURAL HOSPITALS.

(a) EQUALIZING DSH PAYMENT AMOUNTS.—

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

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

(A) in clause (iv)—

(i) in subclause (II)—

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

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

(ii) in subclause (III)—

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

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

(iii) in subclause (IV)—

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

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

(iv) in subclause (V)—

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

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

(v) in subclause (VI)—

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

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

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

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

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

SEC. 405. CRITICAL ACCESS HOSPITAL (CAH) IMPROVEMENTS.

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

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

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

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

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

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

(1) ELIMINATION.—

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

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

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

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

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

(A) in the heading—

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

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

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

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

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to costs incurred for services provided on or after January 1, 2005.

(d) AUTHORIZATION OF PERIODIC INTERIM PAYMENT (PIP).—

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

(A) in subparagraph (C), by striking ''and'' after the semicolon at the end;

(B) in subparagraph (D), by adding ''and'' after the semicolon at the end; and

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

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

(2) EFFECTIVE DATE.—The amendments made by paragraph (1) shall apply to payments for inpatient critical access facility services furnished on or after January 1, 2005.

(e) EXCLUSION OF NEW CAHS FROM PPS HOSPITAL WAGE INDEX CALCULATION.—Section 1886(d)(3)(E)(i) (42 U.S.C. 1395ww(d)(3)(E)(i)), as amended by section 402, is amended by inserting after the first sentence the following new sentence: ''In calculating the hospital wage levels under the preceding sentence applicable with respect to cost reporting periods beginning on or after January 1, 2004, the Secretary shall exclude the wage levels of any facility that became a critical access hospital prior to the cost reporting period for which such hospital wage levels are calculated.''.

(f) PROVISIONS RELATED TO CERTAIN RURAL GRANTS.—

(1) SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM.—Section 1820(g) (42 U.S.C. 1395i–4(g)) is amended—

(A) by redesignating paragraph (3)(F) as paragraph (5) and redesignating and indenting appropriately; and

(B) by inserting after paragraph (3) the following new paragraph:

''(4) SMALL RURAL HOSPITAL IMPROVEMENT PROGRAM.—

''(A) GRANTS TO HOSPITALS.—The Secretary may award grants to hospitals that have submitted applications in accordance with subparagraph (B) to assist eligible small rural hospitals (as defined in paragraph (3)(B)) in meeting the costs of reducing medical errors, increasing patient safety, protecting patient privacy, and improving hospital quality and performance.

''(B) APPLICATION.—A hospital seeking a grant under this paragraph shall submit an application to the Secretary on or before such date and in such form and manner as the Secretary specifies.

''(C) AMOUNT OF GRANT.—A grant to a hospital under this paragraph may not exceed $50,000.

''(D) USE OF FUNDS.—A hospital receiving a grant under this paragraph may use the funds for the purchase of computer software and hardware, the education and training of hospital staff, and obtaining technical assistance.''.

(2) AUTHORIZATION FOR APPROPRIATIONS.—Section 1820(j) (42 U.S.C. 1395i–4(j)) is amended to read as follows:

''(j) AUTHORIZATION OF APPROPRIATIONS.—

''(1) HI TRUST FUND.—There are authorized to be appropriated from the Federal Hospital Insurance Trust Fund for making grants to all States under—

''(A) subsection (g), $25,000,000 in each of the fiscal years 1998 through 2002; and

''(B) paragraphs (1) and (2) of subsection (g), $40,000,000 in each of the fiscal years 2004 through 2008.

''(2) GENERAL REVENUES.—There are authorized to be appropriated from amounts in the Treasury not otherwise appropriated for making grants to all States under subsection (g)(4), $25,000,000 in each of the fiscal years 2004 through 2008.''.

(3) REQUIREMENT THAT STATES AWARDED GRANTS CONSULT WITH THE STATE HOSPITAL ASSOCIATION AND RURAL HOSPITALS ON THE MOST APPROPRIATE WAYS TO USE SUCH GRANTS.—

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

''(6) REQUIRED CONSULTATION FOR STATES AWARDED GRANTS.—A State awarded a grant under paragraph (1) or (2) shall consult with the hospital association of such State and rural hospitals located in such State on the most appropriate ways to use the funds under such grant.''.

(B) EFFECTIVE DATE AND APPLICATION.—The amendment made by subparagraph (A) shall take effect on the date of enactment of this Act and shall apply to grants awarded on or after such date and to grants awarded prior to such date to the extent that funds under such grants have not been obligated as of such date.

SEC. 406. AUTHORIZING USE OF ARRANGEMENTS TO PROVIDE CORE HOSPICE SERVICES IN CERTAIN CIRCUMSTANCES.

(a) IN GENERAL.—Section 1861(dd)(5) (42 U.S.C. 1395x(dd)(5)) is amended by adding at the end the following:

''(D) In extraordinary, exigent, or other non-routine circumstances, such as unanticipated periods of high patient loads, staffing shortages due to illness or other events, or temporary travel of a patient outside a hospice program's service area, a hospice program may enter into arrangements with another hospice program for the provision by that other program of services described in paragraph (2)(A)(ii)(I). The provisions of paragraph (2)(A)(ii)(II) shall apply with respect to the services provided under such arrangements.

''(E) A hospice program may provide services described in paragraph (1)(A) other than directly by the program if the services are highly specialized services of a registered professional nurse and are provided non-routinely and so infrequently so that the provision of such services directly would be impracticable and prohibitively expensive.''.

(b) CONFORMING PAYMENT PROVISION.—Section 1814(i) (42 U.S.C. 1395f(i)) is amended by adding at the end the following new paragraph:

''(4) In the case of hospice care provided by a hospice program under arrangements under section 1861(dd)(5)(D) made by another hospice program, the hospice program that made the arrangements shall bill and be paid for the hospice care.''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to hospice care provided on or after October 1, 2004.

SEC. 407. SERVICES PROVIDED TO HOSPICE PATIENTS BY NURSE PRACTITIONERS, CLINICAL NURSE SPECIALISTS, AND PHYSICIAN ASSISTANTS.

(a) IN GENERAL.—Section 1812(d)(2)(A) (42 U.S.C. 1395d(d)(2)(A) in the matter following clause (i)(II), is amended—

(1) by inserting ''or services described in section 1861(s)(2)(K)'' after ''except that clause (i) shall not apply to physicians' services''; and

(2) by inserting '', or by a physician assistant, nurse practitioner, or clinical nurse specialist whom is not an employee of the hospice program, and who the individual identifies as the health care provider having the most significant role in the determination and delivery of medical care to the individual at the time the individual makes an election to receive hospice care,'' after the ''(if not an employee of the hospice program)''.

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

SEC. 408. AUTHORITY TO INCLUDE COSTS OF TRAINING OF PSYCHOLOGISTS IN PAYMENTS TO HOSPITALS UNDER MEDICARE.

Effective for cost reporting periods beginning on or after October 1, 2004, for purposes of payments to hospitals under the medicare program under title XVIII of the Social Security Act for costs of approved educational activities (as defined in section 413.85 of title 42 of the Code of Federal Regulations), such approved educational activities shall include professional educational training programs, recognized by the Secretary, for psychologists.

SEC. 409. REVISION OF FEDERAL RATE FOR HOSPITALS IN PUERTO RICO.

Section 1886(d)(9) (42 U.S.C. 1395ww(d)(9)) is amended—

(1) in subparagraph (A)—

(A) in clause (i), by striking ''for discharges beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 75 percent)'' and inserting ''the applicable Puerto Rico percentage (specified in subparagraph (E))''; and

(B) in clause (ii), by striking ''for discharges beginning in a fiscal year beginning on or after October 1, 1997, 50 percent (and for discharges between October 1, 1987, and September 30, 1997, 25 percent)'' and inserting ''the applicable Federal percentage (specified in subparagraph (E))''; and

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

''(E) For purposes of subparagraph (A), for discharges occurring—

''(i) between October 1, 1987, and September 30, 1997, the applicable Puerto Rico percentage is 75 percent and the applicable Federal percentage is 25 percent;

''(ii) on or after October 1, 1997, and before October 1, 2004, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent;

''(iii) on or after October 1, 2004, and before October 1, 2009, the applicable Puerto Rico percentage is 0 percent and the applicable Federal percentage is 100 percent; and

''(iv) on or after October 1, 2009, the applicable Puerto Rico percentage is 50 percent and the applicable Federal percentage is 50 percent.''.

SEC. 410. AUTHORITY REGARDING GERIATRIC FELLOWSHIPS.

The Secretary shall have the authority to clarify that geriatric training programs are eligible for 2 years of fellowship support for purposes of making payments for direct graduate medical education under subsection (h) of section 1886 of the Social Security Act (42 U.S.C. 1395ww) and indirect medical education under subsection (d)(5)(B) of such section on or after October 1, 2004.

SEC. 411. CLARIFICATION OF CONGRESSIONAL INTENT REGARDING THE COUNTING OF RESIDENTS IN A NONPROVIDER SETTING AND A TECHNICAL AMENDMENT REGARDING THE 3-YEAR ROLLING AVERAGE AND THE IME RATIO.

(a) CLARIFICATION OF REQUIREMENTS FOR COUNTING RESIDENTS TRAINING IN NONPROVIDER SETTING.—

(1) D-GME.—Section 1886(h)(4)(E) (42 U.S.C. 1395ww(h)(4)(E)) is amended by adding at the end the following new sentence: For purposes of the preceding sentence time shall only be counted from the effective date of a written agreement between the hospital and the entity owning or operating a nonprovider setting. The effective date of such written agreement shall be determined in accordance with generally accepted accounting principles. All, or substantially all, of the costs for the training program in that setting shall be defined as the residents' stipends and benefits and other costs, if any, as determined by the parties.''.

(2) IME.—Section 1886(d)(5)(B)(iv) (42 U.S.C. 1395ww(d)(5)(B)(iv)) is amended by adding at the end the following new sentence: For purposes of the preceding sentence time shall only be counted from the effective date of a written agreement between the hospital and the entity owning or operating a nonprovider setting. The effective date of such written agreement shall be determined in accordance with generally accepted accounting principles. All, or substantially all, of the costs for the training program in that setting shall be defined as the residents' stipends and benefits and other costs, if any, as determined by the parties.''.

(b) LIMITING ONE-YEAR LAG IN THE INDIRECT MEDICAL EDUCATION (IME) RATIO AND THREE-YEAR ROLLING AVERAGE IN RESIDENT COUNT FOR IME AND FOR DIRECT GRADUATE MEDICAL EDUCATION (D-GME) TO MEDICAL RESIDENCY PROGRAMS.—

(1) IME RATIO AND IME ROLLING AVERAGE.—Section 1886(d)(5)(B)(vi) of the Social Security Act (42 U.S.C. 1395ww(d)(5)(B)(vi)) is amended by adding at the end the following new sentence: ''For cost reporting periods beginning during fiscal years beginning on or after October 1, 2004, subclauses (I) and (II) shall be applied only with respect to a hospital's approved medical residency training programs in the fields of allopathic and osteopathic medicine.''.

(2) D-GME ROLLING AVERAGE.—Section 1886(h)(4)(G) of the Social Security Act (42 U.S.C. 1395ww(h)(4)(G)) is amended by adding at the end the following new clause:

''(iv) APPLICATION FOR FISCAL YEAR 2004 AND SUBSEQUENT YEARS.—For cost reporting periods beginning during fiscal years beginning on or after October 1, 2004, clauses (i) through (iii) shall be applied only with respect to a hospital's approved medical residency training program in the fields of allopathic and osteopathic medicine.''.

SEC. 412. LIMITATION ON CHARGES FOR INPATIENT HOSPITAL CONTRACT HEALTH SERVICES PROVIDED TO INDIANS BY MEDICARE PARTICIPATING HOSPITALS.

(a) IN GENERAL.—Section 1866(a)(1) (42 U.S.C. 1395cc(a)(1)) is amended—

(1) in subparagraph (R), by striking ''and'' at the end;

(2) in subparagraph (S), by striking the period and inserting '', and''; and

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

''(T) in the case of hospitals which furnish inpatient hospital services for which payment may be made under this title, to be a participating provider of medical care—

''(i) under the contract health services program funded by the Indian Health Service and operated by the Indian Health Service, an Indian tribe, or tribal organization (as those terms are defined in section 4 of the Indian Health Care Improvement Act), with respect to items and services that are covered under such program and furnished to an individual eligible for such items and services under such program; and

''(ii) under a program funded by the Indian Health Service and operated by an urban Indian organization with respect to the purchase of items and services for an eligible urban Indian (as those terms are defined in such section 4),

in accordance with regulations promulgated by the Secretary regarding admission practices, payment methodology, and rates of payment (including the acceptance of no more than such payment rate as payment in full for such items and services).''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply as of a date specified by the Secretary of Health and Human Services (but in no case later than 6 months after the date of enactment of this Act) to medicare participation agreements in effect (or entered into) on or after such date.

SEC. 413. GAO STUDY AND REPORT ON APPROPRIATENESS OF PAYMENTS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR INPATIENT HOSPITAL SERVICES.

(a) STUDY.—The Comptroller General of the United States, using the most current data available, shall conduct a study to determine—

(1) the appropriate level and distribution of payments in relation to costs under the prospective payment system under section 1886 of the Social Security Act (42 U.S.C. 1395ww) for inpatient hospital services furnished by subsection (d) hospitals (as defined in subsection (d)(1)(B) of such section); and

(2) whether there is a need to adjust such payments under such system to reflect legitimate differences in costs across different geographic areas, kinds of hospitals, and types of cases.

(b) REPORT.—Not later than 24 months after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a) together with such recommendations for legislative and administrative action as the Comptroller General determines appropriate.

Subtitle B—Provisions Relating to Part B

SEC. 421. ESTABLISHMENT OF FLOOR ON GEOGRAPHIC ADJUSTMENTS OF PAYMENTS FOR PHYSICIANS' SERVICES.

Section 1848(e)(1) (42 U.S.C. 1395w–4(e)(1)) is amended—

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

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

''(E) FLOOR FOR WORK GEOGRAPHIC INDICES.—

''(i) IN GENERAL.—For purposes of payment for services furnished on or after January 1, 2004, and before January 1, 2008, after calculating the work geographic indices in subparagraph (A)(iii), the Secretary shall increase the work geographic index to the work floor index for any locality for which such geographic index is less than the work floor index.

''(ii) WORK FLOOR INDEX.—For purposes of clause (i), the term 'applicable floor index' means—

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

''(II) 1.000 for services furnished during 2005, 2006, and 2007.

''(F) FLOOR FOR PRACTICE EXPENSE AND MALPRACTICE GEOGRAPHIC INDICES.—For purposes of payment for services furnished on or after January 1, 2005, and before January 1, 2008, after calculating the practice expense and malpractice indices in clauses (i) and (ii) of subparagraph (A) and in subparagraph (B), the Secretary shall increase any such index to 1.00 for any locality for which such index is less than 1.00.

SEC. 422. MEDICARE INCENTIVE PAYMENT PROGRAM IMPROVEMENTS.

(a) PROCEDURES FOR SECRETARY, AND NOT PHYSICIANS, TO DETERMINE WHEN BONUS PAYMENTS UNDER MEDICARE INCENTIVE PAYMENT PROGRAM SHOULD BE MADE.—Section 1833(m) (42 U.S.C. 1395*l*(m)) is amended—

(1) by inserting ''(1)'' after ''(m)''; and

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

''(2) The Secretary shall establish procedures under which the Secretary, and not the physician furnishing the service, is responsible for determining when a payment is required to be made under paragraph (1).''.

(b) EDUCATIONAL PROGRAM REGARDING THE MEDICARE INCENTIVE PAYMENT PROGRAM.—The Secretary shall establish and implement an ongoing educational program to provide education to physicians under the medicare program on the medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395*l*(m)).

(c) ONGOING GAO STUDY AND ANNUAL REPORT ON THE MEDICARE INCENTIVE PAYMENT PROGRAM.—

(1) ONGOING STUDY.—The Comptroller General of the United States shall conduct an ongoing study on the medicare incentive payment program under section 1833(m) of the Social Security Act (42 U.S.C. 1395*l*(m)). Such study shall focus on whether such program increases the access of medicare beneficiaries who reside in an area that is designated (under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A))) as a health professional shortage area to physicians' services under the medicare program.

(2) ANNUAL REPORTS.—Not later than 1 year after the date of enactment of this Act, and annually thereafter, the Comptroller General of the United States shall submit to Congress a report on the study conducted under paragraph (1), together with recommendations as the Comptroller General considers appropriate.

SEC. 423. INCREASE IN RENAL DIALYSIS COMPOSITE RATE.

Notwithstanding any other provision of law, with respect to payment under part B of title XVIII of the Social Security Act for renal dialysis services furnished in 2005 and 2006, the composite rate for such services shall be increased by 1.6 percent under section 1881(b)(12) of such Act (42 U.S.C. 1395rr(b)(7)), as added by section 433(b)(5).

SEC. 424. EXTENSION OF HOLD HARMLESS PROVISIONS FOR SMALL RURAL HOSPITALS AND TREATMENT OF CERTAIN SOLE COMMUNITY HOSPITALS TO LIMIT DECLINE IN PAYMENT UNDER THE OPD PPS.

(a) SMALL RURAL HOSPITALS.—Section 1833(t)(7)(D)(i) (42 U.S.C. 1395l(t)(7)(D)(i)) is amended by inserting ''and during 2006'' after ''2004,''.

(b) SOLE COMMUNITY HOSPITALS.—Section 1833(t)(7)(D) (42 U.S.C. 1395l(t)(7)(D)) is amended by adding at the end the following:

''(iii) TEMPORARY TREATMENT FOR SOLE COMMUNITY HOSPITALS .—In the case of a sole community hospital (as defined in section 1886(d)(5)(D)(iii)) located in a rural area, for covered OPD services furnished in 2006, for which the PPS amount is less than the pre-BBA amount, the amount of payment under this subsection shall be increased by the amount of such difference.''.

SEC. 425. INCREASE IN PAYMENTS FOR CERTAIN SERVICES FURNISHED BY SMALL RURAL AND SOLE COMMUNITY HOSPITALS UNDER MEDICARE PROSPECTIVE PAYMENT SYSTEM FOR HOSPITAL OUTPATIENT DEPARTMENT SERVICES.

(a) INCREASE.—

(1) IN GENERAL.—In the case of an applicable covered OPD service (as defined in paragraph (2)) that is furnished by a hospital described in clause (i) or (iii) of paragraph (7)(D) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t)), as amended by section 424, on or after January 1, 2005, and before January 1, 2008, the Secretary shall increase the medicare OPD fee schedule amount (as determined under paragraph (4)(A) of such section) that is applicable for such service in that year (determined without regard to any increase under this section in a previous year) by 5 percent.

(2) APPLICABLE COVERED OPD SERVICES DEFINED.—For purposes of this section, the term ''applicable covered OPD service'' means a covered clinic or emergency room visit that is classified within the groups of covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t))) established under paragraph (2)(B) of such section.

(b) NO EFFECT ON COPAYMENT AMOUNT.—The Secretary shall compute the copayment amount for applicable covered OPD services under section 1833(t)(8)(A) of the Social Security Act (42 U.S.C. 1395*l*(t)(8)(A)) as if this section had not been enacted.

(c) NO EFFECT ON INCREASE UNDER HOLD HARMLESS OR OUTLIER PROVISIONS.—The Secretary shall apply the temporary hold harmless provision under clause (i) and (iii) of paragraph (7)(D) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t)) and the outlier provision under paragraph (5) of such section as if this section had not been enacted.

(d) WAIVING BUDGET NEUTRALITY AND NO REVISION OR ADJUSTMENTS.—The Secretary shall not make any revision or adjustment under subparagraph (A), (B), or (C) of section 1833(t)(9) of the Social Security Act (42 U.S.C. 1395*l*(t)(9)) because of the application of subsection (a)(1).

(e) NO EFFECT ON PAYMENTS AFTER INCREASE PERIOD ENDS.—The Secretary shall not take into account any payment increase provided under subsection (a)(1) in determining payments for covered OPD services (as defined in paragraph (1)(B) of section 1833(t) of the Social Security Act (42 U.S.C. 1395*l*(t))) under such section that are furnished after January 1, 2008.

(f) TECHNICAL AMENDMENT.—Section 1833(t)(2)(B) (42 U.S.C. 1395*l*(t)(2)(B)) is amended by inserting ''(and periodically revise such groups pursuant to paragraph (9)(A))'' after ''establish groups''.

SEC. 426. INCREASE FOR GROUND AMBULANCE SERVICES FURNISHED IN A RURAL AREA.

Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 405(b)(2), is amended by adding at the end the following new paragraph:

''(10) TEMPORARY INCREASE FOR GROUND AMBULANCE SERVICES FURNISHED IN A RURAL AREA.—

''(A) IN GENERAL.—Notwithstanding any other provision of this subsection, in the case of ground ambulance services furnished on or after January 1, 2005, and before January 1, 2008, for which the transportation originates in a rural area described in paragraph (9) or in a rural census tract described in such paragraph, the fee schedule established under this section, with respect to both the payment rate for service and the payment rate for mileage, shall provide that such rates otherwise established, after application of any increase under such paragraph, shall be increased by 5 percent.

''(B) APPLICATION OF INCREASED PAYMENTS AFTER 2007.—The increased payments under subparagraph (A) shall not be taken into account in calculating payments for services furnished on or after the period specified in such subparagraph.''.

SEC. 427. ENSURING APPROPRIATE COVERAGE OF AIR AMBULANCE SERVICES UNDER AMBULANCE FEE SCHEDULE.

(a) COVERAGE.—Section 1834(l) (42 U.S.C. 1395m(l)), as amended by section 426, is amended by adding at the end the following new paragraph:

''(11) ENSURING APPROPRIATE COVERAGE OF AIR AMBULANCE SERVICES.—

''(A) IN GENERAL.—The regulations described in section 1861(s)(7) shall ensure that air ambulance services (as defined in subparagraph (C)) are reimbursed under this subsection at the air ambulance rate if the air ambulance service—

''(i) is medically necessary based on the health condition of the individual being transported at or immediately prior to the time of the transport; and

''(ii) complies with equipment and crew requirements established by the Secretary.

''(B) MEDICALLY NECESSARY.—An air ambulance service shall be considered to be medically necessary for purposes of subparagraph (A)(i) if such service is requested—

''(i) by a physician or a hospital in accordance with the physician's or hospital's responsibilities under section 1867 (commonly known as the Emergency Medical Treatment and Active Labor Act);

''(ii) as a result of a protocol established by a State or regional emergency medical service (EMS) agency;

''(iii) by a physician, nurse practitioner, physician assistant, registered nurse, or emergency medical responder who reasonably determines or certifies that the patient's condition is such that the time needed to transport the individual by land or the lack of an appropriate ground ambulance, significantly increases the medical risks for the individual; or

''(iv) by a Federal or State agency to relocate patients following a natural disaster, an act of war, or a terrorist attack.

''(C) AIR AMBULANCE SERVICES DEFINED.—For purposes of this paragraph, the term 'air ambulance service' means fixed wing and rotary wing air ambulance services.''.

(b) CONFORMING AMENDMENT.—Section 1861(s)(7) (42 U.S.C. 1395x(s)(7)) is amended by inserting '', subject to section 1834(l)(11),'' after ''but''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to services furnished on or after January 1, 2005.

SEC. 428. TREATMENT OF CERTAIN CLINICAL DIAGNOSTIC LABORATORY TESTS FURNISHED BY A SOLE COMMUNITY HOSPITAL.

Notwithstanding subsections (a), (b), and (h) of section 1833 of the Social Security Act (42 U.S.C. 1395*l*) and section 1834(d)(1) of such Act (42 U.S.C. 1395m(d)(1)), in the case of a clinical diagnostic laboratory test covered under part B of title XVIII of such Act that is furnished in 2005 or 2006 by a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of such Act (42 U.S.C. 1395ww(d)(5)(D)(iii))) as part of services furnished to patients of the hospital, the following rules shall apply:

(1) PAYMENT BASED ON REASONABLE COSTS.—The amount of payment for such test shall be 100 percent of the reasonable costs of the hospital in furnishing such test.

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

SEC. 429. IMPROVEMENT IN RURAL HEALTH CLINIC REIMBURSEMENT.

Section 1833(f) (42 U.S.C. 1395*l*(f)) is amended—

(1) in paragraph (1), by striking '', and'' at the end and inserting a semicolon;

(2) in paragraph (2)—

(A) by striking ''in a subsequent year'' and inserting ''in 1989 through 2004''; and

(B) by striking the period at the end and inserting a semicolon; and

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

''(3) in 2005, at $80 per visit; and

''(4) in a subsequent year, at the limit established under this subsection for the previous year increased by the percentage increase in the MEI (as so defined) applicable to primary care services (as so defined) furnished as of the first day of that year.''.

SEC. 430. ELIMINATION OF CONSOLIDATED BILLING FOR CERTAIN SERVICES UNDER THE MEDICARE PPS FOR SKILLED NURSING FACILITY SERVICES.

(a) CERTAIN RURAL HEALTH CLINIC AND FEDERALLY QUALIFIED HEALTH CENTER SERVICES.—Section 1888(e) (42 U.S.C. 1395yy(e)) is amended—

(1) in paragraph (2)(A)(i)(II), by striking ''clauses (ii) and (iii)'' and inserting ''clauses (ii), (iii), and (iv)''; and

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

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

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

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

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

(b) CERTAIN SERVICES FURNISHED BY AN ENTITY JOINTLY OWNED BY HOSPITALS AND CRITICAL ACCESS HOSPITALS.—For purposes of applying section 411.15(p)–(3)(iii) of title 42 of the Code of Federal Regulations, the Secretary shall treat an entity that is 100 percent owned as a joint venture by 2 Medicare-participating hospitals or critical access hospitals as a Medicare-participating hospital or a critical access hospital.

(c) TECHNICAL AMENDMENTS.—Sections 1842(b)(6)(E) and 1866(a)(1)(H)(ii) (42 U.S.C. 1395u(b)(6)(E); 1395cc(a)(1)(H)(ii)) are each amended by striking ''section 1888(e)(2)(A)(ii)'' and inserting ''clauses (ii), (iii), and (iv) of section 1888(e)(2)(A)''.

(d) EFFECTIVE DATE.—The amendments made by this section and the provision of subsection (b) shall apply to services furnished on or after January 1, 2005.

SEC. 431. FREEZE IN PAYMENTS FOR CERTAIN ITEMS OF DURABLE MEDICAL EQUIPMENT AND CERTAIN ORTHOTICS; ESTABLISHMENT OF QUALITY STANDARDS AND ACCREDITATION REQUIREMENTS FOR DME PROVIDERS.

(a) FREEZE FOR DME.—Section 1834(a)(14) (42 U.S.C. 1395m(a)(14)) is amended—

(1) in subparagraph (E), by striking ''and'' at the end;

(2) in subparagraph (F)—

(A) by striking ''a subsequent year'' and inserting ''2003''; and

(B) by striking ''the previous year.'' and inserting ''2002;''; and

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

''(G) for each of the years 2004 through 2010—

''(i) in the case of class III medical devices described in section 513(a)(1)(C) of the Federal Food, Drug, and Cosmetic Act (21 U.S.C. 360(c)(1)(C)), the percentage increase described in subparagraph (B) for the year involved; and

''(ii) in the case of covered items not described in clause (i), 0 percentage points; and

''(H) for a subsequent year, the percentage increase described in subparagraph (B) for the year involved.''.

(b) FREEZE FOR OFF-THE-SHELF ORTHOTICS.—Section 1834(h)(4)(A) of the Social Security Act (42 U.S.C. 1395m(h)(4)(A)) is amended—

(1) in clause (vii), by striking ''and'' at the end;

(2) in clause (viii), by striking ''a subsequent year'' and inserting ''2003''; and

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

''(ix) for each of the years 2004 through 2010—

''(I) in the case of orthotics that have not been custom-fabricated, 0 percent; and

''(II) in the case of prosthetics, prosthetic devices, and custom-fabricated orthotics, the percentage increase described in clause (viii) for the year involved; and

''(x) for 2011 and each subsequent year, the percentage increase described in clause (viii) for the year involved;''.

(c) ESTABLISHMENT OF QUALITY STANDARDS AND ACCREDITATION REQUIREMENTS FOR DURABLE MEDICAL EQUIPMENT PROVIDERS.—Section 1834(a) (42 U.S.C. 1395m(a)) is amended—

(1) by redesignating paragraph (17), as added by section 4551(c)(1) of the Balanced Budget Act of 1997 (111 Stat. 458), as paragraph (19); and

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

''(20) IDENTIFICATION OF QUALITY STANDARDS.—

''(A) IN GENERAL.—Subject to subparagraph (C), the Secretary shall establish and implement quality standards for providers of durable medical equipment throughout the United States that are developed by recognized independent accreditation organizations (as designated under subparagraph (B)(i)) and with which such providers shall be required to comply in order to—

''(i) participate in the program under this title;

''(ii) furnish any item or service described in subparagraph (D) for which payment is made under this part; and

''(iii) receive or retain a provider or supplier number used to submit claims for reimbursement for any item or service described in subparagraph (D) for which payment may be made under this title.

''(B) DESIGNATION OF INDEPENDENT ACCREDITATION ORGANIZATIONS.—

''(i) IN GENERAL.—Not later that the date that is 6 months after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall designate independent accreditation organizations for purposes of subparagraph (A).

''(ii) CONSULTATION.—In determining which independent accreditation organizations to designate under clause (i), the Secretary shall consult with an expert outside advisory panel composed of an appropriate selection of representatives of physicians, practitioners, suppliers, and manufacturers to review (and advise the Secretary concerning) selection of accrediting organizations and the quality standards of such organizations.

''(C) QUALITY STANDARDS.—The quality standards described in subparagraph (A) may not be less stringent than the quality standards that would otherwise apply if this paragraph did not apply and shall include consumer services standards.

''(D) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are covered items (as defined in paragraph (13)) for which payment may otherwise be made under this subsection, other than items used in infusion, and inhalation drugs used in conjunction with durable medical equipment.

''(E) PHASED-IN IMPLEMENTATION.—The application of the quality standards described in subparagraph (A) shall be phased-in over a period that does not exceed 3 years.''.

SEC. 432. APPLICATION OF COINSURANCE AND DEDUCTIBLE FOR CLINICAL DIAGNOSTIC LABORATORY TESTS.

(a) COINSURANCE.—

(1) IN GENERAL.—Section 1833(a) (42 U.S.C. 1395*l*(a)) is amended—

(A) in paragraph (1)(D)(i), by striking ''(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis)''; and

(B) in paragraph (2)(D)(i), by striking ''(or 100 percent, in the case of such tests for which payment is made on an assignment-related basis or to a provider having an agreement under section 1866)''.

(2) CONFORMING AMENDMENT.—The third sentence of section 1866(a)(2)(A) of the Social Security Act (42 U.S.C. 1395cc(a)(2)(A) is amended by striking ''and with respect to clinical diagnostic laboratory tests for which payment is made under part B''.

(b) DEDUCTIBLE.—Section 1833(b) of the Social Security Act (42 U.S.C. 1395*l*(b)) is amended—

(1) by striking paragraph (3); and

(2) by redesignating paragraphs (4), (5), and (6) as paragraphs (3), (4), and (5), respectively.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to tests furnished on or after January 1, 2004.

SEC. 433. BASING MEDICARE PAYMENTS FOR COVERED OUTPATIENT DRUGS ON MARKET PRICES.

(a) MEDICARE MARKET BASED PAYMENT AMOUNT.—Section 1842(o) (42 U.S.C. 1395u(o)) is amended—

(1) in paragraph (1), by striking ''equal to 95 percent of the average wholesale price.'' and inserting ''equal to—

''(A) in the case of a drug or biological furnished prior to January 1, 2004, 95 percent of the average wholesale price; and

''(B) in the case of a drug or biological furnished on or after January 1, 2004, the payment amount specified in—

''(i) in the case of such a drug or biological that is first available for payment under this part on or before April 1, 2003, paragraph (4); and

''(ii) in the case of such a drug or biological that is first available for payment under this part after such date, paragraph (5).''; and

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

''(4)(A) Subject to subparagraph (C), the payment amount specified in this paragraph for a year for a drug or biological is an amount equal to the lesser of—

''(i) the average wholesale price for the drug or biological; or

''(ii) the amount determined under subparagraph (B)

''(B)(i) Subject to clause (ii), the amount determined under this subparagraph is an amount equal to—

''(I) in the case of a drug or biological furnished in 2004, 85 percent of the average wholesale price for the drug or biological (determined as of April 1, 2003); and

''(II) in the case of a drug or biological furnished in 2005 or a subsequent year, the amount determined under this subparagraph for the previous year increased by the percentage increase in the consumer price index for medical care for the 12-month period ending with June of the previous year.

''(ii) In the case of a vaccine described in subparagraph (A) or (B) of section 1861(s)(10), the amount determined under this subparagraph is an amount equal to the average wholesale price for the drug or biological.

''(C)(i) The Secretary shall establish a process under which the Secretary determines, for such drugs or biologicals as the Secretary determines appropriate, whether the widely available market price to physicians or suppliers for the drug or biological furnished in a year is different from the payment amount established under subparagraph (B) for the year. Such determination shall be based on the information described in clause (ii) as the Secretary determines appropriate.

''(ii) The information described in this clause is the following information:

''(I) Any report on drug or biological market prices by the Inspector General of the Department of Health and Human Services or the Comptroller General of the United States that is made available after December 31, 1999.

''(II) A review of drug or biological market prices by the Secretary, which may include information on such market prices from insurers, private health plans, manufacturers, wholesalers, distributors, physician supply houses, specialty pharmacies, group purchasing arrangements, physicians, suppliers, or any other source the Secretary determines appropriate.

''(III) Data and information submitted by the manufacturer of the drug or biological or by another entity.

''(IV) Other data and information as determined appropriate by the Secretary.

''(iii) If the Secretary makes a determination under clause (i) with respect to the widely available market price for a drug or biological for a year, the following provisions shall apply:

''(I) Subject to clause (iv), the amount determined under this subparagraph shall be substituted for the amount determined under subparagraph (B) for purposes of applying subparagraph (A)(ii)(I) for the year and all subsequent years.

''(II) The Secretary may make subsequent determinations under clause (i) with respect to the widely available market price for the drug or biological.

''(III) If the Secretary does not make a subsequent determination under clause (i) with respect to the widely available market price for the drug or biological for a year, the amount determined under this subparagraph shall be an amount equal to the amount determined under this subparagraph for the previous year increased by the percentage increase described in subparagraph (B)(i)(II) for the year involved.

''(iv) If the first determination made under clause (i) with respect to the widely available market price for a drug or biological would result in a payment amount in a year that is more than 15 percent less than the amount determined under subparagraph (B) for the drug or biological for the previous year (or, for 2004, the payment amount determined under paragraph (1)(A), determined as of April 1, 2003), the Secretary shall provide for a transition to the amount determined under clause (i) so that the payment amount is reduced in annual increments equal to 15 percent of the payment amount in such previous year until the payment amount is equal to the amount determined under clause (i), as increased each year by the percentage increase described in subparagraph (B)(i)(II) for the year. The preceding sentence shall not apply to a drug or biological where a generic version of the drug or biological first enters the market on or after January 1, 2004 (even if the generic version of the drug or biological is not marketed under the chemical name of such drug or biological).

''(5) In the case of a drug or biological that is first available for payment under this part after April 1, 2003, the following rules shall apply:

''(A) As a condition of obtaining a code to report such new drug or biological and to receive payment under this part, a manufacturer shall provide the Secretary (in a time, manner, and form approved by the Secretary) with data and information on prices at which the manufacturer estimates physicians and suppliers will be able to routinely obtain the drug or biological in the market during the first year that the drug or biological is available for payment under this part and such additional information that the manufacturer determines appropriate.

''(B) During the year that the drug or biological is first available for payment under this part, the manufacturer of the drug or biological shall provide the Secretary (in a time, manner, and form approved by the Secretary) with updated information on the actual market prices paid by such physicians or suppliers for the drug or biological in the year.

''(C) The amount specified in this paragraph for a drug or biological for the year described in subparagraph (B) is equal to an amount determined by the Secretary based on the information provided under subparagraph (A) and other information that the Secretary determines appropriate.

''(D) The amount specified in this paragraph for a drug or biological for the year after the year described in subparagraph (B) is equal to an amount determined by the Secretary based on the information provided under subparagraph (B) and other information that the Secretary determines appropriate.

''(E) The amount specified in this paragraph for a drug or biological for the year beginning after the year described in subparagraph (D) and each subsequent year is equal to the lesser of—

''(i) the average wholesale price for the drug or biological; or

''(ii) the amount determined—

''(I) by the Secretary under paragraph (4)(C)(i) with respect to the widely available market price for the drug or biological for the year, if such paragraph was applied by substituting 'the payment determined under paragraph (5)(E)(ii)(II) for the year' for 'established under subparagraph (B) for the year'; and

''(II) if no determination described in subclause (I) is made for the drug or biological for the year, under this subparagraph with respect to the drug or biological for the previous year increased by the percentage increase described in paragraph (4)(B)(i)(II) for the year involved.''.

(b) ADJUSTMENTS TO PAYMENT AMOUNTS FOR ADMINISTRATION OF DRUGS AND BIOLOGICALS.—

(1) ADJUSTMENT IN PHYSICIAN PRACTICE EXPENSE RELATIVE VALUE UNITS.—Section 1848(c)(2) (42 U.S.C. 1395w–4(c)(2)) is amended—

(A) in subparagraph (B)—

(i) in clause (ii)(II), by striking ''The adjustments'' and inserting ''Subject to clause (iv), the adjustments''; and

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

''(iv) EXEMPTION FROM BUDGET NEUTRALITY IN 2004.—Any additional expenditures under this part that are attributable to subparagraph (H) shall not be taken into account in applying clause (ii)(II) for 2004.''; and

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

''(H) ADJUSTMENTS IN PRACTICE EXPENSE RELATIVE VALUE UNITS FOR DRUG ADMINISTRATION SERVICES FOR 2004.—In establishing the physician fee schedule under subsection (b) with respect to payments for services furnished in 2004, the Secretary shall, in determining practice expense relative value units under this subsection, utilize a survey submitted to the Secretary as of January 1, 2003, by a physician specialty organization pursuant to section 212 of the Medicare, Medicaid, and SCHIP Balanced Budget Refinement Act of 1999 if the survey—

''(i) covers practice expenses for oncology administration services; and

''(ii) meets criteria established by the Secretary for acceptance of such surveys.''.

(2) PAYMENT FOR MULTIPLE CHEMOTHERAPY AGENTS FURNISHED ON A SINGLE DAY THROUGH THE PUSH TECHNIQUE.—

(A) REVIEW OF POLICY.—The Secretary shall review the policy, as in effect on the date of enactment of this Act, with respect to payment under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for the administration of more than 1 anticancer chemotherapeutic agent to an individual on a single day through the push technique.

(B) MODIFICATION OF POLICY.—After conducting the review under subparagraph (A), the Secretary shall modify such payment policy if the Secretary determines such modification to be appropriate.

(C) EXEMPTION FROM BUDGET NEUTRALITY UNDER PHYSICIAN FEE SCHEDULE.—If the Secretary modifies such payment policy pursuant to subparagraph (B), any increased expenditures under title XVIII of the Social Security Act resulting from such modification shall be treated as additional expenditures attributable to subparagraph (H) of section 1848(c)(2) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)), as added by paragraph (1)(B), for purposes of applying the exemption to budget neutrality under subparagraph (B)(iv) of such section, as added by paragraph (1)(A).

(3) TREATMENT OF OTHER SERVICES CURRENTLY IN THE NONPHYSICIAN WORK POOL.—The Secretary shall make adjustments to the nonphysician work pool methodology (as such term is used in the final rule promulgated by the Secretary in the Federal Register on December 31, 2002 (67 Fed. Reg. 251)), for the determination of practice expense relative value units under the physician fee schedule under section 1848(c)(2)(C)(ii) of the Social Security Act (42 U.S.C. 1395w–4(c)(2)(C)(ii)), so that the practice expense relative value units for services determined under such methodology are not disproportionately reduced relative to the practice expense relative value units of services not determined under such methodology, as a result of the amendments to such Act made by paragraph (1).

(4) ADMINISTRATION OF BLOOD CLOTTING FACTORS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2), is amended by adding at the end the following new paragraph:

''(6)(A) Subject to subparagraph (B), in the case of clotting factors furnished on or after January 1, 2004, the Secretary shall, after reviewing the January 2003 report to Congress by the Comptroller General of the United States entitled 'Payment for Blood Clotting Factor Exceeds Providers Acquisition Cost' (GAO–03–184), provide for a separate payment for the administration of such blood clotting factors in an amount that the Secretary determines to be appropriate.

''(B) In determining the separate payment amount under subparagraph (A) for blood clotting factors furnished in 2004, the Secretary shall ensure that the total amount of payments under this part (as estimated by the Secretary) for such factors under paragraphs (4) and (5) and such separate payments for such factors does not exceed the total amount of payments that would have been made for such factors under this part (as estimated by the Secretary) if the amendments made by section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

''(C) The separate payment amount under this subparagraph for blood clotting factors furnished in 2005 or a subsequent year shall be equal to the separate payment amount determined under this paragraph for the previous year increased by the percentage increase described in paragraph (4)(B)(i)(II) for the year involved.''.

(5) INCREASE IN COMPOSITE RATE FOR END STAGE RENAL DISEASE FACILITIES.—Section 1881(b) (42 U.S.C. 1395rr(b) is amended—

(A) in paragraph (7), by adding at the end the following new sentence: ''In the case of dialysis services furnished in 2004 or a subsequent year, the composite rate for such services shall be determined under paragraph (12).''; and

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

''(12)(A) In the case of dialysis services furnished during 2004, the composite rate for such services shall be the composite rate that would otherwise apply under paragraph (7) for the year increased by an amount to ensure (as estimated by the Secretary) that—

''(i) the sum of the total amount of—

''(I) the composite rate payments for such services for the year, as increased under this paragraph; and

''(II) the payments for drugs and biologicals (other than erythropoetin) furnished in connection with the furnishing of renal dialysis services and separately billed by renal dialysis facilities under paragraphs (4) and (5) of section 1842(o) for the year; is equal to

''(ii) the sum of the total amount of the composite rate payments under paragraph (7) for the year and the payments for the separately billed drugs and biologicals described in clause (i)(II) that would have been made if the amendments made by section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.

''(B) Subject to subparagraph (E), in the case of dialysis services furnished in 2005, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (A), increased by 0.05 percent and further increased pursuant to section 423 of the Prescription Drug and Medicare Improvement Act of 2003.

''(C) Subject to subparagraph (E), in the case of dialysis services furnished in 2006, the composite rate for such services shall be an amount equal to the composite rate established under subparagraph (B), increased by 0.05 percent.

''(D) Subject to subparagraph (E), in the case of dialysis services furnished in 2007 or a subsequent year, the composite rate for such services shall be an amount equal to the composite rate established under this paragraph for the previous year (determined as if such section 423 had not been enacted), increased by 0.05 percent.

''(E) If the Secretary implements a reduction in the payment amount under paragraph (4)(C) or (5) for a drug or biological described in subparagraph (A)(i)(II) for a year after 2004, the Secretary shall, as estimated by the Secretary—

''(i) increase the composite rate for dialysis services furnished in such year in the same manner that the composite rate for such services for 2004 was increased under subparagraph (A); and

''(ii) increase the percentage increase under subparagraph (C) or (D) (as applicable) for years after the year described in clause (i) to ensure that such increased percentage would result in expenditures equal to the sum of the total composite rate payments for such services for such years and the total payments for drugs and biologicals described in subparagraph (A)(i)(II) is equal to the sum of the total amount of the composite rate

payments under this paragraph for such years and the payments for the drugs and biologicals described in subparagraph (A)(i)(II) that would have been made if the reduction in payment amount described in subparagraph had not been made.

''(F) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under this paragraph.''.

(6) HOME INFUSION DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraph (4), is amended by adding at the end the following new paragraph:

''(7)(A) Subject to subparagraph (B), in the case of infusion drugs and biologicals furnished through an item of durable medical equipment covered under section 1861(n) on or after January 1, 2004, the Secretary may make separate payments for furnishing such drugs and biologicals in an amount determined by the Secretary if the Secretary determines such separate payment to be appropriate.

''(B) In determining the amount of any separate payment under subparagraph (A) for a year, the Secretary shall ensure that the total amount of payments under this part for such infusion drugs and biologicals for the year and such separate payments for the year does not exceed the total amount of payments that would have been made under this part for the year for such infusion drugs and biologicals if section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted.''.

(7) INHALATION DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4) and (6), is amended by adding at the end the following new paragraph:

''(8)(A) Subject to subparagraph (B), in the case of inhalation drugs and biologicals furnished through durable medical equipment covered under section 1861(n) on or after January 1, 2004, the Secretary may increase payments for such equipment under section 1834(a) and may make separate payments for furnishing such drugs and biologicals if the Secretary determines such increased or separate payments are necessary to appropriately furnish such equipment and drugs and biologicals to beneficiaries.

''(B) The total amount of any increased payments and separate payments under subparagraph (A) for a year may not exceed an amount equal to 10 percent of the amount (as estimated by the Secretary) by which—

''(i) the total amount of payments that would have been made for such drugs and biologicals for the year if section 433 of the Prescription Drug and Medicare Improvement Act of 2003 had not been enacted; exceeds

''(ii) the total amount of payments for such drugs and biologicals under paragraphs (4) and (5).''.

(8) PHARMACY DISPENSING FEE FOR CERTAIN DRUGS AND BIOLOGICALS.—Section 1842(o)(2) (42 U.S.C. 1395u(o)(2)) is amended to read as follows:

''(2) If payment for a drug or biological is made to a licensed pharmacy approved to dispense drugs or biologicals under this part, the Secretary—

''(A) in the case of an immunosuppressive drug described in subparagraph (J) of section 1861(s)(2) and an oral drug described in subparagraph (Q) or (T) of such section, shall pay a dispensing fee determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts) to the pharmacy; and

''(B) in the case of a drug or biological not described in subparagraph (A), may pay a dispensing fee determined appropriate by the Secretary (less the applicable deductible and coinsurance amounts) to the pharmacy.''.

(9) PAYMENT FOR CHEMOTHERAPY DRUGS PURCHASED BUT NOT ADMINISTERED BY PHYSICIANS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6) and (7), is amended by adding at the end the following new paragraph:

''(9)(A) Subject to subparagraph (B), the Secretary may increase (in an amount determined appropriate) the amount of payments to physicians for anticancer chemotherapeutic drugs or biologicals that would otherwise be made under this part in order to compensate such physicians for anticancer chemotherapeutic drugs or biologicals that are purchased by physicians with a reasonable intent to administer to an individual enrolled under this part but which cannot be administered to such individual despite the reasonable efforts of the physician.

''(B) The total amount of increased payments made under subparagraph (A) in a year (as estimated by the Secretary) may not exceed an amount equal to 1 percent of the total amount of payments made under paragraphs (4) and (5) for such anticancer chemotherapeutic drugs or biologicals furnished by physicians in such year (as estimated by the Secretary).''.

(c) LINKAGE OF REVISED DRUG PAYMENTS AND INCREASES FOR DRUG ADMINISTRATION.—The Secretary shall not implement the revisions in payment amounts for a category of drug or biological as a result of the amendments made by subsection (a) unless the Secretary concurrently implements the adjustments to payment amounts for administration of such category of drug or biological for which the Secretary is required to make an adjustment, as specified in the amendments made by, and provisions of, subsection (b).

(d) PROHIBITION OF ADMINISTRATIVE AND JUDICIAL REVIEW.—

(1) DRUGS.—Section 1842(o) (42 U.S.C. 1395u(o)), as amended by subsection (a)(2) and paragraphs (4), (6), (7), and (9) of subsection (b), is amended by adding at the end the following new paragraph:

''(10) There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraph (2) or paragraphs (4) through (9).''.

(2) PHYSICIAN FEE SCHEDULE.—Section 1848(i)(1) (42 U.S.C. 1395w–4(i)(1)) is amended—

(A) in subparagraph (D), by striking ''and'' at the end;

(B) in subparagraph (E), by striking the period at the end and inserting '', and''; and

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

''(F) adjustments in practice expense relative value units under subsection (c)(2)(H).''.

(3) MULTIPLE CHEMOTHERAPY AGENTS AND OTHER SERVICES CURRENTLY ON THE NON-PHYSICIAN WORK POOL.—There shall be no administrative or judicial review under section 1869, section 1878, or otherwise, of determinations of payment amounts, methods, or adjustments under paragraphs (2) and (3) of subsection (b).

(e) STUDIES AND REPORTS.—

(1) GAO STUDY AND REPORT ON BENEFICIARY ACCESS TO DRUGS AND BIOLOGICALS.—

(A) STUDY.—The Comptroller General of the United States shall conduct a study that examines the impact the provisions of, and the amendments made by, this section have on access by medicare beneficiaries to drugs and biologicals covered under the medicare program.

(B) REPORT.—Not later than January 1, 2006, the Comptroller General shall submit a report to Congress on the study conducted under subparagraph (A) together with such recommendations as the Comptroller General determines to be appropriate.

(2) STUDY AND REPORT BY THE HHS INSPECTOR GENERAL ON MARKET PRICES OF DRUGS AND BIOLOGICALS.—

(A) STUDY.—The Inspector General of the Department of Health and Human Services shall conduct 1 or more studies that—

(i) examine the market prices that drugs and biologicals covered under the medicare program are widely available to physicians and suppliers; and

(ii) compare such widely available market prices to the payment amount for such drugs and biologicals under section 1842(o) of the Social Security Act (42 U.S.C. 1395u(o).

(B) REQUIREMENT.—In conducting the study under subparagraph (A), the Inspector General shall focus on those drugs and biologicals that represent the largest portions of expenditures under the medicare program for drugs and biologicals.

(C) REPORT.—The Inspector General shall prepare a report on any study conducted under subparagraph (A).

SEC. 434. INDEXING PART B DEDUCTIBLE TO INFLATION.

The first sentence of section 1833(b) (42 U.S.C. 1395*l*(b)) is amended by striking ''and $100 for 1991 and subsequent years'' and inserting the following: '', $100 for 1991 through 2005, $125 for 2006, and for 2007 and thereafter, the amount in effect for the previous year, increase by the percentage increase in the consumer price index for all urban consumers (U.S. city average) for the 12-month period ending with June of the previous year, rounded to the nearest dollar''.

SEC. 435. REVISIONS TO REASSIGNMENT PROVISIONS.

(a) IN GENERAL.—Section 1842(b)(6)(A)(ii) (42 U.S.C. 1395u(b)(6)(A)(ii)) is amended to read as follows: ''(ii) where the service was provided under a contractual arrangement between such physician or other person and an entity (as defined by the Secretary), to the entity if under such arrangement such entity submits the bill for such service and such arrangement meets such program integrity and other safeguards as the Secretary may determine to be appropriate,''.

(b) CONFORMING AMENDMENT.—The second sentence of section 1842(b)(6) (42 U.S.C. 1395u(b)(6)) is amended by striking ''except to an employer or facility as described in clause (A)'' and inserting ''except to an employer or entity as described in subparagraph (A)''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to payments made on or after the date of enactment of this Act.

SEC. 436. EXTENSION OF TREATMENT OF CERTAIN PHYSICIAN PATHOLOGY SERVICES UNDER MEDICARE.

Section 542(c) of BIPA (114 Stat. 2763A–551) is amended by inserting '', and for services furnished during 2005'' before the period at the end.

SEC. 437. ADEQUATE REIMBURSEMENT FOR OUTPATIENT PHARMACY THERAPY UNDER THE HOSPITAL OUTPATIENT PPS.

(a) SPECIAL RULES FOR DRUGS AND BIOLOGICALS.—Section 1833(t) (42 U.S.C. 1395(t)) is amended—

(1) by redesignating paragraph (13) as paragraph (14); and

(2) by inserting after paragraph (12) the following new paragraph:

''(13) SPECIAL RULES FOR CERTAIN DRUGS AND BIOLOGICALS.—

''(A) BEFORE 2007.—

''(i) IN GENERAL.—Notwithstanding paragraph (6), but subject to clause (ii), with respect to a separately payable drug or biological described in subparagraph (D) furnished on or after January 1, 2005, and before January 1, 2007, hospitals shall be reimbursed as follows:

''(I) DRUGS AND BIOLOGICALS FURNISHED AS PART OF A CURRENT OPD SERVICE.—The amount of payment for a drug or biological described in subparagraph (D) provided as a part of a service that was a covered OPD service on May 1, 2003, shall be the applicable percentage (as defined in subparagraph (C)) of the average wholesale price for the drug or biological that would have been determined under section 1842(o) on such date.

''(II) DRUGS AND BIOLOGICALS FURNISHED AS PART OF OTHER OPD SERVICES.—The amount of payment for a drug or biological described in subparagraph (D) provided as part of any other covered OPD service shall be the applicable percentage (as defined in subparagraph (C)) of the average wholesale price that would have been determined under section 1842(o) on May 1, 2003, if payment for such a drug or biological could have been made under this part on that date.

''(ii) UPDATE FOR 2006.—For 2006, the amounts determined under clauses (i) and (ii) shall be the amount established for 2005 increased by the percentage increase in the Consumer Price Index for all urban consumers (U.S. urban average) for the 12-month period ending with June of the previous year.

''(B) AFTER 2007.—

''(i) ONGOING STUDY AND REPORTS ON ADEQUATE REIMBURSEMENTS.—

''(I) STUDY.—The Secretary shall contract with an eligible organization (as defined in subclause (IV)) to conduct a study to determine the hospital acquisition and handling costs for each individual drug or biological described in subparagraph (D).

''(II) STUDY REQUIREMENTS.—The study conducted under subclause (I) shall—

''(aa) be accurate to within 3 percent of true mean hospital acquisition and handling costs for each drug and biological at the 95 percent confidence level;

''(bb) begin not later than January 1, 2005; and

''(cc) be updated annually for changes in hospital costs and the addition of newly marketed products.

''(III) REPORTS.—Not later than January 1 of each year (beginning with 2006), the Secretary shall submit to Congress a report on the study conducted under clause (i) together with recommendations for such legislative or administrative action as the Secretary determines to be appropriate.

''(IV) ELIGIBLE ORGANIZATION DEFINED.—In this clause, the term 'eligible organization' means a private, nonprofit organization within the meaning of section 501(c) of the Internal Revenue Code.

''(ii) ESTABLISHMENT OF PAYMENT METHODOLOGY.—Notwithstanding paragraph (6), the Secretary, in establishing a payment methodology on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, shall take into consideration the findings of the study conducted under clause (i)(I) in determining payment amounts for each drug and biological provided as part of a covered OPD service furnished on or after January 1, 2007.

''(C) APPLICABLE PERCENTAGE DEFINED.—In this paragraph, the term 'applicable percentage' means—

''(i) with respect to a biological product (approved under a biologics license application under section 351 of the Public Health Service Act), a single source drug (as defined in section 1927(k)(7)(A)(iv)), or an orphan product designated under section 526 of the Food, Drug, and Cosmetic Act to which the prospective payment system established under this subsection did not apply under the final rule for 2003 payments under such system, 94 percent;

''(ii) with respect to an innovator multiple source drug (as defined in section 1927(k)(7)(A)(ii)), 91 percent; and

''(iii) with respect to a noninnovator multiple source drug (as defined in as defined in section 1927(k)(7)(A)(iii)), 71 percent.

''(D) DRUGS AND BIOLOGICALS DESCRIBED.—A drug or biological described in this paragraph is any drug or biological—

''(i) for which the amount of payment was determined under paragraph (6) prior to January 1, 2005;

''(ii) which is assigned to a drug specific ambulatory payment classification on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003; and

''(iii) that would have been reimbursed under paragraph (6) but for the application of this paragraph.''.

(b) EXCEPTIONS TO BUDGET NEUTRALITY REQUIREMENT.—Section 1833(t)(9)(B) (42 U.S.C. 1395l(t)(9)(B)) is amended by adding at the end the following: ''In determining the budget neutrality adjustment required by the preceding sentence for fiscal years 2005 and 2006, the Secretary shall not take into account any expenditures that would not have been made but for the application of paragraph (13).''.

SEC. 438. LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.

Section 1833(t)(6) (42 U.S.C. 1395l(t)(6)) is amended by adding at the end the following new subparagraph:

''(F) LIMITATION OF APPLICATION OF FUNCTIONAL EQUIVALENCE STANDARD.—

''(i) IN GENERAL.—The Secretary may not publish regulations that apply a functional equivalence standard to a drug or biological under this paragraph.

''(ii) APPLICATION.—Paragraph (1) shall apply to the application of a functional equivalence standard to a drug or biological on or after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003 unless—

''(I) such application was being made to such drug or biological prior to such date of enactment; and

''(II) the Secretary applies such standard to such drug or biological only for the purpose of determining eligibility of such drug or biological for additional payments under this paragraph and not for the purpose of any other payments under this title.

''(iii) RULE OF CONSTRUCTION.—Nothing in this subparagraph shall be construed to effect the Secretary's authority to deem a particular drug to be identical to another drug if the 2 products are pharmaceutically equivalent and bioequvalent, as determined by the Commissioner of Food and Drugs.

SEC. 439. MEDICARE COVERAGE OF ROUTINE COSTS ASSOCIATED WITH CERTAIN CLINICAL TRIALS.

(a) IN GENERAL.—With respect to the coverage of routine costs of care for beneficiaries participating in a qualifying clinical trial, as set forth on the date of the enactment of this Act in National Coverage Determination 30-1 of the Medicare Coverage Issues Manual, the Secretary shall deem clinical trials conducted in accordance with an investigational device exemption approved under section 520(g) of the Federal Food, Drug, and Cosmetic Act (42 U.S.C. 360j(g)) to be automatically qualified for such coverage.

(b) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as authorizing or requiring the Secretary to modify the regulations set forth on the date of the enactment of this Act at subpart B of part 405 of title 42, Code of Federal Regulations, or subpart A of part 411 of such title, relating to coverage of, and payment for, a medical device that is the subject of an investigational device exemption by the Food and Drug Administration (except as may be necessary to implement subsection (a)).

(c) EFFECTIVE DATE.—This section shall apply to clinical trials begun on or after January 1, 2005.

SEC. 440. WAIVER OF PART B LATE ENROLLMENT PENALTY FOR CERTAIN MILITARY RETIREES; SPECIAL ENROLLMENT PERIOD.

(a) WAIVER OF PENALTY.—

(1) IN GENERAL.—Section 1839(b) (42 U.S.C. 1395r(b)) is amended by adding at the end the following new sentence: ''No increase in the premium shall be effected for a month in the case of an individual who is 65 years of age or older, who enrolls under this part during 2002, 2003, 2004, or 2005 and who demonstrates to the Secretary before December 31, 2005, that the individual is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code). The Secretary shall consult with the Secretary of Defense in identifying individuals described in the previous sentence.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to premiums for months beginning with January 2005. The Secretary shall establish a method for providing rebates of premium penalties paid for months on or after January 2005 for which a penalty does not apply under such amendment but for which a penalty was previously collected.

(b) MEDICARE PART B SPECIAL ENROLLMENT PERIOD.—

(1) IN GENERAL.—In the case of any individual who, as of the date of enactment of this Act, is 65 years of age or older, is eligible to enroll but is not enrolled under part B of title XVIII of the Social Security Act, and is a covered beneficiary (as defined in section 1072(5) of title 10, United States Code), the Secretary shall provide for a special enrollment period during which the individual may enroll under such part. Such period shall begin 1 year after the date of the enactment of this Act and shall end on December 31, 2005.

(2) COVERAGE PERIOD.—In the case of an individual who enrolls during the special enrollment period provided under paragraph (1), the coverage period under part B of title XVIII of the Social Security Act shall begin on the first day of the month following the month in which the individual enrolls.

SEC. 441. DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.

(a) DEFINITIONS.—In this section:

(1) CHIROPRACTIC SERVICES.—The term ''chiropractic services'' has the meaning given that term by the Secretary for purposes of the demonstration projects, but shall include, at a minimum—

(A) care for neuromusculoskeletal conditions typical among eligible beneficiaries; and

(B) diagnostic and other services that a chiropractor is legally authorized to perform by the State or jurisdiction in which such treatment is provided.

(2) DEMONSTRATION PROJECT.—The term ''demonstration project'' means a demonstration project established by the Secretary under subsection (b)(1).

(3) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means an individual who is enrolled under part B of the medicare program.

(4) MEDICARE PROGRAM.—The term ''medicare program'' means the health benefits program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(b) DEMONSTRATION OF COVERAGE OF CHIROPRACTIC SERVICES UNDER MEDICARE.—

(1) ESTABLISHMENT.—The Secretary shall establish demonstration projects in accordance with the provisions of this section for the purpose of evaluating the feasibility and advisability of covering chiropractic services under the medicare program (in addition to the coverage provided for services consisting of treatment by means of manual manipulation of the spine to correct a subluxation described in section 1861(r)(5) of the Social Security Act (42 U.S.C. 1395x(r)(5))).

(2) NO PHYSICIAN APPROVAL REQUIRED.—In establishing the demonstration projects, the Secretary shall ensure that an eligible beneficiary who participates in a demonstration project, including an eligible beneficiary who is enrolled for coverage under a Medicare+Choice plan (or, on and after January 1, 2006, under a MedicareAdvantage plan), is not required to receive approval from a physician or other health care provider in order to receive a chiropractic service under a demonstration project.

(3) CONSULTATION.—In establishing the demonstration projects, the Secretary shall consult with chiropractors, organizations representing chiropractors, eligible beneficiaries, and organizations representing eligible beneficiaries.

(4) PARTICIPATION.—Any eligible beneficiary may participate in the demonstration projects on a voluntary basis.

(c) CONDUCT OF DEMONSTRATION PROJECTS.—

(1) DEMONSTRATION SITES.—

(A) SELECTION OF DEMONSTRATION SITES.—The Secretary shall conduct demonstration projects at 6 demonstration sites.

(B) GEOGRAPHIC DIVERSITY.—Of the sites described in subparagraph (A)—

(i) 3 shall be in rural areas; and

(ii) 3 shall be in urban areas.

(C) SITES LOCATED IN HPSAS.—At least 1 site described in clause (i) of subparagraph (B) and at least 1 site described in clause (ii) of such subparagraph shall be located in an area that is designated under section 332(a)(1)(A) of the Public Health Service Act (42 U.S.C. 254e(a)(1)(A)) as a health professional shortage area.

(2) IMPLEMENTATION; DURATION.—

(A) IMPLEMENTATION.—The Secretary shall not implement the demonstration projects before October 1, 2004.

(B) DURATION.—The Secretary shall complete the demonstration projects by the date that is 3 years after the date on which the first demonstration project is implemented.

(d) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the demonstration projects—

(A) to determine whether eligible beneficiaries who use chiropractic services use a lesser overall amount of items and services for which payment is made under the medicare program than eligible beneficiaries who do not use such services;

(B) to determine the cost of providing payment for chiropractic services under the medicare program;

(C) to determine the satisfaction of eligible beneficiaries participating in the demonstration projects and the quality of care received by such beneficiaries; and

(D) to evaluate such other matters as the Secretary determines is appropriate.

(2) REPORT.—Not later than the date that is 1 year after the date on which the demonstration projects conclude, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) together with such recommendations for legislation or administrative action as the Secretary determines is appropriate.

(e) WAIVER OF MEDICARE REQUIREMENTS.—The Secretary shall waive compliance with such requirements of the medicare program to the extent and for the period the Secretary finds necessary to conduct the demonstration projects.

(f) FUNDING.—

(1) DEMONSTRATION PROJECTS.—

(A) IN GENERAL.—Subject to subparagraph (B) and paragraph (2), the Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration projects under this section.

(B) LIMITATION.—In conducting the demonstration projects under this section, the Secretary shall ensure that the aggregate payments made by the Secretary under the medicare program do not exceed the amount which the Secretary would have paid under the medicare program if the demonstration projects under this section were not implemented.

(2) EVALUATION AND REPORT.—There are authorized to be appropriated such sums as are necessary for the purpose of developing and submitting the report to Congress under subsection (d).

SEC. 442. MEDICARE HEALTH CARE QUALITY DEMONSTRATION PROGRAMS.

Title XVIII (42 U.S.C. 1395 et seq.) is amended by inserting after section 1866B the following new section:

''HEALTH CARE QUALITY DEMONSTRATION PROGRAM

''SEC. 1866C. (a) DEFINITIONS.—In this section:

''(1) BENEFICIARY.—The term 'beneficiary' means a beneficiary who is enrolled in the original medicare fee-for-service program under parts A and B or a beneficiary in a staff model or dedicated group model health maintenance organization under the Medicare+Choice program (or, on and after January 1, 2006, under the MedicareAdvantage program) under part C.

''(2) HEALTH CARE GROUP.—

''(A) IN GENERAL.—The term 'health care group' means—

''(i) a group of physicians that is organized at least in part for the purpose of providing physician's services under this title;

''(ii) an integrated health care delivery system that delivers care through coordinated hospitals, clinics, home health agencies, ambulatory surgery centers, skilled nursing facilities, rehabilitation facilities and clinics, and employed, independent, or contracted physicians; or

''(iii) an organization representing regional coalitions of groups or systems described in clause (i) or (ii).

''(B) INCLUSION.—As the Secretary determines appropriate, a health care group may include a hospital or any other individual or entity furnishing items or services for which payment may be made under this title that is affiliated with the health care group under an arrangement structured so that such hospital, individual, or entity participates in a demonstration project under this section.

''(3) PHYSICIAN.—Except as otherwise provided for by the Secretary, the term 'physician' means any individual who furnishes services that may be paid for as physicians' services under this title.

''(b) DEMONSTRATION PROJECTS.—The Secretary shall establish a 5-year demonstration program under which the Secretary shall approve demonstration projects that examine health delivery factors that encourage the delivery of improved quality in patient care, including—

''(1) the provision of incentives to improve the safety of care provided to beneficiaries;

''(2) the appropriate use of best practice guidelines by providers and services by beneficiaries;

''(3) reduced scientific uncertainty in the delivery of care through the examination of variations in the utilization and allocation of services, and outcomes measurement and research;

''(4) encourage shared decision making between providers and patients;

''(5) the provision of incentives for improving the quality and safety of care and achieving the efficient allocation of resources;

''(6) the appropriate use of culturally and ethnically sensitive health care delivery; and

''(7) the financial effects on the health care marketplace of altering the incentives for care delivery and changing the allocation of resources.

''(c) ADMINISTRATION BY CONTRACT.—

''(1) IN GENERAL.—Except as otherwise provided in this section, the Secretary may administer the demonstration program established under this section in a manner that is similar to the manner in which the demonstration program established under section 1866A is administered in accordance with section 1866B.

''(2) ALTERNATIVE PAYMENT SYSTEMS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include proposals for the use of alternative payment systems for items and services provided to beneficiaries by the group that are designed to—

''(A) encourage the delivery of high quality care while accomplishing the objectives described in subsection (b); and

''(B) streamline documentation and reporting requirements otherwise required under this title.

''(3) BENEFITS.—A health care group that receives assistance under this section may, with respect to the demonstration project to be carried out with such assistance, include modifications to the package of benefits available under the traditional fee-for-service program under parts A and B or the package of benefits available through a staff model or a dedicated group model health maintenance organization under part C. The criteria employed under the demonstration program under this section to evaluate outcomes and determine best practice guidelines and incentives shall not be used as a basis for the denial of medicare benefits under the demonstration program to patients against their wishes (or if the patient is incompetent, against the wishes of the patient's surrogate) on the basis of the patient's age or expected length of life or of the patient's present or predicted disability, degree of medical dependency, or quality of life.

''(d) ELIGIBILITY CRITERIA.—To be eligible to receive assistance under this section, an entity shall—

''(1) be a health care group;

''(2) meet quality standards established by the Secretary, including—

''(A) the implementation of continuous quality improvement mechanisms that are aimed at integrating community-based support services, primary care, and referral care;

''(B) the implementation of activities to increase the delivery of effective care to beneficiaries;

''(C) encouraging patient participation in preference-based decisions;

''(D) the implementation of activities to encourage the coordination and integration of medical service delivery; and

''(E) the implementation of activities to measure and document the financial impact on the health care marketplace of altering

the incentives of health care delivery and changing the allocation of resources; and

''(3) meet such other requirements as the Secretary may establish.

''(e) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII as may be necessary to carry out the purposes of the demonstration program established under this section.

''(f) BUDGET NEUTRALITY.—With respect to the 5-year period of the demonstration program under subsection (b), the aggregate expenditures under this title for such period shall not exceed the aggregate expenditures that would have been expended under this title if the program established under this section had not been implemented.

''(g) NOTICE REQUIREMENTS.—In the case of an individual that receives health care items or services under a demonstration program carried out under this section, the Secretary shall ensure that such individual is notified of any waivers of coverage or payment rules that are applicable to such individual under this title as a result of the participation of the individual in such program.

''(h) PARTICIPATION AND SUPPORT BY FEDERAL AGENCIES.—In carrying out the demonstration program under this section, the Secretary may direct—

''(1) the Director of the National Institutes of Health to expand the efforts of the Institutes to evaluate current medical technologies and improve the foundation for evidence-based practice;

''(2) the Administrator of the Agency for Healthcare Research and Quality to, where possible and appropriate, use the program under this section as a laboratory for the study of quality improvement strategies and to evaluate, monitor, and disseminate information relevant to such program; and

''(3) the Administrator of the Centers for Medicare & Medicaid Services and the Administrator of the Center for Medicare Choices to support linkages of relevant medicare data to registry information from participating health care groups for the beneficiary populations served by the participating groups, for analysis supporting the purposes of the demonstration program, consistent with the applicable provisions of the Health Insurance Portability and Accountability Act of 1996.

''(i) IMPLEMENTATION.—The Secretary shall not implement the demonstration program before October 1, 2004.''.

SEC. 443. MEDICARE COMPLEX CLINICAL CARE MANAGEMENT PAYMENT DEMONSTRATION.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to make the medicare program more responsive to needs of eligible beneficiaries by promoting continuity of care, helping stabilize medical conditions, preventing or minimizing acute exacerbations of chronic conditions, and reducing adverse health outcomes, such as adverse drug interactions related to polypharmacy.

(2) SITES.—The Secretary shall designate 6 sites at which to conduct the demonstration program under this section, of which at least 3 shall be in an urban area and at least 1 shall be in a rural area. One of the sites shall be located in the State of Arkansas.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 3-year period.

(4) IMPLEMENTATION.—The Secretary shall not implement the demonstration program before October 1, 2004.

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a principal care physician who agrees to manage the complex clinical care of the eligible beneficiary under the demonstration program.

(c) PRINCIPAL CARE PHYSICIAN RESPONSIBILITIES.—The Secretary shall enter into an agreement with each principal care physician who agrees to manage the complex clinical care of an eligible beneficiary under subsection (b) under which the principal care physician shall—

(1) serve as the primary contact of the eligible beneficiary in accessing items and services for which payment may be made under the medicare program;

(2) maintain medical information related to care provided by other health care providers who provide health care items and services to the eligible beneficiary, including clinical reports, medication and treatments prescribed by other physicians, hospital and hospital outpatient services, skilled nursing home care, home health care, and medical equipment services;

(3) monitor and advocate for the continuity of care of the eligible beneficiary and the use of evidence-based guidelines;

(4) promote self-care and family caregiver involvement where appropriate;

(5) have appropriate staffing arrangements to conduct patient self-management and other care coordination activities as specified by the Secretary;

(6) refer the eligible beneficiary to community services organizations and coordinate the services of such organizations with the care provided by health care providers; and

(7) meet such other complex care management requirements as the Secretary may specify.

(d) COMPLEX CLINICAL CARE MANAGEMENT FEE.—

(1) PAYMENT.—Under an agreement entered into under subsection (c), the Secretary shall pay to each principal care physician, on behalf of each eligible beneficiary under the care of that physician, the complex clinical care management fee developed by the Secretary under paragraph (2).

(2) DEVELOPMENT OF FEE.—The Secretary shall develop a complex care management fee under this paragraph that is paid on a monthly basis and which shall be payment in full for all the functions performed by the principal care physician under the demonstration program, including any functions performed by other qualified practitioners acting on behalf of the physician, appropriate staff under the supervision of the physician, and any other person under a contract with the physician, including any person who conducts patient self-management and caregiver education under subsection (c)(4).

(e) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Supplementary Insurance Trust Fund established under section 1841 of the Social Security Act (42 U.S.C. 1395t) of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(f) WAIVER AUTHORITY.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(g) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) ACTIVITY OF DAILY LIVING.—The term ''activity of daily living'' means eating, toiling, transferring, bathing, dressing, and continence.

(2) CHRONIC CONDITION.—The term ''chronic condition'' means a biological, physical, or mental condition that is likely to last a year or more, for which there is no known cure, for which there is a need for ongoing medical care, and which may affect an individual's ability to carry out activities of daily living or instrumental activities of daily living, or both.

(3) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means any individual who—

(A) is enrolled for benefits under part B of the medicare program;

(B) has at least 4 complex medical conditions (one of which may be cognitive impairment); and

(C) has—

(i) an inability to self-manage their care; or

(ii) a functional limitation defined as an impairment in 1 or more activity of daily living or instrumental activity of daily living.

(4) INSTRUMENTAL ACTIVITY OF DAILY LIVING.—The term ''instrumental activity of daily living'' means meal preparation, shopping, housekeeping, laundry, money management, telephone use, and transportation use.

(5) MEDICARE PROGRAM.—The term ''medicare program'' means the health care program under title XVIII of the Social Security Act (42 U.S.C. 1395 et seq.).

(6) PRINCIPAL CARE PHYSICIAN.—The term ''principal care physician'' means the physician with primary responsibility for overall coordination of the care of an eligible beneficiary (as specified in a written plan of care) who may be a primary care physician or a specialist.

SEC. 444. MEDICARE FEE-FOR-SERVICE CARE COORDINATION DEMONSTRATION PROGRAM.

(a) ESTABLISHMENT.—

(1) IN GENERAL.—The Secretary shall establish a demonstration program to contract with qualified care management organizations to provide health risk assessment and care management services to eligible beneficiaries who receive care under the original medicare fee-for-service program under parts A and B of title XVIII of the Social Security Act to eligible beneficiaries.

(2) SITES.—The Secretary shall designate 6 sites at which to conduct the demonstration program under this section. In selecting sites under this paragraph, the Secretary shall give preference to sites located in rural areas.

(3) DURATION.—The Secretary shall conduct the demonstration program under this section for a 5-year period.

(4) IMPLEMENTATION.—The Secretary shall not implement the demonstration program before October 1, 2004.

(b) PARTICIPANTS.—Any eligible beneficiary who resides in an area designated by the Secretary as a demonstration site under subsection (a)(2) may participate in the demonstration program under this section if such beneficiary identifies a care management organization who agrees to furnish care management services to the eligible beneficiary under the demonstration program.

(c) CONTRACTS WITH CMOS.—

(1) IN GENERAL.—The Secretary shall enter into a contract with care management organizations to provide care management services to eligible beneficiaries residing in the area served by the care management organization.

(2) CANCELLATION.—The Secretary may cancel a contract entered into under paragraph (1) if the care management organization does not meet negotiated savings or quality outcomes targets for the year.

(3) NUMBER OF CMOS.—The Secretary may contract with more than 1 care management organization in a geographic area.

(d) PAYMENT TO CMOS.—

(1) PAYMENT.—Under an contract entered into under subsection (c), the Secretary shall pay care management organizations a fee for which the care management organization is partially at risk based on bids submitted by care management organizations.

(2) PORTION OF PAYMENT AT RISK.—The Secretary shall establish a benchmark for quality and cost against which the results of the care management organization are to be measured. The Secretary may not pay a care management organization the portion of the fee described in paragraph (1) that is at risk unless the Secretary determines that the care management organization has met the agreed upon savings and outcomes targets for the year.

(e) FUNDING.—

(1) IN GENERAL.—The Secretary shall provide for the transfer from the Federal Hospital Insurance Trust Fund under section 1817 of the Social Security Act (42 U.S.C. 1395i) and the Federal Supplementary Insurance Trust Fund established under section 1841 of such Act (42 U.S.C. 1395t), in such proportion as the Secretary determines to be appropriate, of such funds as are necessary for the costs of carrying out the demonstration program under this section.

(2) BUDGET NEUTRALITY.—In conducting the demonstration program under this section, the Secretary shall ensure that the aggregate payments made by the Secretary do not exceed the amount which the Secretary would have paid if the demonstration program under this section was not implemented.

(f) WAIVER AUTHORITY.—

(1) IN GENERAL.—The Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purpose of carrying out the demonstration program under this section.

(2) WAIVER OF MEDIGAP PREEMPTIONS.—The Secretary shall waive any provision of section 1882 of the Social Security Act that would prevent an insurance carrier described in subsection (h)(3)(D) from participating in the demonstration program under this section.

(g) REPORT.—Not later than 6 months after the completion of the demonstration program under this section, the Secretary shall submit to Congress a report on such program, together with recommendations for such legislation and administrative action as the Secretary determines to be appropriate.

(h) DEFINITIONS.—In this section:

(1) CARE MANAGEMENT SERVICES.—The term ''care management services'' means services that are furnished to an eligible beneficiary (as defined in paragraph (2)) by a care management organization (as defined in paragraph (3)) in accordance with guidelines established by the Secretary that are consistent with guidelines established by the American Geriatrics Society.

(2) ELIGIBLE BENEFICIARY.—The term ''eligible beneficiary'' means an individual who is—

(A) entitled to (or enrolled for) benefits under part A and enrolled for benefits under part B of the Social Security Act (42 U.S.C. 1395c et seq.; 1395j et seq.);

(B) not enrolled with a Medicare+Choice plan or a MedicareAdvantage plan under part C; and

(C) at high-risk (as defined by the Secretary, but including eligible beneficiaries with multiple sclerosis or another disabling chronic condition, eligible beneficiaries residing in a nursing home or at risk for nursing home placement, or eligible beneficiaries eligible for assistance under a State plan under title XIX).

(3) CARE MANAGEMENT ORGANIZATION.—The term ''care management organization'' means an organization that meets such qualifications as the Secretary may specify and includes any of the following:

(A) A physician group practice, hospital, home health agency, or hospice program.

(B) A disease management organization.

(C) A Medicare+Choice or MedicareAdvantage organization.

(D) Insurance carriers offering medicare supplemental policies under section 1882 of the Social Security Act (42 U.S.C. 1395ss).

(E) Such other entity as the Secretary determines to be appropriate.

SEC. 445. GAO STUDY OF GEOGRAPHIC DIFFERENCES IN PAYMENTS FOR PHYSICIANS' SERVICES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study of differences in payment amounts under the physician fee schedule under section 1848 of the Social Security Act (42 U.S.C. 1395w–4) for physicians' services in different geographic areas. Such study shall include—

(1) an assessment of the validity of the geographic adjustment factors used for each component of the fee schedule;

(2) an evaluation of the measures used for such adjustment, including the frequency of revisions;

(3) an evaluation of the methods used to determine professional liability insurance costs used in computing the malpractice component, including a review of increases in professional liability insurance premiums and variation in such increases by State and physician specialty and methods used to update the geographic cost of practice index and relative weights for the malpractice component;

(4) an evaluation of whether there is a sound economic basis for the implementation of the adjustment under subparagraphs (E) and (F) of section 1848(e)(1) of the Social Security Act (42 U.S.C. 1395w–4(e)(1)), as added by section 421, in those areas in which the adjustment applies;

(5) an evaluation of the effect of such adjustment on physician location and retention in areas affected by such adjustment, taking into account—

(A) differences in recruitment costs and retention rates for physicians, including specialists, between large urban areas and other areas; and

(B) the mobility of physicians, including specialists, over the last decade; and

(6) an evaluation of appropriateness of extending such adjustment or making such adjustment permanent.

(b) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General of the United States shall submit to Congress a report on the study conducted under subsection (a). The report shall include recommendations regarding the use of more current data in computing geographic cost of practice indices as well as the use of data directly representative of physicians' costs (rather than proxy measures of such costs).

Subtitle C—Provisions Relating to Parts A and B

SEC. 451. INCREASE FOR HOME HEALTH SERVICES FURNISHED IN A RURAL AREA.

(a) IN GENERAL.—In the case of home health services furnished in a rural area (as defined in section 1886(d)(2)(D) of the Social Security Act (42 U.S.C. 1395ww(d)(2)(D))) on or after October 1, 2004, and before October 1, 2006, the Secretary shall increase the payment amount otherwise made under section 1895 of such Act (42 U.S.C. 1395fff) for such services by 5 percent.

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

(c) NO EFFECT ON SUBSEQUENT PERIODS.—The payment increase provided under subsection (a) for a period under such subsection—

(1) shall not apply to episodes and visits ending after such period; and

(2) shall not be taken into account in calculating the payment amounts applicable for episodes and visits occurring after such period.

SEC. 452. LIMITATION ON REDUCTION IN AREA WAGE ADJUSTMENT FACTORS UNDER THE PROSPECTIVE PAYMENT SYSTEM FOR HOME HEALTH SERVICES.

Section 1895(b)(4)(C) (42 U.S.C. 1395fff(b)(4)(C)) is amended—

(1) by striking ''FACTORS.—The Secretary'' and inserting ''FACTORS.—

''(i) IN GENERAL.—Subject to clause (ii), the Secretary''; and

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

''(ii) LIMITATION ON REDUCTION IN FISCAL YEAR 2005 AND 2006.—For fiscal years 2005 and 2006, the area wage adjustment factor applicable to home health services furnished in an area in the fiscal year may not be more that 3 percent less than the area wage adjustment factor applicable to home health services for the area for the previous year.''.

SEC. 453. CLARIFICATIONS TO CERTAIN EXCEPTIONS TO MEDICARE LIMITS ON PHYSICIAN REFERRALS.

(a) LIMITS ON PHYSICIAN REFERRALS.—

(1) OWNERSHIP AND INVESTMENT INTERESTS IN WHOLE HOSPITALS.—

(A) IN GENERAL.—Section 1877(d)(3) (42 U.S.C. 1395nn(d)(3)) is amended—

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

(ii) by redesignating subparagraph (B) as subparagraph (C) and inserting after subparagraph (A) the following:

''(B) the hospital is not a specialty hospital (as defined in subsection (h)(7)); and''.

(B) DEFINITION.—Section 1877(h) (42 U.S.C. 1395nn(h)) is amended by adding at the end the following:

''(7) SPECIALTY HOSPITAL.—

''(A) IN GENERAL.—For purposes of this section, except as provided in subparagraph (B), the term 'specialty hospital' means a hospital that is primarily or exclusively engaged in the care and treatment of one of the following:

''(i) patients with a cardiac condition;

''(ii) patients with an orthopedic condition;

''(iii) patients receiving a surgical procedure; or

''(iv) any other specialized category of patients or cases that the Secretary designates as inconsistent with the purpose of permitting physician ownership and investment interests in a hospital under this section.

''(B) EXCEPTION.—For purposes of this section, the term 'specialty hospital' does not include any hospital—

''(i) determined by the Secretary—

''(I) to be in operation before June 12, 2003; or

''(II) under development as of such date;

''(ii) for which the number of beds and the number of physician investors at any time on or after such date is no greater than the number of such beds or investors as of such date; and

''(iii) that meets such other requirements as the Secretary may specify.''.

(2) OWNERSHIP AND INVESTMENT INTERESTS IN A RURAL PROVIDER.—Section 1877(d)(2) (42 U.S.C. 1395nn(d)(2)) is amended to read as follows:

''(2) RURAL PROVIDERS.—In the case of designated health services furnished in a rural area (as defined in section 1886(d)(2)(D)) by an entity, if—

''(A) substantially all of the designated health services furnished by the entity are furnished to individuals residing in such a rural area;

''(B) the entity is not a specialty hospital (as defined in subsection (h)(7)); and

''(C) the Secretary determines, with respect to such entity, that such services would not be available in such area but for the ownership or investment interest.''.

(b) EFFECTIVE DATE.—Subject to paragraph (2), the amendments made by this section shall apply to referrals made for designated health services on or after January 1, 2004.

(c) APPLICATION OF EXCEPTION FOR HOSPITALS UNDER DEVELOPMENT.—For purposes of section 1877(h)(7)(B)(i)(II) of the Social Security Act, as added by subsection (a)(1)(B), in determining whether a hospital is under development as of June 12, 2003, the Secretary shall consider—

(1) whether architectural plans have been completed, funding has been received, zoning requirements have been met, and necessary approvals from appropriate State agencies have been received; and

(2) any other evidence the Secretary determines would indicate whether a hospital is under development as of such date.

SEC. 454. DEMONSTRATION PROGRAM FOR SUBSTITUTE ADULT DAY SERVICES.

(a) ESTABLISHMENT.—The Secretary shall establish a demonstration program (in this section referred to as the ''demonstration program'') under which the Secretary provides eligible medicare beneficiaries with coverage under the medicare program of substitute adult day services furnished by an adult day services facility.

(b) PAYMENT RATE FOR SUBSTITUTE ADULT DAY SERVICES.—

(1) PAYMENT RATE.—For purposes of making payments to an adult day services facility for substitute adult day services under the demonstration program, the following rules shall apply:

(A) ESTIMATION OF PAYMENT AMOUNT.—The Secretary shall estimate the amount that would otherwise be payable to a home health agency under section 1895 of the Social Security Act (42 U.S.C. 1395fff) for all home health services described in subsection (i)(4)(B)(i) under the plan of care.

(B) AMOUNT OF PAYMENT.—Subject to paragraph (3)(B), the total amount payable for substitute adult day services under the plan of care is equal to 95 percent of the amount estimated to be payable under subparagraph (A).

(2) LIMITATION ON BALANCE BILLING.—Under the demonstration program, an adult day services facility shall accept as payment in full for substitute adult day services (including those services described in clauses (ii) through (iv) of subsection (i)(4)(B)) furnished by the facility to an eligible medicare beneficiary the amount of payment provided under the demonstration program for home health services consisting of substitute adult services.

(3) ADJUSTMENT IN CASE OF OVERUTILIZATION OF SUBSTITUTE ADULT DAY SERVICES TO ENSURE BUDGET NEUTRALITY.—The Secretary shall monitor the expenditures under the demonstration program and under title XVIII of the Social Security Act for home health services. If the Secretary estimates that the total expenditures under the demonstration program and under such title XVIII for home health services for a period determined by the Secretary exceed expenditures that would have been made under such title XVIII for home health services for such period if the demonstration program had not been conducted, the Secretary shall adjust the rate of payment to adult day services facilities under paragraph (1)(B) in order to eliminate such excess.

(c) DEMONSTRATION PROGRAM SITES.—The demonstration program shall be conducted in not more than 3 sites selected by the Secretary.

(d) DURATION; IMPLEMENTATION.—

(1) DURATION.—The Secretary shall conduct the demonstration program for a period of 3 years.

(2) IMPLEMENTATION.—The Secretary may not implement the demonstration program before October 1, 2004.

(e) VOLUNTARY PARTICIPATION.—Participation of eligible medicare beneficiaries in the demonstration program shall be voluntary.

(f) WAIVER AUTHORITY.—

(1) IN GENERAL.—Except as provided in paragraph (2), the Secretary may waive such requirements of titles XI and XVIII of the Social Security Act (42 U.S.C. 1301 et seq.; 1395 et seq.) as may be necessary for the purposes of carrying out the demonstration program.

(2) MAY NOT WAIVE ELIGIBILITY REQUIREMENTS FOR HOME HEALTH SERVICES.—The Secretary may not waive the beneficiary eligibility requirements for home health services under title XVIII of the Social Security Act.

(g) EVALUATION AND REPORT.—

(1) EVALUATION.—The Secretary shall conduct an evaluation of the clinical and cost effectiveness of the demonstration program.

(2) REPORT.—Not later than 30 months after the commencement of the demonstration program, the Secretary shall submit to Congress a report on the evaluation conducted under paragraph (1) and shall include in the report the following:

(A) An analysis of the patient outcomes and costs of furnishing care to the eligible medicare beneficiaries participating in the demonstration program as compared to such outcomes and costs to such beneficiaries receiving only home health services under title XVIII of the Social Security Act for the same health conditions.

(B) Such recommendations regarding the extension, expansion, or termination of the program as the Secretary determines appropriate.

(i) DEFINITIONS.—In this section:

(1) ADULT DAY SERVICES FACILITY.—

(A) IN GENERAL.—Except as provided in subparagraphs (B) and (C), the term ''adult day services facility'' means a public agency or private organization, or a subdivision of such an agency or organization, that—

(i) is engaged in providing skilled nursing services and other therapeutic services directly or under arrangement with a home health agency;

(ii) provides the items and services described in paragraph (4)(B); and

(iii) meets the requirements of paragraphs (2) through (8) of subsection (o).

(B) INCLUSION.—Notwithstanding subparagraph (A), the term ''adult day services facility'' shall include a home health agency in which the items and services described in clauses (ii) through (iv) of paragraph (4)(B) are provided—

(i) by an adult day services program that is licensed or certified by a State, or accredited, to furnish such items and services in the State; and

(ii) under arrangements with that program made by such agency.

(C) WAIVER OF SURETY BOND.—The Secretary may waive the requirement of a surety bond under section 1861(o)(7) of the Social Security Act (42 U.S.C. 1395x(o)(7)) in the case of an agency or organization that provides a comparable surety bond under State law.

(2) ELIGIBLE MEDICARE BENEFICIARY.—The term ''eligible medicare beneficiary'' means an individual eligible for home health services under title XVIII of the Social Security Act.

(3) HOME HEALTH AGENCY.—The term ''home health agency'' has the meaning given such term in section 1861(o) of the Social Security Act (42 U.S.C. 1395x(o)).

(4) SUBSTITUTE ADULT DAY SERVICES.—

(A) IN GENERAL.—The term ''substitute adult day services'' means the items and services described in subparagraph (B) that are furnished to an individual by an adult day services facility as a part of a plan under section 1861(m) of the Social Security Act (42 U.S.C. 1395x(m)) that substitutes such services for some or all of the items and services described in subparagraph (B)(i) furnished by a home health agency under the plan, as determined by the physician establishing the plan.

(B) ITEMS AND SERVICES DESCRIBED.—The items and services described in this subparagraph are the following items and services:

(i) Items and services described in paragraphs (1) through (7) of such section 1861(m).

(ii) Meals.

(iii) A program of supervised activities designed to promote physical and mental health and furnished to the individual by the adult day services facility in a group setting for a period of not fewer than 4 and not greater than 12 hours per day.

(iv) A medication management program (as defined in subparagraph (C)).

(C) MEDICATION MANAGEMENT PROGRAM.—For purposes of subparagraph (B)(iv), the term ''medication management program'' means a program of services, including medicine screening and patient and health care provider education programs, that provides services to minimize—

(i) unnecessary or inappropriate use of prescription drugs; and

(ii) adverse events due to unintended prescription drug-to-drug interactions.

TITLE V—MEDICARE APPEALS, REGULATORY, AND CONTRACTING IMPROVEMENTS

Subtitle A—Regulatory Reform

SEC. 501. RULES FOR THE PUBLICATION OF A FINAL REGULATION BASED ON THE PREVIOUS PUBLICATION OF AN INTERIM FINAL REGULATION.

(a) IN GENERAL.—Section 1871(a) (42 U.S.C. 1395hh(a)) is amended by adding at the end the following new paragraph:

''(3)(A) With respect to the publication of a final regulation based on the previous publication of an interim final regulation—

''(i) subject to subparagraph (B), the Secretary shall publish the final regulation within the 12-month period that begins on the date of publication of the interim final regulation;

''(ii) if a final regulation is not published by the deadline established under this paragraph, the interim final regulation shall not continue in effect unless the Secretary publishes a notice described in subparagraph (B) by such deadline; and

''(iii) the final regulation shall include responses to comments submitted in response to the interim final regulation.

''(B) If the Secretary determines before the deadline otherwise established in this paragraph that there is good cause, specified in a notice published before such deadline, for delaying the deadline otherwise applicable under this paragraph, the deadline otherwise established under this paragraph shall be extended for such period (not to exceed 12 months) as the Secretary specifies in such notice.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act and shall apply to interim final regulations published on or after such date.

(c) STATUS OF PENDING INTERIM FINAL REGULATIONS.—Not later than 6 months after the date of enactment of this Act, the Secretary shall publish a notice in the Federal Register that provides the status of each interim final regulation that was published on or before the date of enactment of this Act and for which no final regulation has been published. Such notice shall include the date by which the Secretary plans to publish the final regulation that is based on the interim final regulation.

SEC. 502. COMPLIANCE WITH CHANGES IN REGULATIONS AND POLICIES.

(a) NO RETROACTIVE APPLICATION OF SUBSTANTIVE CHANGES.—

(1) IN GENERAL.—Section 1871 (42 U.S.C. 1395hh) is amended by adding at the end the following new subsection:

''(d)(1)(A) A substantive change in regulations, manual instructions, interpretative rules, statements of policy, or guidelines of general applicability under this title shall not be applied (by extrapolation or otherwise) retroactively to items and services furnished before the effective date of the change, unless the Secretary determines that—

''(i) such retroactive application is necessary to comply with statutory requirements; or

''(ii) failure to apply the change retroactively would be contrary to the public interest.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to substantive changes issued on or after the date of enactment of this Act.

(b) TIMELINE FOR COMPLIANCE WITH SUBSTANTIVE CHANGES AFTER NOTICE.—

(1) IN GENERAL.—Section 1871(d)(1), as added by subsection (a), is amended by adding at the end the following:

''(B) A compliance action may be made against a provider of services, physician, practitioner, or other supplier with respect to noncompliance with such a substantive change only for items and services furnished on or after the effective date of the change.

''(C)(i) Except as provided in clause (ii), a substantive change may not take effect before the date that is the end of the 30-day period that begins on the date that the Secretary has issued or published, as the case may be, the substantive change.

''(ii) The Secretary may provide for a substantive change to take effect on a date that precedes the end of the 30-day period under clause (i) if the Secretary finds that waiver of such 30-day period is necessary to comply with statutory requirements or that the application of such 30-day period is contrary to the public interest. If the Secretary provides for an earlier effective date pursuant to this clause, the Secretary shall include in the issuance or publication of the substantive change a finding described in the first sentence, and a brief statement of the reasons for such finding.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall apply to compliance actions undertaken on or after the date of enactment of this Act.

SEC. 503. REPORT ON LEGAL AND REGULATORY INCONSISTENCIES.

Section 1871 (42 U.S.C. 1395hh), as amended by section 502(a)(1), is amended by adding at the end the following new subsection:

''(e)(1) Not later than 2 years after the date of enactment of this subsection, and every 3 years thereafter, the Secretary shall submit to Congress a report with respect to the administration of this title and areas of inconsistency or conflict among the various provisions under law and regulation.

''(2) In preparing a report under paragraph (1), the Secretary shall collect—

''(A) information from beneficiaries, providers of services, physicians, practitioners, and other suppliers with respect to such areas of inconsistency and conflict; and

''(B) information from medicare contractors that tracks the nature of all communications and correspondence.

''(3) A report under paragraph (1) shall include a description of efforts by the Secretary to reduce such inconsistency or conflicts, and recommendations for legislation or administrative action that the Secretary determines appropriate to further reduce such inconsistency or conflicts.''.

Subtitle B—Appeals Process Reform

SEC. 511. SUBMISSION OF PLAN FOR TRANSFER OF RESPONSIBILITY FOR MEDICARE APPEALS.

(a) SUBMISSION OF TRANSITION PLAN.—

(1) IN GENERAL.—Not later than April 1, 2004, the Commissioner of Social Security and the Secretary shall develop and transmit to Congress and the Comptroller General of the United States a plan under which the functions of administrative law judges responsible for hearing cases under title XVIII of the Social Security Act (and related provisions in title XI of such Act) are transferred from the responsibility of the Commissioner and the Social Security Administration to the Secretary and the Department of Health and Human Services.

(2) CONTENTS.—The plan shall include information on the following:

(A) WORKLOAD.—The number of such administrative law judges and support staff required now and in the future to hear and decide such cases in a timely manner, taking into account the current and anticipated claims volume, appeals, number of beneficiaries, and statutory changes.

(B) COST PROJECTIONS AND FINANCING.—Funding levels required for fiscal year 2005 and subsequent fiscal years to carry out the functions transferred under the plan and how such transfer should be financed.

(C) TRANSITION TIMETABLE.—A timetable for the transition.

(D) REGULATIONS.—The establishment of specific regulations to govern the appeals process.

(E) CASE TRACKING.—The development of a unified case tracking system that will facilitate the maintenance and transfer of case specific data across both the fee-for-service and managed care components of the medicare program.

(F) FEASIBILITY OF PRECEDENTIAL AUTHORITY.—The feasibility of developing a process to give decisions of the Departmental Appeals Board in the Department of Health and Human Services addressing broad legal issues binding, precedential authority.

(G) ACCESS TO ADMINISTRATIVE LAW JUDGES.—The feasibility of—

(i) filing appeals with administrative law judges electronically; and

(ii) conducting hearings using tele- or video-conference technologies.

(H) INDEPENDENCE OF ADMINISTRATIVE LAW JUDGES.—The steps that should be taken to ensure the independence of administrative law judges, including ensuring that such judges are in an office that is functionally and operationally separate from the Centers for Medicare & Medicaid Services and the Center for Medicare Choices.

(I) GEOGRAPHIC DISTRIBUTION.—The steps that should be taken to provide for an appropriate geographic distribution of administrative law judges throughout the United States to ensure timely access to such judges.

(J) HIRING.—The steps that should be taken to hire administrative law judges (and support staff).

(K) PERFORMANCE STANDARDS.—The establishment of performance standards for administrative law judges with respect to timelines for decisions in cases under title XVIII of the Social Security Act.

(L) SHARED RESOURCES.—The feasibility of the Secretary entering into such arrangements with the Commissioner of Social Security as may be appropriate with respect to transferred functions under the plan to share office space, support staff, and other resources, with appropriate reimbursement.

(M) TRAINING.—The training that should be provided to administrative law judges with respect to laws and regulations under title XVIII of the Social Security Act.

(3) ADDITIONAL INFORMATION.—The plan may also include recommendations for further congressional action, including modifications to the requirements and deadlines established under section 1869 of the Social Security Act (as amended by sections 521 and 522 of BIPA (114 Stat. 2763A–534) and this Act).

(b) GAO EVALUATION.—The Comptroller General of the United States shall—

(1) evaluate the plan submitted under subsection (a); and

(2) not later than 6 months after such submission, submit to Congress, the Commissioner of Social Security, and the Secretary a report on such evaluation.

(c) SUBMISSION OF GAO REPORT REQUIRED BEFORE PLAN IMPLEMENTATION.—The Commissioner of Social Security and the Secretary may not implement the plan developed under subsection (a) before the date that is 6 months after the date the report required under subsection (b)(2) is submitted to the Commissioner and the Secretary.

SEC. 512. EXPEDITED ACCESS TO JUDICIAL REVIEW.

(a) IN GENERAL.—Section 1869(b) (42 U.S.C. 1395ff(b)) is amended—

(1) in paragraph (1)(A), by inserting '', subject to paragraph (2),'' before ''to judicial review of the Secretary's final decision''; and

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

''(2) EXPEDITED ACCESS TO JUDICIAL REVIEW.—

''(A) IN GENERAL.—The Secretary shall establish a process under which a provider of services or supplier that furnishes an item or service or a beneficiary who has filed an appeal under paragraph (1) (other than an appeal filed under paragraph (1)(F)(i)) may obtain access to judicial review when a review entity (described in subparagraph (D)), on its own motion or at the request of the appellant, determines that the Departmental Appeals Board does not have the authority to decide the question of law or regulation relevant to the matters in controversy and that there is no material issue of fact in dispute. The appellant may make such request only once with respect to a question of law or regulation for a specific matter in dispute in a case of an appeal.

''(B) PROMPT DETERMINATIONS.—If, after or coincident with appropriately filing a request for an administrative hearing, the appellant requests a determination by the appropriate review entity that the Departmental Appeals Board does not have the authority to decide the question of law or regulations relevant to the matters in controversy and that there is no material issue of fact in dispute, and if such request is accompanied by the documents and materials as the appropriate review entity shall require for purposes of making such determination, such review entity shall make a determination on the request in writing within 60 days after the date such review entity receives the request and such accompanying documents and materials. Such a determination by such review entity shall be considered a final decision and not subject to review by the Secretary.

''(C) ACCESS TO JUDICIAL REVIEW.—

''(i) IN GENERAL.—If the appropriate review entity—

''(I) determines that there are no material issues of fact in dispute and that the only issues to be adjudicated are ones of law or regulation that the Departmental Appeals Board does not have authority to decide; or

''(II) fails to make such determination within the period provided under subparagraph (B);

then the appellant may bring a civil action as described in this subparagraph.

''(ii) DEADLINE FOR FILING.—Such action shall be filed, in the case described in—

''(I) clause (i)(I), within 60 days of the date of the determination described in such clause; or

''(II) clause (i)(II), within 60 days of the end of the period provided under subparagraph (B) for the determination.

''(iii) VENUE.—Such action shall be brought in the district court of the United States for the judicial district in which the appellant is located (or, in the case of an action brought jointly by more than 1 applicant, the judicial district in which the greatest number of applicants are located) or in the District Court for the District of Columbia.

''(iv) INTEREST ON ANY AMOUNTS IN CONTROVERSY.—Where a provider of services or supplier is granted judicial review pursuant to this paragraph, the amount in controversy (if any) shall be subject to annual interest beginning on the first day of the first month beginning after the 60-day period as determined pursuant to clause (ii) and equal to the rate of interest on obligations issued for purchase by the Federal Supplementary Medical Insurance Trust Fund for the month in which the civil action authorized under this paragraph is commenced, to be awarded by the reviewing court in favor of the prevailing party. No interest awarded pursuant to the preceding sentence shall be deemed income or cost for the purposes of determining reimbursement due providers of services, physicians, practitioners, and other suppliers under this Act.

''(D) REVIEW ENTITY DEFINED.—For purposes of this subsection, a 'review entity' is a panel of no more than 3 members from the Departmental Appeals Board, selected for the purpose of making determinations under this paragraph.''.

(b) APPLICATION TO PROVIDER AGREEMENT DETERMINATIONS.—Section 1866(h)(1) (42 U.S.C. 1395cc(h)(1)) is amended—

(1) by inserting ''(A)'' after ''(h)(1)''; and

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

''(B) An institution or agency described in subparagraph (A) that has filed for a hearing under subparagraph (A) shall have expedited access to judicial review under this subparagraph in the same manner as providers of services, suppliers, and beneficiaries may obtain expedited access to judicial review under the process established under section 1869(b)(2). Nothing in this subparagraph shall be construed to affect the application of any remedy imposed under section 1819 during the pendency of an appeal under this subparagraph.''.

(c) GAO STUDY AND REPORT ON ACCESS TO JUDICIAL REVIEW.—

(1) STUDY.—The Comptroller General of the United States shall conduct a study on the access of medicare beneficiaries and health care providers to judicial review of actions of the Secretary and the Department of Health and Human Services with respect to items and services under title XVIII of the Social Security Act subsequent to February 29, 2000, the date of the decision of Shalala, Secretary of Health and Human Services, et al. v. Illinois Council on Long Term Care, Inc. (529 U.S. 1 (2000)).

(2) REPORT.—Not later than 1 year after the date of enactment of this Act, the Comptroller General shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations as the Comptroller General determines to be appropriate.

(d) CONFORMING AMENDMENT.—Section 1869(b)(1)(F)(ii) (42 U.S.C. 1395ff(b)(1)(F)(ii)) is amended to read as follows:

''(ii) REFERENCE TO EXPEDITED ACCESS TO JUDICIAL REVIEW.—For the provision relating to expedited access to judicial review, see paragraph (2).''.

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to appeals filed on or after October 1, 2004.

SEC. 513. EXPEDITED REVIEW OF CERTAIN PROVIDER AGREEMENT DETERMINATIONS.

(a) TERMINATION AND CERTAIN OTHER IMMEDIATE REMEDIES.—

(1) IN GENERAL.—The Secretary shall develop and implement a process to expedite proceedings under sections 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)) in which—

(A) the remedy of termination of participation has been imposed;

(B) a sanction described in clause (i) or (iii) of section 1819(h)(2)(B) of such Act (42 U.S.C. 1395i–3(h)(2)(B)) has been imposed, but only if such sanction has been imposed on an immediate basis; or

(C) the Secretary has required a skilled nursing facility to suspend operations of a nurse aide training program.

(2) PRIORITY FOR CASES OF TERMINATION.—Under the process described in paragraph (1), priority shall be provided in cases of termination described in subparagraph (A) of such paragraph.

(b) INCREASED FINANCIAL SUPPORT.—In addition to any amounts otherwise appropriated, to reduce by 50 percent the average time for administrative determinations on appeals under section 1866(h) of the Social Security Act (42 U.S.C. 1395cc(h)), there are authorized to be appropriated (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund) to the Secretary such sums for fiscal year 2004 and each subsequent fiscal year as may be necessary to increase the number of administrative law judges (and their staffs) at the Departmental Appeals Board of the Department of Health and Human Services and to educate such judges and staff on long-term care issues.

SEC. 514. REVISIONS TO MEDICARE APPEALS PROCESS.

(a) TIMEFRAMES FOR THE COMPLETION OF THE RECORD.—Section 1869(b) (42 U.S.C. 1395ff(b)), as amended by section 512(a)(2), is amended by adding at the end the following new paragraph:

''(3) TIMELY COMPLETION OF THE RECORD.—

''(A) DEADLINE.—Subject to subparagraph (B), the deadline to complete the record in a hearing before an administrative law judge or a review by the Departmental Appeals Board is 90 days after the date the request for the review or hearing is filed.

''(B) EXTENSIONS FOR GOOD CAUSE.—The person filing a request under subparagraph (A) may request an extension of such deadline for good cause. The administrative law judge, in the case of a hearing, and the Departmental Appeals Board, in the case of a review, may extend such deadline based upon a finding of good cause to a date specified by the judge or Board, as the case may be.

''(C) DELAY IN DECISION DEADLINES UNTIL COMPLETION OF RECORD.—Notwithstanding any other provision of this section, the deadlines otherwise established under subsection (d) for the making of determinations in hearings or review under this section are 90 days after the date on which the record is complete.

''(D) COMPLETE RECORD DESCRIBED.—For purposes of this paragraph, a record is complete when the administrative law judge, in the case of a hearing, or the Departmental Appeals Board, in the case of a review, has received—

''(i) written or testimonial evidence, or both, submitted by the person filing the request,

''(ii) written or oral argument, or both,

''(iii) the decision of, and the record for, the prior level of appeal, and

''(iv) such other evidence as such judge or Board, as the case may be, determines is required to make a determination on the request.''.

(b) USE OF PATIENTS' MEDICAL RECORDS.—Section 1869(c)(3)(B)(i) (42 U.S.C. 1395ff(c)(3)(B)(i)) is amended by inserting ''(including the medical records of the individual involved)'' after ''clinical experience''.

(c) NOTICE REQUIREMENTS FOR MEDICARE APPEALS.—

(1) INITIAL DETERMINATIONS AND REDETERMINATIONS.—Section 1869(a) (42 U.S.C. 1395ff(a)) is amended by adding at the end the following new paragraph:

''(4) REQUIREMENTS OF NOTICE OF DETERMINATIONS AND REDETERMINATIONS.—A written notice of a determination on an initial determination or on a redetermination, insofar as such determination or redetermination results in a denial of a claim for benefits, shall be provided in printed form and written in a manner to be understood by the beneficiary and shall include—

''(A) the reasons for the determination, including, as appropriate—

''(i) upon request in the case of an initial determination, the provision of the policy, manual, or regulation that resulted in the denial; and

''(ii) in the case of a redetermination, a summary of the clinical or scientific evidence used in making the determination (as appropriate);

''(B) the procedures for obtaining additional information concerning the determination or redetermination; and

''(C) notification of the right to seek a redetermination or otherwise appeal the determination and instructions on how to initiate such a redetermination or appeal under this section.''.

(2) RECONSIDERATIONS.—Section 1869(c)(3)(E) (42 U.S.C. 1395ff(c)(3)(E)) is amended to read as follows:

''(E) EXPLANATION OF DECISION.—Any decision with respect to a reconsideration of a qualified independent contractor shall be in writing in a manner to be understood by the beneficiary and shall include—

''(i) to the extent appropriate, a detailed explanation of the decision as well as a discussion of the pertinent facts and applicable regulations applied in making such decision;

''(ii) a notification of the right to appeal such determination and instructions on how to initiate such appeal under this section; and

''(iii) in the case of a determination of whether an item or service is reasonable and necessary for the diagnosis or treatment of illness or injury (under section 1862(a)(1)(A)) an explanation of the medical or scientific rationale for the decision.''.

(3) APPEALS.—Section 1869(d) (42 U.S.C. 1395ff(d)) is amended—

(A) in the heading, by inserting ''; NOTICE'' after ''SECRETARY''; and

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

''(4) NOTICE.—Notice of the decision of an administrative law judge shall be in writing in a manner to be understood by the beneficiary and shall include—

''(A) the specific reasons for the determination (including, to the extent appropriate, a summary of the clinical or scientific evidence used in making the determination);

''(B) the procedures for obtaining additional information concerning the decision; and

''(C) notification of the right to appeal the decision and instructions on how to initiate such an appeal under this section.''.

(4) PREPARATION OF RECORD FOR APPEAL.—Section 1869(c)(3)(J) (42 U.S.C. 1395ff(c)(3)(J)) is amended by striking ''such information as is required for an appeal'' and inserting ''the record for the appeal''.

(d) QUALIFIED INDEPENDENT CONTRACTORS.—

(1) ELIGIBILITY REQUIREMENTS OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c) (42 U.S.C. 1395ff(c)) is amended—

(A) in paragraph (2)—

(i) by inserting ''(except in the case of a utilization and quality control peer review organization, as defined in section 1152)'' after ''means an entity or organization that''; and

(ii) by striking the period at the end and inserting the following: ''and meets the following requirements:

''(A) GENERAL REQUIREMENTS.—

''(i) The entity or organization has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise (including knowledge of the program under this title) and sufficient staffing to carry out duties of a qualified independent contractor under this section on a timely basis.

''(ii) The entity or organization has provided assurances that it will conduct activities consistent with the applicable requirements of this section, including that it will not conduct any activities in a case unless the independence requirements of subparagraph (B) are met with respect to the case.

''(iii) The entity or organization meets such other requirements as the Secretary provides by regulation.

''(B) INDEPENDENCE REQUIREMENTS.—

''(i) IN GENERAL.—Subject to clause (ii), an entity or organization meets the independence requirements of this subparagraph with respect to any case if the entity—

''(I) is not a related party (as defined in subsection (g)(5));

''(II) does not have a material familial, financial, or professional relationship with such a party in relation to such case; and

''(III) does not otherwise have a conflict of interest with such a party (as determined under regulations).

''(ii) EXCEPTION FOR COMPENSATION.—Nothing in clause (i) shall be construed to prohibit receipt by a qualified independent contractor of compensation from the Secretary for the conduct of activities under this section if the compensation is provided consistent with clause (iii).

''(iii) LIMITATIONS ON ENTITY COMPENSATION.—Compensation provided by the Secretary to a qualified independent contractor in connection with reviews under this section shall not be contingent on any decision rendered by the contractor or by any reviewing professional.''; and

(B) in paragraph (3)(A), by striking '', and shall have sufficient training and expertise in medical science and legal matters to make reconsiderations under this subsection''.

(2) ELIGIBILITY REQUIREMENTS FOR REVIEWERS.—Section 1869 (42 U.S.C. 1395ff) is amended—

(A) by amending subsection (c)(3)(D) to read as follows:

''(D) QUALIFICATIONS OF REVIEWERS.—The requirements of subsection (g) shall be met (relating to qualifications of reviewing professionals).''; and

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

''(g) QUALIFICATIONS OF REVIEWERS.—

''(1) IN GENERAL.—In reviewing determinations under this section, a qualified independent contractor shall assure that—

''(A) each individual conducting a review shall meet the qualifications of paragraph (2);

''(B) compensation provided by the contractor to each such reviewer is consistent with paragraph (3); and

''(C) in the case of a review by a panel described in subsection (c)(3)(B) composed of physicians or other health care professionals (each in this subsection referred to as a 'reviewing professional'), each reviewing professional meets the qualifications described in paragraph (4).

''(2) INDEPENDENCE.—

''(A) IN GENERAL.—Subject to subparagraph (B), each individual conducting a review in a case shall—

''(i) not be a related party (as defined in paragraph (5));

''(ii) not have a material familial, financial, or professional relationship with such a party in the case under review; and

''(iii) not otherwise have a conflict of interest with such a party (as determined under regulations).

''(B) EXCEPTION.—Nothing in subparagraph (A) shall be construed to—

''(i) prohibit an individual, solely on the basis of affiliation with a fiscal intermediary, carrier, or other contractor, from serving as a reviewing professional if—

''(I) a nonaffiliated individual is not reasonably available;

''(II) the affiliated individual is not involved in the provision of items or services in the case under review;

''(III) the fact of such an affiliation is disclosed to the Secretary and the beneficiary (or authorized representative) and neither party objects; and

''(IV) the affiliated individual is not an employee of the intermediary, carrier, or contractor and does not provide services exclusively or primarily to or on behalf of such intermediary, carrier, or contractor;

''(ii) prohibit an individual who has staff privileges at the institution where the treatment involved takes place from serving as a reviewer merely on the basis of such affiliation if the affiliation is disclosed to the Secretary and the beneficiary (or authorized representative), and neither party objects; or

''(iii) prohibit receipt of compensation by a reviewing professional from a contractor if the compensation is provided consistent with paragraph (3).

''(3) LIMITATIONS ON REVIEWER COMPENSATION.—Compensation provided by a qualified independent contractor to a reviewer in connection with a review under this section shall not be contingent on the decision rendered by the reviewer.

''(4) LICENSURE AND EXPERTISE.—Each reviewing professional shall be a physician (allopathic or osteopathic) or health care professional who—

''(A) is appropriately credentialed or licensed in 1 or more States to deliver health care services; and

''(B) has medical expertise in the field of practice that is appropriate for the items or services at issue.

''(5) RELATED PARTY DEFINED.—For purposes of this section, the term 'related party' means, with respect to a case under this title involving an individual beneficiary, any of the following:

''(A) The Secretary, the medicare administrative contractor involved, or any fiduciary, officer, director, or employee of the Department of Health and Human Services, or of such contractor.

''(B) The individual (or authorized representative).

''(C) The health care professional that provides the items or services involved in the case.

''(D) The institution at which the items or services (or treatment) involved in the case are provided.

''(E) The manufacturer of any drug or other item that is included in the items or services involved in the case.

''(F) Any other party determined under any regulations to have a substantial interest in the case involved.''.

(3) NUMBER OF QUALIFIED INDEPENDENT CONTRACTORS.—Section 1869(c)(4) (42 U.S.C. 1395ff(c)(4)) is amended by striking ''12'' and inserting ''4''.

(e) IMPLEMENTATION OF CERTAIN BIPA REFORMS.—

(1) DELAY IN CERTAIN BIPA REFORMS.—Section 521(d) of BIPA (114 Stat. 2763A–543) is amended to read as follows:

''(d) EFFECTIVE DATE.—

''(1) IN GENERAL.—Except as specified in paragraph (2), the amendments made by this section shall apply with respect to initial determinations made on or after December 1, 2004.

''(2) EXPEDITED PROCEEDINGS AND RECONSIDERATION REQUIREMENTS.—For the following provisions, the amendments made by subsection (a) shall apply with respect to initial determinations made on or after October 1, 2003:

''(A) Subsection (b)(1)(F)(i) of section 1869 of the Social Security Act.

''(B) Subsection (c)(3)(C)(iii) of such section.

''(C) Subsection (c)(3)(C)(iv) of such section to the extent that it applies to expedited reconsiderations under subsection (c)(3)(C)(iii) of such section.

''(3) TRANSITIONAL USE OF PEER REVIEW ORGANIZATIONS TO CONDUCT EXPEDITED RECONSIDERATIONS UNTIL QICS ARE OPERATIONAL.—Expedited reconsiderations of initial determinations under section 1869(c)(3)(C)(iii) of the Social Security Act shall be made by peer review organizations until qualified independent contractors are available for such expedited reconsiderations.''.

(2) CONFORMING AMENDMENTS.—Section 521(c) of BIPA (114 Stat. 2763A–543) and section 1869(c)(3)(C)(iii)(III) of the Social Security Act (42 U.S.C. 1395ff(c)(3)(C)(iii)(III)), as added by section 521 of BIPA, are repealed.

(f) EFFECTIVE DATE.—The amendments made by this section shall be effective as if included in the enactment of the respective provisions of subtitle C of title V of BIPA, 114 Stat. 2763A–534.

(g) TRANSITION.—In applying section 1869(g) of the Social Security Act (as added by subsection (d)(2)), any reference to a medicare administrative contractor shall be deemed to include a reference to a fiscal intermediary under section 1816 of the Social Security Act (42 U.S.C. 1395h) and a carrier under section 1842 of such Act (42 U.S.C. 1395u).

SEC. 515. HEARING RIGHTS RELATED TO DECISIONS BY THE SECRETARY TO DENY OR NOT RENEW A MEDICARE ENROLLMENT AGREEMENT; CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.

(a) HEARING RIGHTS.—

(1) IN GENERAL.—Section 1866 (42 U.S.C. 1395cc) is amended by adding at the end the following new subsection:

''(j) HEARING RIGHTS IN CASES OF DENIAL OR NONRENEWAL.—The Secretary shall establish by regulation procedures under which—

''(1) there are deadlines for actions on applications for enrollment (and, if applicable, renewal of enrollment); and

''(2) providers of services, physicians, practitioners, and suppliers whose application to enroll (or, if applicable, to renew enrollment) are denied are provided a mechanism to appeal such denial and a deadline for consideration of such appeals.''.

(2) EFFECTIVE DATE.—The Secretary shall provide for the establishment of the procedures under the amendment made by paragraph (1) within 18 months after the date of enactment of this Act.

(b) CONSULTATION BEFORE CHANGING PROVIDER ENROLLMENT FORMS.—Section 1871 (42 U.S.C. 1395hh), as amended by sections 502 and 503, is amended by adding at the end the following new subsection:

''(f) The Secretary shall consult with providers of services, physicians, practitioners, and suppliers before making changes in the provider enrollment forms required of such providers, physicians, practitioners, and suppliers to be eligible to submit claims for which payment may be made under this title.''.

SEC. 516. APPEALS BY PROVIDERS WHEN THERE IS NO OTHER PARTY AVAILABLE.

(a) IN GENERAL.—Section 1870 (42 U.S.C. 1395gg) is amended by adding at the end the following new subsection:

''(h) Notwithstanding subsection (f) or any other provision of law, the Secretary shall permit a provider of services, physician, practitioner, or other supplier to appeal any determination of the Secretary under this title relating to services rendered under this title to an individual who subsequently dies if there is no other party available to appeal such determination.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect on the date of enactment of this Act and shall apply to items and services furnished on or after such date.

SEC. 517. PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.

(a) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—Section 1869(f)(5) (42 U.S.C. 1395ff(f)(5)) is amended to read as follows:

''(5) AGGRIEVED PARTY DEFINED.—In this section, the term 'aggrieved party' means—

''(A) with respect to a national coverage determination, an individual entitled to benefits under part A, or enrolled under part B, or both, who is in need of the items or services that are the subject of the coverage determination; and

''(B) with respect to a local coverage determination—

''(i) an individual who is entitled to benefits under part A, or enrolled under part B, or both, who is adversely affected by such a determination; or

''(ii) a provider of services, physician, practitioner, or supplier that is adversely affected by such a determination.''.

(b) CLARIFICATION OF LOCAL COVERAGE DETERMINATION DEFINITION.—Section 1869(f)(2)(B) (42 U.S.C. 1395ff(f)(2)(B)) is amended by inserting '', including, where appropriate, the specific requirements and clinical indications relating to the medical necessity of an item or service'' before the period at the end.

(c) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—Section 1869 (42 U.S.C. 1395ff), as amended by section 514(d)(2)(B), is amended by adding at the end the following new subsection:

''(h) REQUEST FOR LOCAL COVERAGE DETERMINATIONS BY PROVIDERS.—

''(1) ESTABLISHMENT OF PROCESS.—The Secretary shall establish a process under which a provider of services, physician, practitioner, or supplier who certifies that they meet the requirements established in paragraph (3) may request a local coverage determination in accordance with the succeeding provisions of this subsection.

''(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUEST DEFINED.—In this subsection, the term 'provider local coverage determination request' means a request, filed with the Secretary, at such time and in such form and manner as the Secretary may specify, that the Secretary, pursuant to paragraph (4)(A), require a fiscal intermediary, carrier, or program safeguard contractor to make or revise a local coverage determination under this section with respect to an item or service.

''(3) REQUEST REQUIREMENTS.—Under the process established under paragraph (1), by not later than 30 days after the date on which a provider local coverage determination request is filed under paragraph (1), the Secretary shall determine whether such request establishes that—

''(A) there have been at least 5 reversals of redeterminations made by a fiscal intermediary or carrier after a hearing before an administrative law judge on claims submitted by the provider in at least 2 different cases before an administrative law judge;

''(B) each reversal described in subparagraph (A) involves substantially similar material facts;

''(C) each reversal described in subparagraph (A) involves the same medical necessity issue; and

''(D) at least 50 percent of the total number of claims submitted by such provider within the past year involving the substantially similar material facts described in subparagraph (B) and the same medical necessity issue described in subparagraph (C) have been denied and have been reversed by an administrative law judge.

''(4) APPROVAL OR REJECTION OF REQUEST.—

''(A) APPROVAL OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have been satisfied, the Secretary shall require the fiscal intermediary, carrier, or program safeguard contractor identified in the provider local coverage determination request, to make or revise a local coverage determination with respect to the item or service that is the subject of the request not later than the date that is 210 days after the date on which the Secretary makes the determination. Such fiscal intermediary, carrier, or program safeguard contractor shall retain the discretion to determine whether or not, and/or the circumstances under which, to cover the item or service for which a local coverage determination is requested. Nothing in this subsection shall be construed to require a fiscal intermediary, carrier or program safeguard contractor to develop a local coverage determination that is inconsistent with any national coverage determination, or any coverage provision in this title or in regulation, manual, or interpretive guidance of the Secretary.

''(B) REJECTION OF REQUEST.—If the Secretary determines that subparagraphs (A) through (D) of paragraph (3) have not been satisfied, the Secretary shall reject the provider local coverage determination request and shall notify the provider of services, physician, practitioner, or supplier that filed the request of the reason for such rejection and no further proceedings in relation to such request shall be conducted.''.

(d) STUDY AND REPORT ON THE USE OF CONTRACTORS TO MONITOR MEDICARE APPEALS.—

(1) STUDY.—The Secretary shall conduct a study on the feasibility and advisability of requiring fiscal intermediaries and carriers to monitor and track—

(A) the subject matter and status of claims denied by the fiscal intermediary or carrier (as applicable) that are appealed under section 1869 of the Social Security Act (42 U.S.C. 1395ff), as added by section 522 of BIPA (114 Stat. 2763A–543) and amended by this Act; and

(B) any final determination made with respect to such claims.

(2) REPORT.—Not later than the date that is 1 year after the date of enactment of this Act, the Secretary shall submit to Congress a report on the study conducted under paragraph (1) together with such recommendations for legislation and administrative action as the Commission determines appropriate.

(e) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out the amendments made by subsections (a), (b), and (c).

(f) EFFECTIVE DATES.—

(1) PROVIDER ACCESS TO REVIEW OF LOCAL COVERAGE DETERMINATIONS.—The amendments made by subsections (a) and (b) shall apply to—

(A) any review of any local coverage determination filed on or after October 1, 2003;

(B) any request to make such a determination made on or after such date; or

(C) any local coverage determination made on or after such date.

(2) PROVIDER LOCAL COVERAGE DETERMINATION REQUESTS.—The amendment made by subsection (c) shall apply with respect to provider local coverage determination requests (as defined in section 1869(h)(2) of the Social Security Act, as added by subsection (c)) filed on or after the date of enactment of this Act.

Subtitle C—Contracting Reform

SEC. 521. INCREASED FLEXIBILITY IN MEDICARE ADMINISTRATION.

(a) CONSOLIDATION AND FLEXIBILITY IN MEDICARE ADMINISTRATION.—

(1) IN GENERAL.—Title XVIII is amended by inserting after section 1874 the following new section:

''CONTRACTS WITH MEDICARE ADMINISTRATIVE CONTRACTORS

''SEC. 1874A. (a) AUTHORITY.—

''(1) AUTHORITY TO ENTER INTO CONTRACTS.—The Secretary may enter into contracts with any eligible entity to serve as a medicare administrative contractor with respect to the performance of any or all of the functions described in paragraph (4) or parts of those functions (or, to the extent provided in a contract, to secure performance thereof by other entities).

''(2) ELIGIBILITY OF ENTITIES.—An entity is eligible to enter into a contract with respect to the performance of a particular function described in paragraph (4) only if—

''(A) the entity has demonstrated capability to carry out such function;

''(B) the entity complies with such conflict of interest standards as are generally applicable to Federal acquisition and procurement;

''(C) the entity has sufficient assets to financially support the performance of such function; and

''(D) the entity meets such other requirements as the Secretary may impose.

''(3) MEDICARE ADMINISTRATIVE CONTRACTOR DEFINED.—For purposes of this title and title XI—

''(A) IN GENERAL.—The term 'medicare administrative contractor' means an agency, organization, or other person with a contract under this section.

''(B) APPROPRIATE MEDICARE ADMINISTRATIVE CONTRACTOR.—With respect to the performance of a particular function in relation to an individual entitled to benefits under part A or enrolled under part B, or both, a specific provider of services, physician, practitioner, facility, or supplier (or class of such providers of services, physicians, practitioners, facilities, or suppliers), the 'appropriate' medicare administrative contractor is the medicare administrative contractor that has a contract under this section with respect to the performance of that function in relation to that individual, provider of services, physician, practitioner, facility, or supplier or class of provider of services, physician, practitioner, facility, or supplier.

''(4) FUNCTIONS DESCRIBED.—The functions referred to in paragraphs (1) and (2) are payment functions (including the function of developing local coverage determinations, as defined in section 1869(f)(2)(B)), provider services functions, and beneficiary services functions as follows:

''(A) DETERMINATION OF PAYMENT AMOUNTS.—Determining (subject to the provisions of section 1878 and to such review by the Secretary as may be provided for by the contracts) the amount of the payments required pursuant to this title to be made to providers of services, physicians, practitioners, facilities, suppliers, and individuals.

''(B) MAKING PAYMENTS.—Making payments described in subparagraph (A) (including receipt, disbursement, and accounting for funds in making such payments).

''(C) BENEFICIARY EDUCATION AND ASSISTANCE.—Serving as a center for, and communicating to individuals entitled to benefits under part A or enrolled under part B, or both, with respect to education and outreach for those individuals, and assistance with specific issues, concerns, or problems of those individuals.

''(D) PROVIDER CONSULTATIVE SERVICES.—Providing consultative services to institutions, agencies, and other persons to enable them to establish and maintain fiscal records necessary for purposes of this title and otherwise to qualify as providers of services, physicians, practitioners, facilities, or suppliers.

''(E) COMMUNICATION WITH PROVIDERS.—Serving as a center for, and communicating to providers of services, physicians, practitioners, facilities, and suppliers, any information or instructions furnished to the medicare administrative contractor by the Secretary, and serving as a channel of communication from such providers, physicians, practitioners, facilities, and suppliers to the Secretary.

''(F) PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.—Performing the functions described in subsections (e) and (f), relating to education, training, and technical assistance to providers of services, physicians, practitioners, facilities, and suppliers.

''(G) ADDITIONAL FUNCTIONS.—Performing such other functions, including (subject to paragraph (5)) functions under the Medicare Integrity Program under section 1893, as are necessary to carry out the purposes of this title.

''(5) RELATIONSHIP TO MIP CONTRACTS.—

''(A) NONDUPLICATION OF ACTIVITIES.—In entering into contracts under this section, the Secretary shall assure that activities of medicare administrative contractors do not duplicate activities carried out under contracts entered into under the Medicare Integrity Program under section 1893. The previous sentence shall not apply with respect to the activity described in section 1893(b)(5) (relating to prior authorization of certain items of durable medical equipment under section 1834(a)(15)).

''(B) CONSTRUCTION.—An entity shall not be treated as a medicare administrative contractor merely by reason of having entered into a contract with the Secretary under section 1893.

''(6) APPLICATION OF FEDERAL ACQUISITION REGULATION.—Except to the extent inconsistent with a specific requirement of this title, the Federal Acquisition Regulation applies to contracts under this title.

''(b) CONTRACTING REQUIREMENTS.—

''(1) USE OF COMPETITIVE PROCEDURES.—

''(A) IN GENERAL.—Except as provided in laws with general applicability to Federal acquisition and procurement, the Federal Acquisition Regulation, or in subparagraph (B), the Secretary shall use competitive procedures when entering into contracts with medicare administrative contractors under this section.

''(B) RENEWAL OF CONTRACTS.—The Secretary may renew a contract with a medicare administrative contractor under this section from term to term without regard to section 5 of title 41, United States Code, or any other provision of law requiring competition, if the medicare administrative contractor has met or exceeded the performance requirements applicable with respect to the contract and contractor, except that the Secretary shall provide for the application of competitive procedures under such a contract not less frequently than once every 6 years.

''(C) TRANSFER OF FUNCTIONS.—The Secretary may transfer functions among medicare administrative contractors without regard to any provision of law requiring competition. The Secretary shall ensure that performance quality is considered in such transfers. The Secretary shall provide notice (whether in the Federal Register or otherwise) of any such transfer (including a description of the functions so transferred and contact information for the contractors involved) to providers of services, physicians, practitioners, facilities, and suppliers affected by the transfer.

''(D) INCENTIVES FOR QUALITY.—The Secretary may provide incentives for medicare administrative contractors to provide quality service and to promote efficiency.

''(2) COMPLIANCE WITH REQUIREMENTS.—No contract under this section shall be entered into with any medicare administrative contractor unless the Secretary finds that such medicare administrative contractor will perform its obligations under the contract efficiently and effectively and will meet such requirements as to financial responsibility, legal authority, and other matters as the Secretary finds pertinent.

''(3) PERFORMANCE REQUIREMENTS.—

''(A) DEVELOPMENT OF SPECIFIC PERFORMANCE REQUIREMENTS.—The Secretary shall develop contract performance requirements to carry out the specific requirements applicable under this title to a function described in subsection (a)(4) and shall develop standards for measuring the extent to which a contractor has met such requirements. In developing such performance requirements and standards for measurement, the Secretary shall consult with providers of services, organizations representative of beneficiaries under this title, and organizations and agencies performing functions necessary to carry out the purposes of this section with respect to such performance requirements. The Secretary shall make such performance requirements and measurement standards available to the public.

''(B) CONSIDERATIONS.—The Secretary shall include, as 1 of the standards, provider and beneficiary satisfaction levels.

''(C) INCLUSION IN CONTRACTS.—All contractor performance requirements shall be set forth in the contract between the Secretary and the appropriate medicare administrative contractor. Such performance requirements—

''(i) shall reflect the performance requirements published under subparagraph (A), but may include additional performance requirements;

''(ii) shall be used for evaluating contractor performance under the contract; and

''(iii) shall be consistent with the written statement of work provided under the contract.

''(4) INFORMATION REQUIREMENTS.—The Secretary shall not enter into a contract with a medicare administrative contractor under this section unless the contractor agrees—

''(A) to furnish to the Secretary such timely information and reports as the Secretary may find necessary in performing his functions under this title; and

''(B) to maintain such records and afford such access thereto as the Secretary finds necessary to assure the correctness and verification of the information and reports under subparagraph (A) and otherwise to carry out the purposes of this title.

''(5) SURETY BOND.—A contract with a medicare administrative contractor under this section may require the medicare administrative contractor, and any of its officers or employees certifying payments or disbursing funds pursuant to the contract, or otherwise participating in carrying out the contract, to give surety bond to the United States in such amount as the Secretary may deem appropriate.

''(6) RETAINING DIVERSITY OF LOCAL COVERAGE DETERMINATIONS.—A contract with a medicare administrative contractor under this section to perform the function of developing local coverage determinations (as defined in section 1869(f)(2)(B)) shall provide that the contractor shall—

''(A) designate at least 1 different individual to serve as medical director for each State for which such contract performs such function;

''(B) utilize such medical director in the performance of such function; and

''(C) appoint a contractor advisory committee with respect to each such State to provide a formal mechanism for physicians in the State to be informed of, and participate in, the development of a local coverage determination in an advisory capacity.

''(c) TERMS AND CONDITIONS.—

''(1) IN GENERAL.—Subject to subsection (a)(6), a contract with any medicare administrative contractor under this section may contain such terms and conditions as the Secretary finds necessary or appropriate and may provide for advances of funds to the medicare administrative contractor for the making of payments by it under subsection (a)(4)(B).

''(2) PROHIBITION ON MANDATES FOR CERTAIN DATA COLLECTION.—The Secretary may not require, as a condition of entering into, or renewing, a contract under this section, that the medicare administrative contractor match data obtained other than in its activities under this title with data used in the administration of this title for purposes of

identifying situations in which the provisions of section 1862(b) may apply.

''(d) LIMITATION ON LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTORS AND CERTAIN OFFICERS.—

''(1) CERTIFYING OFFICER.—No individual designated pursuant to a contract under this section as a certifying officer shall, in the absence of the reckless disregard of the individual's obligations or the intent by that individual to defraud the United States, be liable with respect to any payments certified by the individual under this section.

''(2) DISBURSING OFFICER.—No disbursing officer shall, in the absence of the reckless disregard of the officer's obligations or the intent by that officer to defraud the United States, be liable with respect to any payment by such officer under this section if it was based upon an authorization (which meets the applicable requirements for such internal controls established by the Comptroller General) of a certifying officer designated as provided in paragraph (1) of this subsection.

''(3) LIABILITY OF MEDICARE ADMINISTRATIVE CONTRACTOR.—No medicare administrative contractor shall be liable to the United States for a payment by a certifying or disbursing officer unless, in connection with such a payment, the medicare administrative contractor acted with reckless disregard of its obligations under its medicare administrative contract or with intent to defraud the United States.

''(4) RELATIONSHIP TO FALSE CLAIMS ACT.—Nothing in this subsection shall be construed to limit liability for conduct that would constitute a violation of sections 3729 through 3731 of title 31, United States Code (commonly known as the ''False Claims Act'').

''(5) INDEMNIFICATION BY SECRETARY.—

''(A) IN GENERAL.—Notwithstanding any other provision of law and subject to the succeeding provisions of this paragraph, in the case of a medicare administrative contractor (or a person who is a director, officer, or employee of such a contractor or who is engaged by the contractor to participate directly in the claims administration process) who is made a party to any judicial or administrative proceeding arising from, or relating directly to, the claims administration process under this title, the Secretary may, to the extent specified in the contract with the contractor, indemnify the contractor (and such persons).

''(B) CONDITIONS.—The Secretary may not provide indemnification under subparagraph (A) insofar as the liability for such costs arises directly from conduct that is determined by the Secretary to be criminal in nature, fraudulent, or grossly negligent.

''(C) SCOPE OF INDEMNIFICATION.—Indemnification by the Secretary under subparagraph (A) may include payment of judgments, settlements (subject to subparagraph (D)), awards, and costs (including reasonable legal expenses).

''(D) WRITTEN APPROVAL FOR SETTLEMENTS.—A contractor or other person described in subparagraph (A) may not propose to negotiate a settlement or compromise of a proceeding described in such subparagraph without the prior written approval of the Secretary to negotiate a settlement. Any indemnification under subparagraph (A) with respect to amounts paid under a settlement are conditioned upon the Secretary's prior written approval of the final settlement.

''(E) CONSTRUCTION.—Nothing in this paragraph shall be construed—

''(i) to change any common law immunity that may be available to a medicare administrative contractor or person described in subparagraph (A); or

''(ii) to permit the payment of costs not otherwise allowable, reasonable, or allocable under the Federal Acquisition Regulations.''.

(2) CONSIDERATION OF INCORPORATION OF CURRENT LAW STANDARDS.—In developing contract performance requirements under section 1874A(b) of the Social Security Act (as added by paragraph (1)) the Secretary shall consider inclusion of the performance standards described in sections 1816(f)(2) of such Act (relating to timely processing of reconsiderations and applications for exemptions) and section 1842(b)(2)(B) of such Act (relating to timely review of determinations and fair hearing requests), as such sections were in effect before the date of enactment of this Act.

(b) CONFORMING AMENDMENTS TO SECTION 1816 (RELATING TO FISCAL INTERMEDIARIES).—Section 1816 (42 U.S.C. 1395h) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART A''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is repealed.

(4) Subsection (c) is amended—

(A) by striking paragraph (1); and

(B) in each of paragraphs (2)(A) and (3)(A), by striking ''agreement under this section'' and inserting ''contract under section 1874A that provides for making payments under this part''.

(5) Subsections (d) through (i) are repealed.

(6) Subsections (j) and (k) are each amended—

(A) by striking ''An agreement with an agency or organization under this section'' and inserting ''A contract with a medicare administrative contractor under section 1874A with respect to the administration of this part''; and

(B) by striking ''such agency or organization'' and inserting ''such medicare administrative contractor'' each place it appears.

(7) Subsection (l) is repealed.

(c) CONFORMING AMENDMENTS TO SECTION 1842 (RELATING TO CARRIERS).—Section 1842 (42 U.S.C. 1395u) is amended as follows:

(1) The heading is amended to read as follows:

''PROVISIONS RELATING TO THE ADMINISTRATION OF PART B''.

(2) Subsection (a) is amended to read as follows:

''(a) The administration of this part shall be conducted through contracts with medicare administrative contractors under section 1874A.''.

(3) Subsection (b) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2)—

(i) by striking subparagraphs (A) and (B);

(ii) in subparagraph (C), by striking ''carriers'' and inserting ''medicare administrative contractors''; and

(iii) by striking subparagraphs (D) and (E);

(C) in paragraph (3)—

(i) in the matter before subparagraph (A), by striking ''Each such contract shall provide that the carrier'' and inserting ''The Secretary'';

(ii) by striking ''will'' the first place it appears in each of subparagraphs (A), (B), (F), (G), (H), and (L) and inserting ''shall'';

(iii) in subparagraph (B), in the matter before clause (i), by striking ''to the policyholders and subscribers of the carrier'' and inserting ''to the policyholders and subscribers of the medicare administrative contractor'';

(iv) by striking subparagraphs (C), (D), and (E);

(v) in subparagraph (H)—

(I) by striking ''if it makes determinations or payments with respect to physicians' services,''; and

(II) by striking ''carrier'' and inserting ''medicare administrative contractor'';

(vi) by striking subparagraph (I);

(vii) in subparagraph (L), by striking the semicolon and inserting a period;

(viii) in the first sentence, after subparagraph (L), by striking ''and shall contain'' and all that follows through the period; and

(ix) in the seventh sentence, by inserting ''medicare administrative contractor,'' after ''carrier,'';

(D) by striking paragraph (5);

(E) in paragraph (6)(D)(iv), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(F) in paragraph (7), by striking ''the carrier'' and inserting ''the Secretary'' each place it appears.

(4) Subsection (c) is amended—

(A) by striking paragraph (1);

(B) in paragraph (2), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B),'' and inserting ''contract under section 1874A that provides for making payments under this part'';

(C) in paragraph (3)(A), by striking ''subsection (a)(1)(B)'' and inserting ''section 1874A(a)(3)(B)'';

(D) in paragraph (4), by striking ''carrier'' and inserting ''medicare administrative contractor'';

(E) in paragraph (5), by striking ''contract under this section which provides for the disbursement of funds, as described in subsection (a)(1)(B), shall require the carrier'' and ''carrier responses'' and inserting ''contract under section 1874A that provides for making payments under this part shall require the medicare administrative contractor'' and ''contractor responses'', respectively; and

(F) by striking paragraph (6).

(5) Subsections (d), (e), and (f) are repealed.

(6) Subsection (g) is amended by striking ''carrier or carriers'' and inserting ''medicare administrative contractor or contractors''.

(7) Subsection (h) is amended—

(A) in paragraph (2)—

(i) by striking ''Each carrier having an agreement with the Secretary under subsection (a)'' and inserting ''The Secretary''; and

(ii) by striking ''Each such carrier'' and inserting ''The Secretary'';

(B) in paragraph (3)(A)—

(i) by striking ''a carrier having an agreement with the Secretary under subsection (a)'' and inserting ''medicare administrative contractor having a contract under section 1874A that provides for making payments under this part''; and

(ii) by striking ''such carrier'' and inserting ''such contractor'';

(C) in paragraph (3)(B)—

(i) by striking ''a carrier'' and inserting ''a medicare administrative contractor'' each place it appears; and

(ii) by striking ''the carrier'' and inserting ''the contractor'' each place it appears; and

(D) in paragraphs (5)(A) and (5)(B)(iii), by striking ''carriers'' and inserting ''medicare administrative contractors'' each place it appears.

(8) Subsection (l) is amended—

(A) in paragraph (1)(A)(iii), by striking ''carrier'' and inserting ''medicare administrative contractor''; and

(B) in paragraph (2), by striking ''carrier'' and inserting ''medicare administrative contractor''.

(9) Subsection (p)(3)(A) is amended by striking ''carrier'' and inserting ''medicare administrative contractor''.

(10) Subsection (q)(1)(A) is amended by striking ''carrier''.

(d) EFFECTIVE DATE; TRANSITION RULE.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as otherwise provided in this subsection, the amendments made by this section shall take effect on October 1, 2005, and the Secretary is authorized to take such steps before such date as may be necessary to implement such amendments on a timely basis.

(B) CONSTRUCTION FOR CURRENT CONTRACTS.—Such amendments shall not apply to contracts in effect before the date specified under subparagraph (A) that continue to retain the terms and conditions in effect on such date (except as otherwise provided under this title, other than under this section) until such date as the contract is let out for competitive bidding under such amendments.

(C) DEADLINE FOR COMPETITIVE BIDDING.—The Secretary shall provide for the letting by competitive bidding of all contracts for functions of medicare administrative contractors for annual contract periods that begin on or after October 1, 2011.

(2) GENERAL TRANSITION RULES.—

(A) AUTHORITY TO CONTINUE TO ENTER INTO NEW AGREEMENTS AND CONTRACTS AND WAIVER OF PROVIDER NOMINATION PROVISIONS DURING TRANSITION.—Prior to the date specified in paragraph (1)(A), the Secretary may, consistent with subparagraph (B), continue to enter into agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u). The Secretary may enter into new agreements under section 1816 during the time period without regard to any of the provider nomination provisions of such section.

(B) APPROPRIATE TRANSITION.—The Secretary shall take such steps as are necessary to provide for an appropriate transition from agreements under section 1816 and contracts under section 1842 of the Social Security Act (42 U.S.C. 1395h, 1395u) to contracts under section 1874A, as added by subsection (a)(1).

(3) AUTHORIZING CONTINUATION OF MIP ACTIVITIES UNDER CURRENT CONTRACTS AND AGREEMENTS AND UNDER TRANSITION CONTRACTS.—The provisions contained in the exception in section 1893(d)(2) of the Social Security Act (42 U.S.C. 1395ddd(d)(2)) shall continue to apply notwithstanding the amendments made by this section, and any reference in such provisions to an agreement or contract shall be deemed to include agreements and contracts entered into pursuant to paragraph (2)(A).

(e) REFERENCES.—On and after the effective date provided under subsection (d)(1), any reference to a fiscal intermediary or carrier under title XI or XVIII of the Social Security Act (or any regulation, manual instruction, interpretative rule, statement of policy, or guideline issued to carry out such titles) shall be deemed a reference to an appropriate medicare administrative contractor (as provided under section 1874A of the Social Security Act).

(f) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this Act, the Secretary shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this section.

(g) REPORTS ON IMPLEMENTATION.—

(1) PROPOSAL FOR IMPLEMENTATION.—At least 1 year before the date specified in subsection (d)(1)(A), the Secretary shall submit a report to Congress and the Comptroller General of the United States that describes a plan for an appropriate transition. The Comptroller General shall conduct an evaluation of such plan and shall submit to Congress, not later than 6 months after the date the report is received, a report on such evaluation and shall include in such report such recommendations as the Comptroller General deems appropriate.

(2) STATUS OF IMPLEMENTATION.—The Secretary shall submit a report to Congress not later than October 1, 2008, that describes the status of implementation of such amendments and that includes a description of the following:

(A) The number of contracts that have been competitively bid as of such date.

(B) The distribution of functions among contracts and contractors.

(C) A timeline for complete transition to full competition.

(D) A detailed description of how the Secretary has modified oversight and management of medicare contractors to adapt to full competition.

Subtitle D—Education and Outreach Improvements

SEC. 531. PROVIDER EDUCATION AND TECHNICAL ASSISTANCE.

(a) COORDINATION OF EDUCATION FUNDING.—

(1) IN GENERAL.—The Social Security Act is amended by inserting after section 1888 the following new section:

''PROVIDER EDUCATION AND TECHNICAL ASSISTANCE

''SEC. 1889. (a) COORDINATION OF EDUCATION FUNDING.—The Secretary shall coordinate the educational activities provided through medicare contractors (as defined in subsection (e), including under section 1893) in order to maximize the effectiveness of Federal education efforts for providers of services, physicians, practitioners, and suppliers.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

(3) REPORT.—Not later than October 1, 2004, the Secretary shall submit to Congress a report that includes a description and evaluation of the steps taken to coordinate the funding of provider education under section 1889(a) of the Social Security Act, as added by paragraph (1).

(b) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE.—

(1) IN GENERAL.—Section 1874A, as added by section 521(a)(1), is amended by adding at the end the following new subsection:

''(e) INCENTIVES TO IMPROVE CONTRACTOR PERFORMANCE IN PROVIDER EDUCATION AND OUTREACH.—

''(1) METHODOLOGY TO MEASURE CONTRACTOR ERROR RATES.—In order to give medicare contractors (as defined in paragraph (3)) an incentive to implement effective education and outreach programs for providers of services, physicians, practitioners, and suppliers, the Secretary shall develop and implement by October 1, 2004, a methodology to measure the specific claims payment error rates of such contractors in the processing or reviewing of medicare claims.

''(2) GAO REVIEW OF METHODOLOGY.—The Comptroller General of the United States shall review, and make recommendations to the Secretary, regarding the adequacy of such methodology.

''(3) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' includes a medicare administrative contractor, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.''.

(2) REPORT.—The Secretary shall submit to Congress a report that describes how the Secretary intends to use the methodology developed under section 1874A(e)(1) of the Social Security Act, as added by paragraph (1), in assessing medicare contractor performance in implementing effective education and outreach programs, including whether to use such methodology as a basis for performance bonuses.

(c) IMPROVED PROVIDER EDUCATION AND TRAINING.—

(1) INCREASED FUNDING FOR ENHANCED EDUCATION AND TRAINING THROUGH MEDICARE INTEGRITY PROGRAM.—Section 1817(k)(4) (42 U.S.C. 1395i(k)(4)) is amended—

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

(B) in subparagraph (B), by striking ''The amount appropriated'' and inserting ''Subject to subparagraph (C), the amount appropriated''; and

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

''(C) ENHANCED PROVIDER EDUCATION AND TRAINING.—

''(i) IN GENERAL.—In addition to the amount appropriated under subparagraph (B), the amount appropriated under subparagraph (A) for a fiscal year (beginning with fiscal year 2004) is increased by $35,000,000.

''(ii) USE.—The funds made available under this subparagraph shall be used only to increase the conduct by medicare contractors of education and training of providers of services, physicians, practitioners, and suppliers regarding billing, coding, and other appropriate items and may also be used to improve the accuracy, consistency, and timeliness of contractor responses to written and phone inquiries from providers of services, physicians, practitioners, and suppliers.''.

(2) TAILORING EDUCATION AND TRAINING FOR SMALL PROVIDERS OR SUPPLIERS.—

(A) IN GENERAL.—Section 1889, as added by subsection (a), is amended by adding at the end the following new subsection:

''(b) TAILORING EDUCATION AND TRAINING ACTIVITIES FOR SMALL PROVIDERS OR SUPPLIERS.—

''(1) IN GENERAL.—Insofar as a medicare contractor conducts education and training activities, it shall take into consideration the special needs of small providers of services or suppliers (as defined in paragraph (2)). Such education and training activities for small providers of services and suppliers may include the provision of technical assistance (such as review of billing systems and internal controls to determine program compliance and to suggest more efficient and effective means of achieving such compliance).

''(2) SMALL PROVIDER OF SERVICES OR SUPPLIER.—In this subsection, the term 'small provider of services or supplier' means—

''(A) an institutional provider of services with fewer than 25 full-time-equivalent employees; or

''(B) a physician, practitioner, or supplier with fewer than 10 full-time-equivalent employees.''.

(B) EFFECTIVE DATE.—The amendment made by subparagraph (A) shall take effect on January 1, 2004.

(d) ADDITIONAL PROVIDER EDUCATION PROVISIONS.—

(1) IN GENERAL.—Section 1889, as added by subsection (a) and as amended by subsection (c)(2), is amended by adding at the end the following new subsections:

''(c) ENCOURAGEMENT OF PARTICIPATION IN EDUCATION PROGRAM ACTIVITIES.—A medicare contractor may not use a record of attendance at (or failure to attend) educational activities or other information gathered during an educational program conducted under this section or otherwise by the Secretary to select or track providers of

services, physicians, practitioners, or suppliers for the purpose of conducting any type of audit or prepayment review.

''(d) CONSTRUCTION.—Nothing in this section or section 1893(g) shall be construed as providing for disclosure by a medicare contractor—

''(1) of the screens used for identifying claims that will be subject to medical review; or

''(2) of information that would compromise pending law enforcement activities or reveal findings of law enforcement-related audits.

''(e) DEFINITIONS.—For purposes of this section and section 1817(k)(4)(C), the term 'medicare contractor' includes the following:

''(1) A medicare administrative contractor with a contract under section 1874A, a fiscal intermediary with a contract under section 1816, and a carrier with a contract under section 1842.

''(2) An eligible entity with a contract under section 1893.

Such term does not include, with respect to activities of a specific provider of services, physician, practitioner, or supplier an entity that has no authority under this title or title XI with respect to such activities and such provider of services, physician, practitioner, or supplier.''.

(2) EFFECTIVE DATE.—The amendment made by paragraph (1) shall take effect on the date of enactment of this Act.

SEC. 532. ACCESS TO AND PROMPT RESPONSES FROM MEDICARE CONTRACTORS.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by section 531(b)(1), is amended by adding at the end the following new subsection:

''(f) COMMUNICATING WITH BENEFICIARIES AND PROVIDERS.—

''(1) COMMUNICATION PROCESS.—The Secretary shall develop a process for medicare contractors to communicate with beneficiaries and with providers of services, physicians, practitioners, and suppliers under this title.

''(2) RESPONSE TO WRITTEN INQUIRIES.—Each medicare contractor (as defined in paragraph (5)) shall provide general written responses (which may be through electronic transmission) in a clear, concise, and accurate manner to inquiries by beneficiaries, providers of services, physicians, practitioners, and suppliers concerning the programs under this title within 45 business days of the date of receipt of such inquiries.

''(3) RESPONSE TO TOLL-FREE LINES.—The Secretary shall ensure that medicare contractors provide a toll-free telephone number at which beneficiaries, providers, physicians, practitioners, and suppliers may obtain information regarding billing, coding, claims, coverage, and other appropriate information under this title.

''(4) MONITORING OF CONTRACTOR RESPONSES.—

''(A) IN GENERAL.—Each medicare contractor shall, consistent with standards developed by the Secretary under subparagraph (B)—

''(i) maintain a system for identifying who provides the information referred to in paragraphs (2) and (3); and

''(ii) monitor the accuracy, consistency, and timeliness of the information so provided.

''(B) DEVELOPMENT OF STANDARDS.—

''(i) IN GENERAL.—The Secretary shall establish (and publish in the Federal Register) standards regarding the accuracy, consistency, and timeliness of the information provided in response to inquiries under this subsection. Such standards shall be consistent with the performance requirements established under subsection (b)(3).

''(ii) EVALUATION.—In conducting evaluations of individual medicare contractors, the Secretary shall consider the results of the monitoring conducted under subparagraph (A) taking into account as performance requirements the standards established under clause (i). The Secretary shall, in consultation with organizations representing providers of services, suppliers, and individuals entitled to benefits under part A or enrolled under part B, or both, establish standards relating to the accuracy, consistency, and timeliness of the information so provided.

''(C) DIRECT MONITORING.—Nothing in this paragraph shall be construed as preventing the Secretary from directly monitoring the accuracy, consistency, and timeliness of the information so provided.

''(5) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in subsection (e)(3).''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall take effect October 1, 2004.

SEC. 533. RELIANCE ON GUIDANCE.

(a) IN GENERAL.—Section 1871(d), as added by section 502(a), is amended by adding at the end the following new paragraph:

''(2) If—

''(A) a provider of services, physician, practitioner, or other supplier follows written guidance provided—

''(i) by the Secretary; or

''(ii) by a medicare contractor (as defined in section 1889(e) and whether in the form of a written response to a written inquiry under section 1874A(f)(1) or otherwise) acting within the scope of the contractor's contract authority,

in response to a written inquiry with respect to the furnishing of items or services or the submission of a claim for benefits for such items or services;

''(B) the Secretary determines that—

''(i) the provider of services, physician, practitioner, or supplier has accurately presented the circumstances relating to such items, services, and claim to the Secretary or the contractor in the written guidance; and

''(ii) there is no indication of fraud or abuse committed by the provider of services, physician, practitioner, or supplier against the program under this title; and

''(C) the guidance was in error;

the provider of services, physician, practitioner, or supplier shall not be subject to any penalty or interest under this title (or the provisions of title XI insofar as they relate to this title) relating to the provision of such items or service or such claim if the provider of services, physician, practitioner, or supplier reasonably relied on such guidance. In applying this paragraph with respect to guidance in the form of general responses to frequently asked questions, the Secretary retains authority to determine the extent to which such general responses apply to the particular circumstances of individual claims.''.

(b) EFFECTIVE DATE.—The amendment made by subsection (a) shall apply to penalties imposed on or after the date of enactment of this Act.

SEC. 534. MEDICARE PROVIDER OMBUDSMAN.

(a) MEDICARE PROVIDER OMBUDSMAN.—Section 1868 (42 U.S.C. 1395ee) is amended—

(1) by adding at the end of the heading the following: ''; MEDICARE PROVIDER OMBUDSMAN'';

(2) by inserting ''PRACTICING PHYSICIANS ADVISORY COUNCIL.—(1)'' after ''(a)'';

(3) in paragraph (1), as so redesignated under paragraph (2), by striking ''in this section'' and inserting ''in this subsection'';

(4) by redesignating subsections (b) and (c) as paragraphs (2) and (3), respectively; and

(5) by adding at the end the following new subsection:

''(b) MEDICARE PROVIDER OMBUDSMAN.—

''(1) IN GENERAL.—By not later than 1 year after the date of enactment of the Prescription Drug and Medicare Improvement Act of 2003, the Secretary shall appoint a Medicare Provider Ombudsman.

''(2) DUTIES.—The Medicare Provider Ombudsman shall—

''(A) provide assistance, on a confidential basis, to entities and individuals providing items and services, including covered drugs under part D, under this title with respect to complaints, grievances, and requests for information concerning the programs under this title (including provisions of title XI insofar as they relate to this title and are not administered by the Office of the Inspector General of the Department of Health and Human Services) and in the resolution of unclear or conflicting guidance given by the Secretary and medicare contractors to such providers of services and suppliers regarding such programs and provisions and requirements under this title and such provisions; and

''(B) submit recommendations to the Secretary for improvement in the administration of this title and such provisions, including—

''(i) recommendations to respond to recurring patterns of confusion in this title and such provisions (including recommendations regarding suspending imposition of sanctions where there is widespread confusion in program administration), and

''(ii) recommendations to provide for an appropriate and consistent response (including not providing for audits) in cases of self-identified overpayments by providers of services and suppliers.

''(3) STAFF.—The Secretary shall provide the Medicare Provider Ombudsman with appropriate staff.''.

(b) FUNDING.—There are authorized to be appropriated to the Secretary (in appropriate part from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund (including the Prescription Drug Account)) to carry out the provisions of subsection (b) of section 1868 of the Social Security Act (42 U.S.C. 1395ee) (relating to the Medicare Provider Ombudsman), as added by subsection (a)(5), such sums as are necessary for fiscal year 2004 and each succeeding fiscal year.

SEC. 535. BENEFICIARY OUTREACH DEMONSTRATION PROGRAMS.

(a) DEMONSTRATION ON THE PROVISION OF ADVICE AND ASSISTANCE TO MEDICARE BENEFICIARIES AT LOCAL OFFICES OF THE SOCIAL SECURITY ADMINISTRATION.—

(1) ESTABLISHMENT.—The Secretary shall establish a demonstration program (in this subsection referred to as the ''demonstration program'') under which medicare specialists employed by the Department of Health and Human Services provide advice and assistance to medicare beneficiaries at the location of existing local offices of the Social Security Administration.

(2) LOCATIONS.—

(A) IN GENERAL.—The demonstration program shall be conducted in at least 6 offices or areas. Subject to subparagraph (B), in selecting such offices and areas, the Secretary shall provide preference for offices with a high volume of visits by medicare beneficiaries.

(B) ASSISTANCE FOR RURAL BENEFICIARIES.—The Secretary shall provide for the selection of at least 2 rural areas to participate in the demonstration program. In conducting the demonstration program in such rural areas, the Secretary shall provide for medicare specialists to travel among local offices in a rural area on a scheduled basis.

(3) DURATION.—The demonstration program shall be conducted over a 3-year period.

(4) EVALUATION AND REPORT.—

(A) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program. Such evaluation shall include an analysis of—

(i) utilization of, and beneficiary satisfaction with, the assistance provided under the program; and

(ii) the cost-effectiveness of providing beneficiary assistance through out-stationing medicare specialists at local social security offices.

(B) REPORT.—The Secretary shall submit to Congress a report on such evaluation and shall include in such report recommendations regarding the feasibility of permanently out-stationing Medicare specialists at local social security offices.

(b) DEMONSTRATION ON PROVIDING PRIOR DETERMINATIONS.—

(1) ESTABLISHMENT.—By not later than 1 year after the date of enactment of this Act, the Secretary shall establish a demonstration project to test the administrative feasibility of providing a process for medicare beneficiaries and entities and individuals furnishing such beneficiaries with items and services under title XVIII of the Social Security Act program to make a request for, and receive, a determination (after an advance beneficiary notice is issued with respect to the item or service involved but before such item or service is furnished to the beneficiary) as to whether the item or service is covered under such title consistent with the applicable requirements of section 1862(a)(1)(A) of such Act (42 U.S.C. 1395y(a)(1)(A)) (relating to medical necessity).

(2) EVALUATION AND REPORT.—

(A) EVALUATION.—The Secretary shall provide for an evaluation of the demonstration program conducted under paragraph (1).

(B) REPORT.—By not later than January 1, 2006, the Secretary shall submit to Congress a report on such evaluation together with recommendations for such legislation and administrative actions as the Secretary considers appropriate.

Subtitle E—Review, Recovery, and Enforcement Reform

SEC. 541. PREPAYMENT REVIEW.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1) and 532(a), is amended by adding at the end the following new subsection:

''(g) CONDUCT OF PREPAYMENT REVIEW.—

''(1) STANDARDIZATION OF RANDOM PREPAYMENT REVIEW.—A medicare administrative contractor shall conduct random prepayment review only in accordance with a standard protocol for random prepayment audits developed by the Secretary.

''(2) LIMITATIONS ON INITIATION OF NONRANDOM PREPAYMENT REVIEW.—A medicare administrative contractor may not initiate nonrandom prepayment review of a provider of services, physician, practitioner, or supplier based on the initial identification by that provider of services, physician, practitioner, or supplier of an improper billing practice unless there is a likelihood of sustained or high level of payment error (as defined by the Secretary).

''(3) TERMINATION OF NONRANDOM PREPAYMENT REVIEW.—The Secretary shall establish protocols or standards relating to the termination, including termination dates, of nonrandom prepayment review. Such regulations may vary such a termination date based upon the differences in the circumstances triggering prepayment review.

''(4) CONSTRUCTION.—Nothing in this subsection shall be construed as preventing the denial of payments for claims actually reviewed under a random prepayment review. In the case of a provider of services, physician, practitioner, or supplier with respect to which amounts were previously overpaid, nothing in this subsection shall be construed as limiting the ability of a medicare administrative contractor to request the periodic production of records or supporting documentation for a limited sample of submitted claims to ensure that the previous practice is not continuing.

''(5) RANDOM PREPAYMENT REVIEW DEFINED.—For purposes of this subsection, the term 'random prepayment review' means a demand for the production of records or documentation absent cause with respect to a claim.''.

(b) EFFECTIVE DATE.—

(1) IN GENERAL.—Except as provided in this subsection, the amendment made by subsection (a) shall take effect on the date of enactment of this Act.

(2) DEADLINE FOR PROMULGATION OF CERTAIN REGULATIONS.—The Secretary shall first issue regulations under section 1874A(g) of the Social Security Act, as added by subsection (a), by not later than 1 year after the date of enactment of this Act.

(3) APPLICATION OF STANDARD PROTOCOLS FOR RANDOM PREPAYMENT REVIEW.—Section 1874A(g)(1) of the Social Security Act, as added by subsection (a), shall apply to random prepayment reviews conducted on or after such date (not later than 1 year after the date of enactment of this Act) as the Secretary shall specify. The Secretary shall develop and publish the standard protocol under such section by not later than 1 year after the date of enactment of this Act.

SEC. 542. RECOVERY OF OVERPAYMENTS.

(a) IN GENERAL.—Section 1874A, as added by section 521(a)(1) and as amended by sections 531(b)(1), 532(a), and 541(a), is amended by adding at the end the following new subsection:

''(h) RECOVERY OF OVERPAYMENTS.—

''(1) USE OF REPAYMENT PLANS.—

''(A) IN GENERAL.—If the repayment, within the period otherwise permitted by a provider of services, physician, practitioner, or other supplier, of an overpayment under this title meets the standards developed under subparagraph (B), subject to subparagraph (C), and the provider, physician, practitioner, or supplier requests the Secretary to enter into a repayment plan with respect to such overpayment, the Secretary shall enter into a plan with the provider, physician, practitioner, or supplier for the offset or repayment (at the election of the provider, physician, practitioner, or supplier) of such overpayment over a period of at least 1 year, but not longer than 3 years. Interest shall accrue on the balance through the period of repayment. The repayment plan shall meet terms and conditions determined to be appropriate by the Secretary.

''(B) DEVELOPMENT OF STANDARDS.—The Secretary shall develop standards for the recovery of overpayments. Such standards shall—

''(i) include a requirement that the Secretary take into account (and weigh in favor of the use of a repayment plan) the reliance (as described in section 1871(d)(2)) by a provider of services, physician, practitioner, and supplier on guidance when determining whether a repayment plan should be offered; and

''(ii) provide for consideration of the financial hardship imposed on a provider of services, physician, practitioner, or supplier in considering such a repayment plan.

In developing standards with regard to financial hardship with respect to a provider of services, physician, practitioner, or supplier, the Secretary shall take into account the amount of the proposed recovery as a proportion of payments made to that provider, physician, practitioner, or supplier.

''(C) EXCEPTIONS.—Subparagraph (A) shall not apply if—

''(i) the Secretary has reason to suspect that the provider of services, physician, practitioner, or supplier may file for bankruptcy or otherwise cease to do business or discontinue participation in the program under this title; or

''(ii) there is an indication of fraud or abuse committed against the program.

''(D) IMMEDIATE COLLECTION IF VIOLATION OF REPAYMENT PLAN.—If a provider of services, physician, practitioner, or supplier fails to make a payment in accordance with a repayment plan under this paragraph, the Secretary may immediately seek to offset or otherwise recover the total balance outstanding (including applicable interest) under the repayment plan.

''(E) RELATION TO NO FAULT PROVISION.—Nothing in this paragraph shall be construed as affecting the application of section 1870(c) (relating to no adjustment in the cases of certain overpayments).

''(2) LIMITATION ON RECOUPMENT.—

''(A) NO RECOUPMENT UNTIL RECONSIDERATION EXERCISED.—In the case of a provider of services, physician, practitioner, or supplier that is determined to have received an overpayment under this title and that seeks a reconsideration of such determination by a qualified independent contractor under section 1869(c), the Secretary may not take any action (or authorize any other person, including any Medicare contractor, as defined in subparagraph (C)) to recoup the overpayment until the date the decision on the reconsideration has been rendered.

''(B) PAYMENT OF INTEREST.—

''(i) RETURN OF RECOUPED AMOUNT WITH INTEREST IN CASE OF REVERSAL.—Insofar as such determination on appeal against the provider of services, physician, practitioner, or supplier is later reversed, the Secretary shall provide for repayment of the amount recouped plus interest for the period in which the amount was recouped.

''(ii) INTEREST IN CASE OF AFFIRMATION.—Insofar as the determination on such appeal is against the provider of services, physician, practitioner, or supplier, interest on the overpayment shall accrue on and after the date of the original notice of overpayment.

''(iii) RATE OF INTEREST.—The rate of interest under this subparagraph shall be the rate otherwise applicable under this title in the case of overpayments.

''(C) MEDICARE CONTRACTOR DEFINED.—For purposes of this subsection, the term 'medicare contractor' has the meaning given such term in section 1889(e).

''(3) PAYMENT AUDITS.—

''(A) WRITTEN NOTICE FOR POST-PAYMENT AUDITS.—Subject to subparagraph (C), if a medicare contractor decides to conduct a post-payment audit of a provider of services, physician, practitioner, or supplier under this title, the contractor shall provide the provider of services, physician, practitioner, or supplier with written notice (which may be in electronic form) of the intent to conduct such an audit.

''(B) EXPLANATION OF FINDINGS FOR ALL AUDITS.—Subject to subparagraph (C), if a medicare contractor audits a provider of services, physician, practitioner, or supplier under this title, the contractor shall—

''(i) give the provider of services, physician, practitioner, or supplier a full review and explanation of the findings of the audit in a manner that is understandable to the provider of services, physician, practitioner, or supplier and permits the development of an appropriate corrective action plan;

''(ii) inform the provider of services, physician, practitioner, or supplier of the appeal

rights under this title as well as consent settlement options (which are at the discretion of the Secretary); and

''(iii) give the provider of services, physician, practitioner, or supplier an opportunity to provide additional information to the contractor.

''(C) EXCEPTION.—Subparagraphs (A) and (B) shall not apply if the provision of notice or findings would compromise pending law enforcement activities, whether civil or criminal, or reveal findings of law enforcement-related audits.

''(4) NOTICE OF OVER-UTILIZATION OF CODES.—The Secretary shall establish, in consultation with organizations representing the classes of providers of services, physicians, practitioners, and suppliers, a process under which the Secretary provides for notice to classes of providers of services, physicians, practitioners, and suppliers served by a medicare contractor in cases in which the contractor has identified that particular billing codes may be overutilized by that class of providers of services, physicians, practitioners, or suppliers under the programs under this title (or provisions of title XI insofar as they relate to such programs).

''(5) STANDARD METHODOLOGY FOR PROBE SAMPLING.—The Secretary shall establish a standard methodology for medicare administrative contractors to use in selecting a sample of claims for review in the case of an abnormal billing pattern.

''(6) CONSENT SETTLEMENT REFORMS.—

''(A) IN GENERAL.—The Secretary may use a consent settlement (as defined in subparagraph (D)) to settle a projected overpayment.

''(B) OPPORTUNITY TO SUBMIT ADDITIONAL INFORMATION BEFORE CONSENT SETTLEMENT OFFER.—Before offering a provider of services, physician, practitioner, or supplier a consent settlement, the Secretary shall—

''(i) communicate to the provider of services, physician, practitioner, or supplier in a nonthreatening manner that, based on a review of the medical records requested by the Secretary, a preliminary evaluation of those records indicates that there would be an overpayment; and

''(ii) provide for a 45-day period during which the provider of services, physician, practitioner, or supplier may furnish additional information concerning the medical records for the claims that had been reviewed.

''(C) CONSENT SETTLEMENT OFFER.—The Secretary shall review any additional information furnished by the provider of services, physician, practitioner, or supplier under subparagraph (B)(ii). Taking into consideration such information, the Secretary shall determine if there still appears to be an overpayment. If so, the Secretary—

''(i) shall provide notice of such determination to the provider of services, physician, practitioner, or supplier, including an explanation of the reason for such determination; and

''(ii) in order to resolve the overpayment, may offer the provider of services, physician, practitioner, or supplier—

''(I) the opportunity for a statistically valid random sample; or

''(II) a consent settlement.

The opportunity provided under clause (ii)(I) does not waive any appeal rights with respect to the alleged overpayment involved.

''(D) CONSENT SETTLEMENT DEFINED.—For purposes of this paragraph, the term 'consent settlement' means an agreement between the Secretary and a provider of services, physician, practitioner, or supplier whereby both parties agree to settle a projected overpayment based on less than a statistically valid sample of claims and the provider of services, physician, practitioner, or supplier agrees not to appeal the claims involved.''.

(b) EFFECTIVE DATES AND DEADLINES.—

(1) Not later than 1 year after the date of enactment of this Act, the Secretary shall first—

(A) develop standards for the recovery of overpayments under section 1874A(h)(1)(B) of the Social Security Act, as added by subsection (a);

(B) establish the process for notice of overutilization of billing codes under section 1874A(h)(4) of the Social Security Act, as added by subsection (a); and

(C) establish a standard methodology for selection of sample claims for abnormal billing patterns under section 1874A(h)(5) of the Social Security Act, as added by subsection (a).

(2) Section 1874A(h)(2) of the Social Security Act, as added by subsection (a), shall apply to actions taken after the date that is 1 year after the date of enactment of this Act.

(3) Section 1874A(h)(3) of the Social Security Act, as added by subsection (a), shall apply to audits initiated after the date of enactment of this Act.

(4) Section 1874A(h)(6) of the Social Security Act, as added by subsection (a), shall apply to consent settlements entered into after the date of enactment of this Act.

SEC. 543. PROCESS FOR CORRECTION OF MINOR ERRORS AND OMISSIONS ON CLAIMS WITHOUT PURSUING APPEALS PROCESS.

(a) IN GENERAL.—The Secretary shall develop, in consultation with appropriate medicare contractors (as defined in section 1889(e) of the Social Security Act, as added by section 531(d)(1)) and representatives of providers of services, physicians, practitioners, facilities, and suppliers, a process whereby, in the case of minor errors or omissions (as defined by the Secretary) that are detected in the submission of claims under the programs under title XVIII of such Act, a provider of services, physician, practitioner, facility, or supplier is given an opportunity to correct such an error or omission without the need to initiate an appeal. Such process shall include the ability to resubmit corrected claims.

(b) DEADLINE.—Not later than 1 year after the date of enactment of this Act, the Secretary shall first develop the process under subsection (a).

SEC. 544. AUTHORITY TO WAIVE A PROGRAM EXCLUSION.

The first sentence of section 1128(c)(3)(B) (42 U.S.C. 1320a–7(c)(3)(B)) is amended to read as follows: ''Subject to subparagraph (G), in the case of an exclusion under subsection (a), the minimum period of exclusion shall be not less than 5 years, except that, upon the request of an administrator of a Federal health care program (as defined in section 1128B(f)) who determines that the exclusion would impose a hardship on beneficiaries of that program, the Secretary may, after consulting with the Inspector General of the Department of Health and Human Services, waive the exclusion under subsection (a)(1), (a)(3), or (a)(4) with respect to that program in the case of an individual or entity that is the sole community physician or sole source of essential specialized services in a community.''.

TITLE VI—OTHER PROVISIONS

SEC. 601. INCREASE IN MEDICAID DSH ALLOTMENTS FOR FISCAL YEARS 2004 AND 2005.

(a) IN GENERAL.—Section 1923(f)(4) (42 U.S.C. 1396r–4(f)(4)) is amended—

(1) in the paragraph heading, by striking ''FISCAL YEARS 2001 AND 2002'' and inserting ''CERTAIN FISCAL YEARS'';

(2) in subparagraph (A)—

(A) in clause (i)—

(i) by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (3)''; and

(ii) by striking ''and'' at the end;

(B) in clause (ii), by striking the period and inserting a semicolon; and

(C) by adding at the end the following:

''(iii) for fiscal year 2004, shall be the DSH allotment determined under paragraph (3) for that fiscal year increased by the amount equal to the product of 0.50 and the difference between—

''(I) the amount that the DSH allotment would be if the DSH allotment for the State determined under clause (ii) were increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002 and 2003; and

''(II) the DSH allotment determined under paragraph (3) for the State for fiscal year 2004; and

''(iv) for fiscal year 2005, shall be the DSH allotment determined under paragraph (3) for that fiscal year increased by the amount equal to the product of 0.50 and the difference between—

''(I) the amount that the DSH allotment would be if the DSH allotment for the State determined under clause (ii) were increased, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2002, 2003, and 2004; and

''(II) the DSH allotment determined under paragraph (3) for the State for fiscal year 2005.''; and

(3) in subparagraph (C)—

(A) in the subparagraph heading, by striking ''AFTER FISCAL YEAR 2002'' and inserting ''FOR OTHER FISCAL YEARS''; and

(B) by striking ''2003 or'' and inserting ''2003, fiscal year 2006, or''.

(b) DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—Section 1923(f)(4) (42 U.S.C. 1396r–4(f)(4)), as amended by paragraph (1), is amended—

(1) in subparagraph (A), by inserting ''and except as provided in subparagraph (C)'' after ''paragraph (2)'';

(2) by redesignating subparagraph (C) as subparagraph (D); and

(3) by inserting after subparagraph (B) the following:

''(C) DSH ALLOTMENT FOR THE DISTRICT OF COLUMBIA.—

''(i) IN GENERAL.—Notwithstanding subparagraph (A), the DSH allotment for the District of Columbia for fiscal year 2004, shall be determined by substituting '49' for '32' in the item in the table contained in paragraph (2) with respect to the DSH allotment for FY 00 (fiscal year 2000) for the District of Columbia, and then increasing such allotment, subject to subparagraph (B) and paragraph (5), by the percentage change in the Consumer Price Index for all urban consumers (all items; U.S. city average) for each of fiscal years 2000, 2001, 2002, and 2003.

''(ii) NO APPLICATION TO ALLOTMENTS AFTER FISCAL YEAR 2004.—The DSH allotment for the District of Columbia for fiscal year 2003, fiscal year 2005, or any succeeding fiscal year shall be determined under paragraph (3) without regard to the DSH allotment determined under clause (i).''.

(c) CONFORMING AMENDMENT.—Section 1923(f)(3) of such Act (42 U.S.C. 1396r–4(f)(3)) is amended by inserting '', paragraph (4),'' after ''subparagraph (B)''.

SEC. 602. INCREASE IN FLOOR FOR TREATMENT AS AN EXTREMELY LOW DSH STATE UNDER THE MEDICAID PROGRAM FOR FISCAL YEARS 2004 AND 2005.

(a) IN GENERAL.—Section 1923(f)(5) (42 U.S.C. 1396r–4(f)(5)) is amended—

(1) by striking ''In the case of'' and inserting the following:

''(A) IN GENERAL.—In the case of''; and

(2) by adding at the end the following:

''(B) INCREASE IN FLOOR FOR FISCAL YEARS 2004 AND 2005.—

''(i) FISCAL YEAR 2004.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2000, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2003, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2004 shall be increased to 3 percent of the State's total amount of expenditures under such plan for such assistance during such fiscal year.

''(ii) FISCAL YEAR 2005.—In the case of a State in which the total expenditures under the State plan (including Federal and State shares) for disproportionate share hospital adjustments under this section for fiscal year 2001, as reported to the Administrator of the Centers for Medicare & Medicaid Services as of August 31, 2004, is greater than 0 but less than 3 percent of the State's total amount of expenditures under the State plan for medical assistance during the fiscal year, the DSH allotment for fiscal year 2005 shall be the DSH allotment determined for the State for fiscal year 2004 (under clause (i) or paragraph (4) (as applicable)), increased by the percentage change in the consumer price index for all urban consumers (all items; U.S. city average) for fiscal year 2004.

''(iii) NO APPLICATION TO ALLOTMENTS AFTER FISCAL YEAR 2005.—The DSH allotment for any State for fiscal year 2006 or any succeeding fiscal year shall be determined under this subsection without regard to the DSH allotments determined under this subparagraph.''.

(b) ALLOTMENT ADJUSTMENT.—

(1) IN GENERAL.—Section 1923(f) of the Social Security Act (42 U.S.C. 1396r–4(f)) is amended—

(A) by redesignating paragraph (6) as paragraph (7); and

(B) by inserting after paragraph (5) the following:

''(6) ALLOTMENT ADJUSTMENT.—Only with respect to fiscal year 2004 or 2005, if a statewide waiver under section 1115 that was implemented on January 1, 1994, is revoked or terminated before the end of either such fiscal year, the Secretary shall—

''(A) permit the State whose waiver was revoked or terminated to submit an amendment to its State plan that would describe the methodology to be used by the State (after the effective date of such revocation or termination) to identify and make payments to disproportionate share hospitals, including children's hospitals and institutions for mental diseases or other mental health facilities (other than State-owned institutions or facilities), on the basis of the proportion of patients served by such hospitals that are low-income patients with special needs; and

''(B) provide for purposes of this subsection for computation of an appropriate DSH allotment for the State for fiscal year 2004 or 2005 (or both) that provides for the maximum amount (permitted consistent with paragraph (3)(B)(ii)) that does not result in greater expenditures under this title than would have been made if such waiver had not been revoked or terminated.''.

(2) TREATMENT OF INSTITUTIONS FOR MENTAL DISEASES.—Section 1923(h)(1) of the Social Security Act (42 U.S.C. 1396r–4(h)(1)) is amended—

(A) in paragraph (1), in the matter preceding subparagraph (A), by inserting ''(subject to paragraph (3))'' after ''the lesser of the following''; and

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

''(3) SPECIAL RULE.—The limitation of paragraph (1) shall not apply in the case of a State to which subsection (f)(6) applies.''.

SEC. 603. INCREASED REPORTING REQUIREMENTS TO ENSURE THE APPROPRIATENESS OF PAYMENT ADJUSTMENTS TO DISPROPORTIONATE SHARE HOSPITALS UNDER THE MEDICAID PROGRAM.

Section 1923 (42 U.S.C. 1396r–4) is amended by adding at the end the following new subsection:

''(j) ANNUAL REPORTS REGARDING PAYMENT ADJUSTMENTS.—With respect to fiscal year 2004 and each fiscal year thereafter, the Secretary shall require a State, as a condition of receiving a payment under section 1903(a)(1) with respect to a payment adjustment made under this section, to submit an annual report that—

''(1) identifies each disproportionate share hospital that received a payment adjustment under this section for the preceding fiscal year and the amount of the payment adjustment made to such hospital for the preceding fiscal year; and

''(2) includes such other information as the Secretary determines necessary to ensure the appropriateness of the payment adjustments made under this section for the preceding fiscal year.''.

SEC. 604. CLARIFICATION OF INCLUSION OF INPATIENT DRUG PRICES CHARGED TO CERTAIN PUBLIC HOSPITALS IN THE BEST PRICE EXEMPTIONS FOR THE MEDICAID DRUG REBATE PROGRAM.

(a) IN GENERAL.—Section 1927(c)(1)(C)(i)(I) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)(i)(I)) is amended by inserting before the semicolon the following: ''(including inpatient prices charged to hospitals described in section 340B(a)(4)(L) of the Public Health Service Act)''.

(b) ANTI-DIVERSION PROTECTION.—Section 1927(c)(1)(C) of the Social Security Act (42 U.S.C. 1396r–8(c)(1)(C)) is amended by adding at the end the following:

''(iii) APPLICATION OF AUDITING AND RECORDKEEPING REQUIREMENTS.—With respect to a covered entity described in section 340B(a)(4)(L) of the Public Health Service Act, any drug purchased for inpatient use shall be subject to the auditing and recordkeeping requirements described in section 340B(a)(5)(C) of the Public Health Service Act.''.

(c) EFFECTIVE DATE.—The amendments made by this section take effect on October 1, 2003.

SEC. 605. ASSISTANCE WITH COVERAGE OF LEGAL IMMIGRANTS UNDER THE MEDICAID PROGRAM AND SCHIP.

(a) MEDICAID PROGRAM.—Section 1903(v) (42 U.S.C. 1396b(v)) is amended—

(1) in paragraph (1), by striking ''paragraph (2)'' and inserting ''paragraphs (2) and (4)''; and

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

''(4)(A) With respect to any or all of fiscal years 2005 through 2007, a State may elect (in a plan amendment under this title) to provide medical assistance under this title (including under a waiver authorized by the Secretary) for aliens who are lawfully residing in the United States (including battered aliens described in section 431(c) of such Act) and who are otherwise eligible for such assistance, within either or both of the following eligibility categories:

''(i) PREGNANT WOMEN.—Women during pregnancy (and during the 60-day period beginning on the last day of the pregnancy).

''(ii) CHILDREN.—Children (as defined under such plan), including optional targeted low-income children described in section 1905(u)(2)(B).

''(B)(i) In the case of a State that has elected to provide medical assistance to a category of aliens under subparagraph (A), no debt shall accrue under an affidavit of support against any sponsor of such an alien on the basis of provision of assistance to such category and the cost of such assistance shall not be considered as an unreimbursed cost.

''(ii) The provisions of sections 401(a), 402(b), 403, and 421 of the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 shall not apply to a State that makes an election under subparagraph (A).''.

(b) SCHIP.—Section 2107(e)(1) (42 U.S.C. 1397gg(e)(1)) is amended by redesignating subparagraphs (C) and (D) as subparagraph (D) and (E), respectively, and by inserting after subparagraph (B) the following new subparagraph:

''(C) Section 1903(v)(4) (relating to optional coverage of categories of permanent resident alien children), but only if the State has elected to apply such section to the category of children under title XIX and only with respect to any or all of fiscal years 2005 through 2007.''.

SEC. 606. ESTABLISHMENT OF CONSUMER OMBUDSMAN ACCOUNT.

(a) IN GENERAL.—Section 1817 (42 U.S.C. 1395i) is amended by adding at the end the following new subsection:

''(i) CONSUMER OMBUDSMAN ACCOUNT.—

''(1) ESTABLISHMENT.—There is hereby established in the Trust Fund an expenditure account to be known as the 'Consumer Ombudsman Account' (in this subsection referred to as the 'Account').

''(2) APPROPRIATED AMOUNTS TO ACCOUNT FOR HEALTH INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE GRANTS.—

''(A) IN GENERAL.—There are hereby appropriated to the Account from the Trust Fund for each fiscal year beginning with fiscal year 2005, the amount described in subparagraph (B) for such fiscal year for the purpose of making grants under section 4360 of the Omnibus Budget Reconciliation Act of 1990.

''(B) AMOUNT DESCRIBED.—For purposes of subparagraph (A), the amount described in this subparagraph for a fiscal year is the amount equal to the product of—

''(i) $1; and

''(ii) the total number of individuals receiving benefits under this title for the calendar year ending on December 31 of the preceding fiscal year.''.

(b) CONFORMING AMENDMENT.—Section 4360(g) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b–4(g)) is amended to read as follows:

''(g) FUNDING.—The Secretary shall use amounts appropriated to the Consumer Ombudsman Account in accordance with section 1817(i) of the Social Security Act for a fiscal year for making grants under this section for that fiscal year.''.

SEC. 607. GAO STUDY REGARDING IMPACT OF ASSETS TEST FOR LOW-INCOME BENEFICIARIES.

(a) STUDY.—The Comptroller General of the United States shall conduct a study to determine the extent to which drug utilization and access to covered drugs for an individual described in subsection (b) differs from the drug utilization and access to covered drugs of an individual who qualifies for

the transitional assistance prescription drug card program under section 1807A of the Social Security Act (as added by section 111) or for the premiums and cost-sharing subsidies applicable to a qualified medicare beneficiary, a specified low-income medicare beneficiary, or a qualifying individual under section 1860D–19 of the Social Security Act (as added by section 101).

(b) INDIVIDUAL DESCRIBED.—An individual is described in this subsection if the individual does not qualify for the transitional assistance prescription drug card program under section 1807A of the Social Security Act or for the premiums and cost-sharing subsidies applicable to a qualified medicare beneficiary, a specified low-income medicare beneficiary, or a qualifying individual under section 1860D–19 of the Social Security Act solely as a result of the application of an assets test to the individual.

(c) REPORT.—Not later than September 30, 2007, the Comptroller General shall submit a report to Congress on the study conducted under subsection (a) that includes such recommendations for legislation as the Comptroller General determines are appropriate.

(d) DEFINITIONS.—In this section:

(1) COVERED DRUGS.—The term ''covered drugs'' has the meaning given that term in section 1860D(a)(D) of the Social Security Act.

(2) QUALIFIED MEDICARE BENEFICIARY; SPECIFIED LOW-INCOME MEDICARE BENEFICIARY; QUALIFYING INDIVIDUAL.—The terms ''qualified medicare beneficiary'', ''specified low-income medicare beneficiary'' and ''qualifying individual'' have the meaning given those terms under section 1860D–19 of the Social Security Act.

SEC. 608. HEALTH CARE INFRASTRUCTURE IMPROVEMENT.

At the end of the Social Security Act, add the following new title:

''TITLE XXII—HEALTH CARE INFRASTRUCTURE IMPROVEMENT

''SEC. 2201. DEFINITIONS.

''In this title, the following definitions apply:

''(1) ELIGIBLE PROJECT COSTS.—The term 'eligible project costs' means amounts substantially all of which are paid by, or for the account of, an obligor in connection with a project, including the cost of—

''(A) development phase activities, including planning, feasibility analysis, revenue forecasting, environmental study and review, permitting, architectural engineering and design work, and other preconstruction activities;

''(B) construction, reconstruction, rehabilitation, replacement, and acquisition of facilities and real property (including land related to the project and improvements to land), environmental mitigation, construction contingencies, and acquisition of equipment;

''(C) capitalized interest necessary to meet market requirements, reasonably required reserve funds, capital issuance expenses, and other carrying costs during construction;

''(D) major medical equipment determined to be appropriate by the Secretary; and

''(E) refinancing projects or activities that are otherwise eligible for financial assistance under subparagraphs (A) through (D).

''(2) FEDERAL CREDIT INSTRUMENT.—The term 'Federal credit instrument' means a secured loan, loan guarantee, or line of credit authorized to be made available under this title with respect to a project.

''(3) INVESTMENT-GRADE RATING.—The term 'investment-grade rating' means a rating category of BBB minus, Baa3, or higher assigned by a rating agency to project obligations offered into the capital markets.

''(4) LENDER.—The term 'lender' means any non-Federal qualified institutional buyer (as defined in section 230.144A(a) of title 17, Code of Federal Regulations (or any successor regulation), known as Rule 144A(a) of the Securities and Exchange Commission and issued under the Securities Act of 1933 (15 U.S.C. 77a et seq.)), including—

''(A) a qualified retirement plan (as defined in section 4974(c) of the Internal Revenue Code of 1986) that is a qualified institutional buyer; and

''(B) a governmental plan (as defined in section 414(d) of the Internal Revenue Code of 1986) that is a qualified institutional buyer.

''(5) LINE OF CREDIT.—The term 'line of credit' means an agreement entered into by the Secretary with an obligor under section 2204 to provide a direct loan at a future date upon the occurrence of certain events.

''(6) LOAN GUARANTEE.—The term 'loan guarantee' means any guarantee or other pledge by the Secretary to pay all or part of the principal of and interest on a loan or other debt obligation issued by an obligor and funded by a lender.

''(7) LOCAL SERVICER.—The term 'local servicer' means a State or local government or any agency of a State or local government that is responsible for servicing a Federal credit instrument on behalf of the Secretary.

''(8) OBLIGOR.—The term 'obligor' means a party primarily liable for payment of the principal of or interest on a Federal credit instrument, which party may be a corporation, partnership, joint venture, trust, or governmental entity, agency, or instrumentality.

''(9) PROJECT.—The term 'project' means any project that is designed to improve the health care infrastructure, including the construction, renovation, or other capital improvement of any hospital, medical research facility, or other medical facility or the purchase of any equipment to be used in a hospital, research facility, or other medical research facility.

''(10) PROJECT OBLIGATION.—The term 'project obligation' means any note, bond, debenture, lease, installment sale agreement, or other debt obligation issued or entered into by an obligor in connection with the financing of a project, other than a Federal credit instrument.

''(11) RATING AGENCY.—The term 'rating agency' means a bond rating agency identified by the Securities and Exchange Commission as a Nationally Recognized Statistical Rating Organization.

''(12) SECURED LOAN.—The term 'secured loan' means a direct loan or other debt obligation issued by an obligor and funded by the Secretary in connection with the financing of a project under section 2203.

''(13) STATE.—The term 'State' has the meaning given the term in section 101 of title 23, United States Code.

''(14) SUBSIDY AMOUNT.—The term 'subsidy amount' means the amount of budget authority sufficient to cover the estimated long-term cost to the Federal Government of a Federal credit instrument, calculated on a net present value basis, excluding administrative costs and any incidental effects on governmental receipts or outlays in accordance with the provisions of the Federal Credit Reform Act of 1990 (2 U.S.C. 661 et seq.).

''(15) SUBSTANTIAL COMPLETION.—The term 'substantial completion' means the opening of a project to patients or for research purposes.

''SEC. 2202. DETERMINATION OF ELIGIBILITY AND PROJECT SELECTION.

''(a) ELIGIBILITY.—To be eligible to receive financial assistance under this title, a project shall meet the following criteria:

''(1) APPLICATION.—A State, a local servicer identified under section 2205(a), or the entity undertaking a project shall submit a project application to the Secretary.

''(2) ELIGIBLE PROJECT COSTS.—To be eligible for assistance under this title, a project shall have total eligible project costs that are reasonably anticipated to equal or exceed $40,000,000.

''(3) SOURCES OF REPAYMENTS.—Project financing shall be repayable, in whole or in part, from reliable revenue sources as described in the application submitted under paragraph (1).

''(4) PUBLIC SPONSORSHIP OF PRIVATE ENTITIES.—In the case of a project that is undertaken by an entity that is not a State or local government or an agency or instrumentality of a State or local government, the project that the entity is undertaking shall be publicly sponsored or sponsored by an entity that is described in section 501(c)(3) of the Internal Revenue Code of 1986 and exempt from tax under section 501(a) of such Code.

''(b) SELECTION AMONG ELIGIBLE PROJECTS.—

''(1) ESTABLISHMENT.—The Secretary shall establish criteria for selecting among projects that meet the eligibility criteria specified in subsection (a).

''(2) SELECTION CRITERIA.—

''(A) IN GENERAL.—The selection criteria shall include the following:

''(i) The extent to which the project is nationally or regionally significant, in terms of expanding or improving the health care infrastructure of the United States or the region or in terms of the medical benefit that the project will have.

''(ii) The creditworthiness of the project, including a determination by the Secretary that any financing for the project has appropriate security features, such as a rate covenant, credit enhancement requirements, or debt services coverages, to ensure repayment.

''(iii) The extent to which assistance under this title would foster innovative public-private partnerships and attract private debt or equity investment.

''(iv) The likelihood that assistance under this title would enable the project to proceed at an earlier date than the project would otherwise be able to proceed.

''(v) The extent to which the project uses or results in new technologies.

''(vi) The amount of budget authority required to fund the Federal credit instrument made available under this title.

''(vii) The extent to which the project helps maintain or protect the environment.

''(B) SPECIFIC REQUIREMENTS.—The selection criteria shall require that a project applicant—

''(i) be engaged in research in the causes, prevention, and treatment of cancer;

''(ii) be designated as a cancer center for the National Cancer Institute or be designated by the State as the official cancer institute of the State; and

''(iii) be located in a State that, on the date of enactment of this title, has a population of less than 3,000,000 individuals.

''(C) RATING LETTER.—For purposes of subparagraph (A)(ii), the Secretary shall require each project applicant to provide a rating letter from at least 1 rating agency indicating that the project's senior obligations have the potential to achieve an investment-grade rating with or without credit enhancement.

''SEC. 2203. SECURED LOANS.

''(a) IN GENERAL.—

''(1) AGREEMENTS.—Subject to paragraphs (2) through (4), the Secretary may enter into agreements with 1 or more obligors to make secured loans, the proceeds of which shall be used—

''(A) to finance eligible project costs;

''(B) to refinance interim construction financing of eligible project costs; or

''(C) to refinance existing debt or prior project obligations;

of any project selected under section 2202.

''(2) LIMITATION ON REFINANCING OF INTERIM CONSTRUCTION FINANCING.—A loan under paragraph (1) shall not refinance interim construction financing under paragraph (1)(B) later than 1 year after the date of substantial completion of the project.

''(3) RISK ASSESSMENT.—Before entering into an agreement for a secured loan under this subsection, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate capital reserve subsidy amount for each secured loan, taking into account such letter.

''(4) INVESTMENT-GRADE RATING REQUIREMENT.—The funding of a secured loan under this section shall be contingent on the project's senior obligations receiving an investment-grade rating, except that—

''(A) the Secretary may fund an amount of the secured loan not to exceed the capital reserve subsidy amount determined under paragraph (3) prior to the obligations receiving an investment-grade rating; and

''(B) the Secretary may fund the remaining portion of the secured loan only after the obligations have received an investment-grade rating by at least 1 rating agency.

''(b) TERMS AND LIMITATIONS.—

''(1) IN GENERAL.—A secured loan under this section with respect to a project shall be on such terms and conditions and contain such covenants, representations, warranties, and requirements (including requirements for audits) as the Secretary determines appropriate.

''(2) MAXIMUM AMOUNT.—The amount of the secured loan shall not exceed 100 percent of the reasonably anticipated eligible project costs.

''(3) PAYMENT.—The secured loan—

''(A) shall—

''(i) be payable, in whole or in part, from reliable revenue sources; and

''(ii) include a rate covenant, coverage requirement, or similar security feature supporting the project obligations; and

''(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

''(4) INTEREST RATE.—The interest rate on the secured loan shall be not less than the yield on marketable United States Treasury securities of a similar maturity to the maturity of the secured loan on the date of execution of the loan agreement.

''(5) MATURITY DATE.—The final maturity date of the secured loan shall be not later than 30 years after the date of substantial completion of the project.

''(6) NONSUBORDINATION.—The secured loan shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligor.

''(7) FEES.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of making a secured loan under this section.

''(c) REPAYMENT.—

''(1) SCHEDULE.—The Secretary shall establish a repayment schedule for each secured loan under this section based on the projected cash flow from project revenues and other repayment sources.

''(2) COMMENCEMENT.—Scheduled loan repayments of principal or interest on a secured loan under this section shall commence not later than 5 years after the date of substantial completion of the project.

''(3) SOURCES OF REPAYMENT FUNDS.—The sources of funds for scheduled loan repayments under this section shall include any revenue generated by the project.

''(4) DEFERRED PAYMENTS.—

''(A) AUTHORIZATION.—If, at any time during the 10 years after the date of substantial completion of the project, the project is unable to generate sufficient revenues to pay the scheduled loan repayments of principal and interest on the secured loan, the Secretary may, subject to subparagraph (C), allow the obligor to add unpaid principal and interest to the outstanding balance of the secured loan.

''(B) INTEREST.—Any payment deferred under subparagraph (A) shall—

''(i) continue to accrue interest in accordance with subsection (b)(4) until fully repaid; and

''(ii) be scheduled to be amortized over the remaining term of the loan beginning not later than 10 years after the date of substantial completion of the project in accordance with paragraph (1).

''(C) CRITERIA.—

''(i) IN GENERAL.—Any payment deferral under subparagraph (A) shall be contingent on the project meeting criteria established by the Secretary.

''(ii) REPAYMENT STANDARDS.—The criteria established under clause (i) shall include standards for reasonable assurance of repayment.

''(5) PREPAYMENT.—

''(A) USE OF EXCESS REVENUES.—Any excess revenues that remain after satisfying scheduled debt service requirements on the project obligations and secured loan and all deposit requirements under the terms of any trust agreement, bond resolution, reimbursement agreement, credit agreement, loan agreement, or similar agreement securing project obligations may be applied annually to prepay the secured loan without penalty.

''(B) USE OF PROCEEDS OF REFINANCING.—The secured loan may be prepaid at any time without penalty, regardless of whether such repayment is from the proceeds of refinancing from non-Federal funding sources.

''(6) FORGIVENESS OF INDEBTEDNESS.—The Secretary may forgive a loan secured under this title under terms and conditions that are analogous to the loan forgiveness provision for student loans under part D of title IV of the Higher Education Act of 1965 (20 U.S.C. 1087a et seq.), except that the Secretary shall condition such forgiveness on the establishment by the project of—

''(A) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to a substantial majority of the residents of a State or region, including residents of rural areas;

''(B) an outreach program for cancer prevention, early diagnosis, and treatment that provides services to multiple Indian tribes; and

''(C)(i) unique research resources (such as population databases); or

''(ii) an affiliation with an entity that has unique research resources.

''(d) SALE OF SECURED LOANS.—

''(1) IN GENERAL.—Subject to paragraph (2), as soon as practicable after substantial completion of a project and after notifying the obligor, the Secretary may sell to another entity or reoffer into the capital markets a secured loan for the project if the Secretary determines that the sale or reoffering can be made on favorable terms.

''(2) CONSENT OF OBLIGOR.—In making a sale or reoffering under paragraph (1), the Secretary may not change the original terms and conditions of the secured loan without the written consent of the obligor.

''(e) LOAN GUARANTEES.—

''(1) IN GENERAL.—The Secretary may provide a loan guarantee to a lender in lieu of making a secured loan if the Secretary determines that the budgetary cost of the loan guarantee is substantially the same as that of a secured loan.

''(2) TERMS.—The terms of a guaranteed loan shall be consistent with the terms set forth in this section for a secured loan, except that the rate on the guaranteed loan and any prepayment features shall be negotiated between the obligor and the lender, with the consent of the Secretary.

''SEC. 2204. LINES OF CREDIT.

''(a) IN GENERAL.—

''(1) AGREEMENTS.—Subject to paragraphs (2) through (4), the Secretary may enter into agreements to make available lines of credit to 1 or more obligors in the form of direct loans to be made by the Secretary at future dates on the occurrence of certain events for any project selected under section 2202.

''(2) USE OF PROCEEDS.—The proceeds of a line of credit made available under this section shall be available to pay debt service on project obligations issued to finance eligible project costs, extraordinary repair and replacement costs, operation and maintenance expenses, and costs associated with unexpected Federal or State environmental restrictions.

''(3) RISK ASSESSMENT.—Before entering into an agreement for a secured loan under this subsection, the Secretary, in consultation with each rating agency providing a rating letter under section 2202(b)(2)(B), shall determine an appropriate subsidy amount for each secured loan, taking into account such letter.

''(4) INVESTMENT-GRADE RATING REQUIREMENT.—The funding of a line of credit under this section shall be contingent on the project's senior obligations receiving an investment-grade rating from at least 1 rating agency.

''(b) TERMS AND LIMITATIONS.—

''(1) IN GENERAL.—A line of credit under this section with respect to a project shall be on such terms and conditions and contain such covenants, representations, warranties, and requirements (including requirements for audits) as the Secretary determines appropriate.

''(2) MAXIMUM AMOUNTS.—

''(A) TOTAL AMOUNT.—The total amount of the line of credit shall not exceed 33 percent of the reasonably anticipated eligible project costs.

''(B) 1-YEAR DRAWS.—The amount drawn in any 1 year shall not exceed 20 percent of the total amount of the line of credit.

''(3) DRAWS.—Any draw on the line of credit shall represent a direct loan and shall be made only if net revenues from the project (including capitalized interest, any debt service reserve fund, and any other available reserve) are insufficient to pay the costs specified in subsection (a)(2).

''(4) INTEREST RATE.—The interest rate on a direct loan resulting from a draw on the line of credit shall be not less than the yield on 30-year marketable United States Treasury securities as of the date on which the line of credit is obligated.

''(5) SECURITY.—The line of credit—

''(A) shall—

''(i) be payable, in whole or in part, from reliable revenue sources; and

''(ii) include a rate covenant, coverage requirement, or similar security feature supporting the project obligations; and

''(B) may have a lien on revenues described in subparagraph (A) subject to any lien securing project obligations.

''(6) PERIOD OF AVAILABILITY.—The line of credit shall be available during the period beginning on the date of substantial completion of the project and ending not later than 10 years after that date.

''(7) RIGHTS OF THIRD-PARTY CREDITORS.—

''(A) AGAINST FEDERAL GOVERNMENT.—A third-party creditor of the obligor shall not have any right against the Federal Government with respect to any draw on the line of credit.

''(B) ASSIGNMENT.—An obligor may assign the line of credit to 1 or more lenders or to a trustee on the lenders' behalf.

''(8) NONSUBORDINATION.—A direct loan under this section shall not be subordinated to the claims of any holder of project obligations in the event of bankruptcy, insolvency, or liquidation of the obligor.

''(9) FEES.—The Secretary may establish fees at a level sufficient to cover all or a portion of the costs to the Federal Government of providing a line of credit under this section.

''(10) RELATIONSHIP TO OTHER CREDIT INSTRUMENTS.—A project that receives a line of credit under this section also shall not receive a secured loan or loan guarantee under section 2203 of an amount that, combined with the amount of the line of credit, exceeds 100 percent of eligible project costs.

''(c) REPAYMENT.—

''(1) TERMS AND CONDITIONS.—The Secretary shall establish repayment terms and conditions for each direct loan under this section based on the projected cash flow from project revenues and other repayment sources.

''(2) TIMING.—All scheduled repayments of principal or interest on a direct loan under this section shall commence not later than 5 years after the end of the period of availability specified in subsection (b)(6) and be fully repaid, with interest, by the date that is 25 years after the end of the period of availability specified in subsection (b)(6).

''(3) SOURCES OF REPAYMENT FUNDS.—The sources of funds for scheduled loan repayments under this section shall include reliable revenue sources.

''SEC. 2205. PROJECT SERVICING.

''(a) REQUIREMENT.—The State in which a project that receives financial assistance under this title is located may identify a local servicer to assist the Secretary in servicing the Federal credit instrument made available under this title.

''(b) AGENCY; FEES.—If a State identifies a local servicer under subsection (a), the local servicer—

''(1) shall act as the agent for the Secretary; and

''(2) may receive a servicing fee, subject to approval by the Secretary.

''(c) LIABILITY.—A local servicer identified under subsection (a) shall not be liable for the obligations of the obligor to the Secretary or any lender.

''(d) ASSISTANCE FROM EXPERT FIRMS.—The Secretary may retain the services of expert firms in the field of project finance to assist in the underwriting and servicing of Federal credit instruments.

''SEC. 2206. STATE AND LOCAL PERMITS.

''The provision of financial assistance under this title with respect to a project shall not—

''(1) relieve any recipient of the assistance of any obligation to obtain any required State or local permit or approval with respect to the project;

''(2) limit the right of any unit of State or local government to approve or regulate any rate of return on private equity invested in the project; or

''(3) otherwise supersede any State or local law (including any regulation) applicable to the construction or operation of the project.

''SEC. 2207. REGULATIONS.

''The Secretary may issue such regulations as the Secretary determines appropriate to carry out this title.

''SEC. 2208. FUNDING.

''(a) FUNDING.—

''(1) IN GENERAL.—There are authorized to be appropriated to carry out this title, $49,000,000 to remain available during the period beginning on July 1, 2004 and ending on September 30, 2008.

''(2) ADMINISTRATIVE COSTS.—From funds made available under paragraph (1), the Secretary may use, for the administration of this title, not more than $2,000,000 for each of fiscal years 2004 through 2008.

''(b) CONTRACT AUTHORITY.—Notwithstanding any other provision of law, approval by the Secretary of a Federal credit instrument that uses funds made available under this title shall be deemed to be acceptance by the United States of a contractual obligation to fund the Federal credit instrument.

''(c) AVAILABILITY.—Amounts appropriated under this section shall be available for obligation on July 1, 2004.

''SEC. 2209. REPORT TO CONGRESS.

''Not later than 4 years after the date of enactment of this title, the Secretary shall submit to Congress a report summarizing the financial performance of the projects that are receiving, or have received, assistance under this title, including a recommendation as to whether the objectives of this title are best served—

''(1) by continuing the program under the authority of the Secretary;

''(2) by establishing a Government corporation or Government-sponsored enterprise to administer the program; or

''(3) by phasing out the program and relying on the capital markets to fund the types of infrastructure investments assisted by this title without Federal participation.''.

SEC. 609. CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM.

(a) IN GENERAL.—Part A of title XVI of the Public Health Service Act (42 U.S.C. 300q et seq.) is amended by adding at the end the following new section:

''CAPITAL INFRASTRUCTURE REVOLVING LOAN PROGRAM

''SEC. 1603. (a) AUTHORITY TO MAKE AND GUARANTEE LOANS.—

''(1) AUTHORITY TO MAKE LOANS.—The Secretary may make loans from the fund established under section 1602(d) to any rural entity for projects for capital improvements, including—

''(A) the acquisition of land necessary for the capital improvements;

''(B) the renovation or modernization of any building;

''(C) the acquisition or repair of fixed or major movable equipment; and

''(D) such other project expenses as the Secretary determines appropriate.

''(2) AUTHORITY TO GUARANTEE LOANS.—

''(A) IN GENERAL.—The Secretary may guarantee the payment of principal and interest for loans made to rural entities for projects for any capital improvement described in paragraph (1) to any non-Federal lender.

''(B) INTEREST SUBSIDIES.—In the case of a guarantee of any loan made to a rural entity under subparagraph (A), the Secretary may pay to the holder of such loan, for and on behalf of the project for which the loan was made, amounts sufficient to reduce (by not more than 3 percent) the net effective interest rate otherwise payable on such loan.

''(b) AMOUNT OF LOAN.—The principal amount of a loan directly made or guaranteed under subsection (a) for a project for capital improvement may not exceed $5,000,000.

''(c) FUNDING LIMITATIONS.—

''(1) GOVERNMENT CREDIT SUBSIDY EXPOSURE.—The total of the Government credit subsidy exposure under the Credit Reform Act of 1990 scoring protocol with respect to the loans outstanding at any time with respect to which guarantees have been issued, or which have been directly made, under subsection (a) may not exceed $50,000,000 per year.

''(2) TOTAL AMOUNTS.—Subject to paragraph (1), the total of the principal amount of all loans directly made or guaranteed under subsection (a) may not exceed $250,000,000 per year.

''(d) CAPITAL ASSESSMENT AND PLANNING GRANTS.—

''(1) NONREPAYABLE GRANTS.—Subject to paragraph (2), the Secretary may make a grant to a rural entity, in an amount not to exceed $50,000, for purposes of capital assessment and business planning.

''(2) LIMITATION.—The cumulative total of grants awarded under this subsection may not exceed $2,500,000 per year.

''(e) TERMINATION OF AUTHORITY.—The Secretary may not directly make or guarantee any loan under subsection (a) or make a grant under subsection (d) after September 30, 2008.''.

(b) RURAL ENTITY DEFINED.—Section 1624 of the Public Health Service Act (42 U.S.C. 300s–3) is amended by adding at the end the following new paragraph:

''(14)(A) The term 'rural entity' includes—

''(i) a rural health clinic, as defined in section 1861(aa)(2) of the Social Security Act;

''(ii) any medical facility with at least 1 bed, but with less than 50 beds, that is located in—

''(I) a county that is not part of a metropolitan statistical area; or

''(II) a rural census tract of a metropolitan statistical area (as determined under the most recent modification of the Goldsmith Modification, originally published in the Federal Register on February 27, 1992 (57 Fed. Reg. 6725));

''(iii) a hospital that is classified as a rural, regional, or national referral center under section 1886(d)(5)(C) of the Social Security Act; and

''(iv) a hospital that is a sole community hospital (as defined in section 1886(d)(5)(D)(iii) of the Social Security Act).

''(B) For purposes of subparagraph (A), the fact that a clinic, facility, or hospital has been geographically reclassified under the medicare program under title XVIII of the Social Security Act shall not preclude a hospital from being considered a rural entity under clause (i) or (ii) of subparagraph (A).''.

(c) CONFORMING AMENDMENTS.—Section 1602 of the Public Health Service Act (42 U.S.C. 300q–2) is amended—

(1) in subsection (b)(2)(D), by inserting ''or 1603(a)(2)(B)'' after ''1601(a)(2)(B)''; and

(2) in subsection (d)—

(A) in paragraph (1)(C), by striking ''section 1601(a)(2)(B)'' and inserting ''sections 1601(a)(2)(B) and 1603(a)(2)(B)''; and

(B) in paragraph (2)(A), by inserting ''or 1603(a)(2)(B)'' after ''1601(a)(2)(B)''.

SEC. 610. FEDERAL REIMBURSEMENT OF EMERGENCY HEALTH SERVICES FURNISHED TO UNDOCUMENTED ALIENS.

(a) TOTAL AMOUNT AVAILABLE FOR ALLOTMENT.—There is appropriated, out of any funds in the Treasury not otherwise appropriated, $250,000,000 for each of fiscal years 2005 through 2008, for the purpose of making allotments under this section to States described in paragraph (1) or (2) of subsection (b). Funds appropriated under the preceding sentence shall remain available until expended.

(b) STATE ALLOTMENTS.—

(1) BASED ON PERCENTAGE OF UNDOCUMENTED ALIENS.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $167,000,000 of such

amount to make allotments for such fiscal year in accordance with subparagraph (B).

(B) FORMULA.—The amount of the allotment for each State for a fiscal year shall be equal to the product of—

(i) the total amount available for allotments under this paragraph for the fiscal year; and

(ii) the percentage of undocumented aliens residing in the State with respect to the total number of such aliens residing in all States, as determined by the Statistics Division of the Immigration and Naturalization Service, as of January 2003, based on the 2000 decennial census.

(2) BASED ON NUMBER OF UNDOCUMENTED ALIEN APPREHENSION STATES.—

(A) IN GENERAL.—Out of the amount appropriated under subsection (a) for a fiscal year, the Secretary shall use $83,000,000 of such amount to make allotments for such fiscal year for each of the 6 States with the highest number of undocumented alien apprehensions for such fiscal year.

(B) DETERMINATION OF ALLOTMENTS.—The amount of the allotment for each State described in subparagraph (A) for a fiscal year shall bear the same ratio to the total amount available for allotments under this paragraph for the fiscal year as the ratio of the number of undocumented alien apprehensions in the State in that fiscal year bears to the total of such numbers for all such States for such fiscal year.

(C) DATA.—For purposes of this paragraph, the highest number of undocumented alien apprehensions for a fiscal year shall be based on the 4 most recent quarterly apprehension rates for undocumented aliens in such States, as reported by the Immigration and Naturalization Service.

(3) RULE OF CONSTRUCTION.—Nothing in this section shall be construed as prohibiting a State that is described in both of paragraphs (1) and (2) from receiving an allotment under both paragraphs for a fiscal year.

(c) USE OF FUNDS.—

(1) AUTHORITY TO MAKE PAYMENTS.—From the allotments made for a State under subsection (b) for a fiscal year, the Secretary shall pay directly to local governments, hospitals, or other providers located in the State (including providers of services received through an Indian Health Service facility whether operated by the Indian Health Service or by an Indian tribe or tribal organization) that provide uncompensated emergency health services furnished to undocumented aliens during that fiscal year, and to the State, such amounts (subject to the total amount available from such allotments) as the local governments, hospitals, providers, or State demonstrate were incurred for the provision of such services during that fiscal year.

(2) LIMITATION ON STATE USE OF FUNDS.—Funds paid to a State from allotments made under subsection (b) for a fiscal year may only be used for making payments to local governments, hospitals, or other providers for costs incurred in providing emergency health services to undocumented aliens or for State costs incurred with respect to the provision of emergency health services to such aliens.

(3) INCLUSION OF COSTS INCURRED WITH RESPECT TO CERTAIN ALIENS.—Uncompensated emergency health services furnished to aliens who have been allowed to enter the United States for the sole purpose of receiving emergency health services may be included in the determination of costs incurred by a State, local government, hospital, or other provider with respect to the provision of such services.

(d) APPLICATIONS; ADVANCE PAYMENTS.—

(1) DEADLINE FOR ESTABLISHMENT OF APPLICATION PROCESS.—

(A) IN GENERAL.—Not later than September 1, 2004, the Secretary shall establish a process under which States, local governments, hospitals, or other providers located in the State may apply for payments from allotments made under subsection (b) for a fiscal year for uncompensated emergency health services furnished to undocumented aliens during that fiscal year.

(B) INCLUSION OF MEASURES TO COMBAT FRAUD.—The Secretary shall include in the process established under subparagraph (A) measures to ensure that fraudulent payments are not made from the allotments determined under subsection (b).

(2) ADVANCE PAYMENT; RETROSPECTIVE ADJUSTMENT.—The process established under paragraph (1) shall allow for making payments under this section for each quarter of a fiscal year on the basis of advance estimates of expenditures submitted by applicants for such payments and such other investigation as the Secretary may find necessary, and for making reductions or increases in the payments as necessary to adjust for any overpayment or underpayment for prior quarters of such fiscal year.

(e) DEFINITIONS.—In this section:

(1) HOSPITAL.—The term ''hospital'' has the meaning given such term in section 1861(e) of the Social Security Act (42 U.S.C. 1395x(e)).

(2) INDIAN TRIBE; TRIBAL ORGANIZATION.—The terms ''Indian tribe'' and ''tribal organization'' have the meanings given such terms in section 4 of the Indian Health Care Improvement Act (25 U.S.C. 1603).

(3) PROVIDER.—The term ''provider'' includes a physician, any other health care professional licensed under State law, and any other entity that furnishes emergency health services, including ambulance services.

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

(5) STATE.—The term ''State'' means the 50 States and the District of Columbia.

SEC. 611. INCREASE IN APPROPRIATION TO THE HEALTH CARE FRAUD AND ABUSE CONTROL ACCOUNT.

Section 1817(k)(3)(A) (42 U.S.C. 1395i(k)(3)(A)) is amended—

(1) in clause (i)—

(A) in subclause (II), by striking ''and'' at the end; and

(B) by striking subclause (III), and inserting the following new subclauses:

''(III) for fiscal year 2004, the limit for fiscal year 2003 increased by $10,000,000;

''(IV) for fiscal year 2005, the limit for fiscal year 2003 increased by $15,000,000;

''(V) for fiscal year 2006, the limit for fiscal year 2003 increased by $25,000,000; and

''(VI) for each fiscal year after fiscal year 2006, the limit for fiscal year 2003.''; and

(2) in clause (ii)—

(A) in subclause (VI), by striking ''and'' at the end;

(B) in subclause (VII)—

(i) by striking ''each fiscal year after fiscal year 2002'' and inserting ''fiscal year 2003''; and

(ii) by striking the period and inserting a semicolon; and

(3) by adding at the end the following:

''(VIII) for fiscal year 2004, $170,000,000;

''(IX) for fiscal year 2005, $175,000,000;

''(X) for fiscal year 2006, $185,000,000; and

''(XI) for each fiscal year after fiscal year 2006, not less than $150,000,000 and not more than $160,000,000.''.

SEC. 612. INCREASE IN CIVIL PENALTIES UNDER THE FALSE CLAIMS ACT.

(a) IN GENERAL.—Section 3729(a) of title 31, United States Code, is amended—

(1) by striking ''$5,000'' and inserting ''$7,500''; and

(2) by striking ''$10,000'' and inserting ''$15,000''.

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

SEC. 613. INCREASE IN CIVIL MONETARY PENALTIES UNDER THE SOCIAL SECURITY ACT.

(a) IN GENERAL.—Section 1128A(a) (42 U.S.C. 1320a–7a(a)), in the matter following paragraph (7), is amended—

(1) by striking ''$10,000'' each place it appears and inserting ''$12,500'';

(2) by striking ''$15,000'' and inserting ''$18,750''; and

(3) striking ''$50,000'' and inserting ''$62,500''.

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

SEC. 614. EXTENSION OF CUSTOMS USER FEES.

Section 13031(j)(3) of the Consolidated Omnibus Budget Reconciliation Act of 1985 (19 U.S.C. 58c(j)(3)) is amended by striking ''September 30, 2003'' and inserting ''September 30, 2013''.

Mr. GRASSLEY. Mr. President, the technical corrections in this modification obviously have been agreed to by Senator BAUCUS or I would not have offered it, and they are not controversial. The corrected items in this modification are technical in nature. It merely perfects policies in the Finance Committee's reported mark that were drafted incorrectly in S. 1. The corrected items also reflect drafting changes that, while small, were important from CBO's perspective in getting us a complete score. All of these technical changes are incorporated now into this modified version of S. 1.

The new version also includes an official line-by-line score from the Congressional Budget Office. I am looking forward to getting on to amendments at this point. I repeat what I said yesterday: My hope is the spirit of comity and consensus building that existed in the Finance Committee last week will be and can be, and I am surely going to work for it to be, replicated here on the Senate floor. The Finance Committee members reached across party lines to arrive at that consensus. For some it was very difficult. But the final vote showed a lot of give and take because that vote out of committee was 16 to 5. I hope that same spirit will prevail here today and in the coming days this week and next week that we are on the bill.

There was another part of the consent I did not ask. I now ask unanimous consent the amendment be agreed to—our professional staff has some disagreement whether or not I should be making that motion at this point, so I will not.

The PRESIDING OFFICER. The Senator from Nevada.

Mr. REID. Mr. President, the Senator from Michigan is now going to offer her amendment. We are willing to enter into a time agreement on the amendment. There are a number of meetings at the White House, I am told, that prevent our arriving at a definite time for the amendment today. I have spoken to the staff on both sides, and maybe at 3:15 we could have a vote.

Members should keep that in mind, that we may be able to do that.

There is nothing definite at this stage. I want the record to reflect we are not trying to stall movement of this bill. We have this amendment, this important amendment. We are ready to vote on it earlier than 3:15. But because of the White House calling Senators down, we will be unable to do that.

Mr. GRASSLEY. Mr. President, in addition to what the Senator expressed, it is a desire on our part that we would have some votes yet today and that we would like to move along very quickly. I think the spirit he has set is one that is shared on our side, even to the point of being specific statements from our leadership, the extent to which they would hope to have some votes today.

I yield the floor.

Mr. REID. It was suggested earlier today that we would rotate back and forth on amendments. That is fine. I think we have more amendments than you have, but if that is the case, we are happy to alternate back and forth.

Mr. GRASSLEY. Mr. President, if I may further add to what the Senator said, for our part, we would like to have a very general rule that we would alternate back and forth, but it is also our belief on this side that we would give great deference to the other side to offer amendments, two Democratic or three Democratic amendments in order so we could be very flexible on that. We did want to reserve and provide some predictability to the order on the floor because there might be some Members on the Republican side who would like to offer an amendment, and they want some certainty when that would be done.

The PRESIDING OFFICER. The Senator from Michigan.

AMENDMENT NO. 931

Ms. STABENOW. Mr. President, I send an amendment to the desk on behalf of myself, Senators BOXER, BOB GRAHAM, ROCKEFELLER, HARKIN, CANTWELL, KERRY, BINGAMAN, JACK REED, CLINTON, and MIKULSKI. I ask for its immediate consideration.

The PRESIDING OFFICER. The clerk will report.

The legislative clerk read as follows:

The Senator from Michigan [Ms. STABENOW], for herself, Mrs. BOXER, Mr. GRAHAM of Florida, Mr. ROCKEFELLER, Mr. HARKIN, Ms. CANTWELL, Mr. KERRY, Mr. BINGAMAN, Mr. REED, Mrs. CLINTON, and Ms. MIKULSKI, proposes an amendment numbered 931.

Ms. STABENOW. 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 require that the Medicare plan, to be known as the Medicare Guaranteed Option, be available to all eligible beneficiaries in every year)

Beginning on page 74, strike line 10 and all that follows through page 84, line 3, and insert the following:

''(e) MEDICARE GUARANTEED OPTION.—

''(1) ACCESS.—

''(A) IN GENERAL.—The Administrator shall enter into a contract with an entity in each area (established under section 1860D–10) to provide eligible beneficiaries enrolled under this part (and not, except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage, enrolled in a MedicareAdvantage plan) and residing in the area with standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)). An entity may be awarded a contract for more than 1 area but the Administrator may enter into only 1 such contract in each such area.

''(B) ENTITY REQUIRED TO MEET BENEFICIARY PROTECTION AND OTHER REQUIREMENTS.—An entity with a contract under subparagraph (A) shall meet the requirements described in section 1860D–5 and such other requirements determined appropriate by the Administrator.

''(C) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into a contract under subparagraph (A).

''(D) SAME TIMEFRAME AS MEDICARE PRESCRIPTION DRUG PLANS.—The Administrator shall apply similar timeframes for the submission of bids and entering into to contracts under this subsection as the Administrator applies to Medicare Prescription Drug plans.

''(2) MONTHLY BENEFICIARY OBLIGATION FOR ENROLLMENT.—In the case of an eligible beneficiary receiving access to qualified prescription drug coverage through enrollment with an entity with a contract under paragraph (1)(A), the monthly beneficiary obligation of such beneficiary for such enrollment shall be an amount equal to the applicable percent (as determined under section 1860D–17(c) before any adjustment under paragraph (2) of such section) of the monthly national average premium (as computed under section 1860D–15 before any adjustment under subsection (b) of such section) for the year.

''(3) PAYMENTS UNDER THE CONTRACT.—

''(A) IN GENERAL.—A contract entered into under paragraph (1)(A) shall provide for—

''(i) payment for the negotiated costs of covered drugs provided to eligible beneficiaries enrolled with the entity; and

''(ii) payment of prescription management fees that are tied to performance requirements established by the Administrator for the management, administration, and delivery of the benefits under the contract.

''(B) PERFORMANCE REQUIREMENTS.—The performance requirements established by the Administrator pursuant to subparagraph (A)(ii) shall include the following:

''(i) The entity contains costs to the Prescription Drug Account and to eligible beneficiaries enrolled under this part and with the entity.

''(ii) The entity provides such beneficiaries with quality clinical care.

''(iii) The entity provides such beneficiaries with quality services.

''(C) ENTITY ONLY AT RISK TO THE EXTENT OF THE FEES TIED TO PERFORMANCE REQUIREMENTS.—An entity with a contract under paragraph (1)(A) shall only be at risk for the provision of benefits under the contract to the extent that the management fees paid to the entity are tied to performance requirements under subparagraph (A)(ii).

''(4) TERM OF CONTRACT.—A contract entered into under paragraph (1)(A) shall be for a period of at least 2 years but not more than 5 years.

''(5) NO EFFECT ON ACCESS REQUIREMENTS.—The contract entered into under subparagraph (1)(A) shall be in addition to the plans required under subsection (d)(1).

''(6) AUTHORITY TO PREVENT INCREASED COSTS.—If the Administrator determines that Federal payments made with respect to eligible beneficiaries enrolled in a contract under paragraph (1)(A) exceed on average the Federal payments made with respect to eligible beneficiaries enrolled in a Medicare Prescription Drug plan or a MedicareAdvantage plan (with respect to qualified prescription drug coverage), the Administrator may adjust the requirements or payments under such a contract to eliminate such excess.

Ms. STABENOW. Mr. President, first of all, before explaining the amendment, I commend my colleagues for their leadership on the Finance Committee. They have been working very diligently—the chairman, Senator GRASSLEY, and the ranking member, Senator BAUCUS, and members on both sides of the aisle. I commend them for bringing forward one of the most critical issues affecting American people, American families, American seniors today. While we may disagree on specifics and on what is the best approach, I very much commend them for giving us the opportunity to debate this critical issue and for the hard work that has gone on, on both sides.

My amendment is a simple one. It would provide another choice of prescription drug plans for seniors on Medicare. In fact, it would provide the choice the majority of seniors want to make on Medicare.

The underlying bill allows seniors to choose a prescription drug plan, but only if the plan is one offered by a private insurance company. My amendment simply allows seniors to get their prescription drugs through the Medicare Program. It is creating one more option. The legislation before us tries to expand health care choices for people on Medicare. Regrettably, it does not provide the full range of choices for seniors.

Without my amendment, we are not in fact providing the full range of choices, including the one for which the seniors are asking. My amendment will allow seniors the choice to get their prescriptions filled within traditional Medicare, to choose a private prescription drug plan, or enroll in a PPO or an HMO. This range of choice will foster competition among the different plans and allow our seniors to make the best possible choice for themselves. This amendment puts all of the plans on the same footing and does not favor one over the other.

I think it is also important to note that the private plans described in the bill don't exist today. In fact, Robert Reischauer was quoted recently in the New York Times saying, ''Private drug-only plans don't exist in nature.'' They don't currently exist in nature. So we are designing a system around plans that do not currently exist.

Medicare does exist. A Medicare plan is one that we know we can put together and that seniors can count on, at the same time giving the opportunity for new plans to be created, as

well as the structures of HMOs and PPOs.

I also think this plan could actually save the Federal Government dollars, and certainly the record would reflect that. There is ample objective evidence that providing health care through the Medicare Program is more efficient than through the private sector. This is one area where the evidence is clear, based on various points of information. Let me just share some with you.

On May 5, 2003, the New York Times reported on findings by MedPAC, our own nonpartisan advisory plan. MedPAC discovered that private health plan fees are about 15 percent higher than Medicare. The Center for Studying Health Systems Change has also made similar findings. So we know that if we go to private plans, on average, services will be about 15 percent higher—more costly for fees for services. Surgeries, they found, were about 26 percent more. Radiology was about 19 percent more. Hospital and nursing home visits and consultations were 9 percent more. On average, we know it doesn't in fact cost less to provide services to private plans. Independent, nonpartisan organizations have found that it in fact costs more.

Also, using private plans would likely cost additional dollars. In the year 2000, our own General Accounting Office estimated that payments to Medicare+Choice plans—and those are the Medicare HMOs that were set up in 1997—exceeded the costs that would have been incurred for treating patients directly through traditional Medicare by an annual average of 13.2 percent.

So, again, we have a situation where our own nonpartisan, objective General Accounting Office said that providing services through Medicare HMOs actually cost, on average, 13.2 percent more than the same service offered under traditional Medicare, where seniors get to select their own doctors and have the dependability of knowing that Medicare will be there.

Thirdly, private plans are not necessarily more efficient than Medicare. The inspector general of the Department of Health and Human Services found that HMOs that contract with Medicare, on average, spent 15 percent of their revenue on administrative costs rather than on health care. In fact, we know those numbers can be even higher in other private sector plans. Dollars have been put aside in this plan to cover higher administrative costs. Some managed care systems spend as much as 32 percent of their revenue. That means that for every precious dollar we have that we want to help seniors pay for their medicine, about one-third of that could go to administration.

By contrast, the Medicare plan spends only 2 percent of its budget on administrative overhead. On average, a private HMO—and we realize more plans are being developed under this proposal than just HMOs, but if we look at what we have to go on in terms of the differences, it is 2 percent administrative costs under Medicare and an average of 15 percent for HMOs. And we know that in some areas, in fact, it is even higher administrative costs for other private insurance plans.

Furthermore, the enrollment experience with private plans in Medicare has certainly not been stellar. In the past 5 years, 2.5 million seniors have been dropped by their Medicare HMO. As I have indicated before, one of those in fact was my own mother in Lansing, MI, who had a very positive experience under a Medicare HMO. But the decision was made, for financial reasons, to no longer cover Medicare recipients. She lost her plan and her doctor, and she was left to figure out how else she would be receiving care under Medicare.

In 2002, three plans in Michigan dropped out of Medicare+Choice altogether, while two dropped significant numbers of enrollees. More than 31,000 seniors in Michigan have been dropped just since 2002. What does that mean in real terms for people? It means that they went into a system, they had a doctor, they were within a certain kind of health care system; then the private managed care plan decided to pull out, and they were then left to go find another plan, actually another doctor, and another way of providing health care.

Only 8 of 83 counties in Michigan now have private Medicare HMO plans, and all of them are concentrated in one area, southeastern Michigan, around metro Detroit, which means that those in the Upper Peninsula of our State don't have that choice. I expect it would be very difficult for them to find a private sector plan, even into the future, in northern Michigan, the Upper Peninsula, or the west side of the State. Right now, the only option is obviously around metro Detroit. None of the remaining Medicare HMOs in Michigan is accepting new enrollees.

One Michigan provider even chose to pay a $25,000 fine to get out of Medicare+Choice and stop serving seniors immediately rather than go through the official withdrawal process. That requires more than 3 months of notice of intent to withdraw. By pulling out immediately, this plan left our seniors in the lurch with very little transition time to explore other ways in order to be able to get their health coverage.

Because of the poor records of the Medicare+Choice plan, almost 9 out of 10 seniors—basically 89 percent—have decided to stay in traditional Medicare. I believe they ought to have the choice to do that. That is what my amendment is all about. It is saying to those right now who have had a choice of a private managed care plan or traditional Medicare since 1997, who have chosen to stay with traditional Medicare, to choose their own doctor, to know that regardless of where they live they will have the dependability, the stability of Medicare, it will be there for those individuals who have chosen overwhelmingly to stay in traditional Medicare—89 percent.

Any one of us would love that kind of a percentage when people are choosing in an election. Eighty-nine percent of the seniors today have said they want traditional Medicare. Yet this choice they have made is not available to them if there are two or more private sector plans available in their region. Essentially, unfortunately, what the current plan says is you have made your choice; we do not like your choice; pick again. My amendment would guarantee seniors would be able to have that choice.

I know some colleagues strongly believe that moving seniors into the private sector is the best way to provide them prescription drug coverage. While I respectfully disagree with this premise, I think it is a good idea to provide private sector options for those who desire them.

Back to my own family, I think my mother should have that choice, and she should be able to go into Medicare+Choice or another managed care plan if she so desires. I absolutely agree with that if it works for them.

The question is whether the Federal Government should force seniors into a plan, whether it is a private insurance plan or traditional Medicare. Should we be deciding what our seniors should have for their prescription drug coverage? Should we make that choice or should they make the choice? That is why my amendment is so important. It will allow seniors to choose the appropriate plan for them, not the Federal Government.

I have heard a lot of arguments that we should provide seniors with the same options that Members of Congress and Federal employees have in the Federal Employees Health Benefits Plan. Under that plan, we have several options ranging from fee for service to PPOs to HMOs. If we like one of those options—and we choose that option, by the way—the Federal Government does not come in and say, If you work for the Senate, you cannot have option A, you can only get B, C, D, and only A under certain circumstances. We say here is the range of options; you select the one that works for you. If we like the one we selected, we can stay in that plan as long as we want. As long as we are covered by the Federal employees health plan, we can choose that plan. We are never forced to switch plans.

Mr. President, can you imagine if we were living under the plan we are asking seniors to live under; if every employee had to switch back and forth, potentially, depending on what was offered in the private sector, rather than remaining with the plan they desired? We have never been forced to switch plans ourselves. It should be the same for our seniors. If we do not have to switch plans year to year, then seniors should not have to switch either.

My guess is most of us like the plans we are in and probably want to stay with them. Certainly, if we do not, we have the opportunity to change. But the last thing we want to do is switch health plans every year or every other year and try to leaf through hundreds of pages of brochures to evaluate the benefits of a new plan. I, for one, find it is difficult to find the time to do that. I cannot imagine anyone would want the chore of going through every year or every other year all of the paperwork to figure out what is best for them, particularly if they like the plan they are in.

Many seniors want stability. They seek a good, solid, guaranteed health plan where they can see their own doctors. There are some seniors who prefer to experiment with private plans, and they should be given that option. But all seniors should have all options, and that is what my amendment would do. It would make sure the choice is in the hands of our seniors.

Again, this approach is within the framework of the bill. It is within the $400 billion that has been carved out within the budget resolution. It is within the framework of the benefits structure that has been designed by the committee. This amendment does not change anything other than to say every senior should have the option, as 89 percent of them have chosen to do, to not only have their own doctor under Medicare, but to have a prescription drug plan under Medicare regardless of where they live, and a plan they can count on and depend on.

Again, I commend my colleagues who have been working diligently on this issue. I know it has been a challenge for everyone. I believe this amendment does exactly what the seniors of America want and allows all of us to enthusiastically embrace this proposal as being the right proposal.

I hope my colleagues will support my amendment to offer one more choice to seniors. It builds on the structure of this bipartisan plan and provides more choices.

I know many of us believe this bill can be improved. Outside objective critics have even used stronger language about the way this is restricted in the bill. For example, former CBO Director Robert Reischauer said:

> The benefit is rather skimpy and has a bizarre structure. It is an insurance structure that exists nowhere in the private sector or in nature.

Through this amendment we will have a structure that makes sense, that is dependable, that is explainable, that is simple and straightforward, that provides all range of options to seniors so they can decide what it is they wish to do in terms of prescription drug coverage.

Mr. President, I have a letter from the National Committee to Preserve Social Security and Medicare. I will read a portion of it:

> On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare, I am writing in support of your ''Medicare Guaranteed Option'' amendment to S. 1. Since the current Senate prescription drug bill, S. 1, wants to offer seniors choices, your amendment would offer seniors real choices because they would have the choice of what they really want, which is a defined benefit under Medicare.

I ask unanimous consent that this letter be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

June 17, 2003.

Hon. DEBBIE STABENOW,
U.S. Senate,
Washington, DC.

DEAR SENATOR STABENOW: On behalf of the millions of members and supporters of the National Committee to Preserve Social Security and Medicare (NCPSSM), I am writing in support of your ''Medicare Guaranteed Option'' amendment to S. 1. Since the current Senate prescription drug bill, S. 1, wants to offer seniors choices, your amendment would offer seniors real choices because they would have the choice of what they really want, which is defined benefit under Medicare.

We understand that your amendment would allow traditional Medicare to be an option that stands side-by-side next to the other two or more private plans that are required to be in that region. Instead of the current requirement that Medicare stand as a fall back, only if there are no private plans in the area, it would allow Medicare to be a third choice for seniors who prefer to get their benefits through traditional Medicare. We agree that seniors should have the right to select the option in which they are most comfortable, and for many, that choice might be to stay with traditional Medicare versus one of private plans that are located within their region.

We applaud your efforts and dedication on behalf of America's seniors, and appreciate your continued leadership on this issue. We look forward to continuing to work with you.

Sincerely,

BARBARA B. KENNELLY,
President.

Ms. STABENOW. I thank the Chair. Mr. President, again, I urge my colleagues to join in this amendment. I am hopeful we can join together enthusiastically in embracing a system that has worked since 1965 for our seniors. I hope also we can join together to improve it, not only prescription drug coverage, but ways to minimize paperwork and focus more on prevention, as the Secretary of HHS has suggested.

There are many opportunities for us to improve within the structure of Medicare a plan that is focused more on prevention, to eliminate the paperwork, and to do it together and still provide our seniors with the choice for which they are asking.

In conclusion, I ask unanimous consent to add Senator LEVIN, Senator KOHL, and Senator DODD as cosponsors of my amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. STABENOW. I thank the Chair. I yield the floor.

The PRESIDING OFFICER. The Senator from Montana.

Mr. BAUCUS. Mr. President, first, I congratulate the Senator from Michigan. She has worked very hard and, I might add, effectively in helping make this a better bill.

Everyone in this body wants legislation passed that gives good, solid prescription drug benefits to seniors.

The debate is somewhat over delivery; that is, how we set the plan up, who provides the benefits and so on. The bottom line is the same for all of us. We want good, solid prescription drug benefits for seniors.

The Senator from Michigan is probably as well-versed in this subject and more of an advocate for seniors than any other Member of this body, or at least as much as any other Member of this body. I thank her very much for what she has done.

The issue basically is that we have roughly $400 billion to spend over 10 years, and the question is how we best assure that seniors get those benefits. Now, $400 billion over 10 years may sound like a lot of money to some folks but when it is cranked out in terms of deductibles, copays, premiums and benefits, it is really a modest benefit for seniors. It is not a lot of money.

Some other programs give much more generous prescription drug benefits than is called for under this legislation. For example, under TRICARE, that is the military plan, military retirees receive substantially more benefits than are called for under this bill. The same is true for the VA. If the U.S. Government, under this legislation, were to provide the same benefits for seniors generally that the military does under TRICARE, this bill would not be $400 billion, it would be upwards of $800 billion to a trillion dollars, which gives one a sense of the difference.

The VA's benefits are greater. The Federal Employees Health Benefits Plan, FEHBP, provides drug benefits that are greater than called for under this bill.

I mention that so the expectations are not raised too high that this legislation is going to be the be-all and end-all, that it is going to help seniors with all their drug expenditures. It will not, but it is a first step. It is a major advancement in helping seniors get their prescription drug benefits.

There will be many bills later on in the next several years as we address ways to improve our health care delivery system generally, on how we can help improve prescription drug benefits to seniors more specifically, but we are operating under a bit of a constraint and the constraint is $400 billion. That is what we in the Congress agreed to, $400 billion on the Senate side for prescription drug benefits for seniors.

Under that constraint, we have to work very hard to try to achieve some balance. One goal is stability, another is efficiency. What do I mean?

Under stability, we clearly want this program to be as stable as possible so seniors know what they are getting for the premiums they will be paying. This is a voluntary program. Seniors are not

required to sign up. What we want is a stable program. We do not want a program that is changing a lot. That is unsettling to seniors.

We also want to achieve efficiencies. By that I mean lower some costs. The Medicare Program is growing exponentially. We all know that not too many years from now, when the baby boomers start to retire, we are going to face some significant challenges on how we address Medicare payments generally, which certainly will include some prescription drug benefits. We want to try to cut costs, and the idea that a balance is struck between stability and efficiency is essentially one where both private plans and the U.S. Government participate.

I strongly wish we were able to have more dollars to spend so we would have more stability and have a program that more closely resembles the military's TRICARE plan or the Federal Employees Health Benefits Plan or the Veterans' Administration plan, and even some private plans, but we do not. We are taking this steadily, a step at a time.

The Senator from Michigan has a good idea. Her idea is that in the interest of stability, as opposed to efficiency, that any senior would have the right to participate for life in the Government-sponsored plan as opposed to the private sector. We in the Finance Committee have labored mightily to try to find the right balance, and the right balance is not easy to find, I must say. We have Senators from one side of the spectrum and Senators from the other side of the spectrum bending my ear and bending the ear of the chairman. Quite often, our ears are bent so much we wonder if there is any rubber left in them. We have been talked to.

I have been talked to very much by the wonderful Senator from Michigan about her amendment. If I had my druthers, it would be something I would prefer, but we are a bit constrained. I do not know that I can support the amendment for that reason because we are trying to keep a balance.

I do want to highly commend the Senator for the great effort she has undertaken. She has clearly helped advance the ball in many ways. She will continue to advance the ball, there is no doubt in my mind. She is a great Senator for the people of the State of Michigan.

I yield the floor.

The PRESIDING OFFICER (Ms. MURKOWSKI). The Senator from Iowa.

Mr. GRASSLEY. Madam President, I rise in opposition to the amendment. I have had a chance to hear what the Senator from Montana has said about the amendment. I associate myself with his remarks. I also heard what he said about the Senator from Michigan being a fair player and offering alternatives, and I share his compliments of her and how she approaches these issues.

This is a place where we have some honest disagreements. We are going to debate those honest disagreements, and I hope the Senator from Michigan comes out on the short end of this debate when we have a rollcall vote.

Before I make some specific statements in opposition to her amendment, I will state that the chart she has before her right now is an accurate chart, but I would like to comment on it from the standpoint of not being maybe a complete picture. I think the percentages are very accurate but we also need to remember that Medicare+Choice is not offered in all parts of the United States. For instance, in my State of Iowa, there is only 1 county out of 99—and that is Pottawattamie County, Council Bluffs county seat across from Omaha—where there are about 4,000 people out of about 350,000 seniors who belong to a Medicare+Choice plan, and I find that they like it very well. They can join in that county because they are associated with Omaha across the river in Nebraska.

Also in several major cities in California, Arizona, Texas, Florida, and New York there are several, maybe even some rural areas in those States, where they get a very high percentage. Now, how much higher than 11 percent, I do not know, but I remember back in the mid-to-late 1990s that I was able to say—whether I can still say it today, I do not know—that 40 percent of the seniors in some large cities did, in fact, choose Medicare+Choice plans. Whatever higher percentage it is in those cities, we have to realize that people are in these Medicare+Choice plans voluntarily.

I also have come in contact with many Iowans who winter in other States where they have Medicare+Choice, and they do not seem to understand why we cannot have Medicare+Choice in Iowa, and I wonder that myself. I took action in 1997 to very dramatically increase the payment to Medicare+Choices so they would come to the State of Iowa, but they still have not come.

We have increased it from $300 per month per beneficiary up to a national floor now of $490, and they still don't come, even considering the fact that fee for service in Iowa is closer to the $300 per month per beneficiary. So I don't know why we can get almost 50 percent more and at least 70 percent more Medicare+Choice, yet the plans don't come to Iowa.

What I am saying to the Senator from Michigan is it is not fair to say Medicare fee for service is so well liked by seniors, as her chart would imply, that we ought to completely forget about anything but fee for service. In a lot of places people like it. A high percentage of seniors are in it. They are in it voluntarily. They can come in one year and get out the next if they want to go to the fee for service. In my State of Iowa, citizens are irritated because in Arizona they see people getting benefits through Medicare+Choice that we do not get in fee for service within the State of Iowa.

There is nothing wrong with your chart except I think it ought to be magnified to some extent so that there are a lot of people with Medicare+Choice who like it. More would choose it if it was more widely available. That is one of the advantages of our PPO section of the bill before the Senate: to give more people that opportunity. That does not necessarily mean HMO. It can be preferred provider organization or it could even be a fee for service.

Let me get back to the specifics of the amendment. The purpose of the amendment is to make the Government-run fallback plan available in every area all the time, even when the bill before us has very strict standards for the presence of private plans, and that these be met, and when they are met or provided for, no fallback is needed.

In essence, this amendment would destroy our bill's competitive incentives and replace them with a Government-controlled regime for dispensing drugs in this country. The amendment before us would also create an unlevel playing field between the Government-run plans and private plans. As a result, it would discourage the initial entry of private plans, dooming the effort to provide the drug benefit through competing private plans. This would place the drug benefit right back in the very command-and-control mentality of Government-run health care plans we ought to try to move away from. It would reinstitute Government micromanagement, and it would bring about price controls.

It would ultimately put the Government into the full-time business of setting drug prices and determining what drugs are covered and which are not.

This is the opposite result of what the underlying bill is seeking to achieve with a competitive private-sector-run prescription health plan. The Government-run approach saves less than competing private plans. Private plans competing to enroll beneficiaries would achieve greater savings because at-risk plans would work harder to negotiate lower prices and work harder to offer more affordable premiums.

This fact is brought out by CBO this year, but it reaffirms everything we knew about every plan in the Senate discussed last July, including the tripartisan plan that set out the tripartisan plan savings and costing less as opposed to the Government-run plans that were offered on the other side of the aisle last summer when we debated this same issue.

CBO has indicated that a structure based on competing at-risk private plans has a higher cost management factor than Government-run plans which cannot respond quickly to market changes. The Congressional Budget Office recognizes that private plans will do a better job of managing drug costs and keeping pace with market changes.

Don't we want the seniors to have a right to choose? And they do have the

right to choose. That is what this approach is all about: not forcing something down the throats of seniors. But don't we all think we ought to have programs that respond to the market because that gives our seniors an opportunity to select products and services that are the result of the dynamics of our marketplace?

You know how long it takes Congress to make a decision. You know how long it takes a bureaucracy to make a decision. It does not serve seniors as adequately as we should be serving seniors. In fact, we know already the Government does a very poor job of reimbursing for prescription drugs because of the years of overpayment for the drugs already covered under Part B of Medicare.

Medicare has been overpaying for Part B drugs for years because of its inability to keep up with the marketplace. Taxpayers are paying more because CMS is about 2 or 3 years behind in pricing new therapies, such as new approaches in the area of prosthetics.

In fact, the bill before us includes reforms to Part B drug payments to end the overpayments Medicare is already making. But it has taken years for General Accounting Office reports and investigations by the Inspector General for Congress to act to fix this problem.

Overpayment for drugs in Part B has cost taxpayers billions of dollars and our underlying bill seeks to correct that problem. But we should learn the lessons of history and recognize that if the Government is wasting billions in overpayments for the drugs covered under Part B today, how much would be wasted by the Government if such a system were used for all prescription drugs dispensed to the seniors.

In answering that question, don't believe the assumption in my question, believe what CBO has already said about it. The Congressional Budget Office has the expertise of pricing these things and accounting for the costs. The potential waste, then, the overpayments for drugs and increased costs to the taxpayers has become astonishingly high.

Setting up a Government-run plan that undermines or eliminates private-sector competition will take choices and savings away from seniors. By pushing private plans out of the market, I believe, regardless of how well-intended the amendment by the Senator from Michigan is, it would reduce the broad array of choices that would otherwise be available to beneficiaries under the bill before the Senate. This would deny seniors the opportunity to enroll in the plan that best fits their needs by forcing these seniors into the typical one-size-fits-all model.

This would effectively deny seniors a private plan operation, which would deny them the enhanced savings achieved by the private plans. This would effectively undermine a major principle of this legislation: the right of seniors to choose. Seniors ought to have that right. They may not want to exercise that right, but we should not assume, when there are 40-some-million seniors in America, that one program is right for all of them. We give alternatives. The right to choose is very important. The right to choose in Medicare is one of the major ways we modernize and strengthen Medicare. Medicare has become a part of the social fabric of America, like Social Security. We do not want to, in any way, affect this integral part of the social fabric of America except to give American seniors more right to choose.

The amendment before the Senate by the Senator from Michigan takes away some right to choose or destroys the dynamics of the choices we are giving to seniors.

I urge my colleagues to defeat this amendment.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Madam President, I will respond to my colleague, the chairman of the Finance Committee. First, I thank the Senator for his kind words and my esteemed ranking member from Montana, as well, for his kind words. We have different views, different perspectives on how best to provide seniors with prescription drug help, but we all share a common desire to do that and, within the confines we are operating under, to create a way to do that.

First, the Senator from Iowa, the chairman of the committee, is correct: A portion of the individuals who are in traditional Medicare are there because there are not plans available in their area. In Michigan, as I indicated in explaining the amendment, only 2 percent of the people right now in Medicare in Michigan have access to Medicare+Choice. So it is definitely true.

It is my understanding, though, that CBO has said under the new plan only 1 or 2 percent of the folks would go into managed care under this bill. If that is correct, we would not see much of a choice even if it were available.

However, the larger point is whether or not the market has worked as it relates to health care for seniors. In 1965, when Medicare was created, it came about because at that time half the seniors in the country could not find health care insurance or could not afford it. The market was not working for older Americans at that time.

I argue, also, the fact that there are no managed care plans in Iowa, northern Michigan, or other parts of the country. Again, it is a question of whether or not the market works in those circumstances. The reason Medicare came into being is because there were not health care plans in rural America, there were not health care plans available to those who needed them. We decided in one of the best decisions that has been made by the Congress—I was not there at that time—one of the wisest things that was done at that time was to say our value, as Americans, is that older Americans, the disabled in our country, should not have to struggle to find health care. We believe health care should be available to them whether they live in a rural community, whether they live in a city or a suburb, anywhere in the United States. Our priority as Americans is to create a system that, regardless of where you live, health care would be available and affordable for older Americans and disabled.

Many say today we should be going in the exact opposite direction of expanding what we are doing to make sure everyone has the opportunity for the same health care that seniors and the disabled have in our country; that children and families, working hard every day, that individuals working two and three part-time jobs who cannot find health insurance, ought to have the ability to buy into a system of health care coverage.

There is a great need to make sure that health care is available and affordable. Medicare has done that.

I agree there are improvements to be made, such as more focus on prevention. We can certainly streamline the paperwork and bring it into the 21st century as far as technology and other options, to make the system better. From my perspective, here is a plan, unfortunately, that moves away from that stability, the dependability and affordability of Medicare.

I see my esteemed colleague from Iowa, Senator HARKIN, and I know he wants to speak. Members feel strongly about this issue. What we are doing with this amendment is the ultimate choice. It is the real choice. It is the choice the majority of seniors have already made, and it is the choice they want. Under the underlying bill, the only way they could get to the place to choose what they want is if private insurance plans were not available in their area. The plan goes through all kinds of changes to try and make that available, even if it costs more.

Ask any small business, any large business in this country today, how fast their private insurance premiums are going up. We have seen small business premiums double in 5 years. We have seen Medicare going up about 5 percent. We see private sector going up 15, 20, 25, 30 percent a year. This says rather than having a plan that goes up 5 percent a year, we are going to design this so it goes up 15 or 20 percent a year.

That does not make sense. In all honesty, the only group this makes sense for are the pharmaceutical companies who do not want folks in one place to be able to bargain and negotiate lower prices, which is what Medicare would be able to do—negotiate lower prices.

For all who want to get this right for our seniors, I urge my colleagues to join in creating real choice for our seniors. Give them the opportunity for the choice they want. If, in fact, someone chooses to go into managed care, an HMO, PPO, or other kinds of private plans, they should have that choice, as

well. This amendment allows them to do that.

I yield the floor.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. HARKIN. Madam President, as the cosponsor of the Stabenow amendment, I add my strong support for the amendment offered by my distinguished colleague from Michigan.

Senator STABENOW has it right. She understands what is happening. Senator STABENOW has time and time again come to the floor to point out we need to give seniors more choices rather than fewer choices. That is what we are doing with this amendment.

The bill we are considering in the Senate this week, S. 1, has a number of flaws despite its good intentions. Its prescription drug benefit for seniors is far from comprehensive. There is a significant coverage gap. Premiums are not fixed. Many of the copays are too high. The bill does not contain the actual costs of prescription drugs. Although the generics amendment, which I assume will be added to the bill, which will certainly help in that regard, the bill does not go into effect until 2006; interestingly enough, just to get us by the 2004 election.

I have a number of concerns. I plan to speak about all of these as we proceed on this bill this week. One of the most significant flaws in this bill is addressed by this amendment offered by Senator STABENOW; that is, this bill requires seniors obtain the prescription drug benefit through private insurance unless there are not two such private insurance plans in their area. In other words, a prescription drug benefit through Medicare is only available as a so-called fallback.

In other words, if you are a senior in, let us say, a rural State where there are no private HMOs—speaking about my State of Iowa, we don't have one Medicare-based HMO in the State of Iowa. Let us say you are in an area and you have two private plans. You don't have a choice other than those two. That is all you have. You have those two. If you are in a State where there are not two plans, then you can get Medicare. Let us talk about this. It is only a fallback position. If the two plans aren't there, then you can get it through Medicare.

What Senator STABENOW's amendment says is that we want a prescription drug benefit through Medicare that would be available to all seniors at all times so they can have a real choice. Under this amendment, this is how it would change the bill.

You are in an area and you have two private plans. You could also have Medicare. Now you have one of three choices. Under the bill here, you have one of two choices. We are expanding the choices. We are saying you can go with private plan A, private plan B, or Medicare. You have the choice. If private plans are so desirable and they are so good, then let them compete against a Medicare benefit. Let us see which one a senior chooses.

I found the arguments propounded by my friend and colleague from my own State of Iowa Orwellian at best. The chairman of the committee was talking about choices. We want to give seniors choices. If a senior has one of two choices, or one of three choices, which one gives the senior more choices? The chairman of the committee said the first one that offers two plans gives them more choices. That is Orwellian. It is Orwellian-speak that somehow two choices are more than three choices. Go figure.

To me, this is the key issue that needs to be fixed in this bill. I am glad it is the first amendment because it is vital. I think it represents the fundamental difference between many on our side and many on the Republican side on this bill.

I want to be very clear. I am not against a free market. I am not against the private sector or private health insurance plans. But the reality is that the private sector by its very nature leaves certain groups of people behind, especially in the health care area.

Let us be honest about it. People with disabilities are not a profitable group. You have a disability. Try getting insurance. Try it. There is no money to be made there. People with mental illnesses are not a profitable group. We have been trying for some time to get mental health parity. We still don't have it because the private sector understands they can't make money.

Guess what other group is not profitable? Senior citizens are not profitable. They use more health care as they get older. So they are not profitable.

If you look back in history, that is why we established Medicare in the first place in the 1960s—to care for those people who were left behind by the private sector.

I remember as though it were yesterday when my father was in his later years and had health care problems. In the 1950s my father was then in his early seventies. He had been quite disabled from working for over 20 years in coal mines. He had ''miners lung,'' as they called it then. Later they called it ''black lung.'' He had had some accidents. He was now in his late sixties. He was in his early seventies in the 1950s. His health was in bad shape. He was on Social Security. That is all he had. He had no life savings. He had no dividends. He owned no stock. My father only went to the 8th grade. He worked most of his life in the coal mines. After that, he worked as a handyman. All he owned was a small house on 1 acre of land. That is all he had. Thank God he worked enough to pay into Social Security to get a Social Security benefit. But he had no health care insurance. He had no outside sources of income. He had some young kids, me being one of them. We had no outside source of income at all. My father's income in the 1950s on an annual basis was probably around about—I would be surprised if it was over $2,000 or maybe $2,500 a year at the most. He couldn't get health insurance.

There was no one who would sell my father health insurance, even if we could have afforded it. Later on, when a couple of his kids got out of college and we looked around to try to see if we could get some, no one would cover him. He was now in his midseventies and had black lung disease. He had a few other problems. Try to find an insurance program. There were health insurance programs at that time. There were a lot of health insurance programs that covered a lot of workers at that time through their employment but they were not about to cover my father. That would not have been profitable.

I remember when Medicare came in. My father got his Medicare card. Now he could go to the doctor and go to the hospital.

There are those of us who lived through this and saw our parents denied health care coverage because they couldn't afford a private health care plan because the private health care plans left them behind. We look at this bill and say: Wait a minute. You are saying you are going to have these two private plans out there but you are not going to have a Medicare choice?

We experimented with private health care and HMOs. Guess what happened. Seniors all over the country were dumped by plans. They had a plan. They signed up. As soon as the plan saw they weren't making money, they said: We are out of town. So seniors were dumped. We didn't have a law that said you had to cover them. They just walked away from it.

That is what is going to happen with this bill, too. Obviously, they can do it on an annual basis. That is another point of this bill that is going to get highlighted. A plan could be in effect and they find out after a year they are not making enough money. Bang, they walk away. Then maybe another plan will come in. Oh, well. Maybe a senior can sign up for that. What is the coverage, or the copay, or what is the deductible? It may be different.

For years, Republicans have not so subtly wanted to privatize Medicare. There were public comments such as then-Speaker Newt Gingrich who said about Medicare that he wanted to ''let it wither on the vine.''

I think when you read those statements and the statements by the third ranking Republican in the Senate who said that the basic Medicare benefit basically needs to be done away with, you get an insight into the long-term goal of those on that side.

What they state is their support for including the private sector here to take advantage of the efficiency by the experience and the virtues of private competition. All well and good. I am all for competition and efficiency. But what happens is that this bill now before us relies on the participation of private plans to deliver this drug benefit to our seniors. But you have to set the rhetoric aside.

The current structure of this bill before us invests unwisely in private health plans to provide the drug benefit for seniors, and it restricts their choice. It restricts it. As I said, the Senator from Iowa, the chairman of the committee, spoke about giving seniors choices. That is exactly what the Stabenow amendment does. If they do not want to be in Medicare, they can go out and get a private plan. But under the bill before us, if they do not want to be in a private plan and want to stay in Medicare, they cannot do it.

Now, again, for some reason I am having trouble understanding this argument made by the chairman of the committee that somehow having two choices gives you more choices than having three choices. Someone has to really explain this to me because that is what the Stabenow amendment does. It gives you three choices: Medicare, plan A, plan B. The bill before us gives you two choices: plan A or plan B.

Now, again, this is especially bad for seniors in rural States where private plans have shown no interest in participating in the Medicare program. Now, again, the scheme in this bill of having the private plans only—if there was some history to back this up, and the chairman of the committee talked about history. Well, OK, let's look at the history. We know from history the administrative costs in Medicare are much lower than in private health plans—2 to 3 percent a year compared to 15 percent in the private health care plans. We know that. That is fact. That is data.

We also know that over the past 30 years Medicare spending has grown at a slower rate than private health care spending; about 9.6 percent for Medicare, over 11 percent for private health care plans. We know that. It is factual. Yet ignoring this history, in the plan before us, this administration and the Republican leadership in the Senate insist on relying almost solely on private plans to provide this drug benefit to our seniors.

As I said, the bill before us might be reasonable if we had some past history to back up the fact that the private health care plans were the most efficient. They want to talk about efficiency. The facts show that administrative costs are about one-fifth—one-fifth—as much in Medicare as in private plans, 2 to 3 percent compared to 15 percent. So efficiency? Obviously, Medicare is more efficient.

And the cost, well, as I said, over the last 30 years Medicare has grown at a slower rate than private health plan spending. So which costs more, Medicare or private health care plans? Well, we have the facts. We have the data. This cannot be ignored.

The only way you can ignore this data and these facts is if your ideology trumps experience. If you have an ideology that says we are going to set up a system that will ensure that Medicare sometime in the future fails, I guess you could ignore facts, you could ignore the history. And that is really what this is all about, folks.

The result of all this private plan investment means there is less money available to actually help seniors get the drugs they need. It is estimated that the underlying bill will actually pay private insurance companies over $25 billion just to participate. Boy, talk about a sweetheart deal.

OK, let me get it straight now. We want only two private plans out there in a region for seniors. The bill will not let Medicare compete. That is what the Stabenow amendment does for us, it allows Medicare to compete. The bill will not. So you have two private plans out there. Because why? ''They are more efficient. They have more experience,'' et cetera, et cetera. ''They will have competition, and the competition will keep the price down.'' Then why are we giving them $25 billion in subsidies to get them into the program? You would think they would be knocking the doors of the Senate down rushing to get in on this.

Let me proffer a question. What if we took out the subsidies to the private insurance plans? How many would come into this program? Zero. No, we are going to give them $25 billion. What if we took that $25 billion and we put it into a prescription drug benefit? Well, we could cut down what? We could cut down the deductible, maybe. We could cut down the copays. We could close the coverage gap—all of which would help our seniors. No, no, no. We are going to take $25 billion and we are going to help the private insurance companies. We are going to coax them. I have a different word. We are going to bribe them. We are going to bribe them with $25 billion of money to come in here.

Talk about efficiency. Boy, isn't the private sector grand. Isn't competition wonderful when the Government comes in with your taxpayers' dollars and gives them $25 billion so they can offer some kind of a prescription drug plan.

I mentioned just a minute ago about how in the past private plans have come into existence. Seniors join them, and then the plans close down, leaving the seniors holding the bag. That is the history. That is the data. That is what has happened. Because of the structure of this plan, seniors could be forced to switch plans and drugs on a yearly basis—yearly—as private plans may join and then pull out of the markets.

So you have these two plans out there. Your grandparents, your parents, join plan B because it looks good for them, and it turns out maybe the first year it is OK for them, but the plan they joined finds they are not making enough money. Guess what. At the end of the year they walk away.

Now, what do your grandma and grandpa do then? Well, they can go to maybe plan A, or maybe another plan will come in, have a different copay, different deductible, different this, different that. And I will tell you, if you think your health plan today is confusing—and it is. I look at my health care plan every year when the open season comes around and I try to make heads or tails of it. I was trained as a lawyer. I may not be a very good one, but I was trained as a lawyer, and reading these things is confusing, even for someone trained. Put these plans out there for the average senior citizen to read every year of who gives what, what is the benefit—total confusion.

Then what happens? Well, people get confused. They get upset with the program. Seniors talk among themselves at their various groups and clubs, and they find out that Mrs. Jones over here, while she has an income of $14,640 a year—guess what—her deductible and her copays are up here, they are high. Mrs. Smith, her friend and neighbor, who comes to the same club, her income is $14,639—$1 less—and she gets all hers free. Think about that. Think about what this is going to mean to the elderly out there when they see: Wait a minute, my neighbor, my friend, they get a few dollars more a year than I do. They pay. I get a few dollars less. I don't have to pay anything.

What is that going to lead to? Not only to confusion, it is going to lead to anger, and it is going to lead ultimately to seniors saying that this whole system has to be changed. And that is the end result of what the Republicans want to do with this bill; that is, to strike a dagger to the heart of Medicare. Now they can't go after the heart right now, so you cut a few veins. You take a leg here and a leg there and an arm here and an arm there, and pretty soon Medicare is done for.

That is why this amendment by Senator STABENOW is so important. It follows a simple and reasonable philosophy that says seniors who want to stay in traditional Medicare ought to have that choice. We are not forcing them. Senator STABENOW is not forcing any senior to stay in any plan. She is simply providing them the choice.

Again, as the chairman of the committee said earlier, as the President has said, they extoll the virtues of giving seniors more choices. I say yes, let's give them more choices. This amendment does that by doing two things. It gives seniors the option of staying in traditional Medicare for all of their health care needs including prescription drugs. They have that choice. They don't have to if they don't want to. And as Senator STABENOW has shown time and time again, 11 percent of the seniors have said no, they don't want to stay in Medicare. Fine, if they want to go somewhere else, that is their privilege. Her amendment would not change that whatsoever.

But the second thing the Stabenow amendment does is it guarantees our seniors, especially those who live in rural areas where private plans are less likely to participate, a reliable and consistent option that will never leave them without coverage.

Throughout this debate, we have heard and will continue to hear our

friends on the other side, the Republicans, talk about how great private plans are, how they will control costs through competition. I just cited some statistics that show that historically this has not been true. The Stabenow amendment will make sure that every senior in every State has access to a consistent benefit and the option of staying in the Medicare Program.

I would think—maybe I am naive; I hope not—that if the chairman of the committee and the Republicans really wanted to give choices to seniors, they would welcome this amendment. If you listen to our friends on the Republican side and trust them, you will believe the private plans will provide a better benefit at a better price to seniors. If that is the case, what are they afraid of?

If the Republicans truly believe the private plans will provide a better benefit at a better price to seniors, why are they so afraid of letting seniors have Medicare as an option then? Because obviously they would pick the private plan because it would be better than Medicare. So what are they afraid of? Why would they not want this amendment? Because, all rhetoric aside, the Republicans want to constrict choice. They want to force seniors into private health care plans—force them—and only if there are not two plans available, then you get this fallback into Medicare. If it is good enough as a fallback, why not let it compete upfront?

I may have an amendment on this later in the week, but if these private plans are going to be so good and they are so good at competition and efficiency and so good at keeping prices down, why do we have to give them $25 billion in subsidies? Let them go out there on their own. That is the private market. I don't think they need the subsidies if they are truly going to provide this kind of a benefit. Again, I am not arguing it now. I am saying that may come along later.

The Stabenow amendment provides seniors with three choices. The bill provides them with two choices. So this amendment offers them more choices than the underlying bill does. If what the Republicans want are more choices, this is it. They should support the amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from New Mexico.

Mr. DOMENICI. Madam President, on behalf of the leadership, I ask unanimous consent that following my remarks, Senator GRAHAM of Florida be recognized to speak for up to 10 minutes on the Stabenow amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

TENTH CIRCUIT COURT OF APPEALS DECISION

Mr. DOMENICI. Madam President, I thank Senator GRAHAM for allowing me to speak on a matter of utmost importance to my State. That accounts for the consent that he would follow me. He was supposed to speak next.

I come to the floor to discuss a situation of grave concern in my State of New Mexico. On June 12, the Tenth Circuit Court of Appeals issued an opinion that puts the fate of a small endangered fish called the silvery minnow ahead of the interests of the people of New Mexico. This ruling has far-reaching implications for all Americans. It essentially favors fish over people.

This ruling requires that the Bureau of Reclamation reassess its contractual obligations to provide water to the cities of Albuquerque, Santa Fe, and others—even water resulting from interbasin transfers. The two judges issuing the majority opinion conclude that under the Endangered Species Act, the water needs of the silvery minnow come before the water needs of the people of my State.

This far-reaching opinion essentially says that the Endangered Species Act can be used to artificially create a drought. That is precisely what is going to happen if the Bureau of Reclamation deprives cities, farms, and Indian reservations in my State of the water they desperately need. The ruling says the Endangered Species Act can preempt anything and everything, essentially.

This opinion creates a new Federal right for endangered species. It effectively invalidates preexisting contracts and orders the importation of water from another basin in violation of New Mexico law that allows only for municipal use. In essence, it says even that water must be used for the fish. The water resulting from the interbasin transfer was never part of the ecosystem or the stream basin. It was brought in for other purposes. Under the court's theory, no city, county, State, or agricultural community can reasonably expect a permanent water supply.

This is not what Congress intended when we passed the Endangered Species Act. This is not what I intended when I voted for the law. The concurring opinion of Judge Porfilio says that the Endangered Species Act can undermine any contract with the Federal Government for the supply of water resources if bureaucrats determine that an endangered fish or threatened species needs the water. As we saw with Klamath Falls 2 years ago, bureaucrats are often wrong in these affairs. But no matter, according to the court, what Federal bureaucrats mandate in the name of ESA must be so, regardless of the devastating consequences.

Did any of us who voted for the Endangered Species Act believe we were amending all Federal laws and contracts at the time of its passage? I certainly did not. Has anyone who has contracted with the Federal Government for a timber lease, mineral lease, for water, or for use of Federal facilities included a clause that says such contract will not be amended by action under the ESA? Because, according to this ruling, if one didn't, the contract won't stand if a bureaucrat somehow or somewhere decides that a fly, a fish, or rodent needs that resource.

This decision cannot be allowed to stand. It threatens all Federal contracts. It undermines the financial integrity of the United States of America and all of those with whom she contracts.

This opinion will be devastating for western water users at a time of growing crisis in the West. Currently, after years of drought, agriculture, States, cities, and counties are struggling to meet their water needs now and in the future. There simply isn't enough water to go around. Members of Congress have been deeply involved in trying to resolve this growing crisis. Now comes the Tenth Circuit Court of Appeals with its announcement that the ESA preempts 75 years of existing water law, all existing contracts, and the needs of the burgeoning western population. This ruling hobbles us in our efforts to address the western water crisis.

Judge Kelly, in his dissent, rightly characterizes the ESA as a Frankenstein. Despite good intentions, this law has become a monster.

Congress never meant for this to happen. Yet, for years, we have stood by as our own law has wreaked havoc—oftentimes needlessly—in the cooperative relationship of man and nature.

I believe there is a better way. I believe we can amend this law to better protect struggling species, while still respecting the authority of this Government, States, localities, and Indian tribes. I believe we can amend this law to better protect struggling species, while still allowing people access to the resources we need to survive.

Critics have rightly pointed out that since the passage of the ESA, the number of threatened and endangered species has increased exponentially. There are now more than 1,100 species on that list. Only a handful have recovered since the passage of the ESA. Most of them, like the bald eagle, recovered because we banned the use of DDT. I have not seen evidence of any species that recovered because of abrogated water rights, which is the principal issue discussed by this Senator regarding this opinion.

As this law is now written and interpreted by the courts, we are failing our struggling species. We are also failing our citizens who look to us, State, and local leaders, for access to the resources they need to live.

This ruling says we cannot even guarantee them the very water they need for survival, sanitation, and food. In fact, it says we cannot do that by importing water into a river basin in which the fish lived before the importation. This decision says that even imported water for local use can and must be allocated for these fish. Government cannot function under such prescribed chaos.

Madam President, we must amend this law. I don't know when it will happen, but I will ask this Senate to address this law and the far-reaching implications of this decision. I will have that ready soon so that the first bill that goes through here can carry it along to fruition.

Certainty is the bedrock of western water law. That certainty is critical for our people and our country and our economy and, yes, our environment, including the endangered species. Certainty is a must for endangered species also. The court, however, chose to abandon collaborative efforts and the 2003 biological opinion and directly threaten every interstate compact in America, established adjudication, and the intent of Congress.

These rights are all out the window by virtue of this 2-to-1 opinion. A request for a rehearing en banc will be made to the Tenth Circuit and, obviously, the State of New Mexico must take it to the Supreme Court, if necessary. But I am going to look to the Senate—at least for New Mexico and what I have described here today—for a way to fix it by statutory prescription. I will be looking for the help of Senators within the next month or two on one of the bills that moves its way through here.

I yield the floor.

AMENDMENT NO. 931

Mr. BAUCUS. Madam President, if I am not mistaken, the pending amendment is the one offered by the Senator from Michigan. I see the Senator from Florida, Senator GRAHAM, who would like to address the Senate.

The PRESIDING OFFICER. The Senator from Florida is recognized.

Mr. GRAHAM of Florida. Madam President, I rise in strong support of the amendment offered by the Senator from Michigan. We are about to undertake a massive social experiment. We are about to do it with the 39 million older Americans, including some of the most vulnerable and frail of our fellow citizens. Why do I say this is a massive social experiment? Because there is no example in America of a freestanding drug-only insurance policy as the means to gain access to prescription drugs.

There are some very fundamental reasons why we don't do that in the Federal Employees Health Benefit Program, and why even the pharmaceutical industry doesn't do it in distributing drugs to its employees. There are two basic reasons why this is a first-of-a-kind social experiment. One is this is not an insurable risk. The example that has been frequently used is the one of fire insurance. If you are going to purchase fire insurance, you buy it on the whole house, from the bedroom to the living room, to the garage, to the kitchen. If you were to go to your insurance company and say I don't want to insure the whole house, I only want to insure the kitchen, the answer would be we won't sell you such a policy because the kitchen is the most vulnerable part of the house to actually have a fire.

This is a similar proposition. Prescription drugs are the fastest growing part of the health care budget. Insurance companies don't want to sell a prescription-drug-only freestanding policy. That is seen in the structure of this bill. Essentially, although the statement is made that we are going to get better prices because of competition and the willingness of insurance agencies to assume the risk, the Federal Government is assuming virtually all the risk under this plan. Therefore, all of the expectations and representations that we are going to have competition through that lower cost is a mirage.

The second reason is the fact that within health care, there are tradeoffs. As an example, just a few years ago the standard way of dealing with ulcers was surgery. Today there is almost no ulcer surgery; the standard treatment is through prescription drugs.

What is the relevance of that? If you are only providing prescription drugs, if you had a freestanding prescription drug only policy, all you would have is the additional cost of prescription drugs. If you are insuring the whole body, you get the savings of avoiding surgery while you get the additional cost of providing the prescription drugs.

Those are just two of the reasons there is no other example of what we are about to impose on 39 million old, many very sick, many very frail, Americans as a social experiment. If we were going to do this, I think what we ought to do is say we are going to change the Federal health insurance policy starting now and let us all be the experiment to find out whether such a freestanding prescription drug policy will work.

We represent a much more diverse population—Federal employees. Many of us are younger, healthier than the Medicare population. We would be a more appropriate guinea pig for this experimentation than to focus this on the oldest and, in many cases, the most vulnerable of our people.

A second concern I have about this approach is that it denies choice. Under the structure of this bill, once the elderly have made two choices, then they will not have any choice at all as it relates to prescription drugs.

The first choice they make is the choice that they are making today and have made for many years in the past: Will I get my total health care coverage through traditional Medicare, the fee-for-service plan, or will I get it through some form of a managed care plan?

The jury has come in and rendered its verdict on that issue. Over 85 percent of America's elderly have decided they want to get their health care through the traditional fee for service. The basic reason they want fee for service is that is the true access to choice. Under fee for service, they can decide what doctor, what hospital they wish to use. Under the various managed care plans, they frequently are restricted in their choice, and they have to use a gatekeeper in order to get to what choices are available.

We have had a big debate in this Chamber, a debate I anticipate we will return to, and that is over the standards of managed care. That debate was sparked because so many people have had a negative experience with managed care, where services were denied or where they did not have access to the physician they wanted for their particular needs.

This whole debate about whether there should be some Federal standards for HMOs is because of the actual real-life human experience of many Americans, including older Americans, as to how these managed care systems work.

After the Americans have made the judgment as to which plan they wish to be in, then they will make a second judgment, and that is, under this prescription drug plan, do they want to take advantage of it? It is yes or no as to whether they will participate in the prescription drug plan.

Once they have decided, yes, I wish to participate, then they lose their choices. If they are in the traditional care plan and if there are not two or more standalone prescription drug plans, then they will be forced to get their prescription drugs through the social experiment with a freestanding prescription drug plan. If there is only one plan where they live, they will be denied access to that single plan and they will have to get their drugs through traditional Medicare. I think that is a denial of the fundamental option and choice which has been a key part of the success of Medicare.

I also think denial of choice could well be the torpedo which will sink prescription drugs. We learned a lesson about 15 years ago when we passed something called catastrophic care which the Congress thought would be received by the elderly with roses and flowers and applause. In fact, it ended up being received by the chairman of the House Ways and Means Committee having his car turned upside down, there was so much objection to that plan.

I think we had better keep our cars in the garage after we pass this because we may experience the same thing, and this issue will be one of the reasons, in my judgment, that there will be less elderly participation in the prescription drugs and an increased likelihood that there will be a sufficient revolt that we will be forced, as were our predecessors, to repeal what we thought was going to be a very popular plan.

This prescription drug architecture only works if a very high percentage of the elderly sign up to participate. If the only ones who sign up are those who are already sick and using high levels of prescription drugs, this plan will crater as being actuarially unsustainable. If it is to attract

enough of the elderly who are not sick and do not have high drug bills, who will see this as a true insurance policy—that is, that they are purchasing this plan not just based on their current prescription drug costs but because they believe they may someday become ill, sicker than they are today, and get into this category of high cost—we must be able to attract that group of the elderly in order to make this plan sustainable.

I think one of the reasons the relatively healthy elderly will resist joining this is precisely this issue of the denial of choice. If I am an elderly person and I live in a rural area of Florida where only one prescription drug plan is available, why shouldn't I be able to elect that one prescription drug plan or traditional Medicare? If, on the other hand, I am in an urban area where there are 20 freestanding plans, although I think this is a highly unlikely prospect, why shouldn't I be allowed to elect one of the prescription drug plans or traditional Medicare?

Why? What is the rationale of us denying the elderly that important choice when there is no evidence that the standalone plans are going to actually save money? This bill itself is the best evidence of its unlikelihood of doing so since the Federal Government is picking up most of the risk that the standalone plans will, of their necessity, entail and while we are denying choice to elderly as to which of the various options they want to utilize.

I cannot conceive of why we are saying to America's elderly that they will be denied the choice how they want to get their prescription drugs, particularly when they have spoken so overwhelmingly of their desire to stay in traditional fee-for-service Medicare for the rest of their benefits.

So for those who favor the approach we are taking, they ought to be the strongest voices for the Stabenow amendment because it is one of the key steps in assuring that this plan will be positively received by Medicare beneficiaries and will actually work once it is in place.

I urge all of my colleagues, those who favor the basic principles of this plan and those who have reservations, to vote for this amendment because it is fundamental to achieving the results that are being sought, a broadly participated in prescription drug plan which is sufficiently attractive, including attractive through choice, for America's older citizens.

The PRESIDING OFFICER (Mr. HAGEL). The Senator from Nevada.

Mr. REID. Parliamentary inquiry. Is there any consent now in effect dealing with who speaks next on this amendment?

The PRESIDING OFFICER. There is none.

Mr. REID. The two managers asked if Senator REED from Rhode Island could speak for up to 5 minutes—is that right?

Mr. REED. Ten.

Mr. REID. Ten minutes. The Senator from Georgia only has 5 minutes to speak generally on the bill. So I am wondering if the Senator from Rhode Island would allow him to speak for 5 minutes?

Mr. REED. I would be happy to.

Mr. REID. Is that right?

Mr. CHAMBLISS. That is correct.

Mr. REID. I ask unanimous consent that the Senator from Georgia be recognized for 5 minutes to speak on the bill generally and following that the Senator from Rhode Island be recognized for 10 minutes to speak on the amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

The Senator from Georgia.

Mr. CHAMBLISS. Mr. President, I thank the Senator from Nevada and my friend Senator REED for being gracious enough to let me speak on this bill.

All of us who have served in this body over the past several years, whether it is during our campaigns, going back home for town halls, or visiting home over the weekends, have talked about the need for a prescription drug benefit within Medicare. We all agree on that. I am very pleased that this week, as well as all of next week, we will be debating this issue regarding the inclusion of a prescription drug benefit within Medicare and the overall improvement of Medicare.

I am also very pleased that the particular bill that came out of the committee has certain options available for seniors in it. The one thing we tend to do from a legislative perspective is to put mandates and dictates on people, particularly when dealing with health care. This particular bill does not do that. There are significant options in this bill that Medicare beneficiaries are going to have with respect to a prescription drug benefit. I think having these options in place is going to put competition in place within Medicare and allow the marketplace to work.

There are senior citizens today that we all refer to, and now I would like to concentrate on. I am talking about those low-income senior citizens who have high drug costs that need to be taken care of. While I remain positive that we are developing a bill—and there are a lot of positive things within this bill—I am very concerned that we are reaching beyond what most of us in this body have talked about over the last several years with respect to a prescription drug benefit; We are going way above and beyond providing that benefit just for those low-income, high-monthly-drug-cost individuals who so desperately need this benefit.

The reason I am so concerned is that from a fiscally responsible standpoint, it is incumbent on us, as Members of this body and as members of the House, that we do not overreach and put a burden on the young people in this country. I don't want them coming back to us one day and saying, ''What in the world did you folks do to us in 2003 by imposing such a heavy financial burden on Medicare? Because of this prescription drug benefit, Medicare cannot remain solvent without increasing payments going into Medicare.''

I have strong concerns that we are overreaching with this bill. That is why I am so pleased the Senator from Nebraska, the Presiding Officer today, and the Senator from Nevada, Senator ENSIGN, who have studied this issue and have developed a substitute which may be offered as an amendment. I look forward to having a healthy debate working with their language in addition to the base bill coming out of committee. It is my sincere hope that we can find the right answers, and at the same time, continue to serve and provide a benefit to those people who so desperately need it.

There is another issue that I want to make sure we are very deliberate about and that we cover, and that is the issue regarding the ability of our pharmacists, particularly in rural areas, to participate in this program. We cannot afford to have a one-size-fits-all benefit that allows individuals to go straight to the manufacturing source for their benefits under this plan. These pharmacists, particularly in rural areas, deal with individual patients and customers on a daily basis. They provide a service that not only benefits the patient and the customer but benefits Medicare. Pharmacists give advice and counsel regarding the drugs that have been prescribed for them, and I think without question will save millions of dollars in future years in this program within Medicare.

Lastly, I could not stand up and talk about a prescription drug benefit without recognizing that our drug companies over the years—and I happened to be sitting in the chair yesterday when Senator DORGAN was talking about this, and Senator DORGAN is exactly right—have stepped up to serve seniors by providing significant amounts of drugs to low-income individuals who simply could not afford to buy those drugs. These companies offer monetary discounts on large quantities of drugs to seniors involved in their plans. One of those companies, Pfizer, happened to be in my office today reiterated exactly what they have done. This is a very positive thing we should all remember when we are talking about our drug companies.

As we move forward with this bill for the next 2 weeks, I remain very cautious about where we are going to be at the end of the day. We do have to make sure that we have a healthy debate in light of the fact that we do have to provide a prescription drug benefit. We know a bill is going to pass, but we certainly need to send the right bill into conference with the House, so that when it comes out of conference it benefits those folks who need it most, those low-income individuals with enormous monthly drug bills. We should be able to look these young

pages in the eye and say we did not saddle them with a burden that will be unaffordable years from now.

So I thank the Senator from Nevada for letting me interrupt and the Senator from Rhode Island for letting me come in and give my speech now. I look forward to the debate over the next 10 days as we conclude this at the end of next week.

I yield the floor.

The PRESIDING OFFICER. The Senator from Rhode Island.

AMENDMENT NO. 931

Mr. REED. Mr. President, I rise in strong support of the Stabenow amendment. I believe the Senator from Michigan has done exactly what is right, proper, and wise to do, which is to provide for a permanent fallback prescription drug benefit for our seniors in the context of this new Part D drug program. Indeed, out of the 650-plus page of this bill, the proposal by the Senator from Michigan is the one that most closely resembles what is familiar to seniors with regard to the current Medicare Program. It is an important issue.

According to the Congressional Budget Office, roughly 32 percent of Medicare beneficiaries enrolled in the proposed new Part D program would receive their drug coverage through the fallback plan, at least during the initial implementation of the program, so a significant number of seniors we already know will participate in these fallback plans.

The reason is because under the existing language of the bill, if two private companies are not prepared to offer pharmaceutical benefits in a particular region, Medicare must have a fallback program for seniors. That makes entirely good sense. The problem is, if and when there are two companies, this fallback provision evaporates. It goes away. What this will lead to is instability and a circumscribed choice for seniors.

We can just imagine a senior who enters the fallback program may spend 1, 2, 3, or 4 years there, is happy with the program, satisfied with the benefits, and suddenly they are told, no, this program is going away because there are now two competitors in the marketplace. It does not make sense. It circumscribes choice and it creates instability and uncertainty in a program that should be full of stability, certainty, and choice. I hope we can adopt this amendment to ensure that the Medicare fallback program is a permanent part of the Part D program.

Let me suggest something else. When we think of the dynamics of this proposed program, two pharmaceutical beneficiary management companies come into a particular region knowing full well if one decides to go, then Medicare would have to reconstitute this fallback program—expensive—probably on short notice. That is tremendous leverage for other PBMs in the market to go back to the Medicare program and say, wait a second, we are leaving unless you provide additional incentives, additional compensation, additional risk sharing.

That is a leverage point that I think will be exploited by businesses. It is a fair point to exploit. They can vote with their feet. They can leave the region. That is tremendous power to put in the hands of any one plan—it is not the two; anyone could decide to go—and suddenly you have to constitute the standby.

If there is a permanent fallback program, that leverage does not exist. Automatically, the senior would choose or not choose to get their benefits from the fallback program. That is another important aspect.

We also understand these managed care programs and pharmaceutical benefit managers operate, obviously, to make a profit. They are prepared and capable of leaving on short notice if, in fact, they believe they are not realizing a profit.

We have seen this in my home State of Rhode Island, a state with a significant penetration of Medicare managed care. Thirty percent of beneficiaries in Medicare in my State are enrolled in a managed care plan. There used to be several managed care plans, but most have left the market, leaving essentially one insurance company providing these managed care benefits. When the other plans departed, we saw increases in costs to seniors and less generous terms offered by the surviving companies. Why? Simple. Competition slacked off; they did not have to be as aggressive competing for seniors. That likelihood could happen in this case.

Again, that is a strong argument for the Stabenow amendment, to have at least one plan that will be there, with permanent, defined benefits that are not likely to change as other competitors drop out of the market. That is another selling point, a strong selling point, for the Stabenow plan.

I believe this amendment is very important. It will go a long way to assuring seniors they are not part of some arbitrary experiment in the marketplace, that there will be at least one plan that is always there, that the benefits are well defined, and that plan will be an important aspect of making sure there is market discipline as well as consumer choice for seniors.

Some people might say: We cannot do this because we have a cap of $400 billion over 10 years that limits us. That is an arbitrary limit, obviously. In fact, it seems to me it is a limit that is not justified, given the generous tax cuts we have already provided to so many wealthy Americans as opposed to those likely recipients of this package. This arbitrary cap should not limit us from creating a program that we hope will not only endure for a long time but will be efficient, effective, and attractive to seniors.

I believe if we pass the Stabenow amendment, we are going to make this program much more attractive to seniors, give them confidence they have at least one choice through the standby plan, that will not leave the marketplace, that will not change benefits as competitive forces change, that will be something they can count on. As well as receiving pharmaceutical benefits, I think seniors are asking for something else, and that is confidence that their benefits will endure and not be ephemeral.

As a result, I urge my colleagues to support the Stabenow amendment.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. STABENOW. Mr. President, I appreciate my colleagues coming to the floor in support of my amendment. I take a moment to reiterate what we are doing in this amendment.

We are indicating in this amendment we want to make sure every senior has the choice of traditional Medicare for prescription drugs as well as a choice of HMOs or PPOs or other private sector plans. We are talking about seniors wanting to have choice or the desire to give seniors choice.

The majority of seniors, as a matter of fact, like traditional Medicare. It is very clear. They either have chosen traditional Medicare or do not have any private options, and 89 percent of our seniors fall in that category. The majority have chosen Medicare or may live in a rural area where they do not have the choice of a private plan but they are in Medicare and they have their coverage, they can choose their doctor, they can live anywhere within their State or anywhere in the country and know the cost will be the same. It is dependable; it is available it them.

That is what we are trying to do, guarantee seniors will be able to continue to have that choice along with new options for those who live in an area where there is a managed care plan and they choose to go into an HMO or PPO, that would be absolutely available to them. If they choose another private insurance plan, assuming there are those available to them, fine, that is certainly an option that we all agree should be available to our seniors.

The question is whether we will shut off the choice the majority of seniors have already selected, the one they say they want. With all of the talk about choices, what I hear from folks is not: Please give me more insurance plans to wade through or to figure out how to get health care; please give me more insurance bureaucracy to wade through each day. Seniors say: Update Medicare and cover prescription drugs.

It is simple. They want their traditional Medicare, choose their own doctor, choose their own pharmacy, to be able to make their own choices and to have them available regardless of where they are in the country, but they want to make sure they have prescription drugs as well.

We know if health care in 1965 were like it is now, prescription drugs would have automatically been covered. We know that. We also know in 1965, as I indicated earlier, Medicare came into being essentially because of a failure in the private market. That is not a criticism; it is a reality that covering older Americans certainly is more costly as we use more health care. As we get up in age, we find we use more health care, we use more prescription drugs. There are fewer carriers wanting to cover. Certainly, way back in 1965, that was the case when half the seniors in the country could not find a private insurance plan or could not afford a private insurance plan available.

Medicare came into being in order to make sure that health care was available for older Americans and for the disabled in our country. It was a value statement about who we are and what we think is important. It was an important value statement just as Social Security coming into being was a value statement about the fact we wanted to make sure there was a basic amount of money for everyone to know there is a certain amount of financial support available to them as they get older, as they retire. It is a value statement. Medicare and Social Security have both been great American success stories.

We are now at a point where medicine has changed, the delivery system, the way we provide care. Most of us go to the doctor's office and walk out with at least one prescription. We have the opportunity to take medicine to keep us well, to manage our high blood pressure, cholesterol, or other issues that allow us to remain healthy and remain out of the hospital. These are all very positive. We also have the opportunity to avoid heart surgery by taking a pill or have other options by taking medications that cause us not to have to go into inpatient care in the hospital.

A lot of good has happened. We are now at a point where it makes sense to update Medicare. The question is how to do that. We really have two different views on how to do that.

One that I share says we should take a system that has worked and we should make sure it is fully funded so our physicians and hospitals and home health care and nursing homes have what they need to provide services. That is another critical issue—the resources being pulled out of Medicare and the underfunding of Medicare which has caused problems. We should provide full funding, and we should make sure it is modernized to cover preventive efforts and that we cover prescription drugs as a part of an integrated, modern health care system under Medicare. We should use more technology so there is less paperwork and more streamlining, which I know is of great concern to health care providers. We can do all that within the framework of Medicare, which has worked so well. Why is that important? Because it is dependable, reliable, affordable, and it is a value statement about who we are as Americans. That is one view.

Another view is we should move back to the model before Medicare came into existence, and that is more of a reliance on private health insurance plans. We hear from many insurance carriers that they are not interested in prescription-only policies. They are not interested. It is different. Insurance usually means you provide insurance to a large number of people assuming only some of them will get sick or some will have automobile crashes or some will have their homes burn down—not everybody.

In the area of prescription drugs for seniors, from an insurance model it is very different. In fact, when you cover people, you can be assured almost all of them, if not all of them, will in fact need your insurance. They will need your coverage. So it is a very different kind of model than traditional insurance, where only some people use the insurance but everybody is paying into a system and spreading the risk.

That is one of the difficulties we have had, trying to fit this model of private insurance into the fact that we are talking about private insurance for health care, prescription drug care, where everyone who is buying the product will be using it. There are a number of questions about how to fit that model in and make it work.

Then there are questions about why. Why do we do that? Why do we propose something that is complicated, that on the one hand provides choice, which is good, from the private sector, but on the other hand is convoluted and complicated for those who want to stay in traditional Medicare and not make them make that choice. That is one of the questions, Why is this happening?

From the pharmaceuticals' standpoint, they are very much opposed to seniors being under one plan, 40 million people in one place, to be able to negotiate large discounts in price. As a result of that, they certainly have lobbied very heavily for a plan that divides seniors into a lot of different places so they have less leverage to be able to lower prices and negotiate discounts. That is also a concern of mine.

We know also that under traditional Medicare, we actually save money. We hear all the talk about market forces and lowering prices. In reality, facts show the opposite. In fact, commonsense I think shows the opposite when we look at what is happening in the private sector today. The average small business has seen its insurance premiums double in the last 5 years. Certainly in Michigan, major high-tech manufacturing in the State has seen 15 or 20 percent or more increases in the cost of private health insurance every year. Yet under Medicare we see the costs going up about 5 percent a year.

We look at this and say: Wait a minute, we are talking about a plan that costs more, not less. How does that make sense?

We also know, when we look at administrative costs, we are told by those who have analyzed it that administrative costs for Medicare to administer the program are about 2 percent. In the private HMOs in place right now under Medicare, their costs are 15 percent for administration. We are told that in the private sector they actually go higher, that in some private plans it has been as high as 31 percent for administrative costs.

We look at that and say, How does this make sense? We don't want 15 percent going into administration when it can be 2 percent so more of those precious dollars that we have can then go into buying medicine. That would seem to make sense.

There are a number of different reasons I believe it makes sense to make sure the real choice seniors want to have, which is traditional Medicare, is one of the choices available to them. I personally believe it will save dollars. It will allow the money we have to be used more for purchasing medicine and for health care rather than for administration or other kinds of costs.

Medicare is a nonprofit system by design. I know there are differences in philosophy about a for-profit system under health care versus a nonprofit system. But the majority of hospitals in this country are nonprofit. The Medicare system itself is set up so that every dollar possible goes into care. I believe that is a model we should continue. I believe it is a model, although it can always be improved—and I would be the first to say we can improve and streamline the Medicare system—fundamentally it has worked for people. It has been there. It has been a system that has held down costs. It has been dependable and reliable for every single person who is an older American, or for a disabled person in our country. I wish we would embrace it rather than talk about dismantling it.

I ask colleagues to come today, as we vote on this amendment, and join together to provide real choice for our seniors, the choice they are asking for as well as every other choice. Let's make sure every choice they might want to have they could have, including traditional Medicare.

Mr. President, I yield the floor. 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. SMITH. 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 Senator from Oregon.

Mr. SMITH. Mr. President, I rise to respond to the Senator from Michigan. I think she makes a number of points that are worth our consideration. I think this can be done through the Government route. But the grand experiment here is predicated on a belief that the marketplace can actually work.

If we were to adopt the Stabenow amendment, it would clearly undermine the private sector from forming plans and offering prices which have the potential of very real savings for our seniors and providing us with some very real reforms which seniors are counting on; that is, that we provide this benefit without undermining the financial integrity of Medicare.

We need to make up our minds. We can either go the Government route or we can go the market route. The Government route can work but it comes at a cost that is, frankly, hard to calculate.

Even as we speak, right now on Part B Medicare, the Government is looking at gross overpayments already on prescription drugs and is having to make reimbursements because of that.

Imagine all of the inefficiencies that would be infused into the system if we relied upon the Federal Government to manage every prescription drug for every senior in this country. If they are overpaying on one and wasting money at the same time, I hate to think of the bill the Federal Government would have to foot if we did this for every senior on the basis that the Senator is describing.

Moreover, the Congressional Budget Office has just announced an initial estimate of what the Stabenow amendment would cost, which is an additional $50 billion over 10 years. Without a doubt, with the budget that provides $400 billion over 10 years, this would exceed that by $50 billion. I am sure at some point a manager of the bill will make a budget point of order. It has come at a significant additional cost of $50 billion.

Again, I return to the point that we can either let the marketplace work or we can let the Government do it. But if you have a permanent Government backup as opposed to a fallback provision until the marketplace develops, you will retard, if not destroy, the marketplace from ever developing. It is that simple.

The predicate of the compromise between Republicans and Democrats that has been a result of the prescription drug benefit coming to our seniors is that we are going to have a fallback. But we are going to give the marketplace a chance. We are going to see which one works. As for me and my money, I am placing my bet on the marketplace, if we provide an economic structure for it to develop. If it develops, it will give real hope and a real renewed life to Medicare, and it will give our seniors the benefit they need of a prescription drug immediately. I think that is the better vote. I think it is the better way.

I think we know how Government works. When it is necessary for a Government bureaucrat to be between you and your medicine cabinet, I shutter, frankly, at the inefficiencies that can come from that; whereas, if you allow the marketplace to work—as with PPOs which the Presiding Officer and I have as Federal employees—frankly, they can take a holistic approach to your health by including prescription drugs. It gives us a very real chance to give our seniors a program that includes prescription drugs, which includes holistic health care, and which doesn't rely on a Government formulary and Government price setting to determine what drugs you can have and what they are going to cost.

I urge my colleagues to vote no on the Stabenow amendment because it undermines entirely the bipartisan agreement that has been arrived at in the Finance Committee.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Mr. President, my friend from Oregon was speaking about medicine cabinets. On the question of whether you want a for-profit insurance company or a bureaucrat between you and your medicine cabinet, or whether you want Medicare, which we have known and relied upon since 1965, I appreciate that there is a different view and philosophy. I think there is a fundamental difference in ideology that is working here.

It is interesting. I had a chance to go back to the debates when Medicare was first developed. The same kind of differences occurred at that time and the same debate about whether or not we should provide care under one plan under Medicare that is stable and reliable or use the private market private insurance company. The very same kind of debate was going on then that is going on now.

I believe the right choice in 1965 was Medicare. I believe it continues to be one of the choices that makes sense to offer to seniors.

I wish to respond to the Congressional Budget Office estimate. It is disappointing to me to find that they have chosen to score it at $50 billion above the $400 billion. We have worked with them. In fact, we made it clear that the intent of this amendment was not to add $1 to the budget resolution. It is to use the $400 billion and within that to have a carve-out or choice of Medicare. In fact, so as to guarantee that, we included at the end of the bill an authority to prevent increased costs. If the administrator—in this case we are talking about HHS—determines that Federal payments made with respect to eligible beneficiaries enrolled in a contract under this section exceed on average the Federal payments made with respect to eligible beneficiaries enrolled in a Medicare prescription drug plan or MedicareAdvantage, the administrator may adjust the requirement or payment under such a contract to eliminate such excess.

The reason we have included that is to guarantee that it is within the $400 billion parameter. If, in fact, the Congressional Budget Office has not looked at that, it is unfortunate. I would disagree with their analysis.

I indicate again that this is not about changing the budget resolution or the amount of dollars. It is about creating the best choice or one more choice. It may not be the best for an individual. They may decide that going through a PPO or an HMO or some other part of the alphabet might be a better choice for them. The question is whether people will have a full range of choices including the choice that the overwhelming number of seniors have told us they want.

The intent of this amendment is in fact not to add anything to the cost of this particular bill.

I yield the floor. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The legislative clerk proceeded to call the roll.

Mrs. HUTCHISON. Mr. President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mrs. HUTCHISON. Mr. President, I have heard the Senator from Michigan describe her amendment. I have to say I would be concerned about a Government-run prescription drug benefit because of what it would do to our free enterprise system and our capability to have competition which I think is very important. I think the underlying bill provides the competitiveness that will be so important for a balanced system, and it is also one that will give seniors the best prices and the best choices.

I would like to make a statement in general about the bill we have before us. I have to say that we have been talking about reform of Medicare for years—maybe for the 10 years I have been here. But today we are now talking about a real bill and maybe a real chance to reform this very important program.

I think it is clear that any time there is reform we must include a prescription drug component. We must have a choice which is similar to that in the private sector, and we must admit that Medicare has not kept pace with the rapid changes in our health care system.

As our research community pushes the envelope and develops lifesaving medicines and procedures, our Nation's health care system must take that innovation into account or it will not be the greatest health care system in the world.

Pharmaceuticals have revolutionized medical care. Increasingly, ailments are treated with medication as opposed to invasive surgeries. It is imperative that those who rely on Medicare have access to affordable prescription drugs.

When Medicare won't pay for medicine to treat diabetes but will pay for the amputation of a limb caused by complications of diabetes, I think we can admit that we have a problem.

A prescription drug benefit alone is not the answer. True reform must provide our Nation's seniors the freedom to choose physicians and benefits based on their individual needs. If a beneficiary is satisfied with existing coverage, the beneficiary should have the option to stay put. But if she chooses to enroll in a private insurance PPO or HMO, she should be allowed that choice. This choice is incorporated in the underlying bill.

Also, I have an amendment, cosponsored by Senators KENNEDY, DURBIN, SPECTER, and TALENT, to restore cuts in Medicare reimbursement to teaching hospitals. Texas hospitals are facing the loss of $26 million in 2003 due to Medicare reimbursement cuts. Nationwide, teaching hospitals will lose $794 million this year and $4.2 billion over the next 5 years. Every State will be similarly affected.

Teaching hospitals are experiencing a terrible financial crisis. My amendment restores the fiscal year 2002 level of reimbursement for indirect medical education—they are called IME payments—to teaching hospitals. This allowance has been cut incrementally since the Balanced Budget Act of 1997 from 7.7 percent to 5.5 percent in fiscal year 2003.

Teaching hospitals have higher costs due to their critical role in educating tomorrow's physicians. They run more tests, they have newer technology, and they require more staff because they are training our future health professionals. The additional payment is vital to continuing this training. A disproportionate percentage of the most seriously ill and injured patients recover and convalesce in teaching hospitals. These hospitals have 78 percent of all trauma centers and 92 percent of all burn beds.

Although only 21 percent of all hospitals are teaching hospitals, they deliver over two-thirds of charity care. They conduct groundbreaking research. The University of Texas Medical Branch in Galveston—as one example in my State—will lose $1.9 million in these payments this year if the amendment is not adopted. UTMB leads research on anthrax, smallpox, and plague. We cannot afford to have teaching hospitals cut back on research that benefits every individual.

In the budget we passed earlier this year, $400 billion was set aside for Medicare reform. It is our responsibility to use that $400 billion wisely and to bring this incredible program into the 21st century so that America's seniors will have the medical coverage they need and deserve.

I think the bill before us needs work. We all agree that it is not a perfect bill and we want to make it better. We want to make sure it does two basic things: that it increases the quality of health care for our seniors, and, secondly, that it does so at a reasonable price for our future generations. We do not want another huge commitment that is going to turn into an entitlement that is unbearable in the future. But when Medicare will cover the cost of a hospital stay for 5 days for the amputation of a limb but it will not allow you to pay for the medicine that will keep you from having to amputate that limb, something is wrong in the system, and we must fix it. This time we can do it.

Thank you, Mr. President. I yield the floor.

The PRESIDING OFFICER. The Senator from Utah.

Mr. HATCH. Mr. President, I have been listening to this debate and listening to the distinguished Senator from Michigan. If you love the Federal Government and the Federal Government's control over all of our lives, boy, this is the program for you, because it certainly would fly in the face of everything we have been trying to do to create a program where you have some options, some choices, and where people can make their own decisions as to what type of health care they want, seniors in particular.

So I rise in opposition to the Stabenow amendment. The way I understand the amendment, it would require a permanent fallback to be offered to beneficiaries in addition to the private stand-alone drug plans. Making the fallback plan a permanent option will completely undermine the very structure upon which this bill is built.

First and foremost, including a permanent fallback plan creates an uneven playing field. Frankly, we hope the Government fallback plan is never needed. The only reason it is in this bill is to take care of those situations where there are no bidding competitors to provide the health care. We believe there would be bidding competitors, and there is no real reason to have a fallback other than in those rural areas or tough areas where it is uneconomical for business to compete for the business, where you are going to need a no-risk, Government sponsored and subsidized, and completely controlled fallback plan.

So first and foremost, including a permanent fallback plan creates an uneven playing field. The Government fallback is a non-risk-bearing entity. The fallback plan will operate in regions without any risk for gains or losses. The Government pays for the fallback plan's administrative costs associated with delivering the drug benefit. If we make the fallback plan permanent, as the distinguished Senator from Michigan would do, we are basically requiring privately delivered drug plans, which are at least partially responsible for bearing the risk of delivering this benefit, to enter this same market and compete with these Government fallback plans.

This would not only be unfair, but it also sets up our drug plan for failure. There isn't a private health plan out there that will enter such a lopsided market where we give their competitors such a large financial advantage. Simply put, this amendment would discourage the initial entry of private plans, dooming the effort to provide beneficiaries the drug benefit through competing private plans with all of the cost savings and benefits that would come from competition.

In addition, including a permanent fallback plan would add billions of dollars to the cost of this bill. CBO estimates that the cost of this fallback plan would be at least $50 billion over 10 years. So, literally, by including a permanent fallback plan that will cost $50 billion-plus over 10 years to the cost of this bill, we would be relying, at least partially, on an inefficient, more costly, Government-controlled, Government-style delivery system to provide beneficiaries with drug coverage.

When the Senate was debating the Medicare prescription drug issue last year, this was one of the biggest criticisms against the Graham drug benefit. The Graham drug benefit plan created a one-size-fits-all drug benefit delivered by the Federal Government. This is not what Medicare beneficiaries want.

Beneficiaries want choice in drug coverage. They do not want to be forced into a Government-run plan and offered a one-size-fits-all benefit. The Stabenow amendment would place the drug benefit right back in the hands of Government-run health care, Government micromanagement, and, worst of all, price controls. Government bureaucrats would ultimately put the Government in charge of setting drug prices. We simply do not want Government bureaucrats in charge of setting drug prices. We want the private market to make these decisions, not the Federal Government.

My colleague from Florida was just reminiscing about the 1988 catastrophic law. I was here. I argued against it. We all saw the people jumping up and down on Danny Rostenkowski's car when they realized they had to pay for their drug expenses. Well, you can imagine what is going to happen if we have Government take over this program.

If this amendment passes, we will be creating another Medicare catastrophe. In fact, we already know the Federal Government does not do the best job of reimbursing for prescription drugs due to years of overpayments for the drugs already covered under Part B of Medicare.

Medicare has been overpaying for Part B drugs for years because of its inability to keep up with the marketplace. The intent of S. 1 is to introduce a new model to deliver care to Medicare beneficiaries. We want to offer Medicare beneficiaries a meaningful drug benefit. This drug benefit will include multiple choices but it only works when all options are expected to participate under the same rules. You

don't set it up so that all the options that have a chance of working fail because you have a government-run, government-subsidized, government-controlled, government-bureaucratized program, which is exactly what the Stabenow amendment would establish.

Those who are extremely liberal will love that program, because it just means Government controls every aspect of our lives in health care. In S. 1, we included the Government fallback as a safety net to ensure that every senior has access to pharmaceutical drug coverage. But it is a fallback of last resort. We hope we will never have to have a fallback plan for any region or any area. But it is a last resort, if we need it. That is because even the Congressional Budget Office concludes that the permanent fallback plan is a more costly, less efficient model to deliver pharmaceutical benefits.

Again, let me remind everybody that the CBO says the Stabenow amendment will cost at least $50 billion over the next 10 years. Knowing the Government as I do, I say at least $50 billion. It will probably be a lot more than that. It will take all the incentives to keep costs down out of the program, as we take away risk, which is what the competing companies have to meet. They have to meet risk factors.

In conclusion, the Stabenow amendment would deny Medicare beneficiaries the opportunity to enroll in the plan that best fits their needs. They would be denied that opportunity. The Stabenow plan would force all our seniors into a government-run, government-controlled, government-bureaucratized drug benefit. It would basically undermine every possible competitive aspect that might possibly hold costs in line and bring them down.

This amendment by the distinguished Senator from Michigan would effectively deny beneficiaries a private plan option thus denying beneficiaries a choice in drug coverage, one of the fundamental principles of this bill—choice, the right to pick the coverage you want. That is what our prescription drug program would give beneficiaries.

There are those who believe that socialism is the answer to everything. Let government do it. Government can do it more efficiently. If you believe that, you haven't watched the last 50 years. I urge my colleagues to defeat this amendment because it will take away important drug coverage choices for Medicare beneficiaries. It will lead us into a situation where Government is going to control everything, and, as a result, Medicare beneficiaries will be left with no choices in drug coverage. I don't want to go back to those days when they were jumping up and down on Danny Rostenkowski's car because the senior citizens realized they had to pay for it. I want to give Medicare beneficiaries choices and make sure there is some competition in the marketplace so that the choices will be good ones. I don't want to go to just a one-size-fits-all government program which literally will not work except at a tremendously costly expense to U.S. taxpayers.

For these reasons, I urge my colleagues to oppose the Stabenow amendment.

I yield the floor.

Ms. MIKULSKI. Mr. President, I want a medicare prescription drug plan that benefits seniors—not a plan that benefits insurance companies. That is why I am a cosponsor of the Stabenow amendment.

This amendment gives seniors a choice: to get their prescription drugs through traditional Medicare or through a private insurance company

Why is this important? Because it lets seniors choose the program that fits their needs. Seniors trust Medicare. It has provided a safety net for seniors for almost 40 years. Medicare hasn't let them down.

We can't say the same about insurance companies. We have been down that road in Maryland with Medicare+Choice. The insurance companies came in. They enticed seniors with promises of better care and prescription drugs. They took the money from our seniors and left town leaving over 100,000 Maryland seniors without coverage.

Seniors in my State were gouged and abandoned. So I don't trust insurance companies to be there for seniors. I trust seniors to make their own decision to decide which prescription drug plan is best for them.

Seniors trust Medicare. When given an opportunity, I think seniors will choose Medicare. In the mid-1990s, when Medicare HMOs offered prescription drug benefits. Only about 15 percent of beneficiaries signed up.

Yet year after year, Senate Democrats have fought off efforts to privatize Medicare—to force seniors to leave their family doctors and join HMOs and other private plans. We heard Newt Gingrich talk about making Medicare ''wither on the vine.'' Then this year, the President's prescription drug proposal would have forced seniors to leave the Medicare they trust to get the drugs they need.

I believe honor thy mother and father is not just a good commandment to live by. It is good public policy to govern by. That is why I feel so strongly about Medicare.

Medicare is not the problem. It is the solution. That is why Congress must now provide a prescription drug benefit for seniors. To benefit seniors—not to benefit insurance companies. We must do it now—to help seniors, to help families, top help American business and to help our economy.

I urge my colleagues to join me in supporting the Stabenow amendment.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. SMITH. Mr. President, I ask unanimous consent that the vote in relationship to the pending amendment No. 931 occur at 3:15 today with no amendments in order to the amendment prior to the vote and 5 minutes for debate equally divided prior to the vote.

I further ask unanimous consent that at 2:15 today the amendment be set aside and Senator ENZI then be recognized to offer an amendment.

Mr. REID. Reserving the right to object, the senior Senator from Illinois is on the floor. I am wondering how long the Senator wishes to speak on the Stabenow amendment. If the Senator from Oregon would allow the Senator from Illinois to speak until 2:15 on the Stabenow amendment.

Mr. SMITH. I have no objection.

Mr. REID. I would ask for a modification; that we be recognized for 10 minutes; following that, Senator ENZI be recognized after the Stabenow amendment is set aside.

The PRESIDING OFFICER (Mr. ALEXANDER). Is there objection to the modified request?

Without objection, it is so ordered.

The Senator from Illinois.

Mr. DURBIN. Pursuant to the unanimous consent request, it is my understanding I am recognized for 10 minutes.

The PRESIDING OFFICER. That is correct.

Mr. DURBIN. Mr. President, at about 3:15 we will have a chance to vote on an amendment. It is an important amendment to the prescription drug plan, an amendment offered by my colleague and friend Senator STABENOW of Michigan, who has been our leader in the Democratic caucus on the prescription drug issue. There is no one who has put more time in it. Senator STABENOW is going to give the Senate a very basic choice to make.

Under the Grassley-Baucus bill, a senior citizen, once this goes in effect after the Presidential election, will take a look at the area they live in and if they can find two private providers for prescription drugs, they have to choose between the two of them. If they can't find two that will provide that protection, that service, then there will be a Medicare plan known as a fallback plan which the senior can turn to, but it is not a plan that will be administered by Medicare. It is a plan that will be administered by a private provider under Medicare. So no matter where you turn as a senior under this plan, you are always going to find a private provider, a private insurance company.

The Republicans, many who support the bill, argue that is real competition. Senator STABENOW takes it to another level and says, if you want real competition, one of the options that should always be available to the senior is to go to a prescription drug plan administered by Medicare itself.

Why would you want a Federal agency to administer this plan? I will give you two reasons. First, there is no profit motive. Medicare is basically going to be involved in this to try to provide

the service, and we know that the services they provide are at a lower administrative cost than any private insurance company. No. 2—and this is where the rubber meets the road—Medicare can say to the drug companies, we want you to be part of the Medicare alternative; therefore, tell us what you will do to contain the cost of your prescription drugs. So they have bargaining power on behalf of seniors to reduce the overall cost of drugs that are offered to seniors, a win/win situation.

Does it work? Go to the Veterans' Administration hospitals. Look what they have accomplished. They said to the drug companies, you want to sell drugs to veterans, great. But tell us the best price you will give us, and the best price offered at veterans' hospitals to the men and women in uniform is 40 to 50 percent below what seniors are paying over the counter for their prescription drugs across America today. So if you go to the Stabenow alternative, a Medicare-administered plan, no profit motive, low administrative cost and a formulary, a group of drugs that has been discounted for seniors, it is an absolute win situation for seniors and for the Government and for the cost of the program.

Those who are arguing for competition on the other side say, just let these private providers get at it. Boy, they will really show you how they can bring prices down. They live in fear that if Medicare is involved in it, Medicare will show them how prices can really come down. That is what this is all about.

I hear these arguments on the floor from people who I respect saying the Stabenow amendment is going to limit choices. The heck it will. The Stabenow amendment gives to seniors the real choice, the Medicare choice, the choice that they want.

I would like to ask the Senator from Michigan if she will respond to a question. She has a chart that shows the interests of senior citizens on this issue. If this is any indication, how would the senior citizens vote on the Stabenow amendment?

Ms. STABENOW. First, I thank my colleague for his eloquence. It is true that 89 percent of the seniors in this country are in traditional Medicare. Only 11 percent are currently in managed HMO plans. Since 1997, seniors have been given a choice between what has been called Medicare+Choice and traditional Medicare. Overwhelmingly, they have stayed in Medicare.

Mr. DURBIN. Does the Senator's amendment limit the choices for seniors—

Ms. STABENOW. Absolutely not.

Mr. DURBIN.—when you compare it to the underlying bill?

Ms. STABENOW. Absolutely not. What we are doing is saying, instead of two private insurance plans, we add a third, so instead of two choices, you have at least three.

Mr. DURBIN. Again, let me ask, through the Chair, if I might, is it not true that if Medicare then can offer this plan on behalf of tens of millions of seniors, Medicare can go to the drug companies and say: All right, you want to sell us Celebrex or Zoloft or whatever; what is the best price you will offer Medicare?

Isn't that more of an assurance that the prices seniors will pay under that alternative will be lower?

Ms. STABENOW. Absolutely. The Senator from Illinois has hit what I think is the most critical point, and the reason there is such opposition, certainly from the pharmaceutical industry, to what we are trying to do through Medicare. They don't want the majority of seniors in one insurance plan together in Medicare where they can force a group discount. They would like to divide seniors up in lots of different insurance plans and not give them the leverage to bring prices down.

Mr. DURBIN. Also, I ask, under the underlying Grassley-Baucus bill, what force is there for cost containment? What kinds of elements are in that bill that will help bring down the cost of prescription drugs for America's families and America's seniors if we don't put Medicare into the process bargaining on their behalf?

Ms. STABENOW. I don't see anything in here that brings it down. In fact, what we are doing in the underlying bill is adding the profit. We are putting for-profit business into this process, so you are actually adding to the cost of this system. I don't see anything in here that will bring prices down. I think that is why the pharmaceutical industry is very supportive of this plan because, unfortunately, the average retail price of an advertised brand is going up three times the rate of inflation. This does nothing to address that and bring the prices down.

Mr. DURBIN. I thank the Senator.

While I still have a minute or two, I will just say this. Time and again, our friends on the Republican side of the aisle say we should contract out Government services, privatize them, to save the taxpayers money. They say, if you will just get it away from the Government bureaucracy and put it into the private sector, we will show you how to really provide a service at a low cost. Sadly, many times that doesn't happen. The costs go up, the quality is not good, and we are stuck with private-side contractors when we contract out.

Now we have an interesting turn of events. We hear from the Republicans and conservative side that we don't want a Government agency to be able to compete with the private sector. We don't think that is going to be fair. There is no real choice there.

There is a choice. I think the choice is obvious. If Medicare—speaking for the vast majority of senior citizens—can bargain for lower prescription drug prices, the winners will be not only the seniors who will pay less but the taxpayers who will pay less. The $400 billion in this bill will go a lot further if we can have lower cost prescription drugs.

I say to my friends on the Republican side of the aisle, don't be afraid of competition, and don't be afraid if one of the competitors is Medicare. The seniors who you represent have already voted on this issue by a 9-to-1 margin. They prefer traditional Medicare. We should not be afraid of it.

The Stabenow amendment is a step in the right direction. It says if we are going to have a prescription drug plan that Americans can afford and that the taxpayers can afford to pay for, yes, we need to have cost containment. This bill has little or none. The Stabenow amendment brings in real competition and, unless that competition is there, let me tell you what we have done; we have said we will subsidize prescription drug costs no matter how high they go. Mark my words, as history has proven, they will continue to increase to a point where it bankrupts the current bill before us.

The Stabenow amendment is, I think, not only a stand for common sense but a guarantee that competition will really be there to protect seniors.

I yield the floor.

The PRESIDING OFFICER. The Democratic leader is recognized.

Mr. DASCHLE. Mr. President, I will use my leader time. I am not sure what the allocation of time is right now.

I commend the distinguished Senator from Michigan and the Senator from Illinois for their work on this particular amendment. I think I can say for most, if not all, of our caucus members, this is the most important amendment as it relates to this bill, in large measure because it goes to the essence of what it is we believe we need to do.

What we have said from the very beginning is let's build on what we have achieved in the Medicare system now for the last 38 years. Obviously, we know there are ways in which the program needs to be updated and reformed. I think there is common agreement among Republicans and Democrats that if we are to reform Medicare, the single most important priority is to ensure that we recognize that health care delivery has changed dramatically in the last 40 years.

Health care delivery now is largely outpatient. Far more people get their health care in an outpatient setting than they do inpatient. With that recognition, we made a decision in the 1960s that was wrong. We said we would reimburse drug costs in a hospital but we would not reimburse drug costs outside of a hospital or doctor's office. Well, had we decided back then that we would reimburse drug costs regardless, we would not be here today. So we made a decision based on, I am sure, a lot of different factors—cost was probably important—that we wish now we could have reversed a long time ago. But that, in essence, is what we are talking about with reform. It is a recognition that health care delivery itself has changed.

The real question is, What will be the mechanism by which seniors acquire these prescription drugs? There are those who have suggested that seniors ought to have choice. I have heard the distinguished Senator from Michigan say so eloquently that if you are in favor of choice, you will be in favor of this amendment because that is basically what we are proposing—choice. We are saying to seniors, if you think you can find a better plan out there somewhere, offered within your region, take it. This is a voluntary program. We are not mandating that you do anything. But if you think Medicare has provided a good service and if you think, in order to be consistent with the spirit and the concept of Medicare to begin with, that it ought to be offered through the Medicare system, you ought to have a right to choose that as well.

Why in Heaven's name would we deny a senior the right to stay within Medicare when they get their doctor and hospital benefits through Medicare? They ought to get prescription drugs through Medicare. So that is, in essence, what the Senator from Michigan is suggesting with her amendment. Let's allow choice; let's allow consistency.

But I think it goes beyond the choice of the senior citizens. The reason it ought to be our choice occurred again last night to me as I listened to some of the debate in the House Committee. The question was asked last night: Can you tell us what the administrative costs will be for the private sector systems providing this new prescription drug benefit? On record last night during that debate the answer was given: 25 percent.

The administrative costs for the private sector plans is anticipated to be 25 percent. That means out of the $400 billion we are committing to the drug program under this legislation, $100 billion could go to paperwork.

We have asked what is the administrative cost of the Medicare system, and we are told by CBO and others that the administrative cost today for Medicare is between 3 and 4 percent. So we could save upwards of 20 percent if we had an opportunity for seniors to use the Medicare system. That is another reason that choice would make sense to us—to keep administrative costs down.

We only have to look to the Veterans Administration to see how effectively they have controlled costs, not only administratively but on drug acquisition costs. The drug acquisition cost through the Veterans Administration is dramatically lower, ranging anywhere from 15 to 30 percent below what is done in the private sector through private insurance companies. We could save in Medicare as well.

From a cost containment point of view, an administrative point of view, and a choice point of view, this amendment ought to pass. I think it is key to sending the right signal not only to our seniors about what kind of services we want to provide, about what kind of consistency, what kind of choice we want to offer, but it ought to be a message to the taxpayer. We are going to do it through the most efficient, most administratively simple concept to which we can subscribe. Extending Medicare, providing drug benefits through Medicare, is the way to do it.

Again, I commend the distinguished Senator from Michigan for her efforts and for her amendment. I hope it will enjoy broad bipartisan support. I yield the floor.

The PRESIDING OFFICER. Under the previous order, the Senator from Wyoming is recognized.

AMENDMENT NO. 932

Mr. ENZI. Mr. President, I send an amendment to the desk, and I ask unanimous consent that the pending amendment be set aside until 5 minutes before the vote.

The PRESIDING OFFICER. Without objection, it is so ordered. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from Wyoming [Mr. ENZI], for himself and Mr. REED, proposes an amendment numbered 932.

Mr. ENZI. Mr. President, I ask unanimous consent that the reading of the amendment be dispensed with.

The PRESIDING OFFICER. Without objection, it is so ordered.

The amendment is as follows:

(Purpose: To improve disclosure requirements and to increase beneficiary choices)

On page 57, between lines 21 and 22, insert the following:

''(3) DISCLOSURE.—The eligible entity offering a Medicare Prescription Drug plan and the MedicareAdvantage organization offering a MedicareAdvantage plan shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made available to the entity or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Administrator under this paragraph in the same manner as such provisions apply to information disclosed under such section.

''(4) AUDITS AND REPORTS.—To protect against fraud and abuse and to ensure proper disclosures and accounting under this part, in addition to any protections against fraud and abuse provided under section 1860D–7(f)(1), the Administrator may periodically audit the financial statements and records of an eligible entity offering a Medicare Prescription Drug plan and a MedicareAdvantage organization offering a MedicareAdvantage plan.

On page 37, between lines 20 and 21, insert the following:

''(C) LEVEL PLAYING FIELD.—An eligible entity offering a Medicare Prescription Drug plan 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 cost paid by such enrollees.

''(D) PARTICIPATING PHARMACIES NOT REQUIRED TO ACCEPT INSURANCE RISK.—An eligible entity offering a Medicare Prescription Drug plan may not require participating pharmacies to accept insurance risk as a condition of participation.

Mr. ENZI. Mr. President, I rise today to offer an amendment that will contribute to fair prices for consumers and fair treatment for pharmacies under the new Medicare prescription drug benefit. I am pleased that my distinguished colleague from Rhode Island, Senator REED, is joining me in offering this amendment. He serves with me on the Health, Education, Labor, and Pensions Committee and has been a stalwart in helping with some of the small pharmacist issues. That is what a large area this bill seeks to take care of.

It is an issue across the entire country. It is not just an issue in Wyoming or the West. We all have local pharmacists. Local pharmacists provide a tremendous service to the people for whom they are providers. One of those local services is to explain how the drugs are used, what their proper use is. They have an excellent knowledge of the drugs a person is taking and recognize conflicts and iron those out with the doctor. They work with the doctor to come up with some generic drugs, in some cases, to save costs. Largely, they are left out of any of the pricing mechanisms. They do all of this on a very low margin.

This bill does not take care of that part of local pharmacists, but it allows them to still be in the market. This bill ensures fair prices for consumers.

The amendment we are proposing would ensure that we hold Medicare drug plans accountable for passing on to consumers a fair portion of the rebates, the discounts, and the other incentives that the plan may receive from drug manufacturers and other sources.

Specifically, the amendment would require Medicare prescription drug plans and Medicare Advantage organizations to disclose to the Federal Government the extent to which they pass those rebates and discounts on to Medicare beneficiaries.

The amendment would also clarify that the Federal Government may audit their financial statements and records to ensure compliance and deter fraud and abuse in this area.

To ensure fair treatment for pharmacies, the amendment we are offering would prohibit Medicare drug plans from implementing restrictions that would steer consumers to the mail order pharmacies. It would require the Medicare drug plans to allow local community pharmacists to fill long-term prescriptions—not just 30-day prescriptions, but 90-day prescriptions—and offer other services they are equipped and licensed to provide. It protects the rights of seniors to choose their trusted local pharmacist over a mail order house.

Our amendment would also prohibit Medicare prescription drug plans and Medicare Advantage organizations from requiring pharmacies to accept

insurance risk as a condition of participation in a plan. Pharmacists and pharmacies dispense medications and provide services; they are not insurance companies.

This provision will ease the minds of the pharmacists who are concerned that Medicare drug plans might force them to share the risk. This has come to light, I am sure, to all of us in town meetings we have held, town meetings where pharmacists have shown up, town meetings where the pharmacists either have their national publication or publications from their colleges that point out some of the difficulties they are having operating in the local market, the local market where they have the actual contact with the consumer, the local market where they are the ones providing the advice, the care, and sometimes the protection of the patient. We want to make absolutely sure we do not leave them out of the mix.

This is a part of the solution that has been suggested in those college publications and those national pharmacist publications. These are local professionals who provide a local service. They do an outstanding job of helping out their customers. They understand who the customer is because they see them face to face; they are not just a voice over the telephone taking an order.

They will play an important role in any drug benefit that is passed, whether it is through a profitable situation for them—and we hope they can stay in business so we have the help of this local pharmacist—or whether it is forced on them in a nonprofitable way. They have been doing that.

It would be nice if we watched out for the small businesses in the towns across America. Small businesses are the heart of America. They are the ones that provide the community help and community services. They are the ones that participate in all kinds of community events.

We have to be careful this bill does not take them out of the loop and put them out of business so that kind of service disappears from the face of America. It is part of America. The drug stores have been the heart of downtown for years and now the heart of the health care system. They are often the main source of health care service and advice, particularly in the rural and frontier areas. In the bigger cities, there may be more contact with people who can provide information. Some of that comes through the HMOs, and some of it comes through the prescription drug managers who are often tied in with those HMOs. But they are not the ones who really do the contact with the customer, particularly in the rural and frontier areas.

I sponsored a bill to remedy our pharmacist shortage, and I am hoping that bill will come to the floor. It is a bill that helps with the forgiveness of the loans it takes to get through the process of becoming a pharmacist. We have to make sure these people are available and continue to be available in smalltown America and in the big cities. We also have to make sure there are faculty to teach these people properly to interact with the customers.

Half of the money would go to providing loan forgiveness for pharmacists who become faculty and half to forgiveness for people who actually become pharmacists in underserved areas, and underserved areas are sometimes urban areas as well. This bill does not address this. That is another bill we need to fill in the pharmacist piece. It unanimously came through the Health, Education, Labor, and Pensions Committee, and it recognizes the need for local pharmacists and that local interface we are all used to having. Seniors and pharmacists are both concerned with how the interaction will happen. Seniors do trust their hometown pharmacist.

Senator REED and I believe this amendment will go a long way toward answering the concerns of seniors and pharmacists about how this new Medicare drug benefit will impact the trusted relationship that pharmacists and their senior patients share.

I encourage all of my colleagues to take a closer look at this amendment and help me get it adopted. As I mentioned, it has bipartisan support. If we had a little more time, I am sure we would have had a lot more cosponsors. We recognize this is an appropriate place for this amendment to appear and an appropriate service to provide under the prescription drug benefit of Medicare.

So I encourage my colleagues to vote for it. I thank them for their consideration.

I yield the floor.

The PRESIDING OFFICER (Mrs. DOLE). The Senator from Oregon.

Mr. SMITH. I thank my colleague for his amendment. I think the Enzi-Reed amendment will clearly improve beneficiaries' access to long-term prescriptions at their local pharmacies, as well as to increased disclosure requirements for participating plans. Community pharmacists play an integral and active role in health care delivery by providing programs that help patients manage their disease, prevent dangerous drug interactions and educate and counsel on the proper use of their medications. Any prescription drug program will rely heavily on community pharmacists.

Under S. 1, the underlying bill, entities eligible to offer a Medicare prescription drug plan would be required to ensure that beneficiaries have convenient access to community pharmacies in both rural and urban areas. Additionally, no eligible plan would be allowed to offer prescription drug coverage solely through mail order pharmacies.

The Enzi amendment builds on the provisions already included in S. 1 and would ensure that beneficiaries who enroll in prescription drug plans and Medicare Advantage plans that offer mail order benefits would also have the option to fill long-term prescriptions in community pharmacies. This amendment also would provide beneficiaries flexibility, convenience, and increased corporate reporting requirements for Medicare prescription drug plans. This should promote, not stifle, competition and improve choice.

So let's be clear. There are efficiencies inherent in mail order pharmacies and beneficiaries would continue to benefit financially by purchasing drugs through the mail, but this amendment would provide them with yet another choice, another option, as well.

It is certainly my intention to vote for the Enzi-Reed amendment. I am not in a position to say that the chairman is saying that yet, but I suspect he will.

I understand Senator ENZI will speak for a few more minutes.

The PRESIDING OFFICER. The Senator from Wyoming.

Mr. ENZI. I thank the Senator from Oregon for his comments. He has very concisely laid it out, has a tremendous understanding of this amendment and the need for it, and made a fair assumption that it could cost slightly more by going through the local pharmacist. But one of the things we want to do is make sure that local pharmacist is an option.

If beneficiaries getting the prescription drugs order it through the local pharmacy and the cost comes to more than it would be through a mail order firm, then the person receiving the prescription drugs does have to make up that difference in cost.

These four provisions in the amendment will make a tremendous difference to both consumers and to pharmacists. The aim is twofold. It is to have fair prices for consumers and then fair treatment for the local pharmacies. As was mentioned, the two provisions that require fair prices would require the Medicare prescription drug plans and Medicare Advantage organizations to disclose, to the extent that they pass Medicare beneficiaries, any rebates or discounts that they negotiate from drug manufacturers. In other words, if they get a break, the consumer is supposed to get a break. It permits the Government to audit the plans and the organizations' financial statements and records—and it is primarily the records that are important—to ensure compliance to make sure there is not fraud and abuse and to make sure, again, that those reductions get passed through to the consumer. So we want fair prices for consumers.

The consumers and pharmacies do support the first two provisions aimed at ensuring this transparency and accountability on the part of pharmacy benefit managers, PBMs, the companies that will probably win contracts or bids to manage the new drug benefit.

Pharmacies argue that the pharmacy benefit managers, the PBMs, are

squeezing their margins while consumers argue that the PBMs have financial incentives to steer patients to the drugs that make the most profits for the PBMs, even when they may not be the most appropriate drugs for the patients. So that is another reason that not only the fair price but the transparency has to be there.

What are these PBMs, pharmacy benefit managers? PBMs administer prescription drug benefits through contracts with employers, managed health care organizations, and insurance carriers. Today, the top 20 firms manage more than 90 percent of retail prescription drug purchases, and three firms, AdvancePCS, Express Scripts, and Merck-Medco Managed Care, dominate the market.

Large self-insured employers turned to PBMs during the 1990s to administer the popular drug benefit, to manage the costs and utilization trends to ensure appropriate use of drugs and improved quality care. However, the employer frustration over rising costs and questions about appropriateness of drug use are stimulating interest in PBM contractual relationships, especially financial arrangements with drug manufacturers, and the bearing those relationships have on the PBM performance.

PBMs once earned the bulk of their revenue by holding down drug costs for health plans. They now earn a large portion of their revenue from drug companies that pay them undisclosed rebates and other financial incentives for promoting certain medications. For nearly 4 years, the U.S. attorney's office in Philadelphia has been looking into how PBMs negotiate discounts, rebates, and payments from pharmaceutical manufacturers and how the resulting revenues are shared with PBM clients.

So what does the amendment do to answer the concerns? The amendment would give the Government the ability to ensure that the Medicare drug plans administered by PBMs are passing through the fair share of their rebates and discounts on to consumers. It would also clarify the Government's authority to audit the drug plans to confirm the accuracy of the disclosure of the rebates and discounts.

The main thrust of it is to make sure the local pharmacist has a fair shot for the service they provide. I hope everybody remembers when they go to a pharmacist the time he spends explaining how often they take the drugs and what they cannot take before or after, and what they can have with them. They also have an understanding of the other medications that people are taking so that if there is a possibility that there will be an interaction between two medications, they can solve that problem.

Of course, the only way that happens is if a person is working with one pharmacist. If people are calling a whole bunch of different pharmacists, because of privacy laws they do not have access to the interaction of the other drugs that a person is taking.

So that local pharmacist provides a tremendous service, and it is only fair that we include those professionals in the ability to compete in this market, and people can continue to place their trust in the local person that they can see face to face and from whom they can pick up their prescriptions. It is a relatively short amendment, but again it is one that has very strong bipartisan support and one that will fulfill a need. So far as we know, there is very little opposition. So I look forward to having my colleagues support it.

Again, I thank the Senator from Oregon for his comments and this opportunity to present the amendment.

I yield the floor.

Mr. SMITH. I suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. REED. 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. REED. Madam President, I rise in support of the Enzi-Reed pharmacy access amendment.

I compliment my colleague and friend, Senator ENZI from Wyoming. We have worked on several issues with respect to the pharmacy benefits. It has been a pleasure and it has been productive, not only for ourselves but for the professional pharmacy community. Pharmacists are the third largest health care profession in the country in terms of numbers of practitioners, and they are becoming increasingly more central to our health care system.

This amendment is designed to accomplish two very important objectives with respect to the proposed Medicare pharmacy benefit for seniors. First, its aim is to assure transparency and accountability in the collection and dissemination of negotiated savings by Medicare prescription drug benefit plans and Medicare Advantage plans. Second, it is designed to guarantee Medicare beneficiaries access to community pharmacies when filling prescriptions of 90 days or longer. Without the Enzi-Reed amendment, these protections, these safeguards, these essential elements would not be present in the bill we are considering today.

This language is very similar to proposed language included in the counterpart legislation being deliberated in the other body. If we are to rely upon private companies to negotiate and administer a benefit on behalf of the Federal Government as well as on behalf of tens of millions of elderly and disabled beneficiaries, we need to be sure these entities operate with the best interests of these parties in mind and not simply and exclusively their bottom line. Through this amendment, plans will be required to disclose to the Government the extent to which they pass on to Medicare beneficiaries rebates, discounts, and any other savings negotiated from the drug manufacturers.

We all recognize one of the essential elements of this legislation is the notion that private pharmacy benefit management companies will negotiate with pharmacies and manufacturers to get the best possible price. We hope that best possible price is passed on almost entirely to the beneficiaries and to the payers, which include the Federal Government. It would be ironic, indeed, if we establish a system in which the intermediaries gained huge profits, while the Government and beneficiaries continue to pay substantial sums for the pharmaceutical benefits.

By requiring disclosure of negotiated savings by drug plan administrators, we guarantee a greater degree of transparency and make sure beneficiaries are getting the best possible savings on their prescription drugs. The essence of the Enzi-Reed amendment is let the markets operate, but make sure everyone has complete information about who is reaping the benefits of these negotiated transactions between purchasers and suppliers of these pharmaceuticals.

Since beneficiaries are expected to pay anywhere between 50 percent and 100 percent of the cost of drugs—those individuals in the gap would be paying 100 percent of the cost of drugs—we have to make sure they are getting the best possible deal. This amendment will go a long way towards ensuring that actually happens.

If the PBMs do not pass these benefits and negotiated savings along to the public and the Federal Government, then we all should know. This amendment will ensure that level of accountability.

Second, the Enzi-Reed amendment allows beneficiaries to receive 90-day prescriptions and other related benefits through community pharmacies. Senator ENZI represents the great State of Wyoming in which a pharmacy—I am sure in some of the smaller communities—might be the only source of pharmaceutical supplies and medical advice and many other things. Pharmacies are an important part of the fabric of a community. To deny seniors the right to get their pharmaceutical supplies from these pharmacies would not only be wrong but inefficient. If that is where they would like to get their prescriptions, they would be assured they can get the benefit through the local pharmacy under this amendment.

Rhode Island is a little different from Wyoming, but pharmacies in Rhode Island have the same role in the lives of seniors, particularly in terms of getting their benefits and other important health care services. This amendment would allow beneficiaries to obtain 90-day supplies through the community pharmacist, wherever they are.

This does not exclude mail order, but it simply makes sure it is not the only option that seniors have; that they can continue to rely upon the local pharmacy for their benefits.

I should say something else. Not only is the local pharmacy a source of pharmaceuticals, it is usually an excellent source of advice and assistance by trained pharmacists. Increasingly, these pharmacists are taking on a very important role in advising seniors, within the limits of their practice, as to the appropriate use of pharmaceuticals and are also a source of advice on many other health care issues. So I hope my colleagues would agree that we should encourage the use of local pharmacies. This amendment will help do that.

I again commend Senator ENZI for his work and leadership on this issue. We share a common belief that professional pharmacy is a critical part of our health care system. If we allow pharmacists to operate, we will get the benefit of their expertise, and it will redound to the health needs of our seniors and to the financial responsibilities that we face in enacting this legislation.

I urge all my colleagues to support this amendment.

I yield the floor.

Mr. ENZI. Madam President, I thank the Senator from Rhode Island, Mr. REED, for his efforts on this bill and the efforts on all the other ones we worked on together over the years. We came to the Senate at the same time and served on the Health, Education, Pensions and Labor Committee since that time. I think we have been able to reach some reasonable solutions before, and we will have yet another one here. I appreciate his comments and his work.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill clerk proceeded to call the roll.

Mr. REID. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

Under the previous order, there are 5 minutes evenly divided before the vote on the Stabenow amendment.

Who yields time?

The Senator from Michigan.

Ms. STABENOW. Madam President, I appreciate those who are cosponsoring my amendment and have joined with me. I ask unanimous consent that Senator LIEBERMAN's name be added as a cosponsor to the amendment.

The PRESIDING OFFICER. Without objection, it is so ordered.

Ms. STABENOW. This amendment is very simple and very straightforward. What we are saying is, seniors ought to have every possible choice for their prescription drugs, and one of those choices should be under traditional Medicare.

Today, 89 percent of seniors and those with disabilities in our country are under the traditional Medicare insurance plan; only 11 percent are not. We want to make sure, in this amendment, those seniors who are under traditional Medicare—choosing their own doctor, having the confidence to know that regardless of where they live they will have the same premium, the same cost, the same benefit, the dependability of Medicare—that they, in fact, will be able to choose traditional Medicare.

Under every cost estimate we have looked at, in terms of administrative costs, the growth in programs, other kinds of costs, Medicare has always come out less expensive than the private plans that have been compared to it. So, in fact, this does not cost more money, it costs less.

In our proposal, we stay within the $400 billion parameters by allowing the Secretary of HHS to actually modify the plan to stay within the $400 billion in the budget resolution. This is no additional cost. This is a question of choice and making sure seniors who, overwhelmingly, choose to stay in traditional Medicare have the opportunity to do so. I ask my colleagues to join with us in creating true choice for our seniors.

Madam President, I reserve the remainder of my time.

The PRESIDING OFFICER. The Senator from Oregon.

Mr. SMITH. Madam President, it is my understanding that CBO has evaluated the information just provided them by the Senator from Michigan, and they are standing by their opinion that her amendment will cost an additional $50 billion over 10 years. So while the Stabenow amendment does violate the budget, which allocates $400 billion, it is my understanding the leadership on this side does not want to raise a point of order and would like to take this vote just straight up on its merits.

The provisions of this bill offer Senators a choice between a new way or the old way. I ask my colleagues: Do you want to go the way of Government price control in which you put a bureaucrat between you and your medicine cabinet regardless of Medicare's terrible experience in evaluating market prices on prescription drugs? If you believe this is the way Medicare's future is best provided, then you should vote for the Stabenow amendment.

If you want to try a new way, if you want to see if the marketplace actually works to provide more choices, more cost control, and even better quality and innovation, then you should vote with the bipartisan agreement that has the support of, I believe, a majority of Senators.

This bill presents a choice between the past and the future, between Government, central planning, price controls, and a marketplace that can evolve. But that marketplace will not evolve if Government comes in and says, on a permanent basis: we are going to be the other choice. I can promise you capital will not follow, and there will be no marketplace developed.

I think seniors of this country are due a prescription drugs package that can pass and that the President will sign. The President is not going to sign a Medicare and Prescription Drugs bill that comprises the Stabenow amendment.

I yield the floor.

The PRESIDING OFFICER. The Senator from Michigan.

Ms. STABENOW. Madam President, prior to 1965, seniors had to go to private insurance companies to get their health care. Half could not find or afford private health care. That is why we created Medicare.

Now we are looking at the opportunity to keep that choice for seniors, plus the opportunity to expand. If they want to be in an HMO, if they want to be in a PPO, they can find insurance in their community. That is terrific. That is their choice. But those who have chosen Medicare deserve the right to pick that choice.

The PRESIDING OFFICER. The Senator's time has expired.

The Senator from Oregon.

Mr. SMITH. Madam President, have the yeas and nays been ordered?

The PRESIDING OFFICER. They have not.

Mr. SMITH. 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 amendment No. 931.

The clerk will call the roll.

The legislative clerk called the roll.

Mr. REID. I announce that the Senator from North Carolina (Mr. EDWARDS), the Senator from Hawaii (Mr. INOUYE), the Senator from Massachusetts (Mr. KERRY), and the Senator from Connecticut (Mr. LIEBERMAN), are necessarily absent.

I also announce that the Senator from Massachusetts (Mr. KENNEDY) is absent attending a funeral.

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—yeas 37, nays 58, as follows:

[Rollcall Vote No. 227 Leg.]

YEAS—37

Akaka	Dayton	Lautenberg
Bayh	Dodd	Leahy
Biden	Dorgan	Levin
Bingaman	Durbin	Lincoln
Boxer	Feingold	Mikulski
Byrd	Feinstein	Murray
Cantwell	Graham (FL)	Nelson (FL)
Clinton	Harkin	Pryor
Conrad	Hollings	Reed
Corzine	Johnson	
Daschle	Kohl	

Reid	Sarbanes	Stabenow
Rockefeller	Schumer	Wyden

NAYS—58

Alexander	DeWine	McConnell
Allard	Dole	Miller
Allen	Domenici	Murkowski
Baucus	Ensign	Nelson (NE)
Bennett	Enzi	Nickles
Bond	Fitzgerald	Roberts
Breaux	Frist	Santorum
Brownback	Graham (SC)	Sessions
Bunning	Grassley	Shelby
Burns	Gregg	Smith
Campbell	Hagel	Snowe
Carper	Hatch	Specter
Chafee	Hutchison	Stevens
Chambliss	Inhofe	Sununu
Cochran	Jeffords	Talent
Coleman	Kyl	Thomas
Collins	Landrieu	Voinovich
Cornyn	Lott	Warner
Craig	Lugar	
Crapo	McCain	

NOT VOTING—5

Edwards	Kennedy	Lieberman
Inouye	Kerry	

The amendment (No. 931) was rejected.

Mr. SMITH. I move to reconsider the vote.

Mr. BAUCUS. I move to lay that motion on the table.

The motion to lay on the table was agreed to.

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. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER (Mr. GRAHAM of South Carolina). Without objection, it is so ordered.

Mr. BAUCUS. Mr. President, we are now on the Enzi amendment. I ask unanimous consent that the Enzi amendment be temporarily set aside so that at 4:20 the Senate can proceed to an amendment offered by the Senator from New Mexico, Mr. BINGAMAN.

The PRESIDING OFFICER. Is there objection?

Without objection, it is so ordered.

Mr. BAUCUS. I also ask that there be 30 minutes on that amendment equally divided in the usual form.

The PRESIDING OFFICER. Is there objection?

Mr. BAUCUS. Mr. President, I withdraw the second request. So the only request pending, which I think the Chair has ruled on favorably, is that we go to the Bingaman amendment at 4:20.

The PRESIDING OFFICER. That is correct.

Mr. BAUCUS. I thank the Chair.

Mr. President, pending 4:20, when the Senator from New Mexico will offer his amendment, I rise to speak about the rural provisions in the Medicare bill.

This bill has a lot of provisions to help rural America. I am very proud of these provisions. I also wish to compliment the chairman of the committee, Senator GRASSLEY. Over the last year, he and I have jointly co-authored legislation to address the imbalance in Medicare payments that exists between rural and urban areas of our country. For many rural areas of our country, providing health care services is very challenging given Medicare's current payment rates.

In rural America, Medicare often dominates. That is, most hospitals, doctors and other health care providers receive the lion's share of their reimbursements from Medicare. I know that in many communities in Montana, particularly the smallest communities, Medicare accounts for over more than 50 percent of hospitals total reimbursements. This share is also as high in some larger towns, but certainly more the case in smaller towns.

Rural hospitals are often the major employer in their communities. It is what makes the small town tick. If it were not for the rural hospital, the population in those towns would deteriorate. I have seen that happen in a good number of communities in Montana, where the hospital—fewer than 20 beds in many cases—is the major employer in the town.

Once Medicare payments start to decline significantly, as is the case in many areas, that smalltown hospital has to close up, or converts to what is called a critical access facility and is no longer the full service hospital it was. So it is very important that rural America be adequately reimbursed under Medicare.

In addition to Medicare reimbursements, I believe we have also provided assistance to rural areas with respect to our proposed drug benefit. I believe that the drug benefit outlined in this bill will work for rural America. For example, if private drug-only plans do not materialize, our bill provides for a hard and fast fallback, a Government guarantee for rural seniors. This guarantee is important because many rural States have had an unfortunate experience with Medicare+Choice, the program that currently allows private health plans to participate in Medicare. But because there are so few people in rural America, HMOs and other Medicare+Choice plans, have found it too difficult to operate and have withdrawn.

I do not have the figures with me off the top of my head, but there are thousands of people in rural areas who once had access to a Medicare+Choice plan but no longer have that opportunity because the areas are just so sparsely populated for health plans to work. That is a real concern with respect to the prescription drug benefit we are providing in this bill; namely, will private drug plans, in addition to the preferred provider organizations, want to offer prescription drug benefits in rural America or not? It is a big question, and it is an unanswered question.

We hope they do want to come in and participate. We hope private plans that currently do not now exist will, under the provisions of this bill, when it goes into effect in a few years, want to provide prescription drug benefits for seniors. We hope that many plans want to come in and compete with each other to help reduce costs.

There is no great assurance that these private plans will reduce costs. If one looks at the HMOs, they currently are paid at a higher rate than what Medicare pays for beneficaries in the fee-for-service program. Some can make a strong argument that these private plans are going to cost more. The theory is that competition will allow them to bring down costs and provide the same benefits for seniors. So it is an unanswered question. People just do not know the degree to which these private plans are going to work. Therein lies the question: What about those parts of America where private plans do not participate? What about those seniors? How can we assure that they are going to get prescription drug benefits? The bill before us tries to address that.

The bill addresses this question by providing for a guaranteed fallback plan. In those parts of the country where there are not two or more competing private drug plans, government-backed fallback plan is guaranteed. Seniors will be able to get the prescription drug benefits under pharmacy benefit manager (PMB), or similar organization that is not required to bear insurance risk. It will only be required to bear performance risk for the administrative costs of providing the benefit. The fallback plan will not bear insurance risk as required of the private drug plans.

The purpose of the fallback plan is to make sure that rural America—in fact, any part of America where there are not two private plans—is served fairly by this prescription drug program.

As I mentioned, the bill includes many provisions to address the current imbalance in Medicare reimbursements between urban and rural America. One provision would correct differences in the standardized amount rate for inpatient hospitals. The standardized amount is higher for urban hospitals than for rural hospitals. The provision says that Medicare should pay the same across the board. Clearly, there will be other adjustments that affect different circumstances and different parts of the country, but the standardized amount would be the same rate for both urban and rural hospitals. That is extremely important to many hospitals in rural areas.

Last year's appropriations bill equalized the standardized amount for a 6-month period. This bill makes that permanent. It is a change that the Medicare Payment Advisory Commission, or MedPAC, has recommended that Congress make. This bill this and other MedPAC recommendations to heart by saying, You are the experts, you know better what is going on than anyone else.

This bill contains a couple of other important MedPAC recommendations. For example, it raises the Medicare disproportionate share threshold for rural hospitals. The Medicare DSH program says if you are a hospital and

have a disproportionate number of people under Medicare who are low income, you should receive extra assistance under Medicare. Our bill raises that threshold for rural hospitals a little higher.

The bill also adjusts payments for hospitals with very low patient volume. We know volume is a big component of whether a hospital is able to make ends meet.

The bill extends the rural home health add-on payment at a level of 5 percent. Home health care is extremely important in rural America.

This bill includes other provisions that not necessarily rural specific. For example, the legislation increases payments to dialysis providers, including those in urban areas, for a 2-year period.

The bill provides desperately needed assistance to urban hospitals that provide a disproportionate share of services to low income individuals. These hospitals are struggling with growing pressures of more uninsured and low income patients. It is not fair for those hospitals that have to bear these costs. They have to provide charity care. In fact, in many respects under the law they are required to. This gives them a bit of a break with these burdens and their nursing shortages

The bill provides much-needed regulatory relief for both rural and urban hospitals. We have heard from doctors and hospitals that say the carriers and fiscal intermediaries are too heavy-handed; they assume physicians and providers are guilty when they question reimbursement, instead of assuming we are innocent. The regulatory relief measures in this bill address this concern. These provisions are significant and go a long way to assure providers spend less time on paperwork burdens and more time with their patients.

Some may say that this bill does not go far enough to relieve these burdens. A lot of doctors and hospitals administrators will say: Gee, why all this Medicare paperwork? We want to spend time with our patients. Nevertheless, the regulatory provisions of this bill will reduce paperwork and unnecessary regulation.

I realize there are a number of provider provisions—with respect to doctors and hospitals and other providers—that are not addressed in this bill. These provisions include payments under the Medicare physician fee schedule, which will be cut in 2004 through 2007 unless further congressional action despite an additional $54 billion in the bill we passed earlier this year. We recognize the need to address these impending cuts in the future. Physician's fees are projected to drop significantly. We cannot address that in this bill. We do not have the money. That is a problem we will have to face in 2004. I alert Senators, that will be expensive. We will have to deal with it.

There are also Senators who want to address what is called IME, or indirect medical education. This is the special payment adjustor under Medicare for teaching hospitals. It is now currently reduced to its lowest level ever. That is, teaching hospitals are receiving less to help train physicians across the country. That is a concern many have. We are going to try to deal with that as best we can as this bill progresses.

Nursing home payments are not addressed. Many Senators have talked about addressing some of the problems facing nursing homes. They, too, experienced a sharp reduction in payments over in 2003. This list of payment provisions is not limited. There are several other provider provisions about which many Senators have raised concerns.

Our ability to deal with these additional issues is limited. Why? Because this is a $400 billion Medicare package. The fact remains, this is a package of relatively sparse drug benefits. Yes, $400 billion sounds like a lot of money, and it is. But $400 billion extended over 10 years, means that we have to carefully consider what the amounts should be for the deductible, copayments, and the premiums. The numbers are OK, but they are not great.

I don't want to oversell this bill or over promise. This legislation is a step in the right direction. This is a good first chapter. It is a start in providing prescription drug benefits for seniors. We only have $400 billion so we have not been able to address these other provisions. We would like to. We would like to find a way to deal with them. But at this time, the dollars are simply not there.

I might add, we will do what we can in future days, weeks, and months to try to address these concerns.

I know the chairman of the committee, Senator GRASSLEY, wants to work with our colleagues to address these provisions and also provide a fair deal for rural, as well as urban, folks in America. We want to address future geographic inequities with respect to the drug benefit. The fact is, rural States are very concerned if we enact this prescription drug benefit, are going to come out on the short end of the stick. More federal money will end up going to go to urban seniors. That will cause a great problem.

At the same time, seniors in urban areas are afraid the money will go to the rural areas, that the urban cities will end up on short end of the stick. The fact is, we do not know how it will work. We just don't know. Senator SNOWE offered an amendment in the Finance Committee for a study to address possible geographic inequities in drug spending across the country. She later amended it, made it a little stronger, to say that HHS will have the discretion to address any geographic inequities. There may be an amendment on the floor to require the HHS Secretary to address the inequities.

It is a point about which we are all very sensitive. We are trying to find a way to make this geographic adjustment process work. Geographic adjustment for drug spending has never been tried before. It is uncharted territory. We just don't know. It probably makes sense the Secretary have discretion.

That is a short summary of some of the rural provisions in the bill. I see the Senator from Texas is on the Senate floor. Does the Senator from Texas wish to speak at this point?

I yield the floor.

The PRESIDING OFFICER. The Senator from Texas.

Mr. CORNYN. Mr. President, I appreciate the Senator from Montana giving me a chance to say just a few words.

May I inquire, my understanding was Senator BINGAMAN was going to be coming at 4:20 under a previous agreement to speak, but there also was a possibility I might be allowed to continue a while longer, perhaps 20 minutes.

The PRESIDING OFFICER. Is there objection to the modification of the agreement?

Mr. BINGAMAN. Mr. President, I have no objection to the request of the Senator from Texas who asked if he could be allowed to speak for 15 or 20 minutes before we begin my amendment. If that is not a problem for the manager of the bill, I have no objection.

The PRESIDING OFFICER. Without objection, it is so ordered.

Mr. CORNYN. I express my appreciation to the managers of the bill and Senator BINGAMAN for his courtesy.

This is obviously a critical issue that confronts the Senate, one this body has talked about for a long time. It appears we are on the precipice of actually delivering what many of us have campaigned on, on both sides of the aisle, in previous elections.

Medicare has been a successful program for the last 30 years, and it has served our seniors well. But it faces major challenges. Obviously, we are all interested in strengthening Medicare so it will continue to be a program that will serve our children and grandchildren as it has our parents and grandparents. Medicare was created in 1965 and reflects the state of health care in that year. While the world has changed and medicine has changed, Medicare has not changed. It is time to improve and strengthen Medicare so it can serve the needs of Americans of this generation and the next, and can also be within our fiscal constraints.

Medicare is stuck in 1965, and so are its beneficiaries. Medicare's promise falls far short when its recipients suffer from outdated and inadequate benefits, limited protection against rising medical costs, or a stodgy Government plan that cannot deliver responsive medical services or ensure high-quality health care.

While health insurance has followed the demands of the free market, Medicare still lacks catastrophic protection or full coverage of many preventive benefits in a comprehensive outpatient prescription drug benefit.

One of the critical improvements included in this bill is immediate assistance, in the form of prescription drug

coverage, for those seniors who cannot currently obtain it or who do so only at great economic hardship and great personal hardship. I have supported the principle of a prescription drug benefit from day 1 for the seniors who need it. I am proud to reiterate my support here today.

Having said that, I have significant concerns about the legislation that is before this body—some aspects of it, significant aspects of it. While a prescription drug benefit and expanded treatment choices will help America's seniors, this bill falls substantially short of President Bush's framework for reform. If we endorse this legislation without real and meaningful reform, we rush to satisfy political interests rather than take the time to form sound policy, and we do a great disservice to the Medicare beneficiaries who depend on this coverage, to our constituencies, and to the future generations who will have the financial burden to pay for it. Ultimately, if we do not take care, we could do more harm than good.

According to estimates of the Congressional Budget Office, this plan will have unintended ramifications for Americans. It will force nearly 40 percent of retired Americans who currently have prescription drug benefits under private plans onto taxpayer-paid plans that would be provided under this bill. The CBO, the Congressional Budget Office, predicts that only 2 percent of seniors will actually choose the only vehicle for reform provided for under this bill, that of the preferred provider organizations, the PPOs, while the rest will remain in Medicare basically as it currently exists with a prescription drug benefit added, hardly what we could call true reform.

We should not fool ourselves. What we are actually providing seniors under Medicare, and through this bill, is actually very different from what Members of Congress receive. Under the Federal Employees Health Benefits Plan, all of us in this body, along with 10 million Federal employees, can enroll in a number of flexible preferred provider organizations. The plans we can choose as Federal employees do not have restrictive price caps, and they provide for more choice. As a result, those of us who work for the Federal Government can obtain better coverage and treatment than the vast majority of our constituents. This disparity, I believe, should not be tolerated under this plan, especially one that charges under the banner of reform.

Price controls are a recipe for long-term disaster. The best determiner of price in a product is the free market, not government bureaucrats sitting in darkened cubicles wearing green eyeshades. My other concern is that this purports to be a universal entitlement, based on nothing like what we have talked about in many of our campaigns, which is actually need. It will provide a prescription drug benefit to millionaires, including Members of this body who just do not need it. I question the morality of any proposal that would take the hard-earned money out of the pockets of truck drivers, schoolteachers, police officers, small business men and women and single moms, to subsidize a prescription drug benefit for people who are well to do.

When it comes to health care, I believe the proper role of government is to protect the freedom of all people to act as they see fit to maintain and improve their health care. Today, millions of Americans suffer from chronic diseases that are for the most part preventable. Our Nation spends about $1.4 trillion a year on health care—more than any other country in the world—and chronic diseases account for roughly 75 percent of those health care costs. Preventing disease before it happens is better, more humane, and less expensive than curing disease after it manifests itself, and prevention can lead to a far better quality of life. If Medicare is to adapt to the demands of a new populace, it must become a system refocused on the importance of preventive care.

I strongly believe that real positive change in our Medicare system must begin with the foundation of individual responsibility and the choices that can only be provided by the free market—not by a government mandate.

We must not offer up a short-term legislative answer that plays politics with people's health and the needs of future beneficiaries. We should not tinker only around the edges and call it reform.

As we work over this week and next to produce a solution to this challenge that lies before us, we cannot allow ourselves to believe our striving will fail, and we must not convince ourselves we have already succeeded.

In conclusion, let me say it is my most ardent hope that this bill, which I know was produced by great effort of the staff and on a bipartisan basis by the Senate Finance Committee, can be improved and that the improvement will allow us to make sure the benefit is targeted to those seniors who actually need the help and not millionaires, thereby having the wealth transferred out of the pockets of hard-working Americans to pay for a prescription drug benefit for millionaires and others who are well to do.

Second, let us make sure we don't crowd out private dollars that are currently paying for prescription drug benefits for many retired persons which they have negotiated under the terms of their retirement or pension plan. Right now up to 40 percent of those dollars will be chased off and the Federal Government—in other words, the taxpayer—will step forward and fill that gap. That is something we should not allow.

Third, if this is truly going to be reform, it has to be something more than business as usual.

What concerns me quite a bit is on the one hand the OMB estimates that some 40 percent of seniors will opt for the true vehicle for reform—the PPOs, the preferred provider organizations—but, on the other hand, another agency of the Federal Government, the Congressional Budget Office, says No, it won't be 43 percent. It won't be 40 percent. It will be 2 percent.

In other words, if the Congressional Budget Office is right, we will not have accomplished what the President has asked us to do and what many in this institution believe is so important; that is, true reform.

It is my hope and prayer we will be able to make the necessary adjustments to this very good start. But there are some very grave concerns that I and others have about the bill as it currently exists.

In a tight budget, I hope we do not vote for what is by most conservative estimates a $400 billion new entitlement on top of $2.2 trillion the Federal Government commits to nondiscretionary entitlement spending each year, unless we make sure it is absolutely necessary and targeted to those who need it most, and that it does not supplant other private insurance and other measures designed to provide prescription drug coverage for our seniors.

I yield the floor.

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. BINGAMAN. Mr. 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. 933

Mr. BINGAMAN. Mr. President, I send an amendment to the desk.

The PRESIDING OFFICER. The clerk will report.

The assistant legislative clerk read as follows:

The Senator from New Mexico [Mr. BINGAMAN] proposes an amendment numbered 933.

Mr. BINGAMAN. 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 eliminate the application of an asset test for purposes of eligibility for premium and cost-sharing subsidies for low-income beneficiaries)

On page 120, between lines 16 and 17, insert the following:

''(I) ELIMINATION OF APPLICATION OF ASSET TEST.—With respect to eligibility determinations for premium and cost-sharing subsidies under this section made on or after October 1, 2008, such determinations shall be made without regard to subparagraph (C) of section 1905(p)(1) (to the extent a State, as of such date, has not already eliminated the application of such subparagraph).

Mr. BINGAMAN. Mr. President, this is a very straightforward, simple amendment that deals with a problem that is buried in this legislation and

which really needs to be dealt with. That is the so-called assets test. My amendment would eliminate the assets test beginning in the year 2009.

The first obvious question everyone should be asking is, What is the assets test? The assets test is as follows: The bill provides a more generous set of benefits for low-income individuals and low-income couples. That is as we intend.

I think all Members of the Senate recognize that those who have the least in the way of income really need the most help in paying for their prescription drugs, particularly when you are dealing with seniors who are not, in most cases, out in the workplace able to increase their income. We believe the proper, the humane, and the compassionate thing is to provide this greater level of subsidy for low-income individuals.

In particular, we look at those individuals with incomes up to 160 percent of poverty. That is the figure we have in this legislation. That translates into, I believe, what we are talking about. A couple with an income of perhaps $17,000 or $18,000 a year would qualify, and if they had any more income than that they would not qualify for this higher level of subsidy.

The bill also provides that if a low-income individual has as much as $4,000 in assets, that individual is not entitled to that subsidy in the same way others would be.

For example, if you have a 70 or 75-year-old widow who is receiving $5,000 a year in income or $6,000 a year or $8,000 in income and that widow also has $1,000 in U.S. savings bonds, and a car that has a blue book value of $3,100, then that widow is not entitled to the full benefit unless and until she goes out and either sells the savings bonds or sells the car or somehow or other impoverishes herself to be able to demonstrate she does not have assets worth $4,000.'

This is a test that was put in the law many years ago. It is one that adds great complexity to the law. In fact, a major effect of this assets test is to discourage a great many low-income individuals from even applying for the increased benefit that is provided for in this legislation because the requirements for reporting, filling out forms, getting blue book values on your automobile—these are complicated requirements that discourage people from applying across the board.

I also point out that under this assets test, not only is it $4,000 for an individual—so if you have $4,000 worth of income, of assets, as a widow, you fail the assets test—but if you are married, it is then $6,000. A lot of the Members of this Senate and the Congress have given speeches about what a terrible thing the marriage penalty is. Here is another marriage penalty that is in the law we are dealing with today. This is a penalty which says, if you get married, your ability to hold on to assets and still get this full benefit is reduced. You cannot hold on to as many assets. You can only hold on to $6,000 as a couple whereas you could hold on to $4,000 as an individual.

In my view, the justification for this assets test has long since gone away. The reality is, if people are unable to work, as most seniors are, unable to increase their income, if they are low-income individuals, and if they have very substantial prescription drug costs, they need the assistance we are providing in this legislation—or trying to provide in this legislation—and we should not take that away from them by virtue of their having $4,000 worth of assets as an individual or $6,000 worth of assets as a couple.

Let me elaborate on this a little bit more. There are about 40 million seniors and people with disabilities who depend on Medicare who could benefit from this prescription drug coverage we are talking about in this bill, and this assistance is particularly critical for those low-income individuals. Here we are talking about 14 million beneficiaries who have incomes less than 160 percent of poverty. Many of those individuals are in the State the Presiding Officer represents. Many of those individuals are in my State of New Mexico.

The bill provides a significant benefit to those low-income seniors and individuals with disabilities, but it does so only if they do not fail the assets test. I do not know the exact figures, but the Congressional Budget Office estimate is that 21 percent of Medicare beneficiaries who would otherwise qualify for this low-income benefit in fact will be denied that full benefit because they fail the assets test.

In fact, for those below 100 percent of poverty, if they fail the assets test, their cost sharing is increased, under this bill, by 400 percent. For those between 100 and 135 percent of poverty, the assets test causes their cost sharing to increase by 200 percent.

I believe strongly that in the year 2009—which is what I have in my amendment—we should eliminate the assets test. I would propose we do it earlier, frankly, but I am informed that the Budget Committee has calculated the cost of the bill in such a way that there is no funding available for us to do anything such as eliminate the assets test before the year 2009. So I have crafted the amendment so that it would become effective in the year 2009.

In addition to protecting low-income beneficiaries below 135 percent of poverty from much higher costs, much higher copays due to this assets test, it should also be noted that the assets test significantly increases the paperwork burden on seniors and on individuals with disabilities.

While the underlying bill provides physicians and other health providers with regulatory relief—and that is one of the things we keep talking about when we try to describe the benefits in this bill—I fear the bill will significantly complicate the ability of Medicare beneficiaries to receive prescription drug coverage, particularly low-income individuals. They may need—I said this in the committee during our markup, and I believe it is not a totally facetious statement—they may need an accountant or a lawyer just to figure out the paperwork having to do with this assets test and how they can access these benefits.

We should not be putting people to the choice of selling their car or liquidating their U.S. savings bonds in order to get the benefits of this bill. There are a great many low-income individuals who have very high prescription drug costs. That is a very unfortunate fact but one we are trying to come to grips with here.

Under the bill, if they fail the assets test, their copay requirement is 10 percent up until they hit the so-called doughnut portion of the bill, which means essentially $4,000 of prescription drug expense in any given year; and then for the next $1,500 or $1,800 beyond that, they pay a 20-percent copay. If you have high prescription drug costs, a 20-percent copay is substantial. If you have high prescription drug costs, even a 10-percent copay can be substantial if your income is extremely low. And that is the group we are talking about here.

So, Mr. President, I hope my colleagues will support the amendment. It is done in a responsible way. It is not drafted in such a way that it would take effect immediately. It takes effect in the year 2009, when we are advised by the Budget Committee funds will be available to pay to eliminate this assets test. It clearly is the right thing to do. It is the humane thing to do if, in fact, we are serious about helping low-income seniors deal with this very substantial burden. We should adopt this amendment and eliminate the assets test as soon as we can afford to do so. And the Budget Committee tells me that is in fiscal year 2009.

So I hope very much colleagues will support the amendment.

Mr. SPECTER. Mr. President, I have sought recognition to express my support for increased funding for rural hospitals. Pennsylvania is a geographically and demographically diverse State, and the health care needs of the communities across the Commonwealth differ significantly. But there is one constant—access to appropriate health care is critical, and if we are not prudent in making wise health care policy decisions now, we may jeopardize our citizens' ability to get the right care, in the right setting, at the right time.

We must be aware of the pressures and challenges that constantly weaken the foundation of the health care system—the medical liability insurance crisis, inadequate State and Federal reimbursements, workforce shortages, growing uncompensated care costs, rising costs of technology and pharmaceuticals, bioterrorism planning and

training, and a growing elderly population. As we look at restructuring a segment of the Medicare Program, we have the opportunity to strengthen that foundation. Improving our prescription drug benefits will not help the senior citizens of this country if health care providers cannot meet their needs.

We must also remember that our actions here in the Senate and by our colleagues in the House have implications not only for the quality and stability of our health care system but for our economic health as well. A recent study completed by the Penn State Cooperative Extension and the Pennsylvania Office of Rural Health shows that the State's hospitals are the largest component of the health services sector, generating more than $33.9 billion to the State's economy. This includes 260,000 full- and part-time jobs, a payroll exceeding $9.3 billion, and a ripple effect that provides another 179,400 jobs and $5.4 billion in additional employee compensation. In many counties, the hospital is the No. 1 employer. Furthermore, the State's research hospitals have been identified as an integral component of biotechnology clusters, serving as an engine of growth in the new economy.

Given all of these dynamics, we must support a legislative plan that adequately funds hospital and health systems. This plan must recognize that our rural communities face a unique set of challenges because they are often the only provider of health care in a vast geographic region and they have greater difficulty recruiting health care workers and physicians in today's health care climate. Such a plan should also include two major rural provisions dealing with the standardized rate amount and a change in the labor component to 62 percent. The standardized rate amount will allow rural hospitals to receive a Medicare standardized payment rate equal to the higher rate paid to urban areas. The adjustment of the labor component from 71 percent to 62 percent for rural hospitals will allow rural hospitals, which traditionally have low labor costs, to base a larger portion of their Medicare reimbursement on nonlabor provisions, thereby receiving a higher reimbursement from Medicare.

I urge my colleagues to join in making sound health care policy decisions to ensure we are strengthening the foundation of our health care delivery system in those areas in which it is most vulnerable.

I yield the floor and suggest the absence of a quorum.

The PRESIDING OFFICER. The clerk will call the roll.

The bill 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. Without objection, it is so ordered.

Mr. FRIST. Mr. President, I wish to take a few minutes to address the Prescription Drug and Medicare Improvement Act of 2003 in a very basic way, and that is to answer some of the questions I have received over the last several days since we have captured much of the attention both of the media as well as constituents around the country who realize we really are going to pass very significant, very important legislation that will affect their lives, that will affect the lives of seniors, individuals with disabilities, and that will affect the lives of future generations. And this will happen in the next 12 to 13 days.

It goes back to the question of, Do we really need to change? Are things really that different that they demand the sort of response we are putting forward where we talk about strengthening and improving the Medicare Program overall and at the same time providing prescription drug coverage for seniors and individuals with disabilities that is not being provided today, and do it in a way that can be sustained over time, recognizing that we will have a huge demographic shift of seniors over the next 30 years as a product of the baby boom following World War II. That fertility curve, that baby boom moving through the system begins to hit about 2007, 2008. That is when the curve moves through.

For the next 25 years after that, we will see this huge explosive growth in the number of seniors with fewer and fewer workers actually paying into the system.

We have now been on the bill Monday, Tuesday, and Wednesday, after having over 30 hearings on Medicare over the last several years and several hearings this year specifically on prescription drugs and Medicare modernization in the Finance Committee. We have done it in a very systematic way, in a bipartisan way that I think captures the very best of what this institution is all about, recognizing that we do not know all of the answers, we cannot cure all of the problems.

We have to be very careful not to overpromise because everybody wants as much health care resources as possible, so we cannot overpromise. As I say, we need to reform the system in a way that does not just respond to the needs of today but responds to the next year, 5 years from now and 10 years from now. Since we cannot do it perfectly now, we have to do it in a way so that the system is flexible and allows us to adapt appropriately.

Working on a bipartisan basis, the goal is to deliver a secure Medicare Program that is comprehensive and, at the same time, offers maximum choice with that increased flexibility and that much-needed prescription drug coverage which seniors do not have today through the Medicare Program.

I look forward to the continued debate over the next 10, 11 days on how we collectively determine how best to accomplish those goals. I am confident we will be able to cull the very best ideas from both sides of the aisle to pass a responsible and effective plan.

As I mentioned, I want to limit my comments today to about how medicine, science, and health care delivery has evolved and, indeed, how that evolution, which has been very rapid in terms of breakthroughs in science, which I have been privileged to watch and participate in as I was in the field of medicine for 20 years before coming to the Senate—it has been miraculous in so many ways. When I close my eyes, I see my patients with artificial hearts I had the privilege of implanting, and with the heart transplants I was blessed to do on a weekly basis or even more often. I was involved in not the whole period since 1965 when Medicare began, but shortly thereafter, I was in the active practice of clinical medicine over that period of time.

If we just look at the last 10 years, life expectancy has increased by around 2 to 3 years, and if we look at the last 40 years, going back to about 1960, life expectancy increased 10 years in that period of time since Medicare was begun.

Death rates from heart disease have been cut in about half over the period since Medicare began. Heart disease happens to be the field in which I specialized.

If we look at the field of cancer, whether it is prostate cancer, breast cancer, or colon cancer, because of new treatments, new medicines, and new diagnostic tools, we have seen markedly increased patient survival rates. At the same time, we have seen these great medical breakthroughs in the health care delivery system, the private health care delivery system—not Medicare—but the private health care delivery system has evolved and has responded.

The problem is that the underlying Medicare system itself has not evolved. In fact, there has been very little change in the Medicare system since 1965. So we have all these great medical advances and advances in health care delivery over time which has skyrocketed, with improved advances throughout, but we have a Medicare system that has changed very little. It is this gap, this difference between the great breakthroughs in medicine, science, and health care delivery and the pretty much nonchanging Medicare system. That gap is what we are attempting to fill, to respond to as we go forward.

Medicare was designed to respond to an acute illness. Let's say you are healthy and all of a sudden you have a heart attack and you have a good response to that heart attack in hospital treatment, and it worked pretty well as long as that was what health care delivery was.

Today, the situation has changed markedly. Preventive medicine today is exponentially more important than in 1965. Why? Because we understand how to prevent disease, how to maintain health. In 1965, we did not fully understand the nature of the science of preventive medicine. It simply was not

developed in 1965 to the degree it is today. Yet we have a Medicare system which has—I came close to saying almost no preventive care is provided in Medicare today. That is a little bit of an overexaggeration because we have to legislate that, yes, Medicare does cover mammography. Almost every one of these procedures has to be legislated, and with so many advances coming through quickly, we cannot keep up.

There is very little preventive care in Medicare today. Yet we all know how important it is if we look at managing one's health today, maximizing one's health.

In the 1970s, health care responded to acute episodic illnesses. Today it is preventive health care, maintaining wellness, management of chronic disease on an outpatient basis, using medicines, but Medicare has not changed very much.

I will give a couple of examples. Again, the goal is health care security for seniors. If you see a senior, you want to be able to say: The Government is helping you with health care security, and health care security means we have to include prescription drugs.

I mentioned Medicare lacks good preventive coverage. It also lacks the wellness care in chronic disease management. For example, Medicare does not cover cholesterol screening. If we look at heart disease, cholesterol is important. Yet Medicare does not cover cholesterol screening.

Medicare does not cover an annual physical examination today. I do not know if it has to be every year or every 18 months, but the point is, systematic regular examinations, if you are going to pick up that cancer when it is small or that heart disease before it becomes a massive heart attack, you can do it through annual physical exams, but they are not covered under Medicare.

Medicare does not protect at the extreme end, what we call catastrophic. That means if you are sick enough, if you have a lot of out-of-pocket expenditures, Medicare has no limit to that. Today if you have a catastrophic illness, there is no upper limit. A lot of people do not realize that.

The one issue we talk a lot about, because it is probably most dramatic, is that Medicare does not at all cover outpatient prescription drugs.

Thus, we have gaps in coverage for seniors. We are promising them health care security which they deserve, and yet we have these huge gaps in coverage which have been created since 1965. It is our obligation, our responsibility to respond, and, thus, over the next 12 days we will be putting together a bipartisan plan—though we do not know all the answers—we will be putting together the very best of what we do know to respond to these needs.

Today, on average—and a lot of people do not understand, or they were not aware of this, so it is important for us to keep saying it—Medicare covers right at about half of what a senior's medical care expenses are. Most think it covers 80 or 90 percent. If one is not yet a senior, it is important for them to know what their Government is doing for them now is to cover only about half of the expenses. Again, most people are not aware of that.

The response to that is that seniors and individuals with disabilities try to fill those gaps on their own, sometimes successfully, and many times not. They try to do it through Medicaid. They try to do it through private supplemental insurance programs, only to find that they are hit with these skyrocketing premiums that are growing 10, 15, 20 percent a year at this point. Or they find that their employer on whom they were depending is scaling back on the benefits that they once had when they were working full time.

I say all of this because it is important for people to understand why we are aggressively moving ahead in the way we are to develop a strengthened and improved Medicare plan.

I mentioned the lack of prescription drugs. If we look at aging, our population over the age of 65, we know prescription drugs become even more important than they are under 65 years of age or under 50 years of age or under 45 years of age, and that is new. It is really within the last 30 years that these medicines have become so important. Thus, it is our obligation to strengthen and improve access to prescription drugs.

I have had the privilege to observe a lot of this as a physician, and I will give a couple of examples. Over the past 3 decades—remember, Medicare started in 1965—the death rate from hardening of the arteries, or atherosclerosis, the underlying pathology within the heart, has declined by 74 percent. Deaths from ischemic heart disease—ischemic is low blood flow where the heart is not getting enough oxygen and blood, and that is what causes a heart attack, hardening of the arteries, myocardial infarction, heart attack—death rates have fallen over the last 30 years by 60 percent.

People ask why. There are lots of reasons, but I would say one of the major reasons is medicines today, that we are treating high blood pressure earlier; we are treating congestive heart failure earlier before these deaths from ischemic and other heart disease occur. Medicines that were not around 30 years ago are the beta blockers. It actually makes the heart so it does not beat so hard. If it is not beating so hard, it does not consume as much energy and does not need as much oxygen. Therefore, low blood flow to the heart does okay. Other drugs called ACE, A-C-E, inhibitors, the medicines, in large part, have explained this increasing survival fall in mortality.

Over the last 30 years since Medicare began, death rates from emphysema, or lung disease—a type of lung disease called chronic obstructive pulmonary disease, emphysema, is one of those two types—have fallen by 60 percent in large part because of the use of anti-inflammatory medications—they decrease the inflammation in the lungs—and also a group of drugs call bronchodilators, which dilate those little bronchial air waves in the lung. The point is, it is these medicines that in large part explain this improved health and the improved treatment of emphysema.

I have a couple of books with which I wanted to illustrate my point. Nearly 400 lifesaving drugs have been produced in the last 10 years. Meanwhile, there are over 600 medicines under development right now by the Nation's pharmaceutical research companies to treat diabetes, heart disease, cancer, stroke, and peripheral vascular disease.

I mentioned these books. This is called the PDR, the Physicians' Desk Reference, for pharmaceutical specialities and biologicals for the physician's desk. Every physician in the country uses this on a regular basis because it allows them to look up individual medicines. It gives the descriptions, the side effects, and the contraindications. No matter how smart one is or how much time one spends with it, there is no way to remember all of these drugs or everything in the book, although some people may be able to.

The point is, this book was printed in 1965. This is the year Medicare was actually passed and then implemented. That was over 30 years ago. Again, this book has 1,060 pages in it. The type is pretty small. It is just medicine after medicine. When I see this, I am kind of glad I do not have to know all of that right now because there is so much in it.

This PDR is the 57th edition, and this one is from 2003. It is pretty interesting to me because this first book is when Medicare started, and this other book is where we are today. Today's book is a little bigger but is a lot thicker, and instead of having 1,060 pages in it—these are not all lifesaving drugs but all drugs which have a real importance in terms of treating and quality of life—this book has 3,500 pages in it. I wish I could show this to the Chair, but the type in this new book is about half the size of the type in the old book. So the truth is, it is about 6,000 pages.

The point is, medicines make a difference. They made a difference in 1965. They really make a difference today. Seniors do not have access to these through our Medicare system in either case. Great advances, and our Medicare system has not changed. It does not recognize that as we go forward. That is why we are here. I want to make this case of why we are here and why this is so important today that the health care system, the delivery system, has markedly improved with great scientific advances, and Medicare is not capturing it today. Our seniors deserve for those to be captured.

Next month does mark the 38th anniversary of the launch of Medicare. On July 30, 1965, President Johnson traveled to Independence, MO, to sign the

bill into law. President Truman, who had initiated the drive for health care security for seniors about 20 years earlier, was on hand to receive that first Medicare card. President Johnson, upon signing that historic legislation, told the assembled lawmakers in 1965:

The benefits under the law are as varied and broad as the marvelous modern medicine itself. No longer will older Americans be denied the healing miracle of modern medicine. No longer will illness crush and destroy the savings that they have so carefully put away over a lifetime so that they might enjoy dignity in their later years. No longer will young families see their own incomes, and their own hopes, eaten away simply because they are carrying out their deep moral obligations to their parents . . .

Nearly 40 years later, we have an opportunity to realize this noble vision. Before the end of next week, the Senate will have the opportunity to pass legislation that does provide prescription drug coverage for our seniors, that does protect seniors and gives them health care security by giving them greater choices so that they can choose the health care coverage that best meets their individual needs.

I believe future generations will judge us by the choices we make over the next several days and at the end of next week, whether we chose to act responsibly, recognizing our obligations to strengthen and improve the system, or whether we chose just to talk about it, the same rhetoric, something that we should do. My position is clear; now is the time to act. I am delighted we are acting in a bipartisan way. Now is the time not just to tinker and play around the edges, but it is time to truly transform the system.

We have a responsibility to provide our seniors with a system that works, that indeed gives them health care security, and now is our opportunity to deliver it. It will require us to focus on the big picture. It will require us to focus on the future. It will require us to focus on our fellow citizens, whom we are so privileged to represent.

The PRESIDING OFFICER (Ms. COLLINS). The Senator from Utah.

Mr. HATCH. Madam President, I compliment the distinguished majority leader for his excellent set of remarks today. The comparison between the two PDR books is startling. Anyone who looks at it has to admit we have come a long way since 1965.

This bill was a great addition to the health care for our people. It could not have happened without the distinguished Senator from Tennessee, our leader, plus the distinguished Senator from Iowa, Senator GRASSLEY, and the distinguished leader from Montana, Senator BAUCUS. I appreciate having a doctor in the Senate. As a former medical liability defense lawyer, I have to say I have always respected Senator FRIST very greatly, but nothing comes close to how much I respect him as a physician, as somebody who cares for people and has given so much of his life to healing people.

I am very grateful to have heard these remarks today.

Mr. FRIST. I thank the Senator.

AMENDMENT NO. 933

Mr. HATCH. Madam President, I will only take a few minutes, but I rise in opposition to the Bingaman amendment.

First, let me make one thing clear, and perfectly clear:

The assets test in S. 1 is the same assets test used for determining eligibility for the qualified Medicare beneficiaries, QMBs, specified low-income Medicare beneficiaries, SLMBs, and qualified individuals, QI–1s.

S. 1 provides a generous low-income subsidy for those who are below 160 percent of the Federal poverty level. Currently, in order for some individuals under 160 percent of poverty to receive limited Medicaid protections, they must meet both an income limit and an assets test.

In S. 1, we simply follow these same rules in order for low-income beneficiaries to receive assistance with their prescription drug coverage.

By including the Medicaid assets test for Medicare prescription drug subsidies, we are providing beneficiaries with seamless health coverage. We are not confusing beneficiaries and we are not adding additional administrative burdens to States.

Let me give you some background on the current assets test included in the Medicaid program.

Qualified Medicare beneficiaries are individuals below 100 percent of poverty. In 2006, the annual income limit is $9,670 for individuals and $13,051 for couples. QMBs are allowed to have assets below $4,000 for individuals and $6,000 for couples.

Specified low-income Medicare beneficiaries and QI–1s are those with incomes between 100 percent of poverty and 135 percent of poverty. In 2006, the annual income limit is $13,054 for individuals and $17,618 for couples. SLMBs and QI–1s are allowed to have assets below $4,000 for individuals and $6,000 for couples.

Beneficiaries between 136 percent and 159 percent of poverty will have annual income limits of $15,472 for individuals and $20,881 for couples in 2006. Beneficiaries between 136 and 159 percent of poverty would not be subjected to assets tests.

Current law establishes resource limits for low-income elderly or disabled individuals. Let met emphasize, this is not a newly added restriction on certain low-income Medicare beneficiaries. However, current law also provides States with the flexibility to choose to disregard all or part of these resources.

The Bingaman amendment, which eliminates the Medicaid assets test limits would add significantly to the number of eligible beneficiaries.

A study prepared for the Kaiser Family Foundation estimates that as many as 11 million individuals would be newly eligible for low-income assistance if the assets test were eliminated. I have no idea how much that will cost but it will be expensive.

In addition to increasing the Federal cost of the bill, this amendment would impose a significant, new, unfunded mandate on States, which must pay a share of Medicaid benefits by paying for the dual eligible beneficiary's liability for premiums, deductibles, and coinsurance.

Also, some States may experience an additional administrative or financial impact from potential program redesigns because, in some cases, States link eligibility for their state-only programs with the eligibility requirements for these special categories of the dually eligible.

S. 1 includes a provision to require the GAO to conduct a study and make recommendations to Congress by 2007 regarding the extent to which drug utilization and access to covered drugs differs between qualifying dual eligibles who receive subsidies and individuals who do not qualify solely because of the application of an assets test.

This amendment will not only cost money, it will cause confusion. I urge my colleagues to defeat the Bingaman amendment.

The PRESIDING OFFICER. The Senator from Iowa.

Mr. GRASSLEY. Madam President, the underlying bill, the bill from the Senate Finance Committee to provide prescription drugs for the improvement and strengthening of Medicare, provides a very generous low-income subsidy for those who are below 160 percent of the Federal poverty level. For some of the seniors below 160 percent of the Federal poverty level, there is no asset test.

Currently, in order for some of the individuals below 160 percent of poverty to receive the most generous low-income subsidies, there is an asset test and there ought to be. The crafting of this bill provided everyone a conscientious effort and decision to make possible this legislation and to make it well balanced. There were extra dollars and the decision was made to fill in the coverage gap rather than eliminate the assets test. There is no limitless amount of funds for this prescription drug benefit.

We are in a position of zero sum gain. We have $400 billion under the budget to work with. This bill works to do the most for all Medicare beneficiaries. Seniors with incomes below 160 percent and who do not pass the established asset test still receive a very generous low-income subsidy. These beneficiaries will not have a gap in coverage.

This amendment by the Senator from New Mexico will add unknown costs to the current bill. It will change the structure of the bill and affect the current Medicaid Program by adding costs that are very substantial in the outyears. Therefore, when we vote tomorrow on the Bingaman amendment I hope we will have a strong vote against it. Not that I denigrate in any way the intentions of the Senator from New Mexico. I know him to be a very conscientious Senator, to do well, and to

be very thoughtful in his approach. Obviously, on this point he has some disagreement with the product of our committee that was voted out 16 to 5 last Thursday.

But, here again, we have to do the most we can within the $400 billion that the Budget Committee has given us to work with for providing a prescription drug benefit to our seniors as part of improving and strengthening the Medicare Program overall. We could have put more money into the asset test as he indicates he wants to do now with this amendment. We chose, as I indicated before, to help more people with the same amount of money by filling in the gap or, as some people would say, the donut hole.

We believe we should put as much effort as we can into taking care of that problem because, to help the very same people Senator BINGAMAN wants to help, we have put a lot of resources into the effort of prescription drugs for seniors, for those below 160 percent of poverty.

So, once again, I urge the amendment be defeated when we vote on it tomorrow.

I yield the floor. 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. GRASSLEY. Madam President, I ask unanimous consent that the order for the quorum call be rescinded.

The PRESIDING OFFICER. Without objection, it is so ordered.

MORNING BUSINESS

Mr. GRASSLEY. The first unanimous consent request is that the Senate proceed to a period for morning business.

The PRESIDING OFFICER. Without objection, it is so ordered.

COUNCIL ON FOREIGN RELATIONS INDEPENDENT TASK FORCE ON BURMA

Mr. MCCONNELL. Madam President, the Council on Foreign Relations Independent Task Force on Burma today released a report entitled: ''Burma: A Time for Change''. I am pleased to have had an opportunity to serve as a member of the Task Force along with my colleagues, Senators LUGAR and FEINSTEIN, and Representative LANTOS.

The report describes the State Peace and Development Council's repressive rule in Burma, and makes a number of recommendations including: increased humanitarian assistance for the people of Burma through NGOS, and in consultation with the NLD and other groups representative of a multiethnic Burma; an import ban on goods produced in Burma, visa denials to leaders of the military regime and its political arms, and the freezing of assets abroad; U.S. leadership in urging the United Nations Security Council to adopt a resolution that demands the immediate release of Suu Kyi and all other political prisoners, and to hold an emergency session to impose other sanctions on Burma; U.S. leadership in working with our allies and Burma's regional neighbors to bolster support for the struggle for freedom and the rule of law in Burma; no certification for Burma on narcotics cooperation as it has ''failed demonstrably'' to curtail drug production, drug trafficking and money laundering; and increased assistance to refugees fleeing Burma in Thailand, India, Bangladesh, and China.

I thank the council for the timeliness of the task force, and all the members for their participation.

Madam President, I ask unanimous consent that a copy of the executive summary of the report be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

BURMA: A TIME FOR CHANGE

EXECUTIVE SUMMARY

On May 30, 2003, the Burmese military regime orchestrated violent attacks by progovernment militia on Aung san Suu Kyi, the leader of the National League for Democracy (NLD) and her supporters as they traveled outside Mandalay. At least four of her bodyguards were killed as well as a significant number of others. She has been held in custody since then. Following the attacks, the regime arrested more than 100 democracy activists, imprisoned at least a dozen, shut down NLD offices across the country, and closed schools and universities. This is the bloodiest confrontation between Burma's military rulers and democracy supporters since 1988, when the government suppressed a popular uprising against the regime and thousands were killed.

Burma has been ruled for more than 40 years by a succession of military regimes that have systematically impoverished a country once known for its high literacy rate, excellent universities, and abundant natural resources. Today, Burma is one of the most tightly controlled dictatorships in the world, lacking any freedom of speech, assembly, or the press; denying any due process of law; and perpetuating human rights abuses, such as forced labor, military rape of civilians, political imprisonment, torture, trafficking in persons, and use of child soldiers. Burma is also facing what the United Nations Childrens Fund (UNICEF) has called a ''silent emergency,'' a health crisis of epidemic proportions. HIV/AIDS is spreading rapidly, and malaria, tuberculosis, leprosy, maternal mortality, and malnutrition are pervasive. Government spending on health and education is miniscule.

Burma is a leading producer of opium and methamphetamine for the illegal drug trade, which is a major source of corruption within Burma. Four decades of military operations against insurgent ethnic nationalities as well as mass forced relocations have created one of the largest refugee populations in Asia. As many as two million people have fled Burma for political and economic reasons; inside Burma, hundred of thousands have been internally displaced. They lack access to food, health care, schools, and even clean water.

In August 1988, a popular uprising against the military regime was brutally suppressed and thousands were killed. In 1990, the regime held elections for a multi-party parliament in which the National League for Democracy (NLD), led by Aung San Suu Kyi who was then under house arrest, won 82 percent of the seats. However, the elections were ignored by the junta and the elected parliamentary representatives never took office. The regime imprisoned hundreds of prodemocracy supporters, including elected members of parliament. Thousands more fled the country.

After the 1988 uprising, the United States imposed graduated sanctions on Burma, initially terminating economic aid, withdrawing trade preferences, imposing an arms embargo, and blocking loans the grants from international financial institutions. In 1997, based on a presidential finding that the Burmese government had committed large-scale repression and violence against the democratic opposition, the United States banned any new American investments in Burma.

In 2000, the United Nations, mandated by UN General Assembly resolutions, sent Special Envoy Razali Ismail to Rangoon to promote substantive political dialogue on transition to democratic government between Burmese government and the democratic opposition. Since then, Ambassador Razali has visited Rangoon nine times with no apparent progress toward establishing this dialogue. He is returning to Rangoon in early June.

In order to strengthen international efforts to install democratic government and end repression in Burma, the Task Force recommends that the United States take specific initiatives in four key areas:

Humanitarian assistance to address Burma's health crisis

In view of Burma's massive public health crisis, the United States should increase humanitarian assistance to Burma, provided that funds are given to international nongovermental organizations (NGOs) for basic human needs through a process that requires transparency, accountability, and consultation with the NLD and other groups representatives of a multiethnic Burma.

Although the United States should not generally provide humanitarian assistance directly to the Burmese government, the United States could provide technical assistance to the Ministry of Health if the Burmese government agrees to meet the U.S. Centers for Disease Control (CDC) standard that HIV/AIDS testing be voluntary and confidential.

The United States should work together with other donor governments, UN agencies, and if possible, the Burmese government State Peace and Development Council (SPDC) to establish certain minimal standards of independence for international NGOs operating in Burma, including clear guidelines for administrative operations, reporting, and other regulations involving duty-free entry privileges, memoranda of understanding and residency permits.

Promoting democracy, human rights, and the rule of law

In view of the recent government-sponsored attacks on members of the democratic opposition, resulting in a number of deaths, and the Burmese government's detention of Aung San Suu Kyi, the United States should urge the United Nations Security Council to adopt a resolution that demands the immediate release of Aung San Suu Kyi and all political prisoners and condemns the Burmese government's egregious human rights abuses as well as its refusal to engage in substantive political dialogue with the democratic opposition. In addition, the United States should urge the Security Council to hold an emergency session on Burma to discuss imposing targeted sanctions, which could include denying visas to leaders of the military regime, the Union Solidarity Development Association (USDA) and their families, freezing their assets and imposing bans

both on new investment in Burma and on importing goods produced in Burma.

Because the Burmese military government has failed to address human rights abuses, including the unconditional release of all political prisoners, and to move forward in talks with the NLD and other pro-democracy groups toward establishing a democratic government, the United States should increase well-targeted sanctions, including an import ban on goods produced in Burma, and encourage the United Nations and other countries to join with the United States in adopting similar sanctions.

The United States should redouble its efforts with the governments of China, Japan and the Association of Southeast Asian Nations (ASEAN) countries, particularly Thailand, Singapore and Malaysia, to press the SPDC to work with the NLD and ethnic nationalities toward political transition in Burma. The United States, as a member of the SEAN Regional Forum, should urge ASEAN to consider seriously the cross-border effects of internal problems including illegal migration, health, trafficking, narcotics and other issues connected with the internal situation in Burma. The United States should also continue to coordinate closely with the European Union on policies toward Burma.

Until the SPDC makes substantial progress in improving human rights and engaging in substantive political dialogue with the democratic opposition, the United States should strongly discourage the government of Japan from forgiving outstanding debt from bilateral grants and loans except those that directly address basic human needs. Such aid should exclude infrastructure projects, such as dams and airport renovations, and also be limited to basic human needs. Moreover, the United States should encourage Japan to use its influence with ASEAN governments to urge them to become pro-active in support of democracy and human rights in Burma.

While maintaining its own sanctions on Burma, the United States, as one of the largest donors to the international financial institutions, should urge Asian investors to press the Burmese government to begin implementing the economic measures recommended by the World Bank, International Monetary Fund and the Asian Development Bank as one of the prerequisites for further investment. The United States should also urge China to use its influence to press the Burmese government to reform its economy and move towards democratic governance in order to promote stability in the region.

In order to develop capacity for future democratic governance and to rebuild technical competence in Burma, the United States should promote cultural, media and educational exchanges with the Burmese, provided that these opportunities are readily accessible to qualified candidates, including representatives of the political opposition. The selection process should include widespread publicity of exchange and fellowship opportunities, a joint selection committee comprised of Burmese civilian authorities (academics, intellectuals) and representatives of the U.S. Embassy in Rangoon who, after consulting broadly, make their selections based on the quality of candidates and their potential to contribute to Burma's future. In addition, the United States should provide increased funding for the American Center in Rangoon as well as for English language training and scholarship opportunities.

U.S. narcotics control policy toward Burma

The United States should not certify Burma at this time because it has ''failed demonstrably'' to curtail drug production, drug trafficking and money laundering. In addition, the United States should not provide any counter-narcotics assistance to the Burmese government. Increased counter-narcotics cooperation should depend, at minimum, on significant steps by the Burmese government to curb methamphetamine production, to arrest leading traffickers, and to stop channeling drug money into the illicit economy.

IV. Refugees, migrants and internally displaced persons

The United States should strongly urge the Thai government to halt deportations of Burmese and protect the security of Burmese living in Thailand, regardless of their status. In addition, the United States should coordinate U.S. policy towards Thailand with donors, such as the governments of Norway, Denmark, Japan, and Canada.

The United States should provide increased humanitarian assistance, including cross-border assistance, for displaced Burmese along both sides of the Thai-Burma border as well as on Burmese's borders with India, Bangladesh, and China, as well as inside Burma. Support should be provided for clean water, sanitation services, primary health care, reproductive health, and health education for refugees and undocumented migrants living in refugee-like circumstances. Support of education, especially for women and children, is also critical.

The United States should urge greater access by international NGOs and UN agencies to northern Rakhine State provide humanitarian assistance and monitor abuses committed against Muslim communities and returned refugees.

SAVING FREEDOM OF SPEECH

Mr. HOLLINGS. Madam President, we are in trouble. The Federal Communications Commission, by a three to two vote, is prepared to bring about monopolistic control of the news, monopolistic control of the media, monopolistic control of entertainment. Public interest rules for cross ownership and market control are being abolished and no one points this out more cogently than Mortimer B. Zuckerman, Editor in Chief, in the June 23, 2003 edition of the U.S. News and World Report. The Congress will be compelled to act if we are to save freedom of speech in this country. To understand the issues I ask unanimous consent that the article be printed in the RECORD. I also commend to my colleagues the Columbia Journalism Review—www.cjr.org—of who owns what, listing the holdings of the five behemoths Viacom, News Corporation, AOL-Time Warner, Walt Disney Company and General Electric too much under the present rulings.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

[From U.S. News & World Report, June 23, 2001]

A SURE-FIRE RECIPE FOR TROUBLE

(By Mortimer B. Zuckerman)

Three anonymous political appointees to the Federal Communications Commission have just delivered a body blow to American democracy. Large media companies are to be allowed to buy up more TV stations and newspapers, becoming more powerful and reaping a financial bonanza. Astonishingly, the FCC has done this without public review, without analyzing its consequences, and without the American people getting a dime in return for their public airwaves. Under the FCC deal, big media companies must make no commitment to provide better news, or even unbiased news. Ditto with local news coverage and children's programming. In fact, the new rules dramatically worsen opportunities for local news coverage, for diversity of views, and for competition. ''The public be damned!'' was a robber baron's slogan from the Gilded Age. Seems to be just what the FCC is saying.

Consider the enormity of the changes. The commissioners removed the ban on broadcasting and newspaper cross-ownership. They raised the national cap on audience reach by station-group owners to 45 percent. They allowed ownership of two stations in more markets, and even three in a handful of markets. There's more, but you get the idea.

Monopolies. These FCC rules allow new merger possibilities without any public-interest review. The details are complicated, but basically, thanks to the FCC, one company now can own UHF TV stations in 199 of the nation's 210 TV markets, which is pretty much the equivalent of owning stations in every TV market in every state except California. That means a single company could influence the elections for 98 U.S. senators, 382 members of the House of Representatives, 49 governors, 49 state legislatures, and countless local races. Employing another strategy now allowed by the FCC, that same company could own VHF stations in every TV market in 38 states, with the power to influence elections in 76 U.S. senate races, 182 House races, 38 gubernatorial races, and 38 state legislatures, along with countless local races. There are other scenarios. But again, you get the idea.

Easing the rules on cross-ownership means that in many local markets one company could own its leading daily newspaper—and, often, its only newspaper—its top-rated TV station, the local cable company, and, as a bonus, five to eight radio stations. Previously, no TV and newspaper mergers were allowed in the same market, except when a firm was failing. Now the merger of the dominant newspaper and TV station could create local news monopolies in 200 markets serving 98 percent of all Americans.

What's going on? Several years ago, the FCC allowed one company to own as many radio stations as it wanted. The unintended result is the monopolization of many local markets and three national companies owning half the stations in America, delivering a homogenized product that neglects local news coverage. Small to midsize firms know that major networks will gobble up affiliates, cut local programming costs, and program centrally from their own stations. Independents will be squeezed out. ''For Sale'' signs are already going up. More consolidation, more news sharing, and fewer journalists add up to an enhanced danger of media corporations abusing market power to slant coverage in ways that fit their political and financial interests—and suppressing coverage that doesn't. One defense of this outrage that big media companies offer is the diversity of the Web. Well, yes. But does anyone really think the Internet is anything like an organized political or media power, much less a counterweight to a claque of billion-dollar media behemoths?

The good news is that the nation, finally, is waking up. The FCC has received hundreds of thousands of protests. Congressmen, both Democrats and Republicans, are alarmed. So are groups as diverse as Common Cause, the National Rifle Association, and the Screen Actors Guild. One of our more thoughtful conservative columnists, William Safire of

the New York Times, writes that ''the concentration of power—political, corporate, media, cultural—should be anathema to conservatives.'' John Roberts in the Chicago Tribune deplores the ''blatantly disingenuous, if not dishonest, explanations being given by FCC Chairman Michael Powell and his supporters for their actions.''

No prizes for guessing who supports the commission: the major media conglomerates who have coincidentally spent more than $80 million on lobbying, plus over $25 million in political contributions, in the past three years and stand to gain enormously from this.

Regardless of their political ideology, we cannot risk nonelected media bosses having inappropriate local, regional, or national power. The FCC was created to ensure that the public interest is served by the media companies that use our airwaves. Everyone is entitled to a mistake sometime, but the FCC is abusing the privilege. Congress must act now and reverse the FCC's irresponsible new rules.

CHANGES TO H. CON. RES. 95 PURSUANT TO SECTION 401 MEDICARE RESERVE FUND ADJUSTMENT

Mr. NICKLES. Madam President, section 401 of H. Con. Res 95, the FY 2004 Budget Resolution, permits the Chairman of the Senate Budget Committee to make adjustments to the allocation of budget authority and outlays to the Senate Committee on Finance, provided certain conditions are met.

Pursuant to section 401, I ask unanimous consent that the following revisions to H. Con. Res. 95 be printed in the RECORD.

There being no objection, the following material was ordered to be printed in the RECORD, as follows:

	Dollars in millions
Current Allocation to Senate Finance Committee	
FY 2004 Budget Authority	769,846
FY 2004 Outlays	773,735
FY 2004–2008 Budget Authority	4,504,397
FY 2004–2008 Outlays	4,513,658
FY 2004–2013 Budget Authority	10,591,162
FY 2004–2013 Outlays	10,606,226
Adjustments	
FY 2004 Budget Authority	.....
FY 2004 Outlays	.....
FY 2004–2008 Budget Authority	113,540
FY 2004–2008 Outlays	113,570
FY 2004–2013 Budget Authority	400,000
FY 2004–2013 Outlays	400,000
Revised Allocation to Senate Finance Committee	
FY 2004 Budget Authority	769,846
FY 2004 Outlays	773,735
FY 2004–2008 Budget Authority	4,617,937
FY 2004–2008 Outlays	4,627,228
FY 2004–2013 Budget Authority	10,991,162
FY 2004–2013 Outlays	11,006,226

PROTECT ACT OF 2003 TECHNICAL AMENDMENT

Mr. HATCH. Madam President, I rise today to speak to an issue that we need to promptly address. As part of the Protect Act of 2003, we authorized a pilot program to study the feasibility of instituting a national background check for those who volunteer in children's activities. The National Center for Missing and Exploited Children will provide its expertise to assist volunteer organizations in evaluating the criminal records of volunteers to determine if the volunteers are fit to interact and provide care for children.

Currently, the Protect Act tasks the National Center with operating the cyber tip line in addition to its participation in the pilot program. The Protect Act presently immunizes the National Center for operating the cyber tip line as long as it does so consistent with the purpose of the tip line. However, no similar protection was provided with respect to the National Center's activities related to the pilot program. The bill I have offered will extend the immunity to the National Center for its participation in the pilot program.

I would urge my colleagues to vote in favor of this technical fix so that the worthy goals of the pilot program can commence.

LOCAL LAW ENFORCEMENT ACT OF 2003

Mr. SMITH. Madam President, I rise today to speak about the need for hate crimes legislation. On May 1, 2003, Senator KENNEDY and I introduced the Local Law Enforcement Act, a bill that would add new categories to current hate crimes law, sending a signal that violence of any kind is unacceptable in our society.

I would like to describe a terrible crime that occurred in San Jose, CA. On October 12, 2001, a pregnant Yemini woman wearing a hijab and a long dress was beaten by a group of angry teenagers. After the attack, the woman needed to be hospitalized and remained in guarded condition until she delivered her baby.

I believe that Government's first duty is to defend its citizens, to defend them against the harms that come out of hate. The Local Law Enforcement Enhancement Act is a symbol that can become substance. I believe that by passing this legislation and changing current law, we can change hearts and minds as well.

WRITING CONTEST ON IMMIGRATION

Mr. KENNEDY. Madam President, each year fifth graders across the United States compete in a writing contest on immigration sponsored by the American Immigrant Law Foundation and the American Immigration Layers Association. Thousands of students participated in this year's competition, responding to the question, ''Why I'm Glad America is a Nation of Immigrants.''

In 1958, President Kennedy, who was then completing his first term as a Senator, published a book with the title, ''A Nation of Immigrants,'' and I had the privilege of serving as one of the judges for this year's contest. It was impressive to see how the students responded. Their essays illustrate the wealth of diverse cultures that immigrants share with our Nation. The students' writings radiate with pride for our diversity and our immigrant heritage. Many students told personal stories of their families and friends and their immigration to the United States.

The winner of this year's contest is Miranda Santucci of Pittsburgh. In her essay, ''An American Patchwork Quilt,'' Miranda explores the value of her friends' cultures and how their diversity has enhanced her life. She compares the United States to a colorful patchwork quilt where ''every fabric piece tells an immigrant's story about overcoming hardship, seeking opportunities, and reaching for dreams,'' and where ''threads of different languages, customs, foods, cultures, religions and skills hold these pieces together.'' Miranda's eloquent essay reaches to the heart of what makes us all uniquely American.

Other students honored for their exceptional writing were Rachel Adams of Houston, Melissa Cheng of Atlanta, Jessica Du of Alameda, and Elias Reisman of Indianapolis. I congratulate these students on their outstanding achievement, and I know my brother would be proud of them too.

These award-winning essays will be of interest to all of us in the Senate, and I ask unanimous consent that they be printed in the RECORD.

The PRESIDING OFFICER. Without objection, so ordered.

There being no objection, the essays were printed in the RECORD, as follows:

[From the Winchester Thurston School, Pittsburgh, PA]

AN AMERICAN PATCHWORK QUILT

(By Miranda Santucci)

America reminds me of a beautiful patchwork quilt that covers our nation with a diversity of immigrants. Each quilt square is made up of different colors and textures with a unique design and pattern. Every fabric piece tells an immigrant's story about overcoming hardships, seeking opportunities, and reaching for dreams. Threads of different languages, customs, foods, cultures, religions, and skills hold all these pieces together. I'm glad America is a nation of immigrants because these individual patchwork pieces make the whole American quilt more beautiful.

The quilt covers my home, school, neighborhood, and city. It warms me when I celebrate the feast of fishes on Christmas Eve like my father's Italian ancestors did, when I play with my Greek friend Katarina Konstantinos after school, or when I share the basket blessing tradition at Easter with my neighbor, Peter Muszalski, in his church on Polish Hill. I see many colors in the fabric at my school when I look around at all the different skin tones. I feel how enormous the quilt is when I go through the Strip District and read the storefront signs like Sam-Bok, Stamboolis, Benkovitz, and Sunseri.

I cherish each piece of our country's quilt. All the immigrant patches are still unique, even though they are sewn together as one. They make our country rich, full and strong. America's patchwork quilt is a precious heirloom that should be handled with pride, and handed down through the generations of American history.

[From the Mayde Creek Elementary, Houston, TX]

AMERICA—MY NEW HOME

(By Rachel Adams)

America, America

lovely and bright,
so full of bluebonnets
and coyotes at night.

Free as a bird,
that soars in the sky,
oh, how I love the way
your flag waves far and wide.

Immigrant, immigrant,
traveling from afar,
warmly welcomed in America,
are those who are scarred.

That's what I am,
and I want to be free,
I want to have value,
and I want to be me.

I set out on a journey
and far will I roam
until I reach my new country,
a place I'll call home.

In this country of immigrants,
I want to have meaning
to have a life of peace
and freedom of being.

I travel to America
where opportunity awaits,
the land of the free
and the home of the brave.

[From the Montgomery Elementary School, Atlanta, GA]

WHY I AM GLAD AMERICA IS A NATION OF IMMIGRANTS

(By Melissa Cheng)

The Dutch Butcher, the German Baker, The Chinese who created paper, to this great land gathers great skill, and we all contribute, so do I, and make America greater still.

From some lands people flee,
To America the place of democracy,
For where they originated they had no freedom or rights for they had a dictator who didn't treat them right.

I am glad I have hearts of hope, dreams of freedom to be and practice who and what I want to be. For freedom there is a price.

We all must stand together willing to fight.
We all must stand together and earn this right.

Without these cultures from near and far, today we wouldn't be who we are.

Pasta from Italy, bread from Germany, and piniatas that come from Mexico, are what makes America unique.

All these things put together strengthen our unity and create one big community.

America the land of opportunity is a place where everybody has an equal chance including me!!!

That is why I am glad America is a nation of immigrants.

[From the Amelia Earhart School, Alameda, CA]

I AM GLAD AMERICA IS A NATION OF IMMIGRANTS

(By Jessica Du)

America is a nation of immigrants
As you can plainly see
Someone in your history
Made a change in your family tree.

Everyone must have a time
When they moved from place to place
To live a better life
And challenge it face to face

People come to America
For freedom and for rights
To speak freely and be educated
And explore new heights

My parents are from Vietnam
Dad escaped by boat
If someone was lucky, they'd make it to shore
If not, in the ocean they'd have to float

My parents changed my whole life
If they hadn't moved here
I would be in a different country
Living in a land of fear

My classmates are from here and there
We are all different races
We speak many languages
And smile with different faces

America is a nation of immigrants
We don't care what race you are
The poor and rich should know
You're welcome from near or far.

[From the International School of Indiana, Indianapolis, IN]

OPEN TO DIFFERENCES

(By Elias Reisman)

My grandma was from Russia
Her dad had a different belief.
The army came and seized him
Which caused her family grief.

She made it to the United States,
Fell in love with a Russian man,
War was looming, he signed up.
''Let's marry while we can.''

They had three kids
All three were raised as Jews.
My dad met mom, a Christian girl
And they had two little new.

Our self portrait is not crystal clear.
When asked, what do we tell?
There is no single label
That tells our story well.

We go to an international school
There are kids of every kind.
Every race and faith and country
Makes it even a better time.

When we seek out those who differ,
Respect all points of view,
We are happier, wiser, stronger,
And our country's safer too.

We do not care
Whether yellow, black, or white,
Immigrant or native—
IT IS ALL RIGHT!

RECOGNIZING GENERAL ERIC SHINSEKI ON HIS RETIREMENT AS ARMY CHIEF OF STAFF

Mr. INOUYE. Madam President, on June 11, 2003, I had the honor and privilege of attending the retirement ceremony at Fort Myer, VA, for GEN Eric Shinseki, who served with distinction during his 4 years as Army Chief of Staff. A native of Hawaii who rose through the ranks while devoting 38 years of his life to defending our Nation, General Shinseki ended his career as the highest ranking Asian-American in the history of the United States military.

His farewell speech was a message of thanks, a reminder of the need for shared values, and an underscoring of the importance of inspired leadership and the dangers of arrogance.

I ask that General Shinseki's speech, as well as the remarks that Acting Secretary of the Army Les Brownlee made during General Shinseki's retirement ceremony, be printed in the RECORD.

There being no objection, the speech was printed in the RECORD, as follows:

SPEECH BY GENERAL ERIC K. SHINSEKI, 34TH CHIEF OF STAFF OF THE U.S. ARMY, AT HIS RETIREMENT CEREMONY, AT FORT MYER, VA, ON JUNE 11, 2003

Secretary Brownlee, thank you for the generosity of your remarks, and for hosting today's ceremony. You lead the Army through a difficult period; best wishes in the execution of your important duties.

Secretary and Mrs. Norm Mineta, Transportation, thank you for being here.

We have received tremendous support from the defense oversight committees: Senate Armed Services Committee—Senators Warner and Levin; Senate Appropriations Committee for defense—Senators Stevens and Inouye; House Armed Services Committee—Congressmen Hunter and Skelton; Congressman Bill Young, Chairman of the House Appropriations Committee; and Congressmen Lewis and Murtha, House Appropriations Committee for Defense. Thank you all and your dedicated staffs, Sid Ashworth, Valerie Baldwin, John Bonsall, Dan Cox, and former Staff Director Steve Cortese, for your support of the Army, its initiatives for the future, and its soldiers.

Let me also acknowledge the leadership of the Senate and House Army Caucuses: Senators Inhofe and Akaka, Congressmen McHugh and Edwards. We truly appreciate the tremendous support you provide for the Army's initiatives.

We are fortunate to have some members of Congress with us today: Senators Dan Inouye, Daniel Akaka, Jack Reed, and former Senator Max Cleland; Congressmen Jerry Lewis, Ike Skelton, Gene Taylor, Neil Abercrombie, Rodney Frelinghuysen, Sylvestre Reyes, Charles Taylor, Chet Edwards, Eni Faleomavaega. Patty and I are honored that you could join us. Thank you.

Sincere thanks to the members of Congress who paid kind tributes to my service in recent days: Congressmen Lewis, McHugh, Edwards, and Skelton. I deeply appreciate the graciousness of your remarks.

Senator Dan Inouye, special thanks to you, sir, for your friendship and mentoring. I am indebted to you for introducing me at my Senate confirmation hearing. Your words then and your support over the last four years have been humbling. Thank you for your patriotism and your leadership.

Deputy Secretary England—Homeland Security, Secretary and Mrs. Jim Roche—Air Force, General Al Haig, thank you for honoring us with your presence. General Barry McCaffrey and Jill, thank you for honoring us as well.

Secretary Togo West, 16th Secretary of the Army, Secretary Tom and Susan White, 18th Secretary of the Army, thanks for your unwavering support of soldiers and the Army, for your friendship, and for being her today. When they call the roll of principled, loyal, tough guys, you will be at the top of the list.

General Dick Myers, our Chairman, his wife, Mary Jo, and Lynne Pace, wife of our Vice Chairman, fellow members of the Joint Chiefs of Staff and your ladies: Vern and Connie Clark, CNO; John and Ellen Jumper, CSAF; Mike and Silke Hagee, Commandant, Marine Corps; Tom and Nancy Collins, Commandant, Coast Guard. To the Joint Chiefs, you have my respect and admiration for the experience you bring to deliberations, the responsibilities you bear for the nation, and the care you engender for people.

Former Army Chiefs of Staff, General and Mrs. Reimer, General and Mrs. Sullivan, General and Mrs. Vuono; members of our outstanding Army Secretariat, including Joe Reeder and Mike Walker; former undersecretaries of the Army; our Vice Chief of Staff, Jack Keane and his wife, Terry, who have worked tirelessly for four years on behalf of soldiers and the Army, thank you both for your dedication and support.

Counterpart Army Chiefs who have traveled long distances to be here today: General and Mrs. Gert Gudera, old friends from Germany since our service together in Bosnia; General Edward Pietrzyk, Poland; General

and Mrs. Hillier, Canada; General Canelo-Franco, Paraguay; General Morozov, Russia; General Marekovic, Croatia. Patty and I are deeply honored by your presence.

Other fellow U.S. general and flag officers, serving and retired, active and reserve components, and your spouses, especially the retired four stars who are here today, thank you all for your support and your leadership. The Army is in good hands and it keeps rolling along. Let me particularly acknowledge the serving four-stars: Jim Ellis, Charlie Holland, Larry and Jean Ellis, Paul and Dede Kern, Leon and Judy Laporte, B.B. Bell, Tom and Toni Hill, Kevin and Carol Byrnes; and those recently retired from active duty, John and Ceil Abrams, Buck and Maryanne Kernan, Jay and Cherie Hendrix, Tom and Sandy Schwartz, John and Jan Coburn. Let me also acknowledge the important service and presence of the Joint and Army Staffs and the Army's general officers in command who provide strong, steady, and enduring leadership.

Sergeant Major of the Army Jack and Gloria Tilley, the Army could not have asked for two more enthusiastic proponents for soldiers and families. To you and the MACOM Sergeants Major who have gathered here today, thanks for your wise counsel and friendship. We are indebted to all of you for your leadership and your care and concern for soldiers.

Master Chief Petty Officer of the Navy and Mrs. Scott, former SMAs Hall, Kidd, and Bainbridge and your ladies, civilian aides to the Secretary of the Army.

My beloved family, some 70-strong, has journeyed great distances to be here. Grandma Shinseki, who turns 92 this year, has chosen not to travel, and my sister, Yvonne, has remained at home with her. But just about everyone else is here—my older brother, Paul, and his family, then Patty and our children—Lori, Ken, and their spouses who have made Patty and me grandparents five times over. Many others from Patty's and my wonderful family are gathered in strength—uncles, aunts, sisters, brothers, cousins, nephews and nieces—wonderful people who live simple lives in proud and vocal support of this Chief. God bless you all.

So many other dear friends and associates—too numerous to name but whose journeys have brought them miles, years, and memories to be here today. Kauai High School classmates, classmates from Hunterdon Central High School, where I spend a defining year of my life as an exchange student in New Jersey; the men and women of the distinguished West Point Class of 1965, representatives from industry and the nonprofits who have done so much for the Army and soldiers, especially Frances Hesselbein of the Leader to Leader Institute, members of our superb, professional media—Joe Galloway, Thom Shanker, Dick Cooper, Dave Moniz, Greg Jaffe, Ann Roosevelt, Joe Burlas, and others—who have helped to tell our soldiers' stories, the international representatives of the attache corps, our wonderful Army Arlington Ladies, who represent the Chief of Staff at each and every Army funeral in Arlington to honor our soldiers when they are laid to rest, thank you.

Youngsters from my front office and the Quarters 1 staffs, John Gingrich and members of my staff group; my XOs, Joe Riojas and Tom Bostick; and Lil Cowell, the steady hand in the office of the CSA for four Chiefs, who quietly retired last week; CW5 Dan Logan; SGM Bruce Cline and Team CSA; SFC John Turk and the Admin Section; Major Pedro Almeida, the last in a series of world-class aides; Linda Jacobs and the heroes of protocol, all kept the office of the Chief well-represented through sheer hard work and dedication, making my life and Patty's most rewarding. Thank you all.

Teri and Karen Maude and the Brian Birdwells, survivors of 11 September 2001, among the many hurt and scarred that day; spouses of the generals who ran the ground war in Iraqi Freedom; Carmen McKiernan, Kimberly Webster, Dee Thurman, and Bea Christianson, thank you for coming today and for your generosity, grace, and courage. Other distinguished guests, ladies and gentlemen.

My name is Shinseki, and I am a soldier—an American soldier, who was born in the midst of World War II, began his service in Vietnam 37 years ago, and retires today in the midst of war in Afghanistan and Iraq. The strategic environment remains dangerous and we, in the military, serve our nation by providing the very best capabilities to restore order in a troubled world. Soldiering is an honorable profession, and I am privileged to have served every day for the past 38 years as a soldier.

The Good Book tells us, to everything there is a season and a time to every purpose. Today is a time for thank yous, and our purpose is to say farewell. As we speak, more than 370,000 soldiers are deployed and forward stationed in 120 countries. Their missions range from combat to peacekeeping to rebuilding nations to humanitarian assistance to disaster relief—and a host of other missions in between. And as busy as they are, there have been no dropped balls—none, on any mission. They are trained, disciplined, focused, and well-led. The soldiers arrayed before us represent the magnificence of that Army. Their parade formation stretches not only from left to right across this field, but also backwards in history to a time before the republic was formed. Precision counts in this profession, and no one does it any better than the Old Guard and Pershing's Own. Please join me in thanking the soldiers on parade today and on duty here, behind the stars and around the world.

Thanks also to former bosses, mentors, friends, and fellow soldiers who trained me as a soldier, and grew me as a leader—some of them are here today. General Fred Franks, who more than anyone else has been coach and mentor in all the years I served as a general officer. Generals Butch Saint, Ed Burba, Rich Cardillo, Tom Tait, who fought to keep me on active duty after a service-disqualifying injury, Dick Davis, Colonel Greynolds, my hospital bunkmate Bill Hale, and Sergeant Ernie Kingcade, noncommissioned officer, who, while under way by ship to Vietnam, provided me the only officer basic course I would receive before going into battle—and I could not have had a better education. Ernie, it has been a long journey, and the example you set has been with me for 38 years. Thanks for that early model of what noncommissioned officers were supposed to be. I have never expected less, and it has made all the difference.

To the men of '65—strength and drive. Thirty-Eight years since we stepped off together as soldiers. You have been role models, friends, associates, and fellow soldiers for these many years. Your notes in the days following 11 September and during the height of Iraqi Freedom were of great comfort—wonderful reminders of all that we had been through together. Thanks for standing my last formation with me. It's been my distinct honor to have been associated with you and with what we've accomplished as a class. Your presence is most appreciated.

To Patty, my wife of 38 years, you taught me the meaning of selflessness, of elegance, of courage, and of a bright spirit undiminished by time or adversity. You have seen me at my worst and stuck with me—and you've seen me at my best and chuckled in disbelief. Throughout it all, your patience, your balance, your encouragement, and your love and support have sustained me. You stood beside my hospital bed for days. Helped me learn to walk a second time, enabled me to regain confidence and a sense of direction, helped me reestablish a professional career, moved our children and our household 31 times, and always, always provided great strength when it was needed most. You could have been and done anything you chose; yet you chose to be a soldier's wife. The profound grace of that decision has blessed me immeasurably. Thank you for 38 wonderful years in a profession I loved nearly as much as you.

Lastly, I want to thank the men who have served in this position, those who saw the Army through some dark days following Vietnam. It was a daunting and enormous task, but they, with others who are present today, did it. They gave us back an NCO Corps, and they gave us back an Army that fights: Generals Creighton Abrams, Fred Weyand, Bernie Rogers, Shy Meyer, John Wickham, Carl Vuono, Gordon Sullivan, and Denny Reimer.

These leaders rose to their enormous task because they understood the important distinction between command and effective leadership. They taught us that command is about authority, about an appointment to position—a set of orders granting title. Effective leadership is different. It must be learned and practiced in order for it to rise to the level of art. It has to do with values internalized and the willingness to sacrifice or subordinate all other concerns—advancement, personal well-being, safety—for others. So these men of iron invested tremendous time, energy, and intellect in leader development—to ensure that those who are privileged to be selected for command approach their duties with a sense of reverence, trust, and the willingness to sacrifice all, if necessary, for those they lead. You must love those you lead before you can be an effective leader. You can certainly command without that sense of commitment, but you cannot lead without it; and without leadership, command is a hollow experience—a vacuum often filled with mistrust and arrogance.

Our mentors understood that mistrust and arrogance are antithetical to inspired and inspiring leadership, breeding discontent, fostering malcontents, and confusing intent within the force. And so our mentors worked to reestablish that most important of virtues in our army—trust—the foundation upon which we have built our reputation as an army. We owe them all a tremendous debt of gratitude for the magnificent Army we have today, and the legacy of trust and honor they sustained.

This week, we celebrate the Army's 228th birthday—228 years. The Army's long history is, in so many ways, also the history of our nation, a history including 10 wars and all the years of restless peace in between. In those years, soldiers have been both servant and savior to the nation. Today, our nation is once again at war. The current war brings me full circle to where I began my journey as a soldier—the lessons I learned in Vietnam are always with me. They involve changes in the way many of my generation learned to train, to lead, to fight, and to always offer our best military judgment to our superiors. These were hard-learned lessons. Lessons about loyalty, about taking care of the people who sacrifice the most for the good of the nation, about uncompromising readiness that is achieved only through tough, realistic training, about the necessity for inspired and inspiring leadership, about the agility and versatility demanded by a dynamic, strategic environment, and most importantly that the Army must do two things well each and every day—train soldiers and

grow them into leaders, leaders who can unequivocally and without hesitation answer the critical question asked of any war fighter. ''Can you fight? Can you fight?''

That question and those lessons are enduring ones for the profession of arms. Four years ago, with these lessons in mind, with the results of our comprehensive Army transition assessment in hand, and with our eyes always on the dynamic strategic environment, we decided to undertake fundamental and comprehensive change. Those initiatives informed the Army vision, a vision that consists of three imperatives. People. Readiness. Transformation.

Secretary Brownlee, thank you for so well capturing the Army's progress toward achieving that vision, a result of hard work by so many people. I'll only reinforce that transformation has never been about just one thing—the future combat system or the objective force—and the Army vision has never been about one person. The Army vision and transformation are about comprehensive change at the very heart of our institution, of our culture: doctrine, organization, training, leader development, materiel, and soldiers. This is the message we have consistently reiterated to all who are listening.

In these last months, the performance of soldiers and Army families has spoken loudly, clearly, and eloquently—since 11 September, we have been enormously successful operationally. In Afghanistan, as members of a combined, joint team, soldiers banished the Taliban and Al Qaeda in weeks. In Iraq, they fought with speed and agility to As-Samawah, An-Najaf, Al-Hillah, Karbala, and Baghdad, unseating a dictator, freeing an oppressed people, defeating a persistent enemy in spite of the harsh, unforgiving environment. Our soldiers demonstrated unprecedented agility and flexibility: JSOTF West—special operators fighting with armor and conventional artillery, JSOTF North—the 173rd ABN BDE—1,000 paratroopers make a night jump and fight alongside TF 1–63 Armor—1st ID, and TF 2–14 INF and a field artillery battery from the 10th Mountain; the 82nd ABN DIV Task organized with 2nd ACR(–), TF 1–41 (MECH) from Fort Riley, and a brigade of the 101st Air Assault Division; the 101st(–) fighting with TF 2–70 Armor of the 1st AD. With the greatest of agility, versatility, and courage, they fought to victory, demonstrating once again that all our magnificent moments as an Army are delivered by our people. They won the fights, and they are now facing and overcoming tremendous challenges to ensure the Afghan and Iraqi people have the opportunity to rebuild their societies and create governments characterized by democracy, prosperity, peace, and hope rather than barbarity, instability, and pervasive fear. Just as impressively, soldiers have simultaneously allowed our nation to fulfill commitments in other important regions—the Sinai, the Balkans, the Philippines, and Korea to name but a few. And had the situation in Korea gone hot, we'd have been there, too. With deeds, not words, they have unequivocally answered the question, ''Can you fight?'' They do not flinch. They do not waiver. Our Army fights and wins.

Those successes are enabled by our great young leaders—noncommissioned officers, lieutenants and captains, battalion and brigade commanders—who understand both what a privilege it is to lead soldiers, and the tremendous responsibility that accompanies that privilege. They love their units and the soldiers who fill them—that is the essence of leadership.

Leadership is essential in any profession, but effective leadership is paramount in the profession of arms—for those who wear the uniform and those who do not. We, in the Army, have been blessed with tremendous civilian leadership, most notably in the service of Secretary Tom White, who we farewelled last month. We understand that leadership is not an exclusive function of uniformed service. So when some suggest that we, in the Army, don't understand the importance of civilian control of the military, well, that's just not helpful. And it isn't true. The Army has always understood the primacy of civilian control. We reinforce that principle to those with whom we train all around the world. So to muddy the waters when important issues are at stake, issues of life and death, is a disservice to all of those in and out of uniform who serve and lead so well.

Our Army's soldiers and leaders have earned our country's highest admiration and our citizens' broad support. But even as we congratulate our soldiers when we welcome them home from battle, we must beware of the tendency some may have to draw the wrong conclusions, the wrong lessons from recent operations, remembering all the while that no lesson is learned until it changes behavior. We must always maintain our focus on readiness. We must ensure that the Army has the capabilities to match the strategic environment in which we operate, a force sized correctly to meet the strategy set forth in the documents that guide us—our national security and national military strategies. Beware the 12-division strategy for a 10-division army. Our soldiers and families bear the risk and the hardship of carrying a mission load that exceeds what force capabilities we can sustain, so we must alleviate risk and hardship by our willingness to resource the mission requirement. And we must remember that decisive victory often has less to do with the plan than it does with years invested in the training of soldiers and the growing of leaders. Our nation has seen war too many times to believe that victory on the battlefield is due primarily to the brilliance of a plan—as opposed to leadership, tactical and technical proficiency, sheer grit and determination of the men and women who do the fighting and the bleeding.

Throughout my career, it has been an honor to serve with leaders who understand and are committed to uphold those obligations and duties to soldiers. Today, we find that kind of dedicated and caring leadership at every level in our Army. We are an institution that lives our values. Loyalty. Duty. Respect. Selfless service. Honor. Integrity. Personal courage. Army values—the bedrock on which our institution is built.

Those values are demonstrated outside our ranks as well as within, shared by Army families, as well as soldiers. In these last months, at the toughest times of greatest sadness and hardship, I have again and again been reminded that Army families and spouses are the most generous people I know.

As I was on the first day of my tenure four years ago, I am humbled to stand here on my last day as the 34th Chief of Staff of the United States Army. I thank the President for his confidence and trust in allowing me the opportunity to serve the nation, and this Army that has been my family for 38 years. To soldiers past and present with whom I have served, you have my deep and abiding respect and my profound thanks.

There is a magnificent Army out there—full of pride, discipline, spirit, values, commitment, and passion. General Creighton Abrams reminded us that ''soldiering is an affair of the heart,'' and it's never been better to be a soldier. We are a magnificent Army, and the nation knows it, and honors our profession. Soldiers represent what's best about our Army and our nation. Noble by sacrifice, magnificent by performance, and respected by all, they make us better than we ever expected to be. And for 38 years now, soldiers have never allowed me to have a bad day.

My name is Shinseki, and I'm a soldier. God bless all of you and your families. God bless our soldiers and our magnificent Army, and God bless our great nation. Thank you, and goodbye.

SPEECH BY THE HONORABLE LES BROWNLEE, ACTING SECRETARY OF THE ARMY, AT THE RETIREMENT CEREMONY FOR GENERAL ERIC K. SHINSEKI AT FORT MYER, VA, ON JUNE 11, 2003

Welcome everyone, and thanks for joining the Army family for this special retirement ceremony in which we are honoring a great American soldier, General Ric Shinseki, and his wife, Patty.

Secretary and Mrs. Mineta, Senator Inouye, Senator Akaka, Senator Reed, Senator Cleland, Congressman Skelton, Congressman Lewis, Congressman Faleomavaega, Congressman Gene Taylor, Congressman Abercrombie, Congressman Charles Taylor, Congressman Frelinghuysen, and Congressman Reyes.

Secretary Gordon England, General Alexander Haig, former Secretary of the Army Togo West, General and Mrs. Barry McCaffrey, Secretary of the Air Force and Mrs. Roche, Jim and Diane, former Secretary of the Army and Mrs. White, Tom and Susan.

The members of our Joint Chiefs of Staff, beginning with our Chairman, General Dick Meyers, and his wife, Mary Jo; the wife of our Vice Chairman, Mrs. Lynne Pace; Chief of Naval Operations, Admiral Vern Clark, and Mrs. Clark; Commandant of the Marine Corps, General Mike Hagee, and Mrs. Hagee; the Commandant of the Coast Guard, Admiral Thomas Collins, and Mrs. Collins; our distinguished former Chiefs of Staff, General Vuono, General Sullivan, and General Reimer; the Vice Chief of Staff, General Jack Keane, and his wife Terry.

Our distinguished counterpart Chiefs of Staff from Canada, Germany, Croatia, Poland, and Russia. And our great Sergeant Major of the Army, the master of the one-armed pushup, Jack Tilley, and his wife, Gloria.

Senior Army leaders from the Secretariat and the Army Staff, our civilian aides to the Secretary of the Army, other distinguished general officers. Three generations of the Shinseki family. Soldiers, family members, and friends of the Army.

Welcome.

To Colonel Laufenberg and the Old Guard, and to Colonel Lamb and the Army Band, ''Pershing's Own,'' you are tremendous representatives of all of our soldiers defending freedom around the globe.

Thank you for your professionalism, and your willingness to serve your country. Let's give them a round of applause.

It has been my distinct privilege to serve with and around Ric Shinseki for the last four decades—from the jungles of Vietnam, through the Cold War, on Capitol Hill, and more recently, in the halls of the Pentagon.

In all of those environments, he has epitomized the quiet professional. And, being the genuinely humble and modest man that he is, Ric Shinseki will never take personal credit for the enormous impact that he has had on our Army.

In organizing these comments for today, I thought back to remarks General Shinseki made in July 2000 at the Hall of Heroes induction ceremony for 22 Medal of Honor recipients of Asian and Pacific Island heritage. He said then:

''Whenever I attend a function of one of these units . . . I am always struck by this

same kind of reticence, this unwillingness ever to bring attention upon oneself. In fact, it usually takes a friend to tell the story of another friend, which is why sometimes even family members of those veterans have never heard those stories. They are unaware of the fact that someone they've known only as a father or husband or uncle or a brother is, to many others, a hero of magnificent proportions.''

Well, I think he has summed up how all of us feel about Ric Shinseki. He is that quiet warrior, reluctant to speak for himself, always deflecting the spotlight to those around him and, most importantly, to the soldiers he has served so well and so faithfully.

General Shinseki has always said that the Army vision cannot be linked to one man, that it must be embraced by the entire Army.

But on this day of his retirement after 38 years of faithful and honorable service, it is fitting that we recognize his personal contributions to our nation and our Army.

Ric Shinseki saw a need to transform the Army and he had the courage, perseverance and intelligence to make it happen.

When war came, as he knew and predicted it would, he ensured that our great soldiers could fight—and that they had what they needed to guarantee victory for our nation.

Simply stated, the Chief looked to the future, and conceived a vision for what our Army must be able to do to protect our nation in the 21st century.

He translated that vision into an ambitious, yet doable, plan of action—revolving around people, readiness, and transformation.

He went out and got the resources and implemented his plan with tremendous intellect, courage, and sheer force of will, irrevocably changing our Army for the better.

All of this took tremendous courage on the Chief's part, at a time when the word ''transformation'' was relatively unknown.

There are some leaders who might have been able to accomplish one or maybe two of the above, but I know of no one else who could have accomplished it all.

While his strategic leadership skills were essential to the Army's successes, equally important have been the Chief's strength of character and love of our soldiers.

Many of you already know the story of the formative years of General Ric Shinseki's life.

He was born during World War II, when many Americans of Japanese ancestry were interned and labeled ''enemy aliens,'' even as their young men etched a legacy of heroism that remains unrivaled in the annuals of our Army's history.

He grew up among these heroes, indeed was appointed to West Point by one of the 442nd Regimental Combat Team's Medal of Honor recipients, Senator Daniel Inouye, who we are honored to have with us here today.

After graduation from the academy in 1965, Ric served twice in Vietnam, both times seriously wounded. His second wound was so severe, and his recovery so difficult, that the doctors wanted to put him out of the military.

He could have easily accepted the honor and accolades justly due a wounded warrior forced from service before his time, but he did not.

His love of soldiers—soldiers who had carried him out of combat on their backs—twice—and his love of our Army—was so deep that he persevered.

The iron will and depth of character that the Chief developed through the long, painful months of recovery steeled an already proven warrior. His willingness to fight on behalf of the Army has had as much to do with our Army's accomplishments as his skills as a strategic leader.

As we all know, transformation has grabbed many headlines, but the Chief's contributions to the warfighting readiness of the entire Army set the conditions for the successes our soldiers have delivered in Afghanistan and Iraq and elsewhere around the globe.

As he said in 1999, he didn't know when or where it would occur, but he knew the Army would fight during his tenure as the Chief. This motivated his focus on preparing for that moment. Nothing escaped his scrutiny, from filling combat units to 100-percent ensuring we had sufficient spare tank engines. The victories in Kabul and Baghdad were accomplished by our soldiers, but those soldiers were supported by an institution that had been keenly focused by the Chief on preparing them for battle. And one thing is certain: No army in history was equal to the Army that this Chief of Staff prepared for battle in Iraq. No Army was ever better equipped, trained, or motivated. All of us are proud of that Army, and about what they accomplished, and continue to accomplish today.

But, Ric, you will always enjoy a special pride—because this was truly your Army—molded and sculpted as a reflection of your leadership and your character.

As an Army, we also owe an enormous debt of gratitude to Patty Shinseki, who epitomizes all that is good and wonderful about Army spouses. Her genuine concern for others, her energy, and her grace under fire are remarkable.

She has known the fear of a wife whose husband goes to combat and returns wounded—twice.

She has moved over 30 times in 38 years, raised a wonderful family in the process, and has served as the senior leadership's greatest ambassador to Army families and so many other constituencies.

Patty and Ric Shinseki are a remarkable team. When Ric set his sights on improving the well-being of our Army, Patty turned a laser-like focus on these issues. The result was: spouse orientation and leadership programs, Army Family Team Building, and the Army Spouse Employment Summit, to name but a few.

In an Army in which over half of our soldiers are married, these measures enable us to retain soldiers and their families despite the many sacrifices they make on behalf of the nation.

Patty, thank you so much for all you have done for our soldiers, their families, for our communities, and the Army. We will deeply miss you.

Once again, I'd like to paraphrase from General Shinseki's own words: ''It has been said, 'Poor is the nation that has no heroes, but beggared is the nation that has and forgets them.' The man we honor today answered his nation's call to duty, and in doing so, honored his heritage and his country.''

In short, he is a soldier.

Ric, thank you for a lifetime of service and sacrifice, for your vision, your courage, your steadfastness, and for all you have done for our soldiers who are the Army. We will be forever in your debt.

May God always bless you and Patty and your family, our magnificent soldiers, our Army and this great nation. Thank you.

ADDITIONAL STATEMENTS

FOSTER'S DAILY DEMOCRAT

● Mr. SUNUNU. Mr. President, I rise today on the 130th anniversary of the first printing of New Hampshire's Foster's Daily Democrat to highlight the outstanding contribution that this family-owned newspaper has made to residents of the Granite State.

On June 18, 1873, Joshua L. Foster printed the paper's premiere edition in Dover, NH, using the motto: ''We shall devote these columns mainly to the material and vital interests of Dover and vicinity. Whatever may tend to benefit this people and enhance their prosperity, will receive our warm and enthusiastic support.''

Since that day, the paper's pages have remained under direct ownership of the Foster family, whose members have diligently guided it to today's milestone in publishing history.

Today, under the direction of Robert and Therese Foster, the paper's motto holds true, its staff continuing to bring readers—more than 30,000 per day—the most accurate and detailed local news, sports, and commentary.

Such an effort takes teamwork, which has existed through more than a century of local news production. Readers have known they could turn to the columns of this paper for the information they wanted, whether it be a birth announcement, a wedding notice, a school board vote, the Little League team photo, or the school bus route.

And, always an organization to stay ahead of the curve, Foster's has moved its pages online, taking the time to provide some of the most up-to-date news and information available in New Hampshire.

I have no doubt that Foster's will continue to demonstrate the positive results of working hard every day toward a common goal. It is a New Hampshire tradition, and one that deserves our recognition today.●

TRIBUTE TO DR. RALPH NURNBERGER

● Mr. MCCAIN. Madam President, I am honored today to pay tribute to a truly remarkable American, Dr. Ralph Nurnberger. As some of my colleagues may already know, Dr. Nurnberger was recently presented with the 2003 Excellence in Teaching Faculty Award from Georgetown University. I can think of no one more deserving of this award than Ralph Nurnberger. I have known Ralph for many years and I have long admired his dedication to Georgetown's students and his fellow faculty members. Anyone who has the privilege of knowing this fine man will agree that Georgetown University continues to be held in such high esteem because of professors like Ralph Nurnberger. He is a good friend and I extend my most sincere congratulations.

I ask unanimous consent that the text of the citation honoring Dr. Nurnberger be printed in the RECORD.

There being no objection, the material was ordered to be printed in the RECORD, as follows:

EXCELLENCE IN TEACHING FACULTY AWARD, GEORGETOWN UNIVERSITY, MAY 17, 2003

In 1977, just three years after the Liberal Studies Program started and two years after

receiving his Ph.D. in Diplomatic History at Georgetown University, Ralph Nurnberger began teaching in the Liberal Studies Degree Program. Over more than two decades he has taught courses in the Liberal Studies Program that focused on American foreign relations, the American national character and international relations, ideals and American foreign policy, Congressional relations and American foreign policy. Most recently he has been teaching a course on the aftermath of 9/11, considering the domestic and international aftermath for the United States.

Dr. Nurnberger's teaching has been accomplished with extensive experience in the field of domestic and international affairs and their interaction. His Capitol Hill experience included serving as foreign policy legislative assistant to Senator James Person (R-Kansas) and as a professional staff member of the Senate Foreign Relations Committee. He has been a senior Fellow and director of Congressional Relations for the Center for Strategic and International Studies (CSIS). He spent over eight years as a lobbyist for the American Israel Public Affairs Committee (AIPAC). In the wake of the Rabin-Arafat signing of the Oslo Accords he was appointed the Executive Director of an organization, ''Builders for Peace,'' set up with the guidance of then Vice-President Al Gore to help the Arab-Israeli peace process. His current position is that of Counsel with Preston Gates Ellis and Rouvelas Meeds law and lobbying firm and he also heads a government relations firm, Nurnberger and Associates, While teaching and filling these positions he has published extensively in major newspapers and journals. His most recent book deals with lobbying in America; his others have dealt with foreign policy and the political process.

Student evaluations applaud the examples and insights he can offer from real life experiences which are tempered and refined by his intellectual understanding and historical perspective. Students are particularly impressed with Dr. Nurnberger's ability to decipher complicated and contentious issues and make them understandable. His courses are engaging and insightful. In addition, students value the skillful balance he offers on these subjects, which in turn leads to thoughtful conversation and debate in class. He has become an example for the students in how to conduct civil discourse regardless of the intensity of emotion generated by a subject or the individual's own principles and convictions.

Over the years Ralph Nurnberger has patiently and meticulously directed numerous student theses, often against great odds but with sincere concern and unforgiving academic precision. When extraordinary demands were made on his time and attention his steady, generous commitment to the student's project made successful completion possible.

Today, we honor Ralph Nurnberger for his academic excellence which he transmits to and requires from his students; for his intellectual integrity whatever the issue; for his generous guidance of students' research; for his loyalty and enthusiasm for teaching Liberal Studies students these many years; for his ability to make sense of a so often chaotic world and America's role in that world. We are please to present him with the Excellence in Teaching Faculty Award for the year 2003.●

FATHER WILLIAM SHERMAN

● Mr. DORGAN. Madam President, for almost a half century a Catholic priest in North Dakota has lived a remarkable double life. In one guise, Father Bill Sherman is a holy man, the kind of warm and perfect parish priest who would have once been played by Spencer Tracy. But in his other role, he is the talented scholar and painstakingly diligent chronicler who, like no other authority, commands the ethnic history of North Dakota.

Because Father Sherman is retiring this month from the religious vineyards, I want to take note of his remarkable alter ego—that of the State's most eminent ethnic historian.

He has been a key player over the last 20 years in producing four impressive volumes on the subject—''Plain Folks: North Dakota's Ethnic History,'' ''Prairie Mosaic: An Ethnic Atlas of Rural North Dakota,'' ''African Americans in North Dakota,'' and the most recent book, ''Prairie Peddlers: Syrian-Lebanese in North Dakota,'' which is now coming off the presses. In addition, he was also one of the authors of ''Scattered Steeples, The Fargo Diocese, A Written Celebration of Its Centennial.''

His volumes on the State's ethnic heritage are extraordinary works—painstakingly researched, rich with thoughtful analysis, brightly written, and handsomely designed. They are works of careful scholarship of a high order and a real treasure for anyone intrigued with the marvelous ethnic diversity of America.

Born in Detroit in 1927, Father Sherman grew up in North Carolina and Oregon before his family moved to Lidgerwood, ND. After high school, he joined the Army, serving in the Philippines and Japan at the end of World War II. He graduated from St. John's University in Collegeville, MN, got a bachelor's degree from North Dakota State University and a master's degree from the University of North Dakota and became a priest in 1955.

He has served the parishes of the Cathedral of St. Mary in Fargo from 1955 to 1962, the Newman Center at the University of North Dakota from 1962 to 1964, St. Raphael's in Verona from 1964 to 1965, the Newman Center at NDSU from 1965 to 1975, St. Patrick's in Enderlin from 1975 to 1976 and finally the diocese's largest parish, the 5,000-member strong St. Michael's of Grand Forks for 27 years.

At UND, he taught religion and, at NDSU, where he is now professor emeritus, he taught sociology of religion and sociology of the Great Plains. He has received numerous awards, most recently an honorary doctorate of leadership degree from the University of Maryland.

In a profile of Father Sherman this month, the Grand Forks Herald said, ''Sherman's style, of being a sometimes gruff, no-nonsense defender of old-fashioned, blue-collar Catholicism, while being genial good company to anyone, and wearing his academic accomplishments lightly, attracted many to the parish. It's difficult, if not impossible, to find a discouraging word said about Sherman, a fairly remarkable fact about any member of the clergy who stays in one spot a long time.''

And a few days later, the editor of the newspaper called Father Sherman ''a remarkable man—a priest first and foremost, a man of old-fashioned faith, but also a scholar, a witty conversationalist, a polished orator, an able administrator, a distinguished patriot, a community builder, a cool head in a crisis, a giver and an excellent friend to many thousands of people both within and outside his church.''

Father Sherman is also a survivor. During the disastrous Red River flood of 1997, one of the worst to ever strike an American community, his parish was completed flooded and his church, school and rectory suffered heavy damage. Among the most painful losses was Father Sherman's collection of North Dakota history, a singular treasury of volumes on the State's heritage. But the indomitable cleric is now busy rebuilding that library and at work writing several more books, one on the transfer of Eastern European architecture to the Great Plains at the time of settlement and a second on another remarkable North Dakota priest who served during World War II with the Polish resistance.

It is clear that retirement to Father Sherman means something different than it does to the rest of us. Not only will he still minister on a part-time basis to Roman Catholics, but he will continue to energetically research and write about intriguing aspects of North Dakota's ethic legacy.

Although he has already provided a valuable and outstanding body of work on ethnic heritage, North Dakotans are grateful for his continued interest in the field. He is a scholar of the first order, a priest of the classic and finest model, and an exemplary citizen indeed.●

HONORING DONOVAN RILEY CLARKSON

● Mr. BUNNING. Madam President, I have the privilege and honor of rising today to recognize Mr. Donovan Riley Clarkson of Paducah, KY. Donovan was recently recognized for his accomplishments in dance.

This 10-year-old gentleman copes daily with the effects of central auditory processing disorder. In a person who suffers from this disorder, information is not correctly processed from the ear to the brain. This makes daily activities, from hearing conversations to hand-eye coordination, difficult to complete. Nevertheless, Donovan has not allowed this disorder to interfere with his dreams and accomplishments.

Donovan performs with a dance troupe at the Beverly Rogers Dance Academy. His family enrolled him in dance four years ago after a medical professional suggested that the movement could help his condition. Everyday after school, Donovan practices the assigned dance routine. He must practice twice as hard as his teammates in

order to execute these moves. This dedication paid off; he earned a spot on a local dance troupe. In fact, Donovan is the youngest member of this group. His big smile and smooth dance moves helped the group place first in many regional competitions and earn an almost perfect score, securing the troupe a spot in the national Odyssey Dance Competition held in Lakeside, FL.

Currently, Donovan attends the fourth grade at Reidland Elementary School in Paducah. His favorite subject is reading, which other individuals with his condition find difficult. In his free time, Donovan enjoys constructing toy models and Lego figures. However, spending time with his brother and sister is always on the top of his list.

What sets Donovan apart from other children is not his disorder or his remarkable dance skills, but his determination. He has overcome every single obstacle placed before him, making his life a testament to hard work. Please join me in congratulating Mr. Donovan Riley Clarkson and wishing him the best of luck.●

MESSAGES FROM THE PRESIDENT

Messages from the President of the United States were communicated to the Senate by Ms. Evans, one of his secretaries.

EXECUTIVE MESSAGES REFERRED

As in executive session the PRESIDING OFFICER laid before the Senate messages from the President of the United States submitting sundry nominations which were referred to the appropriate committees.

(The nominations received today are printed at the end of the Senate proceedings.)

MESSAGE FROM THE HOUSE

At 10:54 a.m., a message from the House of Representatives, delivered by Ms. Niland, one of its reading clerks, announced that the House agrees to the report of the committee of conference on the disagreeing votes of the two Houses on the amendment of the House of Representatives to the bill (S. 342) to amend the Child Abuse Prevention and Treatment Act to make improvements to and reauthorize programs under that Act, and for other purposes.

The message also announced that the House has agreed to the following concurrent resolution, without amendment:

S. Con. Res. 43. Concurrent resolution expressing the sense of Congress that Congress should participate in and support activities to provide decent homes for the people of the United States.

The message further announced that the House has passed the following bill, in which it requests the concurrence of the Senate:

H.R. 658. An act to provide for the protection of investors, increase confidence in the capital markets system, and fully implement the Sarbanes-Oxley Act of 2002 by streamlining the hiring process for certain employment positions in the Securities and Exchange Commission.

MEASURE REFERRED

The following concurrent resolution, previously received from the House of Representatives of concurrence, was referred as indicated:

H. Con. Res. 220. A concurrent resolution commending Medgar Wiley Evers and his widow, Myrlie Evers-Williams, for their lives and accomplishments; to the Committee on the Judiciary.

MEASURE HELD AT THE DESK

The following bill was ordered held at the desk by unanimous consent:

S. 1276. A bill to improve the manner in which the Corporation for National and Community Service approves, and records obligations relating to, national service positions.

EXECUTIVE AND OTHER COMMUNICATIONS

The following communications were laid before the Senate, together with accompanying papers, reports, and documents, and were referred as indicated:

EC–2797. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, a report entitled ''Assessment of Biofuels as an Alternative to Conventional Fossil Fuels''; to the Committee on Environment and Public Works.

EC–2798. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, a report entitled ''Assessment of Emissions Data and State Permit Information Available for Burning Biofuels (e.g., Animal Fats and Reclaimed Greases and Oils)''; to the Committee on Environment and Public Works.

EC–2799. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, a report entitled ''Headquarters Review of Site-Specific Risk Assessment Decisions for Hazardous Waste Combustors''; to the Committee on Environment and Public Works.

EC–2800. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, a report entitled ''Methyl Ethyl Ketone: Proposed Rule to Removal from Regulation as a Toxic Air Pollutant: Fact Sheet''; to the Committee on Environment and Public Works.

EC–2801. A communication from the Principal Deputy Associate Administrator of the Environmental Protection Agency, transmitting, a report entitled ''Use of the Site-Specific Risk Assessment Policy and Guidance for Hazardous Waste''; to the Committee on Environment and Public Works.

EC–2802. A communication from the Director of the Office of Management and Budget, Executive Office of the President, transmitting, pursuant to law, the OMB Cost Estimate for Pay-As-You-Go Calculations for Public Law 108–18; to the Committee on the Budget.

EC–2803. A communication from the Chairman of the United States International Trade Commission, transmitting, pursuant to law, a report on the U.S.-Singapore Free Trade Agreement—Potential Economywide and Selected Sectoral Effects; to the Committee on Finance.

EC–2804. A communication from the Chairman of the United States International Trade Commission, transmitting, pursuant to law, a report on the U.S.-Chile Free Trade Agreement—Potential Economywide and Selected Sectoral Effects; to the Committee on Finance.

EC–2805. A communication from the Regulations Coordinator, Centers for Medicare and Medicaid Services, Department of Health and Human Services, transmitting, pursuant to law, the report of a rule entitled ''Medicare Program: Change in the Methodology for Determining Payment for Extraordinarily High-Cost Cases (Cost Outliers) under the Acute Care Hospital Inpatient and Long-Term Care Hospital Prospective Payment Systems'' (RIN0938–AM41) received on June 9, 2003; to the Committee on Finance.

EC–2806. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Temporary Regulation Regarding Disclosures of Tax Information to Agriculture'' (TD 9060) received on June 5, 2003; to the Committee on Finance.

EC–2807. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Weighted Average Interest Rate Update Notice'' (Notice 2003–30) received on June 5, 2003; to the Committee on Finance.

EC–2808. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Bond Mediation Pilot Program'' (Ann. 2003–36) received on June 5, 2003; to the Committee on Finance.

EC–2809. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''IRC 512(a)(3) and 45B—Unrelated Business Taxable Income and the IRC 45B Credit'' (Rev. Rul. 2003–64) received on June 5, 2003; to the Committee on Finance.

EC–2810. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''LMSB Fast Track Settlement Procedure'' (Rev. Proc. 2003–40) received on June 5, 2003; to the Committee on Finance.

EC–2811. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''SBSE Fast Track Mediation Procedure'' (Rev. Proc. 2003–41) received on June 5, 2003; to the Committee on Finance.

EC–2812. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Salary Reduction of Retirement Benefits'' (Rev. Rul. 2003–62) received on June 5, 2003; to the Committee on Finance.

EC–2813. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Determination of Interest Rate'' (Rev. Rul. 2003–63) received on June 5, 2003; to the Committee on Finance.

EC–2814. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Automatic Extension of Time to File Certain Information Returns and Exempt Organization Returns'' (RIN1545–BB55: TD9061) received on June 5, 2003; to the Committee on Finance.

EC–2815. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Frozen Plan Vesting'' (Rev. Rul. 2003–65) received on June 5, 2003; to the Committee on Finance.

EC–2816. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Coordination of Sections 755 and 1060; Allocation of Basis Adjustments Among Partnership Assets and Application of the Residual Method to Certain Partnership Transactions'' (RIN1545–AX18: TD9059) received on June 5, 2003; to the Committee on Finance.

EC–2817. A communication from the Chief of the Regulations Unit, Internal Revenue Service, Department of the Treasury, transmitting, pursuant to law, the report of a rule entitled ''Update of Rev. Proc. 2002–47—Employee Plans Compliance Resolution System'' (Rev. Proc. 2003–44) received on June 5, 2003; to the Committee on Finance.

REPORTS OF COMMITTEES

The following reports of committees were submitted:

By Mr. INHOFE, from the Committee on Environment and Public Works:

Report to accompany S. 163, a bill to reauthorize the United States Institute for Environmental Conflict Resolution, and for other purposes (Rept. No. 108–74).

By Mr. CAMPBELL, from the Committee on Indian Affairs, with an amendment in the nature of a substitute:

S. 285. A bill to authorize the integration and consolidation of alcohol and substance abuse programs and services provided by Indian tribal governments, and for other purposes (Rept. No. 108–75).

By Mr. CAMPBELL, from the Committee on Indian Affairs, without amendment:

S. 558. A bill to elevate the position of Director of the Indian Health Service within the Department of Health and Human Services to Assistant Secretary for Indian Health, and for other purposes (Rept. No. 108–76).

By Mr. HATCH, from the Committee on the Judiciary, with amendments:

S. 1023. A bill to increase the annual salaries of justices and judges of the United States.

EXECUTIVE REPORTS OF COMMITTEES

The following executive reports of committees were submitted:

By Mr. COCHRAN for the Committee on Agriculture, Nutrition, and Forestry.

*Thomas C. Dorr, of Iowa, to be Under Secretary of Agriculture for Rural Development.

*Thomas C. Dorr, of Iowa, to be a Member of the Board of Directors of the Commodity Credit Corporation, vice Jill L. Long, resigned.

By Mr. WARNER for the Committee on Armed Services.

Army nomination of Lt. Gen. William S. Wallace.

Navy nomination of Adm. Edmund P. Giambastiani, Jr.

By Mr. ROBERTS for the Select Committee on Intelligence.

*Frank Libutti, of New York, to be Under Secretary for Information Analysis and Infrastructure Protection, Department of Homeland Security.

*Nomination was reported with recommendation that it be confirmed subject to the nominee's commitment to respond to requests to appear and testify before any duly constituted committee of the Senate.

(Nominations without an asterisk were reported with the recommendation that they be confirmed.)

INTRODUCTION OF BILLS AND JOINT RESOLUTIONS

The following bills and joint resolutions were introduced, read the first and second times by unanimous consent, and referred as indicated:

By Mr. BOND (for himself, Ms. MIKULSKI, Mr. SPECTER, Ms. COLLINS, Mr. ALEXANDER, Mr. SANTORUM, Mr. KENNEDY, Ms. SNOWE, Mr. BAUCUS, Mr. SARBANES, Mr. NELSON of Nebraska, Mr. BREAUX, Mrs. CLINTON, and Mr. BAYH):

S. 1276. A bill to improve the manner in which the Corporation for National and Community Service approves, and records obligations relating to, national service positions; considered and passed.

By Mr. BIDEN (for himself, Mr. MCCONNELL, Mr. BUNNING, and Mr. GRAHAM of South Carolina):

S. 1277. A bill to amend title I of the Omnibus Crime Control and Safe Streets Act of 1968 to provide standards and procedures to guide both State and local law enforcement agencies and law enforcement officers during internal investigations, interrogation of law enforcement officers, and administrative disciplinary hearings, to ensure accountability of law enforcement officers, to guarantee the due process rights of law enforcement discipline, accountability, and due process laws; to the Committee on the Judiciary.

By Mr. WYDEN (for himself, Mr. SMITH, Mr. ROCKEFELLER, and Mr. BREAUX):

S. 1278. A bill to amend the Public Health Service Act to provide for a public response to the public health crisis of pain, and for other puposes; to the Committee on Health, Education, Labor, and Pensions.

By Mr. VOINOVICH (for himself, Mrs. CLINTON, Mr. DEWINE, and Mr. SCHUMER):

S. 1279. A bill to amend the Robert T. Stafford Disaster Relief and Emergency Assistance Act to authorize the President to carry out a program for the protection of the health and safety of residents, workers, volunteers, and others in a disaster area; to the Committee on Environment and Public Works.

By Mr. HATCH (for himself and Mr. BIDEN):

S. 1280. A bill to amend the Protect Act to clarify certain volunteer liability; to the Committee on the Judiciary.

By Mr. GRAHAM of Florida:

S. 1281. A bill to amend title 38, United States Code, to presume additional diseases of former prisoners of war to be service-connected for compensation purposes, to enhance the Dose Reconstruction Program of the Department of Defense, to enhance and fund certain other epidemiological studies, and for other purposes; to the Committee on Veterans' Affairs.

By Mr. GRAHAM of Florida (for himself, Mr. NELSON of Florida, and Mr. SESSIONS):

S. 1282. A bill to require the Secretary of Veterans Affairs to establish national cemeteries for geographically underserved populations of veterans, and for other purposes; to the Committee on Veterans' Affairs.

By Mr. GRAHAM of Florida:

S. 1283. A bill to require advance notification of Congress regarding any action proposed to be taken by the Secretary of Veterans Affairs in the implementation of the Capital Asset Realignment for Enhanced Services initiative of the Department of Veterans Affairs, and for other purposes; to the Committee on Veterans' Affairs.

By Mrs. CLINTON:

S. 1284. A bill to provide for the establishment of the Kosovar-American Enterprise Fund to promote small business and microcredit lending and housing construction and reconstruction for Kosova; to the Committee on Foreign Relations.

By Mr. CARPER:

S. 1285. A bill to reform the postal laws of the United States; to the Committee on Governmental Affairs.

By Mr. LEAHY (for himself, Mr. DASCHLE, Mr. KENNEDY, Mr. FEINGOLD, and Mr. BINGAMAN):

S. 1286. A bill to combat nursing home fraud and abuse, increase protections for victims of telemarketing fraud, enhance safeguards for pension plans and health care benefit programs, and enhance penalties for crimes against seniors, and for other purposes; to the Committee on the Judiciary.

By Mr. DOMENICI:

S. 1287. A bill to amend section 502(a)(5) of the Higher Education Act of 1965 regarding the definition of a Hispanic-serving institution; to the Committee on Health, Education, Labor, and Pensions.

By Mr. CHAMBLISS (for himself and Mr. MILLER):

S. 1288. A bill to amend title XVIII of the Social Security Act to exclude brachytherapy devices from the prospective payment system for outpatient hospital services under the medicare program ; to the Committee on Finance.

SUBMISSION OF CONCURRENT AND SENATE RESOLUTIONS

The following concurrent resolutions and Senate resolutions were read, and referred (or acted upon), as indicated:

By Mr. HATCH:

S. Res. 174. A resolution designating Thursday, November 20, 2003, as ''Feed America Thursday''; to the Committee on the Judiciary.

By Mr. HATCH:

S. Res. 175. A resolution designating the month of October 2003, as ''Family History Month''; to the Committee on the Judiciary .

ADDITIONAL COSPONSORS

S. 13

At the request of Mr. KYL, the names of the Senator from Oregon (Mr. SMITH) and the Senator from Alaska (Ms. MURKOWSKI) were added as cosponsors of S. 13, a bill to provide financial security to family farm and small business owners by ending the unfair practice of taxing someone at death.

S. 76

At the request of Mr. DASCHLE, the name of the Senator from Massachusetts (Mr. KERRY) was added as a cosponsor of S. 76, a bill to amend the Fair Labor Standards Act of 1938 to provide more effective remedies to victims of discrimination in the payment of wages on the basis of sex, and for other purposes.

S. 171

At the request of Mr. DAYTON, the name of the Senator from Georgia (Mr.

CHAMBLISS) was added as a cosponsor of S. 171, a bill to amend the title XVIII of the Social Security Act to provide payment to medicare ambulance suppliers of the full costs of providing such services, and for other purposes.

S. 189

At the request of Mr. WYDEN, the names of the Senator from Massachusetts (Mr. KERRY) and the Senator from New Jersey (Mr. LAUTENBERG) were added as cosponsors of S. 189, a bill to authorize appropriations for nanoscience, nanoengineering, and nanotechnology research, and for other purposes.

S. 249

At the request of Mrs. MURRAY, her name was added as a cosponsor of S. 249, a bill to amend title 38, United States Code, to provide that remarriage of the surviving spouse of a deceased veteran after age 55 shall not result in termination of dependency and indemnity compensation otherwise payable to that surviving spouse.

S. 251

At the request of Mr. LOTT, the name of the Senator from Rhode Island (Mr. CHAFEE) was added as a cosponsor of S. 251, a bill to amend the Internal Revenue Code of 1986 to repeal the 4.3-cent motor fuel excise taxes on railroads and inland waterway transportation which remain in the general fund of the Treasury.

S. 300

At the request of Mr. KERRY, the names of the Senator from Nebraska (Mr. NELSON), the Senator from Louisiana (Mr. BREAUX), the Senator from Arkansas (Mrs. LINCOLN), the Senator from Minnesota (Mr. DAYTON) and the Senator from Nevada (Mr. REID) were added as cosponsors of S. 300, a bill to award a congressional gold medal to Jackie Robinson (posthumously), in recognition of his many contributions to the Nation, and to express the sense of Congress that there should be a national day in recognition of Jackie Robinson.

S. 316

At the request of Mr. CORZINE, the name of the Senator from Louisiana (Ms. LANDRIEU) was added as a cosponsor of S. 316, a bill to amend part A of title IV of the Social Security Act to include efforts to address barriers to employment as a work activity under the temporary assistance to needy families program, and for other purposes.

S. 333

At the request of Mr. BREAUX, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 333, a bill to promote elder justice, and for other purposes.

S. 480

At the request of Mr. HARKIN, the name of the Senator from Georgia (Mr. CHAMBLISS) was added as a cosponsor of S. 480, a bill to provide competitive grants for training court reporters and closed captioners to meet requirements for realtime writers under the Telecommunications Act of 1996, and for other purposes.

S. 518

At the request of Ms. COLLINS, the name of the Senator from New York (Mrs. CLINTON) was added as a cosponsor of S. 518, a bill to increase the supply of pancreatic islet cells for research, to provide better coordination of Federal efforts and information on islet cell transplantation, and to collect the data necessary to move islet cell transplantation from an experimental procedure to a standard therapy.

S. 557

At the request of Ms. COLLINS, the name of the Senator from Georgia (Mr. MILLER) was added as a cosponsor of S. 557, a bill to amend the Internal Revenue Code of 1986 to exclude from gross income amounts received on account of claims based on certain unlawful discrimination and to allow income averaging for backpay and frontpay awards received on account of such claims, and for other purposes.

S. 595

At the request of Mr. HATCH, the name of the Senator from Arkansas (Mrs. LINCOLN) was added as a cosponsor of S. 595, a bill to amend the Internal Revenue Code of 1986 to repeal the required use of certain principal repayments on mortgage subsidy bond financings to redeem bonds, to modify the purchase price limitation under mortgage subsidy bond rules based on median family income, and for other purposes.

S. 623

At the request of Mr. WARNER, the name of the Senator from New York (Mr. SCHUMER) was added as a cosponsor of S. 623, a bill to amend the Internal Revenue Code of 1986 to allow Federal civilian and military retirees to pay health insurance premiums on a pretax basis and to allow a deduction for TRICARE supplemental premiums.

S. 659

At the request of Mr. CRAIG, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 659, a bill to prohibit civil liability actions from being brought or continued against manufacturers, distributors, dealers, or importers of firearms or ammunition for damages resulting from the misuse of their products by others.

S. 678

At the request of Mr. AKAKA, the name of the Senator from Montana (Mr. BAUCUS) was added as a cosponsor of S. 678, a bill to amend chapter 10 of title 39, United States Code, to include postmasters and postmasters organizations in the process for the development and planning of certain policies, schedules, and programs, and for other purposes.

S. 877

At the request of Mr. BURNS, the name of the Senator from New Jersey (Mr. LAUTENBERG) was added as a cosponsor of S. 877, a bill to regulate interstate commerce by imposing limitations and penalties on the transmission of unsolicited commercial electronic mail via the Internet.

S. 882

At the request of Mr. BAUCUS, the name of the Senator from Utah (Mr. HATCH) was added as a cosponsor of S. 882, a bill to amend the Internal Revenue Code of 1986 to provide improvements in tax administration and taxpayer safe-guards, and for other purposes.

S. 893

At the request of Mr. SANTORUM, the name of the Senator from Missouri (Mr. TALENT) was added as a cosponsor of S. 893, a bill to amend title VII of the Civil Rights Act of 1964 to establish provisions with respect to religious accommodation in employment, and for other purposes.

S. 939

At the request of Mr. HAGEL, the name of the Senator from New Jersey (Mr. CORZINE) was added as a cosponsor of S. 939, a bill to amend part B of the Individuals with Disabilities Education Act to provide full Federal funding of such part, to provide an exception to the local maintenance of effort requirements, and for other purposes.

S. 979

At the request of Mr. ENSIGN, the name of the Senator from Oklahoma (Mr. NICKLES) was added as a cosponsor of S. 979, a bill to direct the Securities and Exchange Commission to require enhanced disclosures of employee stock options, to require a study on the economic impact of broad-based employee stock option plans, and for other purposes.

S. 982

At the request of Mr. SANTORUM, the name of the Senator from Maine (Ms. SNOWE) was added as a cosponsor of S. 982, a bill to halt Syrian support for terrorism, end its occupation of Lebanon, stop its development of weapons of mass destruction, cease its illegal importation of Iraqi oil, and hold Syria accountable for its role in the Middle East, and for other purposes.

S. 982

At the request of Mrs. BOXER, the name of the Senator from Texas (Mr. CORNYN) was added as a cosponsor of S. 982, supra.

S. 983

At the request of Mr. CHAFEE, the names of the Senator from New Hampshire (Mr. SUNUNU), the Senator from Massachusetts (Mr. KERRY) and the Senator from Georgia (Mr. CHAMBLISS) were added as cosponsors of S. 983, a bill to amend the Public Health Service Act to authorize the Director of the National Institute of Environmental Health Sciences to make grants for the development and operation of research centers regarding environmental factors that may be related to the etiology of breast cancer.

S. 985

At the request of Mr. DODD, the name of the Senator from Arizona (Mr.

MCCAIN) was added as a cosponsor of S. 985, a bill to amend the Federal Law Enforcement Pay Reform Act of 1990 to adjust the percentage differentials payable to Federal law enforcement officers in certain high-cost areas, and for other purposes.

S. 1046

At the request of Mr. HOLLINGS, the name of the Senator from Massachusetts (Mr. KENNEDY) was added as a cosponsor of S. 1046, a bill to amend the Communications Act of 1934 to preserve localism, to foster and promote the diversity of television programming, to foster and promote competition, and to prevent excessive concentration of ownership of the nation's television broadcast stations.

S. 1052

At the request of Mr. NELSON of Florida, the name of the Senator from Arkansas (Mr. PRYOR) was added as a cosponsor of S. 1052, a bill to ensure that recipients of unsolicited bulk commercial electronic mail can identify the sender of such electronic mail, and for other purposes.

S. 1091

At the request of Mr. DURBIN, the name of the Senator from Arkansas (Mr. PRYOR) was added as a cosponsor of S. 1091, a bill to provide funding for student loan repayment for public attorneys.

S. 1115

At the request of Mrs. MURRAY, the names of the Senator from California (Mrs. FEINSTEIN) and the Senator from Wisconsin (Mr. FEINGOLD) were added as cosponsors of S. 1115, a bill to amend the Toxic Substances Control Act to reduce the health risks posed by asbestos-containing products.

S. 1180

At the request of Mr. SANTORUM, the name of the Senator from Kentucky (Mr. BUNNING) was added as a cosponsor of S. 1180, a bill to amend the Internal Revenue Code of 1986 to modify the work opportunity credit and the welfare-to-work credit.

S. 1181

At the request of Mr. CORZINE, the name of the Senator from Montana (Mr. BAUCUS) was added as a cosponsor of S. 1181, a bill to promote youth financial education.

S. 1201

At the request of Mr. GRAHAM of South Carolina, the names of the Senator from Kansas (Mr. BROWNBACK) and the Senator from Georgia (Mr. CHAMBLISS) were added as cosponsors of S. 1201, a bill to promote healthy lifestyles and prevent unhealthy, risky behaviors among teenage youth.

S. 1233

At the request of Ms. MIKULSKI, the name of the Senator from Illinois (Mr. DURBIN) was added as a cosponsor of S. 1233, a bill to authorize assistance for the National Great Blacks in Wax Museum and Justice Learning Center.

S. 1237

At the request of Mr. BENNETT, the names of the Senator from West Virginia (Mr. ROCKEFELLER) and the Senator from Nevada (Mr. ENSIGN) were added as cosponsors of S. 1237, a bill to amend the Rehabilitation Act of 1973 to provide for more equitable allotment of funds to States for centers for independent living.

S. 1248

At the request of Mr. GREGG, the name of the Senator from Wyoming (Mr. ENZI) was added as a cosponsor of S. 1248, a bill to reauthorize the Individuals with Disabilities Education Act, and for other purposes.

S. 1273

At the request of Mr. KENNEDY, the name of the Senator from Maryland (Ms. MIKULSKI) was added as a cosponsor of S. 1273, a bill to provide for a study to ensure that students are not adversely affected by changes to the needs analysis tables, and to require the Secretary of Education to consult with the Advisory Committee on Student Financial Assistance regarding such changes.

S. CON. RES. 27

At the request of Mr. BOND, the name of the Senator from Georgia (Mr. CHAMBLISS) was added as a cosponsor of S. Con. Res. 27, a concurrent resolution urging the President to request the United States International Trade Commission to take certain actions with respect to the temporary safeguards on imports of certain steel products, and for other purposes.

S. CON. RES. 45

At the request of Ms. LANDRIEU, the name of the Senator from Indiana (Mr. BAYH) was added as a cosponsor of S. Con. Res. 45, a concurrent resolution expressing appreciation to the Government of Kuwait for the medical assistance it provided to Ali Ismaeel Abbas and other children of Iraq and for the additional humanitarian aid provided by the Government and people of Kuwait, and for other purposes.

S. CON. RES. 52

At the request of Mr. HARKIN, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. Con. Res. 52, a concurrent resolution expressing the sense of Congress that the United States Government should support the human rights and dignity of all persons with disabilities by pledging support for the drafting and working toward the adoption of a thematic convention on the human rights and dignity of persons with disabilities by the United Nations General Assembly to augment the existing United Nations human rights system, and for other purposes.

S. RES. 151

At the request of Mr. WYDEN, the name of the Senator from Oregon (Mr. SMITH) was added as a cosponsor of S. Res. 151, a resolution eliminating secret Senate holds.

STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. BIDEN (for himself, Mr. MCCONNELL, Mr. BUNNING, and Mr. GRAHAM of South Carolina):

S. 1277. A bill to amend title I of the Omnibus Crime Control and Safe Streets Act of 1968 to provide standards and procedures to guide both State and local law enforcement agencies and law enforcement officers during internal investigations, interrogation of law enforcement officers, and administrative disciplinary hearings, to ensure accountability of law enforcement officers, to guarantee the due process rights of law enforcement discipline, accountability, and due process laws; to the Committee on the Judiciary.

Mr. BIDEN. Mr. President, I rise to introduce the Law Enforcement Discipline, Accountability, and Due Process Act of 2003, along with the Chairman of the Judiciary Subcommittee on Crime, Corrections and Victims' Rights Senator GRAHAM, Senator MCCONNELL and Senator BUNNING.

These are trying times for the men and women on our front lines providing domestic security, our Nation's law enforcement personnel. State and local fiscal problems are forcing many communities to cut their police budgets. Each change in the Nation's homeland security alert level results in increased overtime and other costs for local law enforcement. Just yesterday, the FBI reported that the number of murders and rapes was up across the country in 2002. And this Administration is determined to dramatically scale back Federal crime-fighting initiatives like the COPS program, a proven initiative that has been hailed as one of the keys to the crime-drop of the nineties.

At the same time, the men and women of law enforcement work in extremely dangerous environments. An average of 165 police officers are killed in the line of duty every year. And at times, internal police investigations and administrative hearings do not provide officers with basic protections. According to the National Association of Police Organizations, ''[i]n roughly half of the states in this country, officers enjoy some legal protections against false accusations and abusive conduct, but hundreds of thousands of officers have very limited due process rights and confront limitations on their exercise of other rights, such as the right to engage in political activities.'' The Fraternal Order of Police notes that, ''[i]n a startling number of jurisdictions throughout this country, law enforcement officers have no procedural or administrative protections whatsoever; in fact, they can be, and frequently are, summarily dismissed from their jobs without explanation. Officers who lose their careers due to administrative or political expediency almost always find it impossible to find new employment in public safety. An officer's reputation, once tarnished by accusation, is almost impossible to restore.''

This legislation we introduce today seeks to provide officers with certain basic protections in those jurisdictions where such workplace protections are not currently provided. This bill allows law enforcement officials to engage in political activities. It provides standards and procedures to guide State and local law enforcement agencies during internal investigations, interrogations, and administrative disciplinary hearings of law enforcement officers, and it calls upon States to develop and enforce these disciplinary procedures. The bill would preempt State laws which confer fewer rights than those provided for in the legislation, but it would not preempt any State or local laws that confer rights or protections that are equal to or exceed the rights and protections afforded in the bill. My own State of Delaware has its own law enforcement officers' bill of rights, and as such Delaware would not be impacted by the provisions of this bill. I am pleased that the bill has earned the endorsement of the Fraternal Order of Police and of the National Association of Police Organizations.

Beyond benefiting those on the front lines of local law enforcement, this bill would enhance the ability of our citizens to hold their local police accountable if they do transgress while on the job. The legislation includes provisions that will ensure citizen complaints against police officers are investigated, and that citizens are informed of the outcome of these investigations. The bill balances the rights of police officers with the rights of citizens to raise valid concerns about the conduct of some of these officers. In addition, I have consulted with constitutional experts who have opined that the bill is consistent with Congress' powers under the Commerce Clause and that it does not run afoul of the Supreme Court's Tenth Amendment jurisprudence.

While I believe that the bill we introduce today takes the right approach, I want to note the International Association of Chiefs of Police's opposition to this measure. In April of this year I met with Richmond, California Chief of Police Joseph Samuels, the president of the IACP. Chief Samuels and I acknowledged that we disagreed on this bill, but I pledged to him that their concerns would be heard and taken into consideration as the bill we introduce today is debated in Congress. It is my view that without a meeting of the minds between police management and union officials on this issue, enactment of a meaningful law enforcement officers' bill of rights will be difficult. It is my hope that the newly-constituted Subcommittee on Crime, Corrections and Victims' Rights, on which I serve as ranking member, will hold a hearing on this measure. That subcommittee is the proper forum in which to debate the merits of our approach to guaranteeing basic procedural safeguards to the men and women of law enforcement.

I urge my colleagues to join Senators GRAHAM, MCCONNELL, BUNNING and me in providing all of the Nation's law enforcement officers with the basic rights they deserve.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the Bill was ordered to be printed in the RECORD, as follows:

S. 1277

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''State and Local Law Enforcement Discipline, Accountability, and Due Process Act of 2003''.

SEC. 2. FINDINGS AND DECLARATION OF PURPOSE AND POLICY.

(a) FINDINGS.—Congress finds that—

(1) the rights of law enforcement officers to engage in political activity or to refrain from engaging in political activity, except when on duty, or to run as candidates for public office, unless such service is found to be in conflict with their service as officers, are activities protected by the first amendment of the United States Constitution, as applied to the States through the 14th amendment of the United States Constitution, but these rights are often violated by the management of State and local law enforcement agencies;

(2) a significant lack of due process rights of law enforcement officers during internal investigations and disciplinary proceedings has resulted in a loss of confidence in these processes by many law enforcement officers, including those unfairly targeted for their labor organization activities or for their aggressive enforcement of the laws, demoralizing many rank and file officers in communities and States;

(3) unfair treatment of officers has potentially serious long-term consequences for law enforcement by potentially deterring or otherwise preventing officers from carrying out their duties and responsibilities effectively and fairly;

(4) the lack of labor-management cooperation in disciplinary matters and either the perception or the actuality that officers are not treated fairly detrimentally impacts the recruitment of and retention of effective officers, as potential officers and experienced officers seek other careers which has serious implications and repercussions for officer morale, public safety, and labor-management relations and strife and can affect interstate and intrastate commerce, interfering with the normal flow of commerce;

(5) there are serious implications for the public safety of the citizens and residents of the United States which threatens the domestic tranquility of the United States because of a lack of statutory protections to ensure—

(i) the due process and political rights of law enforcement officers;

(ii) fair and thorough internal investigations and interrogations of and disciplinary proceedings against law enforcement officers; and

(iii) effective procedures for receipt, review, and investigation of complaints against officers, fair to both officers and complainants; and

(6) resolving these disputes and problems and preventing the disruption of vital police services is essential to the well-being of the United States and the domestic tranquility of the Nation.

(b) DECLARATION OF POLICY.—Congress declares that it is the purpose of this Act and the policy of the United States to—

(1) protect the due process and political rights of State and local law enforcement officers and ensure equality and fairness of treatment among such officers;

(2) provide continued police protection to the general public;

(3) provide for the general welfare and ensure domestic tranquility; and

(4) prevent any impediments to the free flow of commerce, under the rights guaranteed under the United States Constitution and Congress' authority thereunder.

SEC. 3. DISCIPLINE, ACCOUNTABILITY, AND DUE PROCESS OF OFFICERS.

(a) IN GENERAL.—Part H of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3781 et seq.) is amended by adding at the end the following:

''SEC. 820. DISCIPLINE, ACCOUNTABILITY, AND DUE PROCESS OF STATE AND LOCAL LAW ENFORCEMENT OFFICERS.

''(a) DEFINITIONS.—In this section:

''(1) DISCIPLINARY ACTION.—The term 'disciplinary action' means any adverse personnel action, including suspension, reduction in pay, rank, or other employment benefit, dismissal, transfer, reassignment, unreasonable denial of secondary employment, or similar punitive action taken against a law enforcement officer.

''(2) DISCIPLINARY HEARING.—The term 'disciplinary hearing' means an administrative hearing initiated by a law enforcement agency against a law enforcement officer, based on an alleged violation of law, that, if proven, would subject the law enforcement officer to disciplinary action.

''(3) EMERGENCY SUSPENSION.—The term 'emergency suspension' means the temporary action by a law enforcement agency of relieving a law enforcement officer from the active performance of law enforcement duties without a reduction in pay or benefits when the law enforcement agency, or an official within that agency, determines that there is probable cause, based upon the conduct of the law enforcement officer, to believe that the law enforcement officer poses an immediate threat to the safety of that officer or others or the property of others.

''(4) INVESTIGATION.—The term 'investigation'—

''(A) means an action taken to determine whether a law enforcement officer violated a law by a public agency or a person employed by a public agency, acting alone or in cooperation with or at the direction of another agency, or a division or unit within another agency, regardless of a denial by such an agency that any such action is not an investigation; and

''(B) includes—

''(i) asking questions of any other law enforcement officer or non-law enforcement officer;

''(ii) conducting observations;

''(iii) reviewing and evaluating reports, records, or other documents; and

''(iv) examining physical evidence.

''(5) LAW ENFORCEMENT OFFICER.—The terms 'law enforcement officer' and 'officer' have the meaning given the term 'law enforcement officer' in section 1204, except the term does not include a law enforcement officer employed by the United States, or any department, agency, or instrumentality thereof.

''(6) PERSONNEL RECORD.—The term 'personnel record' means any document, whether in written or electronic form and irrespective of location, that has been or may be used in determining the qualifications of a law enforcement officer for employment, promotion, transfer, additional compensation, termination or any other disciplinary action.

''(7) PUBLIC AGENCY AND LAW ENFORCEMENT AGENCY.—The terms 'public agency' and 'law enforcement agency' each have the meaning given the term 'public agency' in section

1204, except the terms do not include the United States, or any department, agency, or instrumentality thereof.

''(8) SUMMARY PUNISHMENT.—The term 'summary punishment' means punishment imposed—

''(A) for a violation of law that does not result in any disciplinary action; or

''(B) for a violation of law that has been negotiated and agreed upon by the law enforcement agency and the law enforcement officer, based upon a written waiver by the officer of the rights of that officer under subsection (i) and any other applicable law or constitutional provision, after consultation with the counsel or representative of that officer.

''(b) APPLICABILITY.—

''(1) IN GENERAL.—This section sets forth the due process rights, including procedures, that shall be afforded a law enforcement officer who is the subject of an investigation or disciplinary hearing.

''(2) NONAPPLICABILITY.—This section does not apply in the case of—

''(A) an investigation of specifically alleged conduct by a law enforcement officer that, if proven, would constitute a violation of a statute providing for criminal penalties; or

''(B) a nondisciplinary action taken in good faith on the basis of the employment related performance of a law enforcement officer.

''(c) POLITICAL ACTIVITY.—

''(1) RIGHT TO ENGAGE OR NOT TO ENGAGE IN POLITICAL ACTIVITY.—Except when on duty or acting in an official capacity, a law enforcement officer shall not be prohibited from engaging in political activity or be denied the right to refrain from engaging in political activity.

''(2) RIGHT TO RUN FOR ELECTIVE OFFICE.—A law enforcement officer shall not be—

''(A) prohibited from being a candidate for an elective office or from serving in such an elective office, solely because of the status of the officer as a law enforcement officer; or

''(B) required to resign or take an unpaid leave from employment with a law enforcement agency to be a candidate for an elective office or to serve in an elective office, unless such service is determined to be in conflict with or incompatible with service as a law enforcement officer.

''(3) ADVERSE PERSONNEL ACTION.—An action by a public agency against a law enforcement officer, including requiring the officer to take unpaid leave from employment, in violation of this subsection shall be considered an adverse personnel action within the meaning of subsection (a)(1).

''(d) EFFECTIVE PROCEDURES FOR RECEIPT, REVIEW, AND INVESTIGATION OF COMPLAINTS AGAINST LAW ENFORCEMENT OFFICERS.—

''(1) COMPLAINT PROCESS.—Not later than 1 year after the effective date of this section, each law enforcement agency shall adopt and comply with a written complaint procedure that—

''(A) authorizes persons from outside the law enforcement agency to submit written complaints about a law enforcement officer to—

''(i) the law enforcement agency employing the law enforcement officer; or

''(ii) any other law enforcement agency charged with investigating such complaints;

''(B) sets forth the procedures for the investigation and disposition of such complaints;

''(C) provides for public access to required forms and other information concerning the submission and disposition of written complaints; and

''(D) requires notification to the complainant in writing of the final disposition of the complaint and the reasons for such disposition.

''(2) INITIATION OF AN INVESTIGATION.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), an investigation based on a complaint from outside the law enforcement agency shall commence not later than 15 days after the receipt of the complaint by—

''(i) the law enforcement agency employing the law enforcement officer against whom the complaint has been made; or

''(ii) any other law enforcement agency charged with investigating such a complaint.

''(B) EXCEPTION.—Subparagraph (A) does not apply if—

''(i) the law enforcement agency determines from the face of the complaint that each allegation does not constitute a violation of law; or

''(ii) the complainant fails to comply substantially with the complaint procedure of the law enforcement agency established under this section.

''(3) COMPLAINANT OR VICTIM CONFLICT OF INTEREST.—The complainant or victim of the alleged violation of law giving rise to an investigation under this subsection may not conduct or supervise the investigation or serve as an investigator.

''(e) NOTICE OF INVESTIGATION.—

''(1) IN GENERAL.—Any law enforcement officer who is the subject of an investigation shall be notified of the investigation 24 hours before the commencement of questioning or to otherwise being required to provide information to an investigating agency.

''(2) CONTENTS OF NOTICE.—Notice given under paragraph (1) shall include—

''(A) the nature and scope of the investigation;

''(B) a description of any allegation contained in a written complaint;

''(C) a description of each violation of law alleged in the complaint for which suspicion exists that the officer may have engaged in conduct that may subject the officer to disciplinary action; and

''(D) the name, rank, and command of the officer or any other individual who will be conducting the investigation.

''(f) RIGHTS OF LAW ENFORCEMENT OFFICERS PRIOR TO AND DURING QUESTIONING INCIDENTAL TO AN INVESTIGATION.—If a law enforcement officer is subjected to questioning incidental to an investigation that may result in disciplinary action against the officer, the following minimum safeguards shall apply:

''(1) COUNSEL AND REPRESENTATION.—

''(A) IN GENERAL.—Any law enforcement officer under investigation shall be entitled to effective counsel by an attorney or representation by any other person who the officer chooses, such as an employee representative, or both, immediately before and during the entire period of any questioning session, unless the officer consents in writing to being questioned outside the presence of counsel or representative.

''(B) PRIVATE CONSULTATION.—During the course of any questioning session, the officer shall be afforded the opportunity to consult privately with counsel or a representative, if such consultation does not repeatedly and unnecessarily disrupt the questioning period.

''(C) UNAVAILABILITY OF COUNSEL.—If the counsel or representative of the law enforcement officer is not available within 24 hours of the time set for the commencement of any questioning of that officer, the investigating law enforcement agency shall grant a reasonable extension of time for the law enforcement officer to obtain counsel or representation.

''(2) REASONABLE HOURS AND TIME.—Any questioning of a law enforcement officer under investigation shall be conducted at a reasonable time when the officer is on duty, unless exigent circumstances compel more immediate questioning, or the officer agrees in writing to being questioned at a different time, subject to the requirements of subsections (e) and (f)(1).

''(3) PLACE OF QUESTIONING.—Unless the officer consents in writing to being questioned elsewhere, any questioning of a law enforcement officer under investigation shall take place—

''(A) at the office of the individual conducting the investigation on behalf of the law enforcement agency employing the officer under investigation; or

''(B) the place at which the officer under investigation reports for duty.

''(4) IDENTIFICATION OF QUESTIONER.—Before the commencement of any questioning, a law enforcement officer under investigation shall be informed of—

''(A) the name, rank, and command of the officer or other individual who will conduct the questioning; and

''(B) the relationship between the individual conducting the questioning and the law enforcement agency employing the officer under investigation.

''(5) SINGLE QUESTIONER.—During any single period of questioning of a law enforcement officer under investigation, each question shall be asked by or through 1 individual.

''(6) REASONABLE TIME PERIOD.—Any questioning of a law enforcement officer under investigation shall be for a reasonable period of time and shall allow reasonable periods for the rest and personal necessities of the officer and the counsel or representative of the officer, if such person is present.

''(7) NO THREATS, FALSE STATEMENTS, OR PROMISES TO BE MADE.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), no threat against, false or misleading statement to, harassment of, or promise of reward to a law enforcement officer under investigation shall be made to induce the officer to answer any question, give any statement, or otherwise provide information.

''(B) EXCEPTION.—The law enforcement agency employing a law enforcement officer under investigation may require the officer to make a statement relating to the investigation by explicitly threatening disciplinary action, including termination, only if—

''(i) the officer has received a written grant of use and derivative use immunity or transactional immunity by a person authorized to grant such immunity; and

''(ii) the statement given by the law enforcement officer under such an immunity may not be used in any subsequent criminal proceeding against that officer.

''(8) RECORDING.—

''(A) IN GENERAL.—All questioning of a law enforcement officer under an investigation shall be recorded in full, in writing or by electronic device, and a copy of the transcript shall be provided to the officer under investigation before any subsequent period of questioning or the filing of any charge against that officer.

''(B) SEPARATE RECORDING.—To ensure the accuracy of the recording, an officer may utilize a separate electronic recording device, and a copy of any such recording (or the transcript) shall be provided to the public agency conducting the questioning, if that agency so requests.

''(9) USE OF HONESTY TESTING DEVICES PROHIBITED.—No law enforcement officer under investigation may be compelled to submit to the use of a lie detector, as defined in section 2 of the Employee Polygraph Protection Act of 1988 (29 U.S.C. 2001).

''(g) NOTICE OF INVESTIGATIVE FINDINGS AND DISCIPLINARY RECOMMENDATION AND OPPORTUNITY TO SUBMIT A WRITTEN RESPONSE.—

''(1) NOTICE.—Not later than 30 days after the conclusion of an investigation under this section, the person in charge of the investigation or the designee of that person shall notify the law enforcement officer who was the subject of the investigation, in writing, of the investigative findings and any recommendations for disciplinary action.

''(2) OPPORTUNITY TO SUBMIT WRITTEN RESPONSE.—

''(A) IN GENERAL.—Not later than 30 days after receipt of a notification under paragraph (1), and before the filing of any charge seeking the discipline of such officer or the commencement of any disciplinary proceeding under subsection (h), the law enforcement officer who was the subject of the investigation may submit a written response to the findings and recommendations included in the notification.

''(B) CONTENTS OF RESPONSE.—The response submitted under subparagraph (A) may include references to additional documents, physical objects, witnesses, or any other information that the law enforcement officer believes may provide exculpatory evidence.

''(h) DISCIPLINARY HEARING.—

''(1) NOTICE OF OPPORTUNITY FOR HEARING.—Except in a case of summary punishment or emergency suspension (subject to subsection (k)), before the imposition of any disciplinary action the law enforcement agency shall notify the officer that the officer is entitled to a due process hearing by an independent and impartial hearing officer or board.

''(2) REQUIREMENT OF DETERMINATION OF VIOLATION.—No disciplinary action may be taken against a law enforcement officer unless an independent and impartial hearing officer or board determines, after a hearing and in accordance with the requirements of this subsection, that the law enforcement officer committed a violation of law.

''(3) TIME LIMIT.—No disciplinary charge may be brought against a law enforcement officer unless—

''(A) the charge is filed not later than the earlier of—

''(i) 1 year after the date on which the law enforcement agency filing the charge had knowledge or reasonably should have had knowledge of an alleged violation of law; or

''(ii) 90 days after the commencement of an investigation; or

''(B) the requirements of this paragraph are waived in writing by the officer or the counsel or representative of the officer.

''(4) NOTICE OF HEARING.—Unless waived in writing by the officer or the counsel or representative of the officer, not later than 30 days after the filing of a disciplinary charge against a law enforcement officer, the law enforcement agency filing the charge shall provide written notification to the law enforcement officer who is the subject of the charge, of—

''(A) the date, time, and location of any disciplinary hearing, which shall be scheduled in cooperation with the law enforcement officer, or the counsel or representative of the officer, and which shall take place not earlier than 30 days and not later than 60 days after notification of the hearing is given to the law enforcement officer under investigation;

''(B) the name and mailing address of the independent and impartial hearing officer, or the names and mailing addresses of the independent and impartial hearing board members; and

''(C) the name, rank, command, and address of the law enforcement officer prosecuting the matter for the law enforcement agency, or the name, position, and mailing address of the person prosecuting the matter for a public agency, if the prosecutor is not a law enforcement officer.

''(5) ACCESS TO DOCUMENTARY EVIDENCE AND INVESTIGATIVE FILE.—Unless waived in writing by the law enforcement officer or the counsel or representative of that officer, not later than 15 days before a disciplinary hearing described in paragraph (4)(A), the law enforcement officer shall be provided with—

''(A) a copy of the complete file of the pre-disciplinary investigation; and

''(B) access to and, if so requested, copies of all documents, including transcripts, records, written statements, written reports, analyses, and electronically recorded information that—

''(i) contain exculpatory information;

''(ii) are intended to support any disciplinary action; or

''(iii) are to be introduced in the disciplinary hearing.

''(6) EXAMINATION OF PHYSICAL EVIDENCE.—Unless waived in writing by the law enforcement officer or the counsel or representative of that officer—

''(A) not later than 15 days before a disciplinary hearing, the prosecuting agency shall notify the law enforcement officer or the counsel or representative of that officer of all physical, non-documentary evidence; and

''(B) not later than 10 days before a disciplinary hearing, the prosecuting agency shall provide a reasonable date, time, place, and manner for the law enforcement officer or the counsel or representative of the law enforcement officer to examine the evidence described in subparagraph (A).

''(7) IDENTIFICATION OF WITNESSES.—Unless waived in writing by the law enforcement officer or the counsel or representative of the officer, not later than 15 days before a disciplinary hearing, the prosecuting agency shall notify the law enforcement officer or the counsel or representative of the officer, of the name and address of each witness for the law enforcement agency employing the law enforcement officer.

''(8) REPRESENTATION.—During a disciplinary hearing, the law enforcement officer who is the subject of the hearing shall be entitled to due process, including—

''(A) the right to be represented by counsel or a representative;

''(B) the right to confront and examine all witnesses against the officer; and

''(C) the right to call and examine witnesses on behalf of the officer.

''(9) HEARING BOARD AND PROCEDURE.—

''(A) IN GENERAL.—A State or local government agency, other than the law enforcement agency employing the officer who is subject of the disciplinary hearing, shall—

''(i) determine the composition of an independent and impartial disciplinary hearing board;

''(ii) appoint an independent and impartial hearing officer; and

''(iii) establish such procedures as may be necessary to comply with this section.

''(B) PEER REPRESENTATION ON DISCIPLINARY HEARING BOARD.—A disciplinary hearing board that includes employees of the law enforcement agency employing the law enforcement officer who is the subject of the hearing, shall include not less than 1 law enforcement officer of equal or lesser rank to the officer who is the subject of the hearing.

''(10) SUMMONSES AND SUBPOENAS.—

''(A) IN GENERAL.—The disciplinary hearing board or independent hearing officer—

''(i) shall have the authority to issue summonses or subpoenas, on behalf of—

''(I) the law enforcement agency employing the officer who is the subject of the hearing; or

''(II) the law enforcement officer who is the subject of the hearing; and

''(ii) upon written request of either the agency or the officer, shall issue a summons or subpoena, as appropriate, to compel the appearance and testimony of a witness or the production of documentary evidence.

''(B) EFFECT OF FAILURE TO COMPLY WITH SUMMONS OR SUBPOENA.—With respect to any failure to comply with a summons or a subpoena issued under subparagraph (A)—

''(i) the disciplinary hearing officer or board shall petition a court of competent jurisdiction to issue an order compelling compliance; and

''(ii) subsequent failure to comply with such a court order issued pursuant to a petition under clause (i) shall—

''(I) be subject to contempt of a court proceedings according to the laws of the jurisdiction within which the disciplinary hearing is being conducted; and

''(II) result in the recess of the disciplinary hearing until the witness becomes available to testify and does testify or is held in contempt.

''(11) CLOSED HEARING.—A disciplinary hearing shall be closed to the public unless the law enforcement officer who is the subject of the hearing requests, in writing, that the hearing be open to specified individuals or to the general public.

''(12) RECORDING.—All aspects of a disciplinary hearing, including pre-hearing motions, shall be recorded by audio tape, video tape, or transcription.

''(13) SEQUESTRATION OF WITNESSES.—Either side in a disciplinary hearing may move for and be entitled to sequestration of witnesses.

''(14) TESTIMONY UNDER OATH.—The hearing officer or board shall administer an oath or affirmation to each witness, who shall testify subject to the laws of perjury of the State in which the disciplinary hearing is being conducted.

''(15) FINAL DECISION ON EACH CHARGE.—

''(A) IN GENERAL.—At the conclusion of the presentation of all the evidence and after oral or written argument, the hearing officer or board shall deliberate and render a written final decision on each charge.

''(B) FINAL DECISION ISOLATED TO CHARGE BROUGHT.—The hearing officer or board may not find that the law enforcement officer who is the subject of the hearing is liable for disciplinary action for any violation of law, as to which the officer was not charged.

''(16) BURDEN OF PERSUASION AND STANDARD OF PROOF.—The burden of persuasion or standard of proof of the prosecuting agency shall be—

''(A) by clear and convincing evidence as to each charge alleging false statement or representation, fraud, dishonesty, deceit, moral turpitude, or criminal behavior on the part of the law enforcement officer who is the subject of the charge; and

''(B) by a preponderance of the evidence as to all other charges.

''(17) FACTORS OF JUST CAUSE TO BE CONSIDERED BY THE HEARING OFFICER OR BOARD.—A law enforcement officer who is the subject of a disciplinary hearing shall not be found guilty of any charge or subjected to any disciplinary action unless the disciplinary hearing board or independent hearing officer finds that—

''(A) the officer who is the subject of the charge could reasonably be expected to have had knowledge of the probable consequences of the alleged conduct set forth in the charge against the officer;

''(B) the rule, regulation, order, or procedure that the officer who is the subject of the charge allegedly violated is reasonable;

''(C) the charging party, before filing the charge, made a reasonable, fair, and objective effort to discover whether the officer did

in fact violate the rule, regulation, order, or procedure as charged;

''(D) the charging party did not conduct the investigation arbitrarily or unfairly, or in a discriminatory manner, against the officer who is the subject of the charge, and the charge was brought in good faith; and

''(E) the proposed disciplinary action reasonably relates to the seriousness of the alleged violation and to the record of service of the officer who is the subject of the charge.

''(18) NO COMMISSION OF A VIOLATION.—If the officer who is the subject of the disciplinary hearing is found not to have committed the alleged violation—

''(A) the matter is concluded;

''(B) no disciplinary action may be taken against the officer;

''(C) the personnel file of that officer shall not contain any reference to the charge for which the officer was found not guilty; and

''(D) any pay and benefits lost or deferred during the pendency of the disposition of the charge shall be restored to the officer as though no charge had ever been filed against the officer, including salary or regular pay, vacation, holidays, longevity pay, education incentive pay, shift differential, uniform allowance, lost overtime, or other premium pay opportunities, and lost promotional opportunities.

''(19) COMMISSION OF A VIOLATION.—

''(A) IN GENERAL.—If the officer who is the subject of the charge is found to have committed the alleged violation, the hearing officer or board shall make a written recommendation of a penalty to the law enforcement agency employing the officer or any other governmental entity that has final disciplinary authority, as provided by applicable State or local law.

''(B) PENALTY.—The employing agency or other governmental entity may not impose a penalty greater than the penalty recommended by the hearing officer or board.

''(20) APPEAL.—Any officer who has been found to have committed an alleged violation may appeal from a final decision of a hearing officer or hearing board to a court of competent jurisdiction or to an independent neutral arbitrator to the extent available in any other administrative proceeding under applicable State or local law, or a collective bargaining agreement.

''(i) WAIVER OF RIGHTS.—

''(1) IN GENERAL.—An officer who is notified that the officer is under investigation or is the subject of a charge may, after such notification, waive any right or procedure guaranteed by this section.

''(2) WRITTEN WAIVER.—A written waiver under this subsection shall be—

''(A) in writing; and

''(B) signed by—

''(i) the officer, who shall have consulted with counsel or a representative before signing any such waiver; or

''(ii) the counsel or representative of the officer, if expressly authorized by subsection (h).

''(j) SUMMARY PUNISHMENT.—Nothing in this section shall preclude a public agency from imposing summary punishment.

''(k) EMERGENCY SUSPENSION.—Nothing in this section may be construed to preclude a law enforcement agency from imposing an emergency suspension on a law enforcement officer, except that any such suspension shall—

''(1) be followed by a hearing in accordance with the requirements of subsection (h); and

''(2) not deprive the affected officer of any pay or benefit.

''(l) RETALIATION FOR EXERCISING RIGHTS.—There shall be no imposition of, or threat of, disciplinary action or other penalty against a law enforcement officer for the exercise of any right provided to the officer under this section.

''(m) OTHER REMEDIES NOT IMPAIRED.—Nothing in this section may be construed to impair any other right or remedy that a law enforcement officer may have under any constitution, statute, ordinance, order, rule, regulation, procedure, written policy, collective bargaining agreement, or any other source.

''(n) DECLARATORY OR INJUNCTIVE RELIEF.—A law enforcement officer who is aggrieved by a violation of, or is otherwise denied any right afforded by, the Constitution of the United States, a State constitution, this section, or any administrative rule or regulation promulgated pursuant thereto, may file suit in any Federal or State court of competent jurisdiction for declaratory or injunctive relief to prohibit the law enforcement agency from violating or otherwise denying such right, and such court shall have jurisdiction, for cause shown, to restrain such a violation or denial.

''(o) PROTECTION OF LAW ENFORCEMENT OFFICER PERSONNEL FILES.—

''(1) RESTRICTIONS ON ADVERSE MATERIAL MAINTAINED IN OFFICERS' PERSONNEL RECORDS.—

''(A) IN GENERAL.—Unless the officer has had an opportunity to review and comment, in writing, on any adverse material included in a personnel record relating to the officer, no law enforcement agency or other governmental entity may—

''(i) include the adverse material in that personnel record; or

''(ii) possess or maintain control over the adverse material in any form as a personnel record within the law enforcement agency or elsewhere in the control of the employing governmental entity.

''(B) RESPONSIVE MATERIAL.—Any responsive material provided by an officer to adverse material included in a personnel record pertaining to the officer shall be—

''(i) attached to the adverse material; and

''(ii) released to any person or entity to whom the adverse material is released in accordance with law and at the same time as the adverse material is released.

''(2) RIGHT TO INSPECTION OF, AND RESTRICTIONS ON ACCESS TO INFORMATION IN, THE OFFICER'S OWN PERSONNEL RECORDS.—

''(A) IN GENERAL.—Subject to subparagraph (B), a law enforcement officer shall have the right to inspect all of the personnel records of the officer not less than annually.

''(B) RESTRICTIONS.—A law enforcement officer shall not have access to information in the personnel records of the officer if the information—

''(i) relates to the investigation of alleged conduct that, if proven, would constitute or have constituted a definite violation of a statute providing for criminal penalties, but as to which no formal charge was brought;

''(ii) contains letters of reference for the officer;

''(iii) contains any portion of a test document other than the results;

''(iv) is of a personal nature about another officer, and if disclosure of that information in non-redacted form would constitute a clearly unwarranted intrusion into the privacy rights of that other officer; or

''(v) is relevant to any pending claim brought by or on behalf of the officer against the employing agency of that officer that may be discovered in any judicial or administrative proceeding between the officer and the employer of that officer.

''(p) STATES' RIGHTS.—

''(1) IN GENERAL.—Nothing in this section may be construed—

''(A) to preempt any State or local law, or any provision of a State or local law, in effect on the date of enactment of the State and Local Law Enforcement Discipline, Accountability, and Due Process Act of 2001, that confers a right or a protection that equals or exceeds the right or protection afforded by this section; or

''(B) to prohibit the enactment of any State or local law that confers a right or protection that equals or exceeds a right or protection afforded by this section.

''(2) STATE OR LOCAL LAWS PREEMPTED.—A State or local law, or any provision of a State or local law, that confers fewer rights or provides less protection for a law enforcement officer than any provision in this section shall be preempted by this section.

''(q) COLLECTIVE BARGAINING AGREEMENTS.—Nothing in this section may be construed to—

''(1) preempt any provision in a mutually agreed-upon collective bargaining agreement, in effect on the date of enactment of the State and Local Law Enforcement Discipline, Accountability, and Due Process Act of 2001, that provides for substantially the same or a greater right or protection afforded under this section; or

''(2) prohibit the negotiation of any additional right or protection for an officer who is subject to any collective bargaining agreement.''.

(b) TECHNICAL AMENDMENT.—The table of contents of title I of the Omnibus Crime Control and Safe Streets Act of 1968 (42 U.S.C. 3711 et seq.) is amended by inserting after the item relating to section 819 the following:

''Sec. 820. Discipline, accountability, and due process of State and local law enforcement officers.''.

SEC. 4. PROHIBITION OF FEDERAL CONTROL OVER STATE AND LOCAL CRIMINAL JUSTICE AGENCIES.

Nothing in this Act shall be construed to authorize any department, agency, officer, or employee of the United States to exercise any direction, supervision, or control of any police force or any criminal justice agency of any State or any political subdivision thereof.

SEC. 5. EFFECTIVE DATE.

The amendments made by this Act shall take effect with respect to each State on the earlier of—

(1) 2 years after the date of enactment of this Act; or

(2) the conclusion of the second legislative session of the State that begins on or after the date of enactment of this Act.

By Mr. VOINOVICH (for himself, Mrs. CLINTON, Mr. DEWINE, and Mr. SCHUMER):

S. 1279. A bill to amend the Robert T. Stafford Disaster Relief and Emergency Assistance Act to authorize the President to carry out a program for the protection of the health and safety of residents, workers, volunteers, and others in a disaster area; to the Committee on Environmental and Public Works.

Mr. VOINOVICH. Mr. President, I ask unanimous consent that the text of the Disaster Area and Health and Environmental Monitoring Act of 2003 be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1279

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Disaster Area Health and Environmental Monitoring Act of 2003''.

SEC. 2. PROTECTION OF HEALTH AND SAFETY OF INDIVIDUALS IN A DISASTER AREA.

Title IV of the Robert T. Stafford Disaster Relief and Emergency Assistance Act is amended by inserting after section 408 (42 U.S.C. 5174) the following:

''SEC. 409. PROTECTION OF HEALTH AND SAFETY OF INDIVIDUALS IN A DISASTER AREA.

''(a) DEFINITIONS.—In this section:

''(1) INDIVIDUAL.—The term 'individual' includes—

''(A) a worker or volunteer who responds to a disaster, including—

''(i) a police officer;

''(ii) a firefighter;

''(iii) an emergency medical technician;

''(iv) any participating member of an urban search and rescue team; and

''(v) any other relief or rescue worker or volunteer that the President determines to be appropriate;

''(B) a worker who responds to a disaster by assisting in the cleanup or restoration of critical infrastructure in and around a disaster area;

''(C) a person whose place of residence is in a disaster area;

''(D) a person who is employed in or attends school, child care, or adult day care in a building located in a disaster area; and

''(E) any other person that the President determines to be appropriate.

''(2) PROGRAM.—The term 'program' means a program described in subsection (b) that is carried out for a disaster area.

''(3) SUBSTANCE OF CONCERN.—The term 'substance of concern' means any chemical or substance associated with potential acute or chronic human health effects, the risk of exposure to which could potentially be increased as the result of a disaster.

''(b) PROGRAM.—

''(1) IN GENERAL.—If the President determines that 1 or more substances of concern are being, or have been, released in an area declared to be a disaster area under this Act, the President may carry out a program for the protection, assessment, monitoring, and study of the health and safety of individuals to ensure that—

''(A) the individuals are adequately informed about and protected against potential health impacts of the substance of concern and potential mental health impacts in a timely manner;

''(B) the individuals are monitored and studied over time, including through baseline and follow-up clinical health examinations, for—

''(i) any short- and long-term health impacts of any substance of concern; and

''(ii) any mental health impacts;

''(C) the individuals receive health care referrals as needed and appropriate; and

''(D) information from any such monitoring and studies is used to prevent or protect against similar health impacts from future disasters.

''(2) ACTIVITIES.—A program under paragraph (1) may include such activities as—

''(A) collecting and analyzing environmental exposure data;

''(B) developing and disseminating information and educational materials;

''(C) performing baseline and follow-up clinical health and mental health examinations and taking biological samples;

''(D) establishing and maintaining an exposure registry;

''(E) studying the long-term human health impacts of any exposures through epidemiological and other health studies; and

''(F) providing assistance to individuals in determining eligibility for health coverage and identifying appropriate health services.

''(3) TIMING.—To the maximum extent practicable, a program under paragraph (1) shall be established, and activities under the program shall be commenced (including baseline health examinations), in a timely manner that will ensure the highest level of public health protection and effective monitoring.

''(4) PARTICIPATION IN REGISTRIES AND STUDIES.—

''(A) IN GENERAL.—Participation in any registry or study that is part of a program under paragraph (1) shall be voluntary.

''(B) PROTECTION OF PRIVACY.—The President shall take appropriate measures to protect the privacy of any participant in a registry or study described in subparagraph (A).

''(5) COOPERATIVE AGREEMENTS.—The President may carry out a program under paragraph (1) through a cooperative agreement with a medical institution, or a consortium of medical institutions, that is—

''(A) located near the disaster area, and near groups of individuals that worked or volunteered in response to the disaster in the disaster area, with respect to which the program is carried out; and

''(B) experienced in the area of environmental or occupational health, toxicology, and safety, including experience in—

''(i) developing clinical protocols and conducting clinical health examinations, including mental health assessments;

''(ii) conducting long-term health monitoring and epidemiological studies;

''(iii) conducting long-term mental health studies; and

''(iv) establishing and maintaining medical surveillance programs and environmental exposure or disease registries.

''(6) INVOLVEMENT.—

''(A) IN GENERAL.—In establishing and maintaining a program under paragraph (1), the President shall ensure the involvement of interested and affected parties, as appropriate, including representatives of—

''(i) Federal, State, and local government agencies;

''(ii) labor organizations;

''(iii) local residents, businesses, and schools (including parents and teachers);

''(iv) health care providers; and

''(v) other organizations and persons.

''(B) COMMITTEES.—Involvement under subparagraph (A) may be provided through the establishment of an advisory or oversight committee or board.

''(c) REPORTS.—Not later than 1 year after the establishment of a program under subsection (b)(1), and every 5 years thereafter, the President, or the medical institution or consortium of such institutions having entered into a cooperative agreement under subsection (b)(5), shall submit to the Secretary of Homeland Security, the Secretary of Health and Human Services, the Secretary of Labor, the Administrator of the Environmental Protection Agency, and appropriate committees of Congress a report on programs and studies carried out under the program.''.

SEC. 3. BLUE RIBBON PANEL ON DISASTER AREA HEALTH PROTECTION AND MONITORING.

(a) ESTABLISHMENT.—Not later than 60 days after the date of enactment of this section, the Secretary of Homeland Security, the Secretary of Health and Human Services, and the Administrator of the Environmental Protection Agency shall jointly establish a Blue Ribbon Panel on Disaster Area Health Protection and Monitoring (referred to in this section as the ''Panel'').

(b) MEMBERSHIP.—

(1) IN GENERAL.—The Panel shall be composed of—

(A) 15 voting members, to be appointed by the Secretary of Homeland Security, the Secretary of Health and Human Services, and the Administrator of the Environmental Protection Agency in accordance with paragraph (2); and

(B) officers or employees of the Department of Health and Human Services, the Department of Homeland Security, the Environmental Protection Agency, and other Federal agencies, as appropriate, to be appointed by the Secretary of Health and Human Services, the Secretary of Homeland Security, and the Administrator of the Environmental Protection Agency as nonvoting, ex officio members of the Panel.

(2) BACKGROUND AND EXPERTISE.—The voting members of the Panel shall be individuals who—

(A) are not officers or employees of the Federal Government; and

(B) have expertise in—

(i) environmental health, safety, and medicine;

(ii) occupational health, safety, and medicine;

(iii) clinical medicine, including pediatrics;

(iv) toxicology;

(v) epidemiology;

(vi) mental health;

(vii) medical monitoring and surveillance;

(viii) environmental monitoring and surveillance;

(ix) environmental and industrial hygiene;

(x) emergency planning and preparedness;

(xi) public outreach and education;

(xii) State and local health departments;

(xiii) State and local environmental protection departments;

(xiv) functions of workers that respond to disasters, including first responders; and

(xv) public health and family services.

(c) DUTIES.—

(1) IN GENERAL.—The Panel shall provide advice and recommendations regarding protecting and monitoring the health and safety of individuals potentially exposed to any chemical or substance associated with potential acute or chronic human health effects as the result of a disaster, including advice and recommendations regarding—

(A) the implementation of programs under section 409 of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (as added by section 2); and

(B) the establishment of protocols for the monitoring of and response to releases of substances of concern (as defined in section 409(a) of the Robert T. Stafford Disaster Relief and Emergency Assistance Act (as added by section 2)) in a disaster area for the purpose of protecting public health and safety, including—

(i) those substances of concern for which samples should be collected in the event of a disaster, including a terrorist attack;

(ii) chemical-specific methods of sample collection, including sampling methodologies and locations;

(iii) chemical-specific methods of sample analysis;

(iv) health-based threshold levels to be used and response actions to be taken in the event that thresholds are exceeded for individual chemicals or substances;

(v) procedures for providing monitoring results to—

(I) appropriate Federal, State, and local government agencies;

(II) appropriate response personnel; and

(III) the public;

(vi) responsibilities of Federal, State and local agencies for—

(I) collecting and analyzing samples;

(II) reporting results; and

(III) taking appropriate response actions; and

(vii) capabilities and capacity within the Federal Government to conduct appropriate environmental monitoring and response in the event of a disaster, including a terrorist attack; and

(C) other issues as specified by the Secretary of Homeland Security, the Secretary of Health and Human Services, and the Administrator of the Environmental Protection Agency.

(2) REPORT.—Not later than 1 year after the date of establishment of the Panel, the Panel shall submit to the Secretary of Homeland Security, the Secretary of Health and Human Services, and the Administrator of the Environmental Protection Agency a report of the findings and recommendations of the Panel under this section, including recommendations for such legislative and administrative actions as the Panel considers to be appropriate.

(d) POWERS.—

(1) HEARINGS.—The Panel may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the Panel considers necessary to carry out this section.

(2) INFORMATION FROM FEDERAL AGENCIES.—

(A) IN GENERAL.—The Panel may secure directly from any Federal department or agency such information as the Panel considers necessary to carry out this section.

(B) FURNISHING OF INFORMATION.—On request of the Panel, the head of the department or agency shall furnish the information to the Panel.

(3) POSTAL SERVICES.—The Panel may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

(e) PERSONNEL.—

(1) TRAVEL EXPENSES.—The members of the Panel shall not receive compensation for the performance of services for the Panel, but shall be allowed travel expenses, including per diem in lieu of subsistence, at rates authorized for employees of agencies under subchapter I of chapter 57 of title 5, United States Code, while away from their homes or regular places of business in the performance of services for the Panel.

(2) VOLUNTARY AND UNCOMPENSATED SERVICES.—Notwithstanding section 1342 of title 31, United States Code, the Secretary may accept the voluntary and uncompensated services of members of the Panel.

(3) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the Panel without reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

(4) STAFF, INFORMATION, AND OTHER ASSISTANCE.—The Secretary of Homeland Security, the Secretary of Health and Human Services, and the Administrator of the Environmental Protection Agency shall provide to the Panel such staff, information, and other assistance as may be necessary to carry out the duties of the Panel.

(f) AUTHORIZATION OF APPROPRIATIONS.—There are authorized to be appropriated such sums as are necessary to carry out this section.

(g) TERMINATION OF AUTHORITY.—This section, the authority provided under this section, and the Panel shall terminate on the date that is 18 months after the date of enactment of this Act.

By Mr. GRAHAM of Florida:

S. 1281. A bill to amend title 38, United Stated Code, to presume additional diseases of former prisoners of war to be service-connected for compensation purposes, to enhance the Dose Reconstruction Program of the Department of Defense, to enhance and fund certain other epidemiological studies, and for other purposes; to the Committee on Veterans' Affairs.

Mr. GRAHAM of Florida. Madam President, today I introduce legislation that would take one more step toward finding answers for veterans who may have been exposed to radiation, Agent Orange, or other hazards during their military service.

The last century saw the nature of war change forever. When mustard gas drifted across the trenches of World War I, troops learned that dangers less tangible, but no less deadly, than bullets might fill the air. Since then, many veterans have questioned whether health effects of the environmental hazards that they faced on and off the battlefield might appear years or even decades later.

Congress, VA, the military, and scores of independent researchers have struggled to answer those questions. Many veterans still wait for scientific evidence to fill the gaps. However, research in some areas has linked specific exposures to a risk of later disease, and we must respond to those new findings and encourage further investigation.

Peer-reviewed studies published in recent years suggest that veterans held prisoner during World War II, the Korean War, and in Vietnam suffer from some chronic diseases at a higher rate than expected. Scientists now report that the toll taken by malnutrition, long periods of forced confinement, and untreated infections appears to pose a lifelong risk. Based on these findings, I have introduced legislation that would add heart disease, strokes, and chronic liver diseases to the list of diseases that can be presumptively connected to service for certain former prisoners of war. This would allow eligible veterans with these conditions to seek VA benefits without having to prove that their illnesses resulted from deprivations suffered during captivity.

Other veterans who were exposed to large doses of ionizing radiation in post-war Japan or during nuclear tests, and who suffer from illnesses thought to be caused by radiation, can currently claim eligibility for VA benefits. However, some veterans who believe they received high doses of radiation have been frustrated to find that their military records do not reflect the same assumptions. Congress mandated nearly 20 years ago that veterans who suffer from diseases that they suspect might be linked to radiation exposure during service could request a dose reconstruction, or a scientific estimate of past exposure levels, to remedy this.

Many veterans felt that this method fell short of expectations, and Congress responded in 1998 by requiring an independent review of the Dose Reconstruction Program conducted by the Department of Defense. A panel of experts convened by the National Academy of Sciences reported recently that this contractor-operated program suffered from a shockingly cavalier approach to quality assurance, resulting in data that failed to meet the standards assumed by VA and veterans. This is not acceptable. Provisions introduced here would require the Secretaries of VA and Defense to establish permanent independent oversight of the Dose Reconstruction Program, and to create an advisory board to improve the program as necessary.

Our understanding of the consequences of exposure to the herbicides and dioxin in Agent Orange remains far from complete. It has been almost 25 years since Congress required the Air Force to conduct an epidemiologic study of the veterans of Operation Ranch Hand, the unit responsible for aerial spraying of herbicides during the Vietnam War. The last scheduled round of physical examinations took place just last month, and the fate of the millions of medical records and specimens remains undecided. Experts agree that both samples and data should be preserved for further research, but do not share an opinion on the best way to do so. The bill that I have introduced would task the National Academy of Sciences to develop research recommendations for extending the Air Force Health Study, or for preserving the samples and making them accessible to independent researchers as requested by many veterans' organizations.

Finally, the legislation that I have introduced would ensure that the scientific body charged with tracking veterans' and military health can continue its mission. The Medical Follow-Up Agency, MFUA, a board of the Institute of Medicine—the health agency of the National Academy of Sciences—was created at the end of World War II at the urging of the Army Surgeon General. For many years, it received funding only sporadically. In 1988, the now-defunct Office of Technology Assessment reported that MFUA's critical contribution to understanding military health issues was limited by a lack of consistent funding, which caused high staff turnover, incohesiveness in the research portfolio, and failure to maintain records.

Congress responded with Public Law 102–585, which required that VA and the military each contribute $250,000 in annual core funding to MFUA for 10 years. MFUA's staff uses this funding to update, maintain, and improve long-term epidemiological studies of military and veterans populations. Congress, VA, the military, and independent scientists have relied on these studies to evaluate whether specific exposures might have long-term health effects that suggest a need for benefits, new treatments, or further research. The legislation that I have introduced would extend MFUA's core funding for 10 more years.

This legislation would demonstrate to those who serve their nation now

that our commitment to them will not end with the wars that they fight. We must continue to seek remedies for the sometimes invisible wounds of the new battlefield, and ensure that those who have borne them receive the support that they need. I urge my colleagues in the Senate to join me in supporting this legislation.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1281

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Veterans Information and Benefits Enhancement Act of 2003''.

SEC. 2. PRESUMPTION OF ADDITIONAL DISEASES OF FORMER PRISONERS OF WAR TO BE SERVICE-CONNECTED FOR COMPENSATION PURPOSES.

(a) PRESUMPTION.—Section 1112(b) of title 38, United States Code, is amended—

(1) in paragraph (14), by striking ''or'' at the end; and

(2) by inserting after paragraph (15) the following new paragraphs:

''(16) cardiovascular disease (heart disease),

''(17) cerebrovascular disease (stroke), or

''(18) chronic liver disease, including cirrhosis and primary liver carcinoma,''.

(b) EFFECTIVE DATE.—(1) The amendments made by subsection (a) shall take effect on the date of the enactment of this Act.

(2) No benefit may be paid by reason of the amendments made by subsection (a) for any period before the date of the enactment of this Act.

SEC. 3. DOSE RECONSTRUCTION PROGRAM OF DEPARTMENT OF DEFENSE.

(b) REVIEW OF MISSION, PROCEDURES, AND ADMINISTRATION.—(1) The Secretary of Veterans Affairs and the Secretary of Defense shall jointly conduct a review of the mission, procedures, and administration of the Dose Reconstruction Program of the Department of Defense.

(2) In conducting the review under paragraph (1), the Secretaries shall—

(A) determine whether any additional actions are required to ensure that the quality assurance and quality control mechanisms of the Dose Reconstruction Program are adequate and sufficient for purposes of the program; and

(B) determine the actions that are required to ensure that the mechanisms of the Dose Reconstruction Program for communication and interaction with veterans are adequate and sufficient for purposes of the program, including mechanisms to permit veterans to review the assumptions utilized in their dose reconstructions.

(3) Not later than 90 days after the date of the enactment of this Act, the Secretaries shall jointly submit to Congress a report on the review under paragraph (1). The report shall set forth—

(A) the results of the review;

(B) a plan for any actions determined to be required under paragraph (2); and

(C) such other recommendations for the improvement of the mission, procedures, and administration of the Dose Reconstruction Program as the Secretaries jointly consider appropriate.

(b) ON-GOING REVIEW AND OVERSIGHT.—The Secretaries shall jointly take appropriate actions to ensure the on-going independent review and oversight of the Dose Reconstruction Program, including the establishment of the advisory board required by subsection (c).

(c) ADVISORY BOARD.—(1) In taking actions under subsection (b), the Secretaries shall jointly appoint an advisory board to provide review and oversight of the Dose Reconstruction Program.

(2) The advisory board under paragraph (1) shall be composed of the following:

(A) At least one expert in historical dose reconstruction of the type conducted under the Dose Reconstruction Program.

(B) At least one expert in radiation health matters.

(C) At least one expert in risk communications matters.

(D) A representative of the Department of Veterans Affairs.

(E) A representative of the Defense Threat Reduction Agency.

(F) At least three veterans, including at least one veteran who is a member of an atomic veterans group.

(3) The advisory board under paragraph (1) shall—

(A) conduct periodic, random audits of dose reconstructions and decisions on claims for radiogenic diseases under the Dose Reconstruction Program;

(B) assist the Department of Veterans Affairs and the Defense Threat Reduction Agency in communicating to veterans information on the mission, procedures, and evidentiary requirements of the Dose Reconstruction Program; and

(C) carry out such other activities with respect to the review and oversight of the Dose Reconstruction Program as the Secretaries shall jointly specify.

(4) The advisory board under paragraph (1) may make such recommendations on modifications in the mission or procedures of the Dose Reconstruction Program as the advisory board considers appropriate as a result of the audits conducted under paragraph (3)(A).

SEC. 4. STUDY ON DISPOSITION OF AIR FORCE HEALTH STUDY.

(a) IN GENERAL.—The Secretary of Veterans Affairs shall, in accordance with this section, carry out a study to determine the appropriate disposition of the Air Force Health Study, an epidemiologic study of Air Force personnel who were responsible for conducting aerial spray missions of herbicides during the Vietnam era.

(b) STUDY THROUGH NATIONAL ACADEMY OF SCIENCES.—Not later than sixty days after the date of the enactment of this Act, the Secretary shall seek to enter into an agreement with the National Academy of Sciences, or another appropriate scientific organization, to carry out the study required by subsection (a).

(c) ELEMENTS.—Under the study under subsection (a), the National Academy of Sciences, or other appropriate scientific organization, shall address the following:

(1) The scientific merit of retaining and maintaining the medical records, other study data, and laboratory specimens collected in the course of the Air Force Health Study after the currently-scheduled termination date of the study in 2006.

(2) Whether or not any obstacles exist to retaining and maintaining the medical records, other study data, and laboratory specimens referred to in paragraph (1), including privacy concerns.

(3) The advisability of providing independent oversight of the medical records, other study data, and laboratory specimens referred to in paragraph (1), and of any further study of such records, data, and specimens, and, if so, the mechanism for providing such oversight.

(4) The advisability of extending the Air Force Health Study, including the potential value and relevance of extending the study, the potential cost of extending the study, and the Federal or non-Federal entity best suited to continue the study if extended.

(5) The advisability of making the laboratory specimens of the Air Force Health Study available for independent research, including the potential value and relevance of such research, and the potential cost of such research.

(d) REPORT.—Not later than 60 days after entering into an agreement under subsection (b), the National Academy of Sciences, or other appropriate scientific organization, shall submit to the Secretary and Congress a report on the results of the study under subsection (a). The report shall include the results of the study, including the matters addressed under subsection (c), and such other recommendations as the Academy, or other appropriate scientific organization, considers appropriate as a result of the study.

SEC. 5. FUNDING OF MEDICAL FOLLOW-UP AGENCY OF INSTITUTE OF MEDICINE OF NATIONAL ACADEMY OF SCIENCES FOR EPIDEMIOLOGICAL RESEARCH ON MEMBERS OF THE ARMED FORCES AND VETERANS.

(a) FUNDING BY DEPARTMENT OF VETERANS AFFAIRS.—(1) The Secretary of Veterans Affairs shall make available to the National Academy of Sciences in each of fiscal years 2004 through 2013, $250,000 for the Medical Follow-Up Agency of the Institute of Medicine of the Academy for purposes of epidemiological research on members of the Armed Forces and veterans.

(2) The Secretary of Veterans Affairs shall make available amounts under paragraph (1) for a fiscal year from amounts available for the Department of Veterans Affairs for that fiscal year.

(b) FUNDING BY DEPARTMENT OF DEFENSE.—(1) The Secretary of Defense shall make available to the National Academy of Sciences in each of fiscal years 2004 through 2013, $250,000 for the Medical Follow-Up Agency for purposes of epidemiological research on members of the Armed Forces and veterans.

(2) The Secretary of Defense shall make available amounts under paragraph (1) for a fiscal year from amounts available for the Department of Defense for that fiscal year.

(c) USE OF FUNDS.—The Medical Follow-Up Agency shall use funds made available under subsections (a) and (b) for epidemiological research on members of the Armed Forces and veterans.

(d) SUPPLEMENT NOT SUPPLANT.—Amounts made available to the Medical Follow-Up Agency under this section for a fiscal year for the purposes referred to in subsection (c) are in addition to any other amounts made available to the Agency for that fiscal year for those purposes.

By Mr. GRAHAM of Florida (for himself, Mr. NELSON of Florida, and Mr. SESSIONS):

S. 1282. A bill to require the Secretary of Veterans Affairs to establish national cemeteries for geographically underserved populations of veterans, and for other purposes; to the Committee on Veterans' Affairs.

Mr. GRAHAM of Florida. Madam President, I rise today to introduce legislation that will ensure that America's veterans and their families have access to the funeral honors they have earned. The brave men and women who fought for our Nation are a population that is aging rapidly. In 2002, America

lost 646,264 veterans. Projections show that this rate will continue to climb through the year 2008, when the annual death of the World War II and Korea-era veterans will peak at 700,000.

By the end of 2004, only 64 of the 124 veterans national cemeteries will be available for both casketed and cremated remains. As cemetery service capabilities decrease, veterans in areas near those cemeteries that are at capacity may lose access to burial options located within a reasonable distance of their homes. In order to ensure that burial options are provided for veterans and their family members, we must develop new cemeteries and expand existing cemeteries. This process must start as soon as possible because the construction of a new cemetery takes an average of 7 years.

That is why I offer this bill today, which would authorize the construction of ten new national cemeteries and ensure that the burial needs of veterans and their family members will be met in the future.

In anticipation of veterans' future needs, the Department of Veterans Affairs conducted a study that identifies veteran population centers not served by an open national or state veterans cemetery. The report, ''Future Burial Needs,'' was initially released in May 2002 and has been recently revised using veteran population estimates from the 2000 census. My legislation would direct the Department of Veterans Affairs to establish ten new national veterans cemeteries in the top ten areas identified to be in the greatest need. These areas would include Sarasota, FL, Salem, OR, Birmingham, AL, St. Louis, MO, San Antonio, TX, Chesapeake, VA, Sumter, FL, Bakersfield, CA, Jacksonville, FL, and Philadelphia, PA.

We can not afford to wait any longer if we are to fulfill this commitment to our nation's veterans. Mr. President, I am proud to sponsor this important bill, and look forward to the support of my colleagues as we provide for our veterans who have given so much for our country. Thank you.

I ask unanimous consent that the text of this bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1281

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

SECTION 1. ESTABLISHMENT OF NATIONAL CEMETERIES FOR GEOGRAPHICALLY UNDERSERVED POPULATIONS OF VETERANS.

(a) IDENTIFICATION OF UNDERSERVED BURIAL SERVICE AREAS.—The Secretary of Veterans Affairs shall identify the 10 burial service areas in the United States that, as determined by the Secretary, are most in need of a new national cemetery in order to ensure that 90 percent of the veterans who reside in each such service area live within 75 miles of a national cemetery.

(b) BURIAL SERVICE AREA.—For purposes of this section, the term ''burial service area'' means a service area for burial in national cemeteries that is established by the Secretary utilizing the most current population data available to the Secretary as of the date of the enactment of this Act, which service area—

(1) has a radius of approximately 75 miles;

(2) contains a minimum population of veterans of approximately 170,000 veterans; and

(3) is not served as of the date of the enactment of this Act by a national cemetery or State cemetery for veterans.

(c) ESTABLISHMENT OF NATIONAL CEMETERIES.—The Secretary shall establish, in accordance with chapter 24 of title 38, United States Code, a national cemetery in each burial service area identified under subsection (a) in order to serve the burial needs of veterans and their families.

(d) ADVANCE PLANNING.—(1) The Secretary shall carry out in fiscal year 2004 such activities as the Secretary considers appropriate for advance planning for the establishment of national cemeteries under subsection (c).

(2) Amounts appropriated for fiscal year 2004 for the advance planning fund in the Construction, Major Projects account shall be available for activities under paragraph (1).

(e) REPORTS.—(1) Not later than 120 days after the date of the enactment of this Act, the Secretary shall submit to Congress a report on the establishment of national cemeteries under subsection (c). The report shall set forth the following:

(A) Each burial service area identified by the Secretary under subsection (a) to require the establishment of a national cemetery under subsection (c).

(B) A schedule for the establishment of each such national cemetery.

(C) An estimate of the costs of the establishment of each such national cemetery.

(D) The amount to be obligated under subsection (d) during fiscal year 2004 for advance planning required under that subsection.

(2) Not later than one year after the date of the report under paragraph (1), and annually thereafter until the completion of each national cemetery required by subsection (c), the Secretary shall submit to Congress an update of the report under that paragraph (as previously updated, if at all, under this paragraph).

By Mr. GRAHAM of Florida:

S. 1283. A bill to require advance notification of Congress regarding any action proposed to be taken by the Secretary of Veterans Affairs in the implementation of the Capital Asset Realignment for Enhanced Services initiative of the Department of Veterans Affairs, and for other purposes; to the Committee on Veterans' Affairs.

Mr. GRAHAM of Florida. Madam President, the Department of Veterans Affairs, VA, is in the midst of determining how best to serve the millions of veterans who turn to the VA health care system for their care. This process—known as CARES or Capital Asset Realignment for Enhanced Services—will likely bring significant change to the VA system. Recommendations stemming from this process could lead to billions of dollars in new facilities construction, on the one hand, and possible closure of facilities and thousands of beds, on the other. Despite the magnitude of these possible changes, Congress has virtually no formal role in the process.

I introduce legislation today that would allow for Congressional review of the CARES recommendations that the Secretary of VA will begin to implement at the end of this year.

The CARES initiative has been ongoing since the Fall of 2002, tasking VA facilities with developing recommendations based on a review of population data; the conduct of market analyses of veterans' health care needs; the identification of planning initiatives for each market area; and most important, the significant involvement of stakeholders, including myriad public meetings. These so-called planning initiatives are ultimately slated to be passed on to the Secretary, who will then make the final decisions.

While an independent review led by a national CARES Commission is already planned, in addition to public hearings—which I fully support—I must reiterate that Congress has little, if any, role in the CARES effort outside of construction authorization and appropriation activities. Yet, all states and most health care facilities will be affected by the results. The legislation I introduce today would give Congress a 60-day period to review the CARES recommendations submitted by the Secretary of Veterans Affairs. During that time, VA would be prohibited from moving forward with any bed or facility closures.

This oversight is absolutely essential—particularly in light of recent events. Just last month, all VA health care networks submitted their plans to VA headquarters. These plans were developed following substantial analysis and thorough stakeholder involvement. While abiding by the criteria and process set forth by VA, facilities made their recommendations to the Under Secretary for Health. In a surprise move and an apparent manipulation of the process, VA instructed the network directors to re-evaluate the plans they had already submitted for 20 different VA facilities. They were told to ''evaluate a strategy to convert from a 24-hour operation to an 8 hour a day operation. This includes any inpatient care, including long term care.''

One of these hospitals is in Lake City, in my home State of Florida. Network 8, which has responsibility for Lake City, had previously recommended that no long-term care beds be deactivated at this facility, yet they were told to go back to the drawing board to develop a strategy to close nursing home beds there.

Another facility tasked with re-examining their plan is Bedford, Massachusetts. In their network's plan, submitted to the Under Secretary, officials stated that they had in fact considered ''alternatives to consolidate Long Term Care, LTC, including the Alzheimer's and SCI Units, and Psychiatry inpatient beds from the Bedford to Brockton facilities'' yet, ''as final projections are not available for LTC inpatient beds and earlier projections indicated a substantial increase in LTC beds, it was determined to utilize current capacities.'' Despite these assessments to the contrary, VA has asked

that they instead plan to convert these facilities to outpatient operations only.

Yet one more example of this apparent manipulation involves another facility now slated for bed closures, the Leavenworth VA Medical Center in Kansas. The network plan concluded that ''[r]ealignment of workload from Leavenworth to Kansas City would exceed current capacity. . . . Elimination of inpatient and outpatient primary care capabilities at Leavenworth would seriously undermine continuity of care for the remaining long-term care patients, reduce timely access to care, hinder its ability to provide ongoing support to the DoD facility located at Ft. Leavenworth . . . '' . Again, analysis conducted at the regional level resulted in a recommendation that VA is now directing be reconsidered.

The VA facility in Knoxville, IA, is being targeted for significant changes as well. The current proposal is to move all of the beds from Knoxville to Des Moines. The Knoxville facility has more than 226 long-term care beds, 40 domiciliary beds, and 34 inpatient psychiatric beds. We need to take a look at this proposal and the many others that will affect veterans all across the country.

Other facilities asked to re-evaluate are: Batavia, Lyons, St. Albans, Montrose, Pittsburgh at Highland Drive, Augusta, Dublin, Lexington, Brecksville, Gulfport, Marlin/Waco, Vancouver, Livermore, and Hot Springs.

While VA intends to present a five-year capital plan to Congress, there is nothing that requires VA to inform Members about possible reductions, closures, and other decisions that would have a deleterious effect on VA health care services and our veterans. This is unacceptable. Congress' role should not be limited to merely funding the implementation of these decisions; rather, we should be involved in a process that could result in the significant loss of inpatient, long-term care, and domiciliary capacity at VA health care facilities nationwide. We can rectify this problem very easily, however, by enacting the legislation I propose today.

In an internal VA memo, Secretary Principi stated that ''the CARES process may be one of the most important activities undertaken by VA this decade. The outcome of this process will construct the foundation for, and set the course of, our health care system for the first half of the 21st century.'' In light of the great impact of this initiative on VA health care services, as well as recent actions that threaten the integrity of the process, it is imperative that Congress be granted a mere 60 days to review VA's proposals. I urge my colleagues to join me in this effort to secure the future of health care for our nation's veterans.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1283

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

SECTION 1. ADVANCE NOTIFICATION OF A DEPARTMENT OF VETERANS AFFAIRS CAPITAL ASSET REALIGNMENT INITIATIVE.

(a) REQUIREMENT FOR ADVANCE NOTIFICATION.—Before taking any action proposed under the Capital Asset Realignment for Enhanced Services initiative of the Department of Veterans Affairs, the Secretary of Veterans Affairs shall submit to Congress a written notification of the intent to take such action.

(b) LIMITATION.—The Secretary of Veterans Affairs may not take any proposed action described in subsection (a) until the later of—

(1) the expiration of the 60-day period beginning on the date on which the Secretary submits to Congress the notification of the proposed action required under subsection (a); or

(2) the expiration of a period of 30 days of continuous session of Congress beginning on such date of notification or, if either House of Congress is not in session on such date, the first day after such date that both Houses of Congress are in session.

(c) CONTINUOUS SESSION OF CONGRESS.—For the purposes of subsection (b)—

(1) the continuity of session of Congress is broken only by an adjournment of Congress sine die; and

(2) the days on which either House is not in session because of an adjournment of more than three days to a day certain are excluded in the computation of any period of time in which Congress is in continuous session.

By Mr. CARPER:

S. 1285. A bill to reform the postal laws of the United States; to the Committee on Governmental Affairs.

Mr. CARPER. Madam President, I rise today to introduce the Postal Accountability and Enhancement Act of 2003, legislation that makes the reforms necessary for the Postal Service to thrive in the 21st Century and to better serve the American people.

The Postal Service has, for the most part, operated in the same manner for more than thirty years. In the early 1970s, Senator STEVENS and others led the effort in the Senate to create the Postal Service out of the failing Post Office Department. At the time, the Post Office Department received about 20 percent of its revenue from taxpayer subsidies. The service it provided was suffering and there was little money available to expand. By all accounts, the product of Senator STEVENS' labors, the Postal Reorganization Act signed into law by President Nixon in 1971, has been a phenomenal success. The Postal Service today receives virtually no taxpayer support and the service its hundreds of thousands of employees provide to every American, every day is second to none. More than thirty years later, the Postal Service now delivers to 141 million addresses each day and is the anchor of a $900 billion mailing industry.

All that said, the Postal Service is clearly in need of modernization once again. When it started out in 1971, nobody had access to fax machines, cell phones and pagers and nobody imagined that we would ever enjoy conveniences like e-mail and electronic bill pay. After decades of success, electronic diversion of mail volume coupled with economic recession and terrorism have made for some rough going at the Postal Service in recent years. In 2001, as Postmaster General Potter assumed his position, the Postal Service was projecting its third consecutive year of deficits. They lost $199 million in fiscal year 2000 and $1.68 billion in fiscal year 2001. They were projecting losses of up to $4 billion in fiscal year 2002. Mail volume was falling, revenues were below projections and the Postal Service was estimating that it needed to spend $4 billion on security enhancements in order to prevent a repeat of the tragic anthrax attacks that took several lives. The Postal Service was also perilously close to its $15 billion debt ceiling and had been forced to raise rates three times in less than two years in order to pay for its operations, further eroding mail volume.

In recent months, however, the Postal Service's short-term financial outlook has improved. Under General Potter's strong leadership, Postal Service management cut a total of $2.9 billion in costs fiscal year 2002. They did this mostly by eliminating 23,000 positions, mostly through attrition. This included 800 management positions at postal headquarters in Washington and 2,000 administrative positions in regional offices. They also continued their drive to further automate their processing operations, most notably in the area of flats processing. They have continued their construction freeze and ended their self-imposed ban on post office closings, resulting in the closing of dozens of post offices across the country.

Most dramatically, the Postal Service learned in 2002 that an unfunded pension liability they once believed was as high as $32 billion was actually $5 billion. My friend from Maine, Ms. COLLINS, and I responded with legislation, the Postal Civil Service Retirement System Funding Reform Act, signed into law by President Bush last month, which cuts the amount the Postal Service must pay into the Civil Service Retirement System each year by nearly $3 billion. This will free up money for debt reduction and prevent the need for another rate increase until at least 2006.

Aggressive cost cutting and the lower pension payment, then, have put off the emergency that would have come if the Postal Service had reached their debt limit. Cost cutting can only go so far, however, and will not solve the Postal Service's long-term problems. It could actually hurt service. The Postal Service continues to add about 1.7 million new delivery points each year, creating the need for thousands of new routes and thousands of new letter carriers to work them. In addition, faster-

growing parts of the country will need new or expanded postal facilities in the coming years. Even if the economy recovers soon and the Postal Service begins to see volume and revenues improve, we will still need to make the fundamental reforms necessary to make the Postal Service as successful in the 21st Century as it was in the 20th Century.

As more and more customers turn to electronic forms of communication, letter carriers are bringing fewer and fewer pieces of mail to each address they serve. The rate increases that will be needed to maintain the Postal Service's current infrastructure, finance retirement obligations to its current employees, pay for new letter carriers and build facilities in growing parts of the country will only further erode mail volume. The Postal Service has been trying to improve on its own. They are making progress, but there is only so much they can do on their own.

That is where my bill comes in. First, the Postal Accountability and Enhancement Act begins the process of developing a modern rate system for pricing Postal Service products. The new rate system, to be developed by a strengthened Postal Rate Commission, re-named the Postal Regulatory Commission, would allow retained earnings, provide the Postal Service more flexibility in setting prices and streamline today's burdensome ratemaking process. It would also allow rates to be increased on an expedited basis during crises like a sharp spike in fuel prices and require that the Regulatory Commission develop a ''phased rate'' schedule whereby rate increases would be phased in gradually over a period of time.

In addition, the new rate system authorized through my bill will allow the Postal Service to negotiate service agreements with individual mailers. The Postal Rate Commission recently approved a service agreement the Postal Service negotiated with Capital One, but the process for considering the agreement took almost a year and the Postal Service's authority to enter into agreements is not clearly spelled out in law. The Postal Accountability and Enhancement Act allows the Postal Service to enter into agreements if the revenue generated from them covers all costs attributable to the Postal Service and results in a greater contribution to the Postal Service's institutional costs. No agreement would be permitted if it resulted in higher rates for any other mailer or prohibited any similarly situated mailer from negotiating a similar agreement.

Second, the Postal Accountability and Enhancement Act requires the Postal Regulatory Commission to set strong service standards for the Postal Service's Market Dominant products, a category made up mostly of those products, like First Class Mail, that are part of the postal monopoly. The Postal Service currently sets its own service standards, which allows them to pursue efforts like the elimination of Saturday delivery, a proposal floated two years ago. The new standards set by the Commission will aim to improve service and will be used by the Postal Service to establish performance goals and to rationalize their physical infrastructure. Once the standards are established, the Postal Service will recommend a list of facilities that can be closed or consolidated without hindering their ability to meet the standards. A new commission, called the Postal Network Modernization Commission, would then study the Postal Service's recommendations. The closings and consolidations recommended by this commission would be carried out, subject to approval by the President, unless Congress passed a resolution disapproving them.

Third, the Postal Accountability and Enhancement Act ensures that the Postal Service competes fairly. The bill prohibits the Postal Service from issuing anti-competitive regulations and makes the State Department, instead of the Postal Service, responsible for setting U.S. foreign policy on mailing issues. It also subjects the Postal Service to State zoning, planning and land use laws, requires them to pay an assumed Federal income tax on products like packages and Express Mail that private firms also offer and requires that these products as a whole pay their share of the Postal Service's institutional costs.

Fourth, the Postal Accountability and Enhancement Act improves Postal Service accountability, mostly by strengthening oversight. Qualifications for membership on the Regulatory Commission would be stronger than those for the Rate Commission so that Commissioners would have a background in finance or economics. Commissioners would also have the power to demand information from the Postal Service, including by subpoena, and have the power to punish them for violating rate and service regulations. In addition, the Commission will make an annual determination as to whether the Postal Service is in compliance with rate law and meeting service standards and will have the power to punish them for any transgressions.

Finally, and most importantly, the Postal Accountability and Enhancement Act preserves universal service and forces the Postal Service to concentrate solely on what they do best—processing and delivering the mail to all Americans. The bill for the first time limits the Postal Service to providing ''postal services,'' meaning they would be prohibited from engaging in other lines of business, such as e-commerce, that draw time and resources away from letter and package delivery. It also explicitly preserves the requirement that the Postal Service ''bind the Nation together through the mail'' and serve all parts of the country, urban, suburban and rural, in a non-discriminatory fashion. Any service standards established by the Postal Regulatory Commission will continue to ensure delivery to every address, every day. In addition, the bill maintains the prohibition on closing post offices solely because they operate at a deficit, ensuring that rural and urban customers continue to enjoy full access to retail postal services.

One thing the Postal Accountability and Enhancement Act does not do, is blame postal employees for the Postal Service's problems. The bill preserves collective bargaining and does nothing that would harm postal employees' pay or benefits.

Another thing the Postal Accountability and Enhancement Act does not do is privatize or downsize the Postal Service. The bill preserves the Postal Service's monopoly along with its sole access to the mailbox. While it could result in the closing of some postal facilities, the process I have laid out in the bill is completely driven by the service standards established by the Postal Regulatory Commission. Nothing will be closed for the sake of being closed. Instead, the bill encourages the Postal Service to find ways to improve customer access to retail services through things like vending machines or post offices located in grocery stores or pharmacies.

As my colleagues are aware, President Bush last year announced the creation of the President's Commission on the United States Postal Service, which is expected to release a set of postal reform proposals this summer that I hope will offer some fair, balanced recommendations. It is also my hope, however, that the President's Commission look to the Postal Accountability and Enhancement Act as a touchstone as they complete their work. The bill is the product of nearly a decade's worth of work on postal reform in the House of Representatives led by Congressman JOHN MCHUGH from New York and is based in large part on legislation Congressman MCHUGH introduced towards the end of the 107th Congress. While I cannot claim that the McHugh bill had unanimous support, it did draw the support of most postal employees, much of the mailing industry and the Postal Service's Board of Governors.

When Treasury Department Under Secretary Peter Fisher addressed the President's Commission at its first meeting, he stated that everything was on the table and that the Commission's findings were not predetermined. I know there is some concern that the Commission will recommend privatization, and that this was the idea from the beginning. I will admit that I initially shared these feelings but, based on what I have heard about the Commission's deliberations, they appear on track to develop a reasonable set of recommendations. That said, I urge them to take careful consideration of the work Congress has done on postal reform in the past. Radical reforms undertaken at a number of foreign posts in recent years should teach us a lesson

about going too far. When the British deregulated Royal Mail, service began to suffer dramatically. When the New Zealand Post Office was privatized, universal service was eliminated and customers in rural areas were forced to pay for delivery. When Argentina privatized its Postal Authority, the new private entity went bankrupt even before the country's economic crisis began. We cannot afford to gamble with similar reforms at the Postal Service.

I look forward to working with Chairman COLLINS, the Governmental Affairs Committee and all of my colleagues in passing comprehensive postal reform this year.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1285

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Postal Accountability and Enhancement Act''.

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

TITLE I—DEFINITIONS; POSTAL SERVICES

SEC. 101. DEFINITIONS.

Section 102 of title 39, United States Code, is amended by striking ''and'' at the end of paragraph (3), by striking the period at the end of paragraph (4) and inserting a semicolon, and by adding at the end the following:

''(5) 'postal service' refers to the physical delivery of letters, printed matter, or packages weighing up to 70 pounds, including physical acceptance, collection, sorting, transportation, or other services ancillary thereto;

''(6) 'product' means a postal service with a distinct cost or market characteristic for which a rate is applied;

''(7) 'rates', as used with respect to products, includes fees for postal services;

''(8) 'market-dominant product' or 'product in the market-dominant category of mail' means a product subject to subchapter I of chapter 36; and

''(9) 'competitive product' or 'product in the competitive category of mail' means a product subject to subchapter II of chapter 36; and

''(10) 'year', as used in chapter 36 (other than subchapters I and VI thereof), means a fiscal year.''.

SEC. 102. POSTAL SERVICES.

(a) IN GENERAL.—Section 404 of title 39, United States Code, is amended—

(1) in subsection (a), by striking paragraph (6) and by redesignating paragraphs (7) through (9) as paragraphs (6) through (8), respectively; and

(2) by adding at the end the following:

''(c) Nothing in this title shall be considered to permit or require that the Postal Service provide any special nonpostal or similar services.''.

(b) CONFORMING AMENDMENTS.—(1) Section 1402(b)(1)(B)(ii) of the Victims of Crime Act of 1984 (98 Stat. 2170; 42 U.S.C. 10601(b)(1)(B)(ii)) is amended by striking ''404(a)(8)'' and inserting ''404(a)(7)''.

(2) Section 2003(b)(1) of title 39, United States Code, is amended by striking ''and nonpostal''.

TITLE II—MODERN RATE REGULATION

SEC. 201. PROVISIONS RELATING TO MARKET-DOMINANT PRODUCTS.

(a) IN GENERAL.—Chapter 36 of title 39, United States Code, is amended by striking sections 3621, 3622, and 3623 and inserting the following:

''§ 3621. Applicability; definitions

''(a) APPLICABILITY.—This subchapter shall apply with respect to—

''(1)(A) single piece first-class letters (both domestic and international);

''(B) single piece first-class cards (both domestic and international);

''(C) single piece parcels (both domestic and international); and

''(D) special services;

''(2) all first-class mail not included under paragraph (1);

''(3) periodicals;

''(4) standard mail (except for parcel post);

''(5) media mail;

''(6) library mail; and

''(7) bound printed matter,

subject to any changes the Postal Regulatory Commission may make under section 3642.

''(b) RULE OF CONSTRUCTION.—Mail matter referred to in subsection (a) shall, for purposes of this subchapter, be considered to have the meaning given to such mail matter under the mail classification schedule.

''§ 3622. Modern rate regulation

''(a) AUTHORITY GENERALLY.—The Postal Regulatory Commission shall, within 24 months after the date of the enactment of this section, by regulation establish (and may from time to time thereafter by regulation revise) a modern system for regulating rates and classes for market-dominant products.

''(b) OBJECTIVES.—Such system shall be designed to achieve the following objectives:

''(1) To reduce the administrative burden of the ratemaking process.

''(2) To create predictability and stability in rates.

''(3) To maximize incentives to reduce costs and increase efficiency.

''(4) To enhance mail security and deter terrorism by promoting secure, sender-identified mail.

''(5) To allow the Postal Service pricing flexibility, including the ability to use pricing to promote intelligent mail and encourage increased mail volume during nonpeak periods.

''(6) To assure adequate revenues, including retained earnings, to maintain financial stability and meet the service standards established under section 3691.

''(c) FACTORS.—In establishing or revising such system, the Postal Regulatory Commission shall take into account—

''(1) the establishment and maintenance of a fair and equitable schedule for rates and classification system;

''(2) the value of the mail service actually provided each class or type of mail service to both the sender and the recipient, including but not limited to the collection, mode of transportation, and priority of delivery;

''(3) the direct and indirect postal costs attributable to each class or type of mail service plus that portion of all other costs of the Postal Service reasonably assignable to such class or type;

''(4) the effect of rate increases upon the general public, business mail users, and enterprises in the private sector of the economy engaged in the delivery of mail matter other than letters;

''(5) the available alternative means of sending and receiving letters and other mail matter at reasonable costs;

''(6) the degree of preparation of mail for delivery into the postal system performed by the mailer and its effect upon reducing costs to the Postal Service;

''(7) simplicity of structure for the entire schedule and simple, identifiable relationships between the rates or fees charged the various classes of mail for postal services;

''(8) the relative value to the people of the kinds of mail matter entered into the postal system and the desirability and justification for special classifications and services of mail;

''(9) the importance of providing classifications with extremely high degrees of reliability and speed of delivery and of providing those that do not require high degrees of reliability and speed of delivery;

''(10) the desirability of special classifications from the point of view of both the user and of the Postal Service;

''(11) the educational, cultural, scientific, and informational value to the recipient of mail matter; and

''(12) the policies of this title as well as such other factors as the Commission deems appropriate.

''(d) ALLOWABLE PROVISIONS.—The system for regulating rates and classes for market-dominant products may include—

''(1) price caps, revenue targets, or other form of incentive regulation;

''(2) cost-of-service regulation; or

''(3) such other form of regulation as the Commission considers appropriate to achieve, consistent with subsection (c), the objectives of subsection (b).

''(e) REQUIREMENTS.—The system for regulating rates and classes for market-dominant products shall—

''(1) establish a schedule whereby rates, when necessary, would increase at regular intervals by predictable amounts; and

''(2) establish procedures whereby rates may be increased on a expedited basis when an unexpected decline in revenue or increase in costs threatens the ability of the Postal Service to maintain service at the standards established by the Postal Regulatory Commission under section 3691.

''(f) TRANSITION RULE.—Until regulations under this section first take effect, rates and classes for market-dominant products shall remain subject to modification in accordance with the provisions of this chapter and section 407, as such provisions were last in effect before the date of the enactment of this section.

''§ 3623. Service agreements for market-dominant products

''(a) IN GENERAL.—

''(1) AUTHORITY.—The Postal Service may enter into service agreements with mailers that provide for the provision of postal services under terms and conditions that differ from those that would apply under the otherwise applicable market-dominant mail classification.

''(2) AGREEMENTS.—An agreement under this section may involve—

''(A) performance by the contracting mail user of mail preparation, processing, transportation, or other functions that reduce costs to the Postal Service;

''(B) performance by the Postal Service of additional mail preparation, processing, transportation, or other functions that increase costs to the Postal Service; or

''(C) other terms and conditions that meet the requirements of subsections (b) and (c).

''(b) REQUIREMENTS.—A service agreement under this section may only be entered into if the agreement will benefit the contracting mailer, the Postal Service, and mailers who are not parties to the agreement and if each of the following conditions is met:

''(1) The total revenue generated under the agreement—

''(A) will cover all costs attributable to the Postal Service; and

''(B) will result in a greater contribution to the institutional costs of the Postal Service than would have been granted had the agreement not been entered into.

''(2) Rates and fees for other mailers will not increase as a result of the agreement.

''(3) The agreement pertains exclusively to products in the market-dominant category of mail.

''(4) The agreement will not preclude or materially hinder similarly situated mail users from entering into agreements with the Postal Service on the same, or substantially the same, terms, and the Postal Service remains willing and able to enter into such.

''(c) LIMITATIONS.—A service agreement under this section shall—

''(1) be for a term of not to exceed 3 years; and

''(2) provide that such agreement shall be subject to the cancellation authority of the Commission under section 3662.

''(d) NOTICE REQUIREMENTS.—

''(1) IN GENERAL.—At least 30 days before a service agreement under this section is to take effect, the Postal Service shall file with the Postal Regulatory Commission and publish in the Federal Register the following:

''(A) With respect to each condition under subsection (b), information in sufficient detail to demonstrate the bases for the Postal Service's view that such condition would be met.

''(B) A description of the type of mail the agreement involves.

''(C) The mail preparation, processing, transportation, administration, or other additional functions, if any, the mail user is to perform under the agreement.

''(D) The services or benefits the Postal Service is to perform under the agreement.

''(E) The rates and fees payable by the mail user during the term of the agreement.

''(2) AGREEMENTS LESS THAN NATIONAL IN SCOPE.—In the case of a service agreement under this section that is less than national in scope, the information described under paragraph (1) shall also be published by the Postal Service in a manner designed to afford reasonable notice to persons within any geographic area to which such agreement (or any amendment thereto) pertains.

''(e) EQUAL TREATMENT REQUIRED.—If the Postal Service enters into a negotiated service agreement with a mailer under this section, the Postal Service shall make such agreement available to other mailers on the same terms and conditions.

''(f) COMPLAINTS.—Any person who believes that a service agreement under this section is not (or, in the case of a proposed agreement or a proposed amendment to a service agreement under this section, would not be) in conformance with the requirements of this section and regulations thereunder, or who aggrieved by a decision of the Postal Service not to enter into an agreement under this section, may file a complaint with the Postal Regulatory Commission in accordance with section 3662.

''(g) POSTAL REGULATORY COMMISSION ROLE.—

''(1) REGULATIONS.—The Postal Regulatory Commission may promulgate such regulations regarding service agreements as the Commission determines necessary to implement the requirements of this section.

''(2) REVIEW.—The Postal Regulatory Commission may review any agreement or proposed agreement under this section and may suspend, cancel, or prevent such agreement if the Commission finds that the agreement does not meet the requirements of this section or the regulations thereunder.

''(h) INTERPRETATION.—The determination of whether the revenue generated under the agreement meets the requirements of (b)(1)(B) shall be based on the actual contribution of the mail involved, not on the average contribution made by the mail classification most similar to the services performed under the agreement.

''(i) RATE DISCOUNTS.—In the administration of this section, the Postal Regulatory Commission shall not permit rate discounts for additional mail preparation, processing, transportation, or other functions that exceed the costs avoided by the Postal Service by virtue of the additional functions performed by the mailer. Such discounts are allowable only if the Commission has, after notice and opportunity for a public hearing and comment, determined that such discounts are reasonable and equitable and are necessary to enable the Postal Service, under best practices of honest, efficient, and economical management, to maintain and continue the development of postal services of the kind and quality adapted to the needs of the United States consistent with the service standards established under section 3691.''.

(b) REPEALED SECTIONS.—Sections 3624, 3625, and 3628 of title 39, United States Code, are repealed.

(c) REDESIGNATION.—Chapter 36 of title 39, United States Code (as in effect after the amendment made by section 601, but before the amendment made by section 202) is amended by striking the heading for subchapter II and inserting the following:

''SUBCHAPTER I—PROVISIONS RELATING TO MARKET-DOMINANT PRODUCTS''.

SEC. 202. PROVISIONS RELATING TO COMPETITIVE PRODUCTS.

Chapter 36 of title 39, United States Code, is amended by inserting after section 3629 the following:

''SUBCHAPTER II—PROVISIONS RELATING TO COMPETITIVE PRODUCTS

''§ 3631. Applicability; definitions and updates

''(a) APPLICABILITY.—This subchapter shall apply with respect to—

''(1) priority mail;

''(2) expedited mail;

''(3) mailgrams;

''(4) international mail; and

''(5) parcel post,

subject to subsection (d) and any changes the Postal Regulatory Commission may make under section 3642.

''(b) DEFINITION.—For purposes of this subchapter, the term 'costs attributable', as used with respect to a product, means the direct and indirect postal costs attributable to such product.

''(c) RULE OF CONSTRUCTION.—Mail matter referred to in subsection (a) shall, for purposes of this subchapter, be considered to have the meaning given to such mail matter under the mail classification schedule.

''(d) LIMITATION.—Notwithstanding any other provision of this section, nothing in this subchapter shall be considered to apply

with respect to any product then currently in the market-dominant category of mail.

"§ 3632. Action of the Governors

''(a) AUTHORITY TO ESTABLISH RATES AND CLASSES.—The Governors, with the written concurrence of a majority of all of the Governors then holding office, shall establish rates and classes for products in the competitive category of mail in accordance with the requirements of this subchapter and regulations promulgated under section 3633.

''(b) PROCEDURES.—

''(1) IN GENERAL.—Rates and classes shall be established in writing, complete with a statement of explanation and justification, and the date as of which each such rate or class takes effect.

''(2) PUBLICATION.—The Governors shall cause each rate and class decision under this section and the record of the Governors' proceedings in connection with such decision to be published in the Federal Register by such date before the effective date of any new rates or classes as the Governors consider appropriate.

''(c) TRANSITION RULE.—Until regulations under section 3633 first take effect, rates and classes for competitive products shall remain subject to modification in accordance with the provisions of this chapter and section 407, as such provisions were as last in effect before the date of the enactment of this section.

"§ 3633. Provisions applicable to rates for competitive products

''The Postal Regulatory Commission shall, within 180 days after the date of the enactment of this section, promulgate (and may from time to time thereafter revise) regulations—

''(1) to prohibit the subsidization of competitive products by market-dominant products;

''(2) to ensure that each competitive product covers its costs attributable; and

''(3) to ensure that all competitive products collectively cover their share of the institutional costs of the Postal Service.''.

SEC. 203. PROVISIONS RELATING TO EXPERIMENTAL AND NEW PRODUCTS.

Subchapter III of chapter 36 of title 39, United States Code, is amended to read as follows:

''SUBCHAPTER III—PROVISIONS RELATING TO EXPERIMENTAL AND NEW PRODUCTS

"§ 3641. Market tests of experimental products

''(a) AUTHORITY.—

''(1) IN GENERAL.—The Postal Service may conduct market tests of experimental products in accordance with this section.

''(2) PROVISIONS WAIVED.—A product shall not, while it is being tested under this section, be subject to the requirements of sections 3622, 3633, or 3642, or regulations promulgated under those sections.

''(b) CONDITIONS.—A product may not be tested under this section unless it satisfies each of the following:

''(1) SIGNIFICANTLY DIFFERENT PRODUCT.—The product is, from the viewpoint of the mail users, significantly different from all products offered by the Postal Service within the 2-year period preceding the start of the test.

''(2) MARKET DISRUPTION.—The introduction or continued offering of the product will not create an unfair or otherwise inappropriate competitive advantage for the Postal Service or any mailer, particularly in regard to small business concerns (as defined under subsection (h)).

''(3) CORRECT CATEGORIZATION.—The Postal Service identifies the product, for the purpose of a test under this section, as either market dominant or competitive, consistent with the criteria under section 3642(b)(1). Costs and revenues attributable to a product identified as competitive shall be included in any determination under section 3633(3)(relating to provisions applicable to competitive products collectively).

''(c) NOTICE.—

''(1) IN GENERAL.—At least 30 days before initiating a market test under this section, the Postal Service shall file with the Postal Regulatory Commission and publish in the Federal Register a notice—

''(A) setting out the basis for the Postal Service's determination that the market test is covered by this section; and

''(B) describing the nature and scope of the market test.

''(2) SAFEGUARDS.—For a competitive experimental product, the provisions of section 504(g) shall be available with respect to any information required to be filed under paragraph (1) to the same extent and in the same manner as in the case of any matter described in section 504(g)(1). Nothing in paragraph (1) shall be considered to permit or require the publication of any information as to which confidential treatment is accorded under the preceding sentence (subject to the same exception as set forth in section 504(g)(3)).

''(d) DURATION.—

''(1) IN GENERAL.—A market test of a product under this section may be conducted over a period of not to exceed 24 months.

''(2) EXTENSION AUTHORITY.—If necessary in order to determine the feasibility or desirability of a product being tested under this section, the Postal Regulatory Commission may, upon written application of the Postal Service (filed not later than 60 days before the date as of which the testing of such product would otherwise be scheduled to terminate under paragraph (1)), extend the testing of such product for not to exceed an additional 12 months.

''(e) DOLLAR-AMOUNT LIMITATION.—

''(1) IN GENERAL.—A product may only be tested under this section if the total revenues that are anticipated, or in fact received, by the Postal Service from such product do not exceed $10,000,000 in any year, subject to paragraph (2) and subsection (g).

''(2) EXEMPTION AUTHORITY.—The Postal Regulatory Commission may, upon written application of the Postal Service, exempt the market test from the limit in paragraph (1) if the total revenues that are anticipated, or in fact received, by the Postal Service from such product do not exceed $50,000,000 in any year, subject to subsection (g). In reviewing an application under this paragraph, the Postal Regulatory Commission shall approve such application if it determines that—

''(A) the product is likely to benefit the public and meet an expected demand;

''(B) the product is likely to contribute to the financial stability of the Postal Service; and

''(C) the product is not likely to result in unfair or otherwise inappropriate competition.

''(f) CANCELLATION.—If the Postal Regulatory Commission at any time determines that a market test under this section fails, with respect to any particular product, to meet one or more of the requirements of this section, it may order the cancellation of the test involved or take such other action as it considers appropriate. A determination under this subsection shall be made in accordance with such procedures as the Commission shall by regulation prescribe.

''(g) ADJUSTMENT FOR INFLATION.—For purposes of each year following the year in which occurs the deadline for the Postal Service's first report to the Postal Regulatory Commission under section 3652(a), each dollar amount contained in this section shall be adjusted by the change in the Consumer Price Index for such year (as determined under regulations of the Commission).

''(h) DEFINITION OF A SMALL BUSINESS CONCERN.—The criteria used in defining small business concerns or otherwise categorizing business concerns as small business concerns shall, for purposes of this section, be established by the Postal Regulatory Commission in conformance with the requirements of section 3 of the Small Business Act.

''(i) EFFECTIVE DATE.—Market tests under this subchapter may be conducted in any year beginning with the first year in which occurs the deadline for the Postal Service's first report to the Postal Regulatory Commission under section 3652(a).

"§ 3642. New products and transfers of products between the market-dominant and competitive categories of mail

''(a) IN GENERAL.—Upon request of the Postal Service or users of the mails, or upon its own initiative, the Postal Regulatory Commission may change the list of market-dominant products under section 3621 and the list of competitive products under section 3631 by adding new products to the lists, removing products from the lists, or transferring products between the lists.

''(b) CRITERIA.—All determinations by the Postal Regulatory Commission under subsection (a) shall be made in accordance with the following criteria:

''(1) The market-dominant category of products shall consist of each product in the sale of which the Postal Service exercises sufficient market power that it can effectively set the price of such product substantially above costs, raise prices significantly, decrease quality, or decrease output, without risk of losing business to other firms offering similar products. The competitive category of products shall consist of all other products.

''(2) EXCLUSION OF PRODUCTS COVERED BY POSTAL MONOPOLY.—A product covered by the postal monopoly shall not be subject to transfer under this section from the market-dominant category of mail. For purposes of the preceding sentence, the term 'product covered by the postal monopoly' means any product the conveyance or transmission of which is reserved to the United States under section 1696 of title 18, subject to the same exception as set forth in the last sentence of section 409(e)(1).

''(3) ADDITIONAL CONSIDERATIONS.—In making any decision under this section, due regard shall be given to—

''(A) the availability and nature of enterprises in the private sector engaged in the delivery of the product involved;

''(B) the views of those who use the product involved on the appropriateness of the proposed action; and

''(C) the likely impact of the proposed action on small business concerns (within the meaning of section 3641(h)).

''(c) TRANSFERS OF SUBCLASSES AND OTHER SUBORDINATE UNITS ALLOWABLE.—Nothing in this title shall be considered to prevent transfers under this section from being made by reason of the fact that they would involve only some (but not all) of the subclasses or other subordinate units of the class of mail or type of postal service involved (without regard to satisfaction of minimum quantity requirements standing alone).

''(d) NOTIFICATION AND PUBLICATION REQUIREMENTS.—

''(1) NOTIFICATION REQUIREMENT.—The Postal Service shall, whenever it requests to add a product or transfer a product to a different category, file with the Postal Regulatory Commission and publish in the Federal Register a notice setting out the basis for its determination that the product satisfies the

criteria under subsection (b) and, in the case of a request to add a product or transfer a product to the competitive category of mail, that the product meets the regulations promulgated by the Postal Regulatory Commission pursuant to section 3633. The provisions of section 504(g) shall be available with respect to any information required to be filed.

''(2) PUBLICATION REQUIREMENT.—The Postal Regulatory Commission shall, whenever it changes the list of products in the market-dominant or competitive category of mail, prescribe new lists of products. The revised lists shall indicate how and when any previous lists (including the lists under sections 3621 and 3631) are superseded, and shall be published in the Federal Register.

''(e) PROHIBITION.—Except as provided in section 3641, no product that involves the physical delivery of letters, printed matter, or packages may be offered by the Postal Service unless it has been assigned to the market-dominant or competitive category of mail (as appropriate) either—

''(1) under this subchapter; or

''(2) by or under any other provision of law.''.

SEC. 204. REPORTING REQUIREMENTS AND RELATED PROVISIONS.

(a) REDESIGNATION.—Chapter 36 of title 39, United States Code (as in effect before the amendment made by subsection (b)) is amended by striking the heading for subchapter IV and inserting the following:

''SUBCHAPTER V—POSTAL SERVICES, COMPLAINTS, AND JUDICIAL REVIEW''.

(b) REPORTS AND COMPLIANCE.—Chapter 36 of title 39, United States Code, is amended by inserting after subchapter III the following:

''SUBCHAPTER IV—REPORTING REQUIREMENTS AND RELATED PROVISIONS

''§ 3651. Annual reports by the Commission

''(a) IN GENERAL.—The Postal Regulatory Commission shall submit an annual report to the President and the Congress concerning the operations of the Commission under this title, including the extent to which regulations are achieving the objectives under sections 3622, 3633, and 3691.

''(b) INFORMATION FROM POSTAL SERVICE.—The Postal Service shall provide the Postal Regulatory Commission with such information as may, in the judgment of the Commission, be necessary in order for the Commission to prepare its reports under this section.

''§ 3652. Annual reports to the Commission

''(a) COSTS, REVENUES, RATES, AND SERVICE.—Except as provided in subsection (c), the Postal Service shall, no later than 90 days after the end of each year, prepare and submit to the Postal Regulatory Commission a report (together with such nonpublic annex thereto as the Commission may require under subsection (e))—

''(1) which shall analyze costs, revenues, rates, and quality of service in sufficient detail to demonstrate that all products during such year complied with all applicable requirements of this title; and

''(2) which shall, for each market-dominant product provided in such year, provide—

''(A) market information, including mail volumes; and

''(B) measures of the service afforded by the Postal Service in connection with such product, including—

''(i) the level of service (described in terms of speed of delivery and reliability) provided; and

''(ii) the degree of customer satisfaction with the service provided.

Before submitting a report under this subsection (including any annex thereto and the information required under subsection (b)), the Postal Service shall have the information contained in such report (and annex) audited by the Inspector General. The results of any such audit shall be submitted along with the report to which it pertains.

''(b) INFORMATION RELATING TO WORKSHARE DISCOUNTS.

''(1) IN GENERAL.—The Postal Service shall include, in each report under subsection (a), the following information with respect to each market-dominant product for which a workshare discount was in effect during the period covered by such report:

''(A) The per-item cost avoided by the Postal Service by virtue of such discount.

''(B) The percentage of such per-item cost avoided that the per-item workshare discount represents.

''(C) The per-item contribution made to institutional costs.

''(2) WORKSHARE DISCOUNT DEFINED.—For purposes of this subsection, the term 'workshare discount' refers to presorting, barcoding, dropshipping, and other similar discounts, as further defined under regulations which the Postal Regulatory Commission shall prescribe.

''(c) SERVICE AGREEMENTS AND MARKET TESTS.—In carrying out subsections (a) and (b) with respect to service agreements (including service agreements entered into under section 3623) and experimental products offered through market tests under section 3641 in a year, the Postal Service—

''(1) may report summary data on the costs, revenues, and quality of service by service agreement and market test; and

''(2) shall report such data as the Postal Regulatory Commission requires.

''(d) SUPPORTING MATTER.—The Postal Regulatory Commission shall have access, in accordance with such regulations as the Commission shall prescribe, to the working papers and any other supporting matter of the Postal Service and the Inspector General in connection with any information submitted under this section.

''(e) CONTENT AND FORM OF REPORTS.—

''(1) IN GENERAL.—The Postal Regulatory Commission shall, by regulation, prescribe the content and form of the public reports (and any nonpublic annex and supporting matter relating thereto) to be provided by the Postal Service under this section. In carrying out this subsection, the Commission shall give due consideration to—

''(A) providing the public with adequate information to assess the lawfulness of rates charged;

''(B) avoiding unnecessary or unwarranted administrative effort and expense on the part of the Postal Service; and

''(C) protecting the confidentiality of commercially sensitive information.

''(2) REVISED REQUIREMENTS.—The Commission may, on its own motion or on request of an interested party, initiate proceedings (to be conducted in accordance with regulations that the Commission shall prescribe) to improve the quality, accuracy, or completeness of Postal Service data required by the Commission under this subsection whenever it shall appear that—

''(A) the attribution of costs or revenues to products has become significantly inaccurate or can be significantly improved;

''(B) the quality of service data has become significantly inaccurate or can be significantly improved; or

''(C) such revisions are, in the judgment of the Commission, otherwise necessitated by the public interest.

''(f) CONFIDENTIAL INFORMATION.—

''(1) IN GENERAL.—If the Postal Service determines that any document or portion of a document, or other matter, which it provides to the Postal Regulatory Commission in a nonpublic annex under this section or pursuant to subsection (d) contains information which is described in section 410(c) of this title, or exempt from public disclosure under section 552(b) of title 5, the Postal Service shall, at the time of providing such matter to the Commission, notify the Commission of its determination, in writing, and describe with particularity the documents (or portions of documents) or other matter for which confidentiality is sought and the reasons therefor.

''(2) TREATMENT.—Any information or other matter described in paragraph (1) to which the Commission gains access under this section shall be subject to paragraphs (2) and (3) of section 504(g) in the same way as if the Commission had received notification with respect to such matter under section 504(g)(1).

''(g) OTHER REPORTS.—The Postal Service shall submit to the Postal Regulatory Commission, together with any other submission that the Postal Service is required to make under this section in a year, copies of its then most recent—

''(1) comprehensive statement under section 2401(e);

''(2) strategic plan under section 2802;

''(3) performance plan under section 2803; and

''(4) program performance reports under section 2804.

''§ 3653. Annual determination of compliance

''(a) OPPORTUNITY FOR PUBLIC COMMENT.—After receiving the reports required under section 3652 for any year, the Postal Regulatory Commission shall promptly provide an opportunity for comment on such reports by users of the mails, affected parties, and an officer of the Commission who shall be required to represent the interests of the general public.

''(b) DETERMINATION OF COMPLIANCE OR NONCOMPLIANCE.—Not later than 90 days after receiving the submissions required under section 3652 with respect to a year, the Postal Regulatory Commission shall make a written determination as to—

''(1) whether any rates or fees in effect during such year (for products individually or collectively) were not in compliance with applicable provisions of this chapter (or regulations promulgated thereunder); or

''(2) whether any service standards in effect during such year were not met.

If, with respect to a year, no instance of noncompliance is found under this subsection to have occurred in such year, the written determination shall be to that effect.

''(c) IF ANY NONCOMPLIANCE IS FOUND.—If, for a year, a timely written determination of noncompliance is made under subsection (b), the Postal Regulatory Commission shall take appropriate action in accordance with section 3662.

''(d) REBUTTABLE PRESUMPTION.—A timely written determination described in the last sentence of subsection (b) shall, for purposes of any proceeding under section 3662, create a rebuttable presumption of compliance by the Postal Service (with regard to the matters described in paragraphs (1) through (3) of subsection (b)) during the year to which such determination relates.''.

SEC. 205. COMPLAINTS; APPELLATE REVIEW AND ENFORCEMENT.

Chapter 36 of title 39, United States Code, is amended by striking sections 3662 and 3663 and inserting the following:

''§ 3662. Rate and service complaints

''(a) IN GENERAL.—Interested persons (including an officer of the Postal Regulatory Commission representing the interests of the general public) who believe the Postal Service is not operating in conformance with the requirements of chapter 1, 4, or 6, or this chapter (or regulations promulgated under

any of those chapters) may lodge a complaint with the Postal Regulatory Commission in such form and manner as the Commission may prescribe.

''(b) PROMPT RESPONSE REQUIRED.—

''(1) IN GENERAL.—The Postal Regulatory Commission shall, within 90 days after receiving a complaint under subsection (a), either—

''(A) begin proceedings on such complaint; or

''(B) issue an order dismissing the complaint (together with a statement of the reasons therefor).

''(2) TREATMENT OF COMPLAINTS NOT TIMELY ACTED ON.—For purposes of section 3663, any complaint under subsection (a) on which the Commission fails to act in the time and manner required by paragraph (1) shall be treated in the same way as if it had been dismissed pursuant to an order issued by the Commission on the last day allowable for the issuance of such order under paragraph (1).

''(c) ACTION REQUIRED IF COMPLAINT FOUND TO BE JUSTIFIED.—If the Postal Regulatory Commission finds the complaint to be justified, it shall order that the Postal Service take such action as the Commission considers appropriate in order to achieve compliance with the applicable requirements and to remedy the effects of any noncompliance. Such action may include ordering unlawful rates to be adjusted to lawful levels, ordering the cancellation of market tests, ordering the Postal Service to discontinue providing loss-making products, and requiring the Postal Service to make up for revenue shortfalls in competitive products.

''(d) AUTHORITY TO ORDER FINES IN CASES OF DELIBERATE NONCOMPLIANCE.—In addition, in cases of deliberate noncompliance by the Postal Service with the requirements of this title, the Postal Regulatory Commission may order, based on the nature, circumstances, extent, and seriousness of the noncompliance, a fine (in the amount specified by the Commission in its order) for each incidence of noncompliance. Fines resulting from the provision of competitive products shall be paid out of the Competitive Products Fund established in section 2011. All receipts from fines imposed under this subsection shall be deposited in the general fund of the Treasury of the United States.

''§ 3663. Appellate review

''A person adversely affected or aggrieved by a final order or decision of the Postal Regulatory Commission may, within 30 days after such order or decision becomes final, institute proceedings for review thereof by filing a petition in the United States Court of Appeals for the District of Columbia. The court shall review the order or decision in accordance with section 706 of title 5, and chapter 158 and section 2112 of title 28, on the basis of the record before the Commission.

''§ 3664. Enforcement of orders

''The several district courts have jurisdiction specifically to enforce, and to enjoin and restrain the Postal Service from violating, any order issued by the Postal Regulatory Commission.''.

SEC. 206. CLERICAL AMENDMENT.

Chapter 36 of title 39, United States Code, is amended by striking the heading and analysis for such chapter and inserting the following:

''CHAPTER 36—POSTAL RATES, CLASSES, AND SERVICES

''SUBCHAPTER I—PROVISIONS RELATING TO MARKET-DOMINANT PRODUCTS

''Sec.
''3621. Applicability; definitions.
''3622. Modern rate regulation.
''3623. Service agreements for market-dominant products.
''[3624. Repealed.]
''[3625. Repealed.]
''3626. Reduced Rates.
''3627. Adjusting free rates.
''[3628. Repealed.]
''3629. Reduced rates for voter registration purposes.

''SUBCHAPTER II—PROVISIONS RELATING TO COMPETITIVE PRODUCTS

''3631. Applicability; definitions and updates.
''3632. Action of the Governors.
''3633. Provisions applicable to rates for competitive products.
''3634. Assumed Federal income tax on competitive products.

''SUBCHAPTER III—PROVISIONS RELATING TO EXPERIMENTAL AND NEW PRODUCTS

''3641. Market tests of experimental products.
''3642. New products and transfers of products between the market-dominant and competitive categories of mail.

''SUBCHAPTER IV—REPORTING REQUIREMENTS AND RELATED PROVISIONS

''3651. Annual reports by the Commission.
''3652. Annual reports to the Commission.
''3653. Annual determination of compliance.

''SUBCHAPTER V—POSTAL SERVICES, COMPLAINTS, AND JUDICIAL REVIEW

''3661. Postal Services.
''3662. Rate and service complaints.
''3663. Appellate review.
''3664. Enforcement of orders.

''SUBCHAPTER VI—GENERAL

''3681. Reimbursement.
''3682. Size and weight limits.
''3683. Uniform rates for books; films, other materials.
''3684. Limitations.
''3685. Filing of information relating to periodical publications.
''3686. Change-of-address order involving a commercial mail receiving agency.
''3687. Bonus authority.

''SUBCHAPTER VII—MODERN SERVICE STANDARDS

''3691. Establishment of modern service standards.''.

TITLE III—MODERN SERVICE STANDARDS

SEC. 301. ESTABLISHMENT OF MODERN SERVICE STANDARDS.

Chapter 36 of title 39, United States Code, as amended by this Act, is further amended by adding at the end the following:

''SUBCHAPTER VII—MODERN SERVICE STANDARDS

''§ 3691. Establishment of modern service standards

''(a) AUTHORITY GENERALLY.—The Postal Regulatory Commission shall, within 24 months after the date of the enactment of this section, by regulation establish (and may from time to time thereafter by regulation revise) a set of service standards for market-dominant products consistent with sections 101 (a) and (b) and 403.

''(b) OBJECTIVES.—Such standards shall be designed to achieve the following objectives:

''(1) To increase the value of postal services to both senders and recipients.

''(2) To provide a benchmark for Postal Service performance goals.

''(3) To guarantee Postal Service customers delivery speed and frequency consistent with reasonable rates.

''(c) FACTORS.—In establishing or revising such standards, the Postal Regulatory Commission shall take into account—

''(1) any service standards previously established by the Postal Service;

''(2) the actual level of service Postal Service customers receive;

''(3) customer satisfaction with Postal Service performance;

''(4) mail volume and revenues projected for future years;

''(5) the projected growth in the number of addresses the Postal Service will be required to serve in future years;

''(6) the current and projected future cost of serving Postal Service customers; and

''(7) the policies of this title as well as such other factors as the Commission determines appropriate.''.

SEC. 302. POSTAL SERVICE PLAN.

(a) IN GENERAL.—Within 1 year after the establishment of the service standards under section 3691 of title 39, United States Code, as added by this Act, the Postal Service shall, in consultation with the Postal Regulatory Commission, develop and submit to Congress a plan for meeting those standards.

(b) CONTENT.—The plan under this section shall—

(1) establish performance goals;

(2) describe any changes to the Postal Service's processing, transportation, delivery, and retail networks necessary to allow the Postal Service to meet the performance goals; and

(3) describe any changes to planning and performance management documents previously submitted to Congress to reflect new performance goals.

(c) RECOMMENDATIONS.—The Postal Service plan shall include a list of any processing and retail facilities that can be closed or consolidated without hindering the Postal Service's ability to meet established service standards. The recommendations shall be consistent with the provisions in section 101(b) of title 39, United States Code prohibiting the closing of post offices, including post offices in rural areas and small towns, solely because they are not self-sustaining or operate at a deficit.

(d) ALTERNATE RETAIL OPTIONS.—The Postal Service plan shall include, to the extent possible, plans to provide postal services by other means, including—

(1) vending machines;

(2) the Internet;

(3) Postal Service employees on delivery routes; and

(4) retail facilities in which overhead costs are shared with private businesses and other government agencies.

(e) REEMPLOYMENT ASSISTANCE AND RETIREMENT BENEFITS.—The Postal Service plan shall include—

(1) a plan under which reemployment assistance shall be afforded to employees displaced as a result of the automation or privatization of any of its functions or the closing and consolidation of any of its facilities; and

(2) a plan, developed in consultation with the Office of Personnel Management, to offer early retirement benefits.

(f) INSPECTOR GENERAL REPORT.—

(1) IN GENERAL.—Before submitting the plan under this section to Congress, the Postal Service shall submit the plan to the Inspector General of the United States Postal Service in a timely manner to carry out this subsection.

(2) REPORT.—The Inspector General shall prepare a report describing the extent to which the Postal Service plan—

(A) is consistent with the continuing obligations of the Postal Service under title 39, United States Code; and

(B) provides for the Postal Service to meet the service standards established under section 3691.

(3) SUBMISSION OF REPORT.—The Postal Service shall submit the report of the Inspector General under this subsection with the

plan submitted to Congress under subsection (a).

(g) RECOMMENDED FACILITY CLOSINGS AND CONSOLIDATIONS.—The list of recommended facility closings and consolidations, including the criteria used for selection, justifications for each recommendation, and any comments received from affected communities, shall be transmitted to the Postal Network Modernization Commission at the same time the Postal Service plan is transmitted to Congress.

(h) CONTINUING RESPONSIBILITIES.—Nothing in this section shall affect the responsibilities of the Postal Service under section 404(b) of title 39, United States Code, with respect to any postal facility by reason of that facility being recommended for closing or consolidation under this section.

SEC. 303. POSTAL NETWORK MODERNIZATION COMMISSION.

(a) ESTABLISHMENT.—There is established an independent commission to be known as the ''Postal Network Modernization Commission''.

(b) DUTIES.—The Commission shall carry out the duties specified in this title.

(c) APPOINTMENT.—

(1) IN GENERAL.—

(A) COMPOSITION.—The Commission shall be composed of 8 members appointed by the President, by and with the advice and consent of the Senate.

(B) LIMITATION ON POLITICAL PARTY MEMBERSHIP.—No more than 4 members of the Commission at any time shall be from the same political party.

(C) EMPLOYEE REPRESENTATION.—One member of the Commission shall be chosen from among persons nominated for such office with the unanimous concurrence of all organizations representing postmasters and all employee organizations described under section 1004(b) of title 39, United States Code.

(D) UNION REPRESENTATION.—One member of the Commission shall be chosen from among persons nominated for such office with the unanimous concurrence of all labor organizations described in section 206(a)(1) of title 39, United States Code.

(2) CHAIRMAN.—At the time the President nominates individuals for appointment to the Commission, the President shall designate one such individual who shall serve as Chairman of the Commission.

(d) MEETINGS.—

(1) OPEN MEETINGS.—Each meeting of the Commission shall be open to the public.

(2) PROCEEDINGS, INFORMATION, AND DELIBERATIONS.—All of the proceedings, information, and deliberation of the Commission shall be open, upon request, to the following:

(A) COMMITTEE ON GOVERNMENTAL AFFAIRS.—The Chairman and the ranking minority party member of the Committee on Governmental Affairs of the Senate, or such other members of the Committee designated by such Chairman or ranking minority party member.

(B) COMMITTEE ON GOVERNMENT REFORM.—The Chairman and the ranking minority party member of the Committee on Government Reform of the House of Representatives, or such other members of the Committee designated by such Chairman or ranking minority party member.

(C) COMMITTEES ON APPROPRIATIONS.—The Chairmen and ranking minority party members of the Subcommittees on Transportation, Treasury, and General Government of the Committees on Appropriations of the Senate and the House of Representatives, or such other members of the Subcommittees designated by such Chairmen or ranking minority party members.

(e) VACANCIES.—A vacancy in the Commission shall be filled in the same manner as the original appointment.

(f) PAY AND TRAVEL EXPENSES.—

(1) IN GENERAL.—

(A) PAY.—Each member, other than the Chairman, shall be paid at a rate equal to the daily equivalent of the minimum annual rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which the member is engaged in the actual performance of duties vested in the Commission.

(B) PAY FOR CHAIRMAN.—The Chairman shall be paid for each day referred to in subparagraph (A) at a rate equal to the daily equivalent of the minimum annual rate of basic pay payable for level III of the Executive Schedule under section 5314 of title 5, United States Code.

(2) TRAVEL EXPENSES.—Members shall receive travel expenses, including per diem in lieu of subsistence, in accordance with sections 5702 and 5703 of title 5, United States Code.

(g) DIRECTOR OF STAFF.—

(1) APPOINTMENT.—The Commission shall, without regard to section 5311(b) of title 5, United States Code, appoint a Director who was not employed by the Postal Service during the 1-year period preceding the date of such appointment.

(2) PAY.—The Director shall be paid at the rate of basic pay payable for level IV of the Executive Schedule under section 5315 of title 5, United States Code.

(h) STAFF.—

(1) IN GENERAL.—Subject to paragraphs (2) and (3), the Director, with the approval of the Commission, may appoint and fix the pay of additional personnel.

(2) CONDITIONS OF APPOINTMENTS.—The Director may make such appointments without regard to the provisions of title 5, United States Code, governing appointments in the competitive service, and any personnel so appointed may be paid without regard to the provisions of chapter 51 and subchapter III of chapter 53 of that title relating to classification and General Schedule pay rates, except that an individual so appointed may not receive pay in excess of the highest annual rate of basic pay payable for a position classified at above GS–15 of the General Schedule.

(3) DETAILS.—

(A) IN GENERAL.—Not more than ⅓ of the personnel employed by or detailed to the Commission may be on detail from the Postal Service.

(B) ANALYSTS.—Not more than ⅓ of the professional analysts of the Commission staff may be persons detailed from the Postal Service to the Commission.

(C) LIMITATIONS.—A person may not be detailed from the Postal Service to the Commission if that person participated personally and substantially in any matter within the Postal Service concerning the preparation of recommendations for closures or consolidations of postal facilities. No employee of the Postal Service may—

(i) prepare any report concerning the effectiveness, fitness, or efficiency of the performance on the staff of the Commission of any person detailed from the Postal Service to that staff;

(ii) review the preparation of such a report; or

(iii) approve or disapprove such a report.

(4) DETAIL UPON REQUEST.—Upon request of the Director, the head of any Federal department or agency may detail any of the personnel of that department or agency to the Commission to assist the Commission in carrying out its duties under this part.

(5) COMPTROLLER GENERAL ASSISTANCE.—The Comptroller General of the United States shall provide assistance, including the detailing of employees, to the Commission in accordance with an agreement entered into with the Commission.

(6) LIMITATION ON NUMBER OF STAFF.—There may not be more than 15 persons on the staff at any one time.

(i) OTHER AUTHORITY.—

(1) EXPERTS AND CONSULTANTS.—The Commission may procure by contract, to the extent funds are available, the temporary of intermittent services of experts or consultants under section 3109 of title 5, United States Code.

(2) LEASE OF SPACE.—The Commission may lease space and acquire personal property to the extent funds are available.

(j) FUNDING.—There are authorized to be appropriated to the Commission such funds as are necessary to carry out its duties under this part. Such funds shall remain available until expended.

(k) REVIEW OF POSTAL SERVICE RECOMMENDATIONS.—

(1) IN GENERAL.—After receiving the recommendations from the Postal Service under section 302, the Commission shall conduct public hearings on the recommendations. All testimony before the Commission at a public hearing conducted under this paragraph shall be presented under oath. The hearings shall solicit views from Postal Service customers and employees and community leaders and government officials in the communities affected by the Postal Service's recommendations.

(2) REPORT.—

(A) TRANSMISSION.—The Commission shall, no later than 1 year following receipt of the Postal Service's recommendations under section 302, transmit to the President a report containing the Commission's findings and conclusions based on a review and analysis of the recommendations made by the Postal Service, together with the Commission's recommendations for closures and consolidations.

(B) CHANGES IN RECOMMENDATIONS.—In making its recommendations, the Commission may make changes in any of the recommendations made by the Postal Service if the Commission determines that the Postal Service's recommended closings and consolidations would not allow them to meet the service standards established by the Postal Regulatory Commission under section 301.

(3) EXPLANATION.—The Commission shall explain and justify in its report submitted to the President under paragraph (2) any recommendation made by the Commission that is different from the recommendations made by the Postal Service under section 302. The Commission shall transmit a copy of such report to the Committee on Governmental Affairs of the Senate, Committee on Government Reform of the House of Representatives and the Subcommittees on Transportation, Treasury, and General Government of the Committees on Appropriations of the Senate and the House of Representatives on the same date on which it transmits its recommendations to the President under paragraph (2).

(4) PROVISION OF INFORMATION.—After transmitting its recommendations, the Commission shall promptly provide, upon request, to any member of Congress information used by the Commission in making its recommendations.

(5) COMPTROLLER GENERAL.—The Comptroller General of the United States shall—

(A) assist the Commission, to the extent requested, in the Commission's review and analysis of the recommendations made by the Postal Service under section 302; and

(B) not later than 30 days following receipt of the Postal Service's recommendations, transmit to Congress and the Commission a detailed analysis of the Postal Service's recommendations.

(l) REVIEW BY THE PRESIDENT.—

(1) REPORT.—The President shall, no later than 14 days following receipt of the Commission's recommendations, transmit to the Commission and to Congress a report containing the President's approval or disapproval of the Commission's recommendations.

(2) APPROVAL.—If the President approves all the recommendations, the President shall transmit a copy of such recommendations to Congress, together with a certification of such approval.

(3) DISAPPROVAL.—If the President disapproves the recommendations of the Commission, in whole or in part, the President shall transmit to the Commission and the Congress the reasons for that disapproval. The Commission shall than transmit to the President, within 30 days, a revised list of recommendations.

(4) APPROVAL AFTER REVISIONS.—If the President approves all of the revised recommendations of the Commission transmitted to the President under paragraph (3), the President shall transmit a copy of such revised recommendations to Congress, together with a certification of such approval.

SEC. 304. CLOSURE AND CONSOLIDATION OF FACILITIES.

(a) IN GENERAL.—Subject to subsection (b), the Postal Service shall—

(1) close all postal facilities recommended by the Commission in such report transmitted to the Congress by the President under section 303(l);

(2) consolidate all postal facilities recommended for consolidation by the Commission in such report;

(3) initiate all such closures and consolidations no later than 1 year after the date on which the President transmits a report to Congress under section 303(l) containing the recommendations for such closures or consolidations; and

(4) complete all such closures and consolidations no later than the end of the 2-year period beginning on the date on which the President transmits the report under section 303(l) containing the recommendations for such closures and consolidations.

(b) CONGRESSIONAL DISAPPROVAL.—

(1) IN GENERAL.—The Postal Service may not carry out any closure or consolidation recommended by the Commission in a report transmitted from the President under section 303(l) if a joint resolution is enacted, in accordance with section 305, disapproving such recommendations of the Commission before the earlier of—

(A) the end of the 45-day period beginning on the date on which the President transmits such report; or

(B) the adjournment of the Congress sine die for the session during which such report is transmitted.

(2) DAYS OF SESSION.—For purposes of paragraph (1) and subsections (a) and (c) of section 305, the days on which either House of Congress is not in session because of an adjournment of more than 3 days to a day certain shall be excluded in the computation of a period.

SEC. 305. CONGRESSIONAL CONSIDERATION OF COMMISSION REPORT.

(a) TERMS OF THE RESOLUTION.—For purposes of this title, the term ''joint resolution'' means only a joint resolution which is introduced within the 10-day period beginning on the date on which the President transmits the report to the Congress under section 303(l), and—

(1) which does not have a preamble;

(2) the matter after the resolving clause of which is as follows: ''That Congress disapproves the recommendations of the Postal Facility Closure and Consolidation Commission as submitted by the President on ———'', the blank space being filled in with the appropriate date; and

(3) the title of which is as follows: ''Joint resolution disapproving the recommendations of the Postal Facility Closure and Consolidation Commission.''.

(b) REFERRAL.—A resolution described in subsection (a) that is introduced in the House of Representatives shall be referred to the Committee on Government Reform of the House of Representatives. A resolution described in subsection (a) introduced in the Senate shall be referred to the Committee on Governmental Affairs of the Senate.

(c) DISCHARGE.—If the committee to which a resolution described in subsection (a) is referred has not reported such resolution (or an identical resolution) by the end of the 20-day period beginning on the date on which the President transmits the report to the Congress under section 303(l), such committee shall be, at the end of such period, discharged from further consideration of such resolution, and such resolution shall be placed on the appropriate calendar of the House involved.

(d) CONSIDERATION.—

(1) IN GENERAL.—On or after the third day after the date on which the committee to which such a resolution is referred has reported, or has been discharged (under subsection (c)) from further consideration of, such a resolution, it is in order (even though a previous motion to the same effect has been disagreed to) for any Member of the respective House to move to proceed to the consideration of the resolution. A Member may make the motion only on the day after the calendar day on which the Member announces to the House concerned the Member's intention to make the motion, except that, in the case of the House of Representatives, the motion may be made without such prior announcement if the motion is made by direction of the committee to which the resolution was referred. All points of order against the resolution (and against consideration of the resolution) are waived. The motion is highly privileged in the House of Representatives and is privileged in the Senate and is not debatable. The motion is not subject to amendment, or to a motion to postpone, or to a motion to proceed to the consideration of other business. A motion to reconsider the vote by which the motion is agreed to or disagreed to shall not be in order. If a motion to proceed to the consideration of the resolution is agreed to, the respective House shall immediately proceed to consideration of the joint resolution without intervening motion, order, or other business, and the resolution shall remain the unfinished business of the respective House until disposed of.

(2) DEBATE.—Debate on the resolution, and on all debatable motions and appeals in connection therewith, shall be limited to not more than 2 hours, which shall be divided equally between those favoring and those opposing the resolution. An amendment to the resolution is not in order. A motion further to limit debate is in order and not debatable. A motion to postpone, or a motion to proceed to the consideration of other business, or a motion to recommit the resolution is not in order. A motion to reconsider the vote by which the resolution is agreed to or disagreed to is not in order.

(3) VOTE ON FINAL PASSAGE.—Immediately following the conclusion of the debate on a resolution described in subsection (a) and a single quorum call at the conclusion of the debate if requested in accordance with the rules of the appropriate House, the vote on final passage of the resolution shall occur.

(4) APPEALS.—Appeals from the decisions of the Chair relating to the application of the rules of the Senate or the House of Representatives, as the case may be, to the procedure relating to a resolution described in subsection (a) shall be decided without debate.

(e) CONSIDERATION BY OTHER HOUSE.—

(1) IN GENERAL.—If, before the passage by one House of a resolution of that House described in subsection (a), that House receives from the other House a resolution described in subsection (a), then the following procedures shall apply:

(A) The resolution of the other House shall not be referred to a committee and may not be considered in the House receiving it except in the case of final passage as provided in subparagraph (B)(ii).

(B) With respect to a resolution described in subsection (a) of the House receiving the resolution—

(i) the procedure in that House shall be the same as if no resolution had been received from the other House; but

(ii) the vote on final passage shall be on the resolution of the other House.

(2) DISPOSITION OF A RESOLUTION.—Upon disposition of the resolution received from the other House, it shall no longer be in order to consider the resolution that originated in the receiving House.

(f) RULES OF THE SENATE AND HOUSE.—This section is enacted by Congress—

(1) as an exercise of the rulemaking power of the Senate and House of Representatives, respectively, and as such it is deemed a part of the rules of each House, respectively, but applicable only with respect to the procedure to be followed in that House in the case of a resolution described in subsection (a), and it supersedes other rules only to the extent that it is inconsistent with such rules; and

(2) with full recognition of the constitutional right of either House to change the rules (so far as relating to the procedure of that House) at any time, in the same manner, and to the same extent as in the case of any other rule of that House.

SEC. 306. NONAPPEALIBILITY TO THE POSTAL REGULATORY COMMISSION.

The closing or consolidation of any post office or other postal facility under this title may not be appealed to the Postal Regulatory Commission under the provisions of title 39, United States Code, including section 404(b)(5) of that title.

TITLE IV—PROVISIONS RELATING TO FAIR COMPETITION

SEC. 401. POSTAL SERVICE COMPETITIVE PRODUCTS FUND.

(a) PROVISIONS RELATING TO POSTAL SERVICE COMPETITIVE PRODUCTS FUND AND RELATED MATTERS.—

(1) IN GENERAL.—Chapter 20 of title 39, United States Code, is amended by adding at the end the following:

''§ 2011. Provisions relating to competitive products

''(a) There is established in the Treasury of the United States a revolving fund, to be called the Postal Service Competitive Products Fund, which shall be available to the Postal Service without fiscal year limitation for the payment of—

''(1) costs attributable to competitive products; and

''(2) all other costs incurred by the Postal Service, to the extent allocable to competitive products.

For purposes of this subsection, the term 'costs attributable' has the meaning given such term by section 3631.

''(b) There shall be deposited in the Competitive Products Fund, subject to withdrawal by the Postal Service—

''(1) revenues from competitive products;

''(2) amounts received from obligations issued by the Postal Service under subsection (e);

''(3) interest and dividends earned on investments of the Competitive Products Fund; and

''(4) any other receipts of the Postal Service (including from the sale of assets), to the extent allocable to competitive products.

''(c) If the Postal Service determines that the moneys of the Competitive Products Fund are in excess of current needs, it may invest such amounts as it considers appropriate in—

''(1) obligations of, or obligations guaranteed by, the Government of the United States; and

''(2) in accordance with regulations which the Secretary of the Treasury shall prescribe (by not later than 12 months after the date of enactment of the Postal Accountability and Enhancement Act), such other obligations or securities as it considers appropriate, with the exception of obligations of or securities in any business entity subject to Postal Service regulations other than those regulations applying to the mailing public generally.

''(d) The Postal Service may, in its sole discretion, provide that moneys of the Competitive Products Fund be deposited in a Federal Reserve bank or a depository for public funds.

''(e)(1) Subject to the limitations specified in section 2005(a), the Postal Service is authorized to borrow money and to issue and sell such obligations as it determines necessary to provide for competitive products and deposit such amounts in the Competitive Products Fund, except that the Postal Service may pledge only assets related to the provision of competitive products (as determined under subsection (h) or, for purposes of any period before accounting practices and principles under subsection (h) have been established and applied, the best information available from the Postal Service, including the audited statements required by section 2008(e)), and the revenues and receipts from such products, for the payment of the principal of or interest on such obligations, for the purchase or redemption thereof, and for other purposes incidental thereto, including creation of reserve, sinking, and other funds which may be similarly pledged and used, to such extent and in such manner as the Postal Service determines necessary or desirable.

''(2) The Postal Service may enter into binding covenants with the holders of such obligations, and with the trustee, if any, under any agreement entered into in connection with the issuance thereof with respect to—

''(A) the establishment of reserve, sinking, and other funds;

''(B) application and use of revenues and receipts of the Competitive Products Fund;

''(C) stipulations concerning the subsequent issuance of obligations or the execution of leases or lease purchases relating to properties of the Postal Service; and

''(D) such other matters as the Postal Service considers necessary or desirable to enhance the marketability of such obligations.

''(3) Obligations issued by the Postal Service under this subsection—

''(A) may not be purchased by the Secretary of the Treasury;

''(B) shall not be exempt either as to principal or interest from any taxation now or hereafter imposed by any State or local taxing authority;

''(C) shall not be obligations of, nor shall payment of the principal thereof or interest thereon be guaranteed by, the Government of the United States, and the obligations shall so plainly state; and

''(D) notwithstanding the provisions of the Federal Financing Bank Act of 1973 or any other provision of law (except as specifically provided by reference to this subparagraph in a law enacted after this subparagraph takes effect), shall not be eligible for purchase by, commitment to purchase by, or sale or issuance to, the Federal Financing Bank.

''(4)(A) This paragraph applies with respect to the period beginning on the date of the enactment of this paragraph and ending at the close of the 5-year period which begins on the date on which the Postal Service makes its submission under subsection (h)(1).

''(B) During the period described in subparagraph (A), nothing in subparagraph (A) or (D) of paragraph (3) or the last sentence of section 2006(b) shall, with respect to any obligations sought to be issued by the Postal Service under this subsection, be considered to affect such obligations' eligibility for purchase by, commitment to purchase by, or sale or issuance to, the Federal Financing Bank.

''(C) The Federal Financing Bank may elect to purchase such obligations under such terms, including rates of interest, as the Bank and the Postal Service may agree, but at a rate of yield no less than the prevailing yield on outstanding marketable securities of comparable maturity issued by entities with the same credit rating as the rating then most recently obtained by the Postal Service under subparagraph (D), as determined by the Bank.

''(D) In order to be eligible to borrow under this paragraph, the Postal Service shall first obtain a credit rating from a nationally recognized credit rating organization. Such rating—

''(i) shall be determined taking into account only those assets and activities of the Postal Service which are described in section 3634(a)(2) (relating to the Postal Service's assumed taxable income from competitive products); and

''(ii) may, before final rules of the Postal Regulatory Commission under subsection (h) are issued (or deemed to have been issued), be based on the best information available from the Postal Service, including the audited statements required by section 2008(e).

''(f) The receipts and disbursements of the Competitive Products Fund shall be accorded the same budgetary treatment as is accorded to receipts and disbursements of the Postal Service Fund under section 2009a.

''(g) A judgment against the Postal Service or the Government of the United States (or settlement of a claim) shall, to the extent that it arises out of activities of the Postal Service in the provision of competitive products, be paid out of the Competitive Products Fund.

''(h)(1) The Postal Service, in consultation with an independent, certified public accounting firm and such other advisors as it considers appropriate, shall develop recommendations regarding—

''(A) the accounting practices and principles that should be followed by the Postal Service with the objectives of identifying the capital and operating costs incurred by the Postal Service in providing competitive products, and preventing the cross-subsidization of such products by market-dominant products; and

''(B) the substantive and procedural rules that should be followed in determining the Postal Service's assumed Federal income tax on competitive products income for any year (within the meaning of section 3634).

Such recommendations shall be submitted to the Postal Regulatory Commission no earlier than 6 months, and no later than 12 months, after the effective date of this section.

''(2)(A) Upon receiving the recommendations of the Postal Service under paragraph (1), the Commission shall give interested parties, including the Postal Service, users of the mails, and an officer of the Commission who shall be required to represent the interests of the general public, an opportunity to present their views on those recommendations through submission of written data, views, or arguments with or without opportunity for oral presentation, or in such other manner as the Commission considers appropriate.

''(B) After due consideration of the views and other information received under subparagraph (A), the Commission shall by rule—

''(i) provide for the establishment and application of the accounting practices and principles which shall be followed by the Postal Service;

''(ii) provide for the establishment and application of the substantive and procedural rules described in paragraph (1)(B); and

''(iii) provide for the submission by the Postal Service to the Postal Regulatory Commission of annual and other periodic reports setting forth such information as the Commission may require.

Final rules under this subparagraph shall be issued not later than 12 months after the date on which the Postal Service makes its submission to the Commission under paragraph (1) (or by such later date as the Commission and the Postal Service may agree to). If final rules are not issued by the Commission by the deadline under the preceding sentence, the recommendations submitted by the Postal Service under paragraph (1) shall be treated as the final rules. The Commission is authorized to promulgate regulations revising such rules.

''(C) Reports described in subparagraph (B)(iii) shall be submitted at such time and in such form, and shall include such information, as the Commission by rule requires. The Commission may, on its own motion or on request of an interested party, initiate proceedings (to be conducted in accordance with such rules as the Commission shall prescribe) to improve the quality, accuracy, or completeness of Postal Service data under such subparagraph whenever it shall appear that—

''(i) the quality of the information furnished in those reports has become significantly inaccurate or can be significantly improved; or

''(ii) such revisions are, in the judgment of the Commission, otherwise necessitated by the public interest.

''(D) A copy of each report described in subparagraph (B)(iii) shall also be transmitted by the Postal Service to the Secretary of the Treasury and the Inspector General of the United States Postal Service.

''(i) The Postal Service shall render an annual report to the Secretary of the Treasury concerning the operation of the Competitive Products Fund, in which it shall address such matters as risk limitations, reserve balances, allocation or distribution of moneys, liquidity requirements, and measures to safeguard against losses. A copy of its then most recent report under this subsection shall be included with any other submission that it is required to make to the Postal Regulatory Commission under section 3652(g).''.

(2) CLERICAL AMENDMENT.—The analysis for chapter 20 of title 39, United States Code, is amended by adding after the item relating to section 2010 the following:

''2011. Provisions relating to competitive products.''.

(b) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) DEFINITION.—Section 2001 of title 39, United States Code, is amended by striking ''and'' at the end of paragraph (1), by redesignating paragraph (2) as paragraph (3), and by inserting after paragraph (1) the following:

''(2) 'Competitive Products Fund' means the Postal Service Competitive Products Fund established by section 2011; and''.

(2) CAPITAL OF THE POSTAL SERVICE.—Section 2002(b) of title 39, United States Code, is amended by striking ''Fund,'' and inserting ''Fund and the balance in the Competitive Products Fund,''.

(3) POSTAL SERVICE FUND.—

(A) PURPOSES FOR WHICH AVAILABLE.—Section 2003(a) of title 39, United States Code, is amended by striking ''title.'' and inserting ''title (other than any of the purposes, functions, or powers for which the Competitive Products Fund is available).''.

(B) DEPOSITS.—Section 2003(b) of title 39, United States Code, is amended by striking ''There'' and inserting ''Except as otherwise provided in section 2011, there''.

(4) RELATIONSHIP BETWEEN THE TREASURY AND THE POSTAL SERVICE.—Section 2006 of title 39, United States Code, is amended—

(A) in subsection (b), by adding at the end the following: ''Nothing in this chapter shall be considered to permit or require the Secretary of the Treasury to purchase any obligations of the Postal Service other than those issued under section 2005.''; and

(B) in subsection (c), by inserting ''under section 2005'' before ''shall be obligations''.

SEC. 402. ASSUMED FEDERAL INCOME TAX ON COMPETITIVE PRODUCTS INCOME.

Subchapter II of chapter 36 of title 39, United States Code, as amended by section 202, is amended by adding at the end the following:

''§ 3634. Assumed Federal income tax on competitive products income

''(a) DEFINITIONS.—For purposes of this section—

''(1) the term 'assumed Federal income tax on competitive products income' means the net income tax that would be imposed by chapter 1 of the Internal Revenue Code of 1986 on the Postal Service's assumed taxable income from competitive products for the year; and

''(2) the term 'assumed taxable income from competitive products', with respect to a year, refers to the amount representing what would be the taxable income of a corporation under the Internal Revenue Code of 1986 for the year, if—

''(A) the only activities of such corporation were the activities of the Postal Service allocable under section 2011(h) to competitive products; and

''(B) the only assets held by such corporation were the assets of the Postal Service allocable under section 2011(h) to such activities.

''(b) COMPUTATION AND TRANSFER REQUIREMENTS.—The Postal Service shall, for each year beginning with the year in which occurs the deadline for the Postal Service's first report to the Postal Regulatory Commission under section 3652(a)—

''(1) compute its assumed Federal income tax on competitive products income for such year; and

''(2) transfer from the Competitive Products Fund to the Postal Service Fund the amount of that assumed tax.

''(c) DEADLINE FOR TRANSFERS.—Any transfer required to be made under this section for a year shall be due on or before the January 15th next occurring after the close of such year.''.

SEC. 403. UNFAIR COMPETITION PROHIBITED.

(a) SPECIFIC LIMITATIONS.—Chapter 4 of title 39, United States Code, is amended by adding after section 404 the following:

''§ 404a. Specific limitations

''(a) Except as specifically authorized by law, the Postal Service may not:

''(1) establish any rule or regulation (including any standard) the effect of which is to preclude competition or establish the terms of competition unless the Postal Service demonstrates that the regulation does not create an unfair competitive advantage for itself or any entity funded (in whole or in part) by the Postal Service;

''(2) compel the disclosure, transfer, or licensing of intellectual property to any third party (such as patents, copyrights, trademarks, trade secrets, and proprietary information); or

''(3) obtain information from a person that provides (or seeks to provide) any product, and then offer any product or service that uses or is based in whole or in part on such information, without the consent of the person providing that information, unless substantially the same information is obtained (or obtainable) from an independent source or is otherwise obtained (or obtainable).

''(b) The Postal Regulatory Commission shall prescribe regulations to carry out this section.

''(c) Any party (including an officer of the Commission representing the interests of the general public) who believes that the Postal Service has violated this section may bring a complaint in accordance with section 3662.''.

(b) CONFORMING AMENDMENTS.—

(1) GENERAL POWERS.—Section 401 of title 39, United States Code, is amended by striking ''The'' and inserting ''Subject to the provisions of section 404a, the''.

(2) SPECIFIC POWERS.—Section 404(a) of title 39, United States Code, is amended by striking ''Without'' and inserting ''Subject to the provisions of section 404a, but otherwise without''.

(c) CLERICAL AMENDMENT.—The analysis for chapter 4 of title 39, United States Code, is amended by inserting after the item relating to section 404 the following:

''404a. Specific limitations.''.

SEC. 404. SUITS BY AND AGAINST THE POSTAL SERVICE.

(a) IN GENERAL.—Section 409 of title 39, United States Code, is amended by striking subsections (d) and (e) and inserting the following:

''(d)(1) For purposes of the provisions of law cited in paragraphs (2)(A) and (2)(B), respectively, the Postal Service—

''(A) shall be considered to be a 'person', as used in the provisions of law involved; and

''(B) shall not be immune under any other doctrine of sovereign immunity from suit in Federal court by any person for any violation of any of those provisions of law by any officer or employee of the Postal Service.

''(2) This subsection applies with respect to—

''(A) the Act of July 5, 1946 (commonly referred to as the 'Trademark Act of 1946' (15 U.S.C. 1051 and following)); and

''(B) the provisions of section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair or deceptive acts or practices.

''(e)(1) To the extent that the Postal Service, or other Federal agency acting on behalf of or in concert with the Postal Service, engages in conduct with respect to any product which is not reserved to the United States under section 1696 of title 18, the Postal Service or other Federal agency (as the case may be)—

''(A) shall not be immune under any doctrine of sovereign immunity from suit in Federal court by any person for any violation of Federal law by such agency or any officer or employee thereof; and

''(B) shall be considered to be a person (as defined in subsection (a) of the first section of the Clayton Act) for purposes of—

''(i) the antitrust laws (as defined in such subsection); and

''(ii) section 5 of the Federal Trade Commission Act to the extent that such section 5 applies to unfair methods of competition.

For purposes of the preceding sentence, any private carriage of mail allowable by virtue of section 601 shall not be considered a service reserved to the United States under section 1696 of title 18.

''(2) No damages, interest on damages, costs or attorney's fees may be recovered under the antitrust laws (as so defined) from the Postal Service or any officer or employee thereof acting in an official capacity for any conduct with respect to a product in the market-dominant category of mail.

''(3) This subsection shall not apply with respect to conduct occurring before the date of the enactment of this subsection.

''(f) To the extent that the Postal Service engages in conduct with respect to the provision of competitive products, it shall be considered a person for the purposes of the Federal bankruptcy laws.

''(g)(1) Each building constructed or altered by the Postal Service shall be constructed or altered, to the maximum extent feasible as determined by the Postal Service, in compliance with one of the nationally recognized model building codes and with other applicable nationally recognized codes.

''(2) Each building constructed or altered by the Postal Service shall be constructed or altered only after consideration of all requirements (other than procedural requirements) of zoning laws, land use laws, and applicable environmental laws of a State or subdivision of a State which would apply to the building if it were not a building constructed or altered by an establishment of the Government of the United States.

''(3) For purposes of meeting the requirements of paragraphs (1) and (2) with respect to a building, the Postal Service shall—

''(A) in preparing plans for the building, consult with appropriate officials of the State or political subdivision, or both, in which the building will be located;

''(B) upon request, submit such plans in a timely manner to such officials for review by such officials for a reasonable period of time not exceeding 30 days; and

''(C) permit inspection by such officials during construction or alteration of the building, in accordance with the customary schedule of inspections for construction or alteration of buildings in the locality, if such officials provide to the Postal Service—

''(i) a copy of such schedule before construction of the building is begun; and

''(ii) reasonable notice of their intention to conduct any inspection before conducting such inspection.

Nothing in this subsection shall impose an obligation on any State or political subdivision to take any action under the preceding sentence, nor shall anything in this subsection require the Postal Service or any of its contractors to pay for any action taken by a State or political subdivision to carry out this subsection (including reviewing plans, carrying out on-site inspections, issuing building permits, and making recommendations).

''(4) Appropriate officials of a State or a political subdivision of a State may make recommendations to the Postal Service concerning measures necessary to meet the requirements of paragraphs (1) and (2). Such officials may also make recommendations to the Postal Service concerning measures which should be taken in the construction or alteration of the building to take into account local conditions. The Postal Service shall give due consideration to any such recommendations.

''(5) In addition to consulting with local and State officials under paragraph (3), the Postal Service shall establish procedures for soliciting, assessing, and incorporating local community input on real property and land use decisions.

''(6) For purposes of this subsection, the term 'State' includes the District of Columbia, the Commonwealth of Puerto Rico, and a territory or possession of the United States.

''(h)(1) Notwithstanding any other provision of law, legal representation may not be furnished by the Department of Justice to the Postal Service in any action, suit, or proceeding arising, in whole or in part, under any of the following:

''(A) Subsection (d) or (e) of this section.

''(B) Subsection (f) or (g) of section 504 (relating to administrative subpoenas by the Postal Regulatory Commission).

''(C) Section 3663 (relating to appellate review).

The Postal Service may, by contract or otherwise, employ attorneys to obtain any legal representation that it is precluded from obtaining from the Department of Justice under this paragraph.

''(2) In any circumstance not covered by paragraph (1), the Department of Justice shall, under section 411, furnish the Postal Service such legal representation as it may require, except that, with the prior consent of the Attorney General, the Postal Service may, in any such circumstance, employ attorneys by contract or otherwise to conduct litigation brought by or against the Postal Service or its officers or employees in matters affecting the Postal Service.

''(3)(A) In any action, suit, or proceeding in a court of the United States arising in whole or in part under any of the provisions of law referred to in subparagraph (B) or (C) of paragraph (1), and to which the Commission is not otherwise a party, the Commission shall be permitted to appear as a party on its own motion and as of right.

''(B) The Department of Justice shall, under such terms and conditions as the Commission and the Attorney General shall consider appropriate, furnish the Commission such legal representation as it may require in connection with any such action, suit, or proceeding, except that, with the prior consent of the Attorney General, the Commission may employ attorneys by contract or otherwise for that purpose.

''(i) A judgment against the Government of the United States arising out of activities of the Postal Service shall be paid by the Postal Service out of any funds available to the Postal Service, subject to the restriction specified in section 2011(g).''.

(b) TECHNICAL AMENDMENT.—Section 409(a) of title 39, United States Code, is amended by striking ''Except as provided in section 3628 of this title,'' and inserting ''Except as otherwise provided in this title,''.

SEC. 405. INTERNATIONAL POSTAL ARRANGEMENTS.

(a) IN GENERAL.—Section 407 of title 39, United States Code, is amended to read as follows:

''§ 407. International postal arrangements

''(a) It is the policy of the United States—

''(1) to promote and encourage communications between peoples by efficient operation of international postal services and other international delivery services for cultural, social, and economic purposes;

''(2) to promote and encourage unrestricted and undistorted competition in the provision of international postal services and other international delivery services, except where provision of such services by private companies may be prohibited by law of the United States;

''(3) to promote and encourage a clear distinction between governmental and operational responsibilities with respect to the provision of international postal services and other international delivery services by the Government of the United States and by intergovernmental organizations of which the United States is a member; and

''(4) to participate in multilateral and bilateral agreements with other countries to accomplish these objectives.

''(b)(1) The Secretary of State shall be responsible for formulation, coordination, and oversight of foreign policy related to international postal services and other international delivery services, and shall have the power to conclude treaties, conventions and amendments related to international postal services and other international delivery services, except that the Secretary may not conclude any treaty, convention, or other international agreement (including those regulating international postal services) if such treaty, convention, or agreement would, with respect to any competitive product, grant an undue or unreasonable preference to the Postal Service, a private provider of international postal or delivery services, or any other person.

''(2) In carrying out the responsibilities specified in paragraph (1), the Secretary of State shall exercise primary authority for the conduct of foreign policy with respect to international postal services and international delivery services, including the determination of United States positions and the conduct of United States participation in negotiations with foreign governments and international bodies. In exercising this authority, the Secretary—

''(A) shall coordinate with other agencies as appropriate, and in particular, shall give full consideration to the authority vested by law or Executive order in the Postal Regulatory Commission, the Department of Commerce, the Department of Transportation, and the Office of the United States Trade Representative in this area;

''(B) shall maintain continuing liaison with other executive branch agencies concerned with postal and delivery services;

''(C) shall maintain continuing liaison with the Committee on Government Reform of the House of Representatives and the Committee on Governmental Affairs of the Senate;

''(D) shall maintain appropriate liaison with both representatives of the Postal Service and representatives of users and private providers of international postal services and other international delivery services to keep informed of their interests and problems, and to provide such assistance as may be needed to ensure that matters of concern are promptly considered by the Department of State or (if applicable, and to the extent practicable) other executive branch agencies; and

''(E) shall assist in arranging meetings of such public sector advisory groups as may be established to advise the Department of State and other executive branch agencies in connection with international postal services and international delivery services.

''(3) The Secretary of State shall establish an advisory committee (within the meaning of the Federal Advisory Committee Act) to perform such functions as the Secretary considers appropriate in connection with carrying out subparagraphs (A) through (D) of paragraph (2).

''(c)(1) Before concluding any treaty, convention, or amendment that establishes a rate or classification for a product subject to subchapter I of chapter 36, the Secretary of State shall request the Postal Regulatory Commission to submit a decision on whether such rate or classification is consistent with the standards and criteria established by the Commission under section 3622.

''(2) The Secretary shall ensure that each treaty, convention, or amendment concluded under subsection (b) is consistent with a decision of the Commission adopted under paragraph (1), except if, or to the extent, the Secretary determines, by written order, that considerations of foreign policy or national security require modification of the Commission's decision.

''(d) Nothing in this section shall be considered to prevent the Postal Service from entering into such commercial or operational contracts related to providing international postal services and other international delivery services as it deems appropriate, except that—

''(1) any such contract made with an agency of a foreign government (whether under authority of this subsection or otherwise) shall be solely contractual in nature and may not purport to be international law; and

''(2) a copy of each such contract between the Postal Service and an agency of a foreign government shall be transmitted to the Secretary of State and the Postal Regulatory Commission not later than the effective date of such contract.

''(e)(1) With respect to shipments of international mail that are competitive products within the meaning of section 3631 that are exported or imported by the Postal Service, the Customs Service and other appropriate Federal agencies shall apply the customs laws of the United States and all other laws relating to the importation or exportation of such shipments in the same manner to both shipments by the Postal Service and similar shipments by private companies.

''(2) For purposes of this subsection, the term 'private company' means a private company substantially owned or controlled by persons who are citizens of the United States.

''(3) In exercising the authority pursuant to subsection (b) to conclude new treaties, conventions and amendments related to international postal services and to renegotiate such treaties, conventions and amendments, the Secretary of State shall, to the maximum extent practicable, take such measures as are within the Secretary's control to encourage the governments of other countries to make available to the Postal Service and private companies a range of nondiscriminatory customs procedures that will fully meet the needs of all types of American shippers. The Secretary of State shall consult with the United States Trade Representative and the Commissioner of Customs in carrying out this paragraph.

''(4) The provisions of this subsection shall take effect 6 months after the date of the enactment of this subsection or such earlier date as the Customs Service may determine in writing.''.

(b) EFFECTIVE DATE.—Notwithstanding any provision of the amendment made by subsection (a), the authority of the United States Postal Service to establish the rates of postage or other charges on mail matter conveyed between the United States and other countries shall remain available to the Postal Service until—

(1) with respect to market-dominant products, the date as of which the regulations promulgated under section 3622 of title 39, United States Code (as amended by section 201(a)) take effect; and

(2) with respect to competitive products, the date as of which the regulations promulgated under section 3633 of title 39, United States Code (as amended by section 202) take effect.

SEC. 406. CHANGE-OF-ADDRESS ORDER INVOLVING A COMMERCIAL MAIL RECEIVING AGENCY.

(a) REDESIGNATION.—Chapter 36 of title 39, United States Code (as in effect before the amendment made by section 204(a)) is amended by striking the heading for subchapter V and inserting the following:

''SUBCHAPTER VI—GENERAL''.

(b) CHANGE-OF-ADDRESS ORDER INVOLVING A COMMERCIAL MAIL RECEIVING AGENCY.—Subchapter VI of chapter 36 of title 39, United States Code (as so redesignated by subsection (a)) is amended by adding at the end the following:

''§ 3686. Change-of-address order involving a commercial mail receiving agency

''(a) For the purpose of this section, the term 'commercial mail receiving agency' or 'CMRA' means a private business that acts as the mail receiving agent for specific clients.

''(b) Upon termination of an agency relationship between an addressee and a commercial mail receiving agency—

''(1) the addressee or, if authorized to do so, the CMRA may file a change-of-address order with the Postal Service with respect to such addressee;

''(2) a change-of-address order so filed shall, to the extent practicable, be given full force and effect; and

''(3) any mail for the addressee that is delivered to the CMRA after the filing of an appropriate order under this subsection shall be subject to subsection (c).

''(c) Mail described in subsection (b)(3) shall, if marked for forwarding and remailed by the CMRA, be forwarded by the Postal Service in the same manner as, and subject to the same terms and conditions (including limitations on the period of time for which a change-of-address order shall be given effect) as apply to, mail forwarded directly by the Postal Service to the addressee.''.

SEC. 407. EXCEPTION FOR COMPETITIVE PRODUCTS.

(a) IN GENERAL.—Section 403(c) of title 39, United States Code, is amended by striking ''user.'' and inserting ''user, except that this subsection shall not apply to competitive products.''.

(b) EFFECTIVE DATE.—The amendments made by this section shall apply with respect to services, classifications, rates, and fees, to the extent provided or applicable (as the case may be) on or after the date as of which the regulations promulgated under section 3633 of title 39, United States Code (as amended by section 202) take effect.

TITLE V—GENERAL PROVISIONS

SEC. 501. QUALIFICATION REQUIREMENTS FOR GOVERNORS.

(a) IN GENERAL.—Section 202(a) of title 39, United States Code, is amended by striking ''(a)'' and inserting ''(a)(1)'' and by striking the fourth sentence and inserting the following: ''The Governors shall represent the public interest generally, and at least 4 of the Governors shall be chosen solely on the basis of their demonstrated ability in managing organizations or corporations (in either the public or private sector) of substantial size; for purposes of this sentence, an organization or corporation shall be considered to be of substantial size if it employs at least 50,000 employees. The Governors shall not be representatives of specific interests using the Postal Service, and may be removed only for cause.''.

(b) CONSULTATION REQUIREMENT.—Section 202(a) of title 39, United States Code, is amended by adding at the end the following:

''(2) In selecting the individuals described in paragraph (1) for nomination for appointment to the position of Governor, the President should consult with the Speaker of the House of Representatives, the minority leader of the House of Representatives, the majority leader of the Senate, and the minority leader of the Senate.''.

(c) RESTRICTION.—Section 202(b) of title 39, United States Code, is amended by striking ''(b)'' and inserting ''(b)(1)'', and by adding at the end the following:

''(2)(A) Notwithstanding any other provision of this section, in the case of the office of the Governor the term of which is the first one scheduled to expire at least 4 months after the date of the enactment of this paragraph—

''(i) such office may not, in the case of any person commencing service after that expiration date, be filled by any person other than an individual chosen from among persons nominated for such office with the unanimous concurrence of all labor organizations described in section 206(a)(1); and

''(ii) instead of the term that would otherwise apply under the first sentence of paragraph (1), the term of any person so appointed to such office shall be 3 years.

''(B) Except as provided in subparagraph (A), an appointment under this paragraph shall be made in conformance with all provisions of this section that would otherwise apply.''.

(d) APPLICABILITY.—The amendment made by subsection (a) shall not affect the appointment or tenure of any person serving as a Governor of the Board of Governors of the United States Postal Service pursuant to an appointment made before the date of the enactment of this Act, or, except as provided in the amendment made by subsection (c), any nomination made before that date; however, when any such office becomes vacant, the appointment of any person to fill that office shall be made in accordance with such amendment. The requirement set forth in the fourth sentence of section 202(a)(1) of title 39, United States Code (as amended by subsection (a)) shall be met beginning not later than 9 years after the date of the enactment of this Act.

SEC. 502. OBLIGATIONS.

(a) PURPOSES FOR WHICH OBLIGATIONS MAY BE ISSUED.—The first sentence of section 2005(a)(1) of title 39, United States Code, is amended by striking ''title.'' and inserting ''title, other than any of the purposes for which the corresponding authority is available to the Postal Service under section 2011.''.

(b) INCREASE RELATING TO OBLIGATIONS ISSUED FOR CAPITAL IMPROVEMENTS.—The third sentence of section 2005(a)(1) of title 39, United States Code, is amended by striking ''$2,000,000,000'' and inserting ''$3,000,000,000''.

(c) INCREASE IN MAXIMUM OUTSTANDING OBLIGATIONS ALLOWABLE.—Paragraph (2) of section 2005(a) of title 39, United States Code, is amended—

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

(2) by striking subparagraph (C) and inserting the following:

''(C) $15,000,000,000 for each of fiscal years 1992 through 2002; and

''(D) $25,000,000,000 for fiscal year 2003 and each fiscal year thereafter.''.

(d) LIMITATIONS ON OBLIGATIONS OUTSTANDING.—

(1) IN GENERAL.—Subsection (a) of section 2005 of title 39, United States Code, is amended by adding at the end the following:

''(3) For purposes of applying the respective limitations under this subsection, the aggregate amount of obligations issued by the Postal Service which are outstanding as of any one time, and the net increase in the amount of obligations outstanding issued by the Postal Service for the purpose of capital improvements or for the purpose of defraying operating expenses of the Postal Service in any fiscal year, shall be determined by aggregating the relevant obligations issued by the Postal Service under this section with the relevant obligations issued by the Postal Service under section 2011.''.

(2) CONFORMING AMENDMENT.—The second sentence of section 2005(a)(1) of title 39, United States Code, is amended by striking ''any such obligations'' and inserting ''obligations issued by the Postal Service which may be''.

(e) AMOUNTS WHICH MAY BE PLEDGED, ETC.—

(1) OBLIGATIONS TO WHICH PROVISIONS APPLY.—The first sentence of section 2005(b) of title 39, United States Code, is amended by striking ''such obligations,'' and inserting ''obligations issued by the Postal Service under this section,''.

(2) ASSETS, REVENUES, AND RECEIPTS TO WHICH PROVISIONS APPLY.—Subsection (b) of section 2005 of title 39, United States Code, is amended by striking ''(b)'' and inserting ''(b)(1)'', and by adding at the end the following:

''(2) Notwithstanding any other provision of this section—

''(A) the authority to pledge assets of the Postal Service under this subsection shall be available only to the extent that such assets are not related to the provision of competitive products (as determined under section 2011(h) or, for purposes of any period before accounting practices and principles under section 2011(h) have been established and applied, the best information available from the Postal Service, including the audited statements required by section 2008(e)); and

''(B) any authority under this subsection relating to the pledging or other use of revenues or receipts of the Postal Service shall be available only to the extent that they are not revenues or receipts of the Competitive Products Fund.''.

SEC. 503. PRIVATE CARRIAGE OF LETTERS.

(a) IN GENERAL.—Section 601 of title 39, United States Code, is amended by striking subsection (b) and inserting the following:

''(b) A letter may also be carried out of the mails when—

''(1) the amount paid for the private carriage of the letter is at least the amount equal to 6 times the rate then currently charged for the 1st ounce of a single-piece first class letter;

''(2) the letter weighs at least 12½ ounces; or

''(3) such carriage is within the scope of services described by regulations of the United States Postal Service (as in effect on July 1, 2001) that purport to permit private carriage by suspension of the operation of this section (as then in effect).

''(c) Any regulations necessary to carry out this section shall be promulgated by the Postal Regulatory Commission.''.

(b) EFFECTIVE DATE.—This section shall take effect on the date as of which the regulations promulgated under section 3633 of title 39, United States Code (as amended by section 202) take effect.

SEC. 504. RULEMAKING AUTHORITY.

Paragraph (2) of section 401 of title 39, United States Code, is amended to read as follows:

''(2) to adopt, amend, and repeal such rules and regulations, not inconsistent with this title, as may be necessary in the execution of its functions under this title and such other functions as may be assigned to the Postal Service under any provisions of law outside of this title;''.

SEC. 505. NONINTERFERENCE WITH COLLECTIVE BARGAINING AGREEMENTS, ETC.

(a) NONINTERFERENCE WITH COLLECTIVE BARGAINING AGREEMENTS.—Nothing in this Act or any amendment made by this Act shall restrict, expand, or otherwise affect any of the rights, privileges, or benefits of either employees of or labor organizations representing employees of the United States Postal Service under chapter 12 of title 39, United States Code, the National Labor Relations Act, any handbook or manual affecting employee labor relations within the

United States Postal Service, or any collective bargaining agreement.

(b) FREE MAILING PRIVILEGES CONTINUE UNCHANGED.—Nothing in this Act or any amendment made by this Act shall affect any free mailing privileges accorded under section 3217 or sections 3403 through 3406 of title 39, United States Code.

SEC. 506. BONUS AUTHORITY.

Title 39, United States Code, is amended by adding after section 3686 (as added by section 406(b)) the following:

''§ 3687. Bonus authority

''(a) IN GENERAL.—The Postal Service may establish one or more programs to provide bonuses or other rewards to officers and employees of the Postal Service to achieve the objectives of this chapter.

''(b) WAIVER OF LIMITATION ON COMPENSATION.—

''(1) IN GENERAL.—Under any such program, the Postal Service may award a bonus or other reward in excess of the limitation set forth in the last sentence of section 1003(a), if such program has been approved under paragraph (2).

''(2) APPROVAL PROCESS.—If the Postal Service wishes to have the authority, under any program described in subsection (a), to award bonuses or other rewards in excess of the limitation referred to in paragraph (1)—

''(A) the Postal Service shall make an appropriate request to the Postal Regulatory Commission, in such form and manner as the Commission requires; and

''(B) the Postal Regulatory Commission shall approve any such request if it finds that the program is likely to achieve the objectives of this chapter.

''(3) REVOCATION AUTHORITY.—If the Postal Regulatory Commission finds that a program previously approved under paragraph (2) is not achieving the objectives of this chapter, the Commission may revoke or suspend the authority of the Postal Service to continue such program until such time as appropriate corrective measures have, in the judgment of the Commission, been taken.

''(c) REPORTING REQUIREMENT RELATING TO BONUSES OR OTHER REWARDS.—Included in its comprehensive statement under section 2401(e) for any period shall be—

''(1) the name of each person receiving a bonus or other reward during such period which would not have been allowable but for the provisions of subsection (a)(2);

''(2) the amount of the bonus or other reward; and

''(3) the amount by which the limitation referred to in subsection (a)(2) was exceeded as a result of such bonus or other reward.''.

TITLE VI—ENHANCED REGULATORY COMMISSION

SEC. 601. REORGANIZATION AND MODIFICATION OF CERTAIN PROVISIONS RELATING TO THE POSTAL REGULATORY COMMISSION.

(a) TRANSFER AND REDESIGNATION.—Title 39, United States Code, is amended—

(1) by inserting after chapter 4 the following:

''CHAPTER 5—POSTAL REGULATORY COMMISSION

''§ 501. Establishment

''The Postal Regulatory Commission is an independent establishment of the executive branch of the Government of the United States.

''§ 502. Commissioners

''(a) The Postal Regulatory Commission is composed of 5 Commissioners, appointed by the President, by and with the advice and consent of the Senate. The Commissioners shall be chosen solely on the basis of their technical qualifications, professional standing, and demonstrated expertise in economics, accounting, law, or public administration, and may be removed by the President only for cause. Each individual appointed to the Commission shall have the qualifications and expertise necessary to carry out the enhanced responsibilities accorded Commissioners under the Postal Accountability and Enhancement Act. Not more than 3 of the Commissioners may be adherents of the same political party.

''(b) No Commissioner shall be financially interested in any enterprise in the private sector of the economy engaged in the delivery of mail matter.

''(c) A Commissioner may continue to serve after the expiration of his term until his successor has qualified, except that a Commissioner may not so continue to serve for more than 1 year after the date upon which his term otherwise would expire under subsection (f).

''(d) One of the Commissioners shall be designated as Chairman by, and shall serve in the position of Chairman at the pleasure of, the President.

''(e) The Commissioners shall by majority vote designate a Vice Chairman of the Commission. The Vice Chairman shall act as Chairman of the Commission in the absence of the Chairman.

''(f) The Commissioners shall serve for terms of 6 years.'';

(2) by striking, in subchapter I of chapter 36 (as in effect before the amendment made by section 201(c)), the heading for such subchapter I and all that follows through section 3602; and

(3) by redesignating sections 3603 and 3604 as sections 503 and 504, respectively, and transferring such sections to the end of chapter 5 (as inserted by paragraph (1)).

(b) APPLICABILITY.—The amendment made by subsection (a)(1) shall not affect the appointment or tenure of any person serving as a Commissioner on the Postal Regulatory Commission (as so redesignated by section 604) pursuant to an appointment made before the date of the enactment of this Act or any nomination made before that date, but, when any such office becomes vacant, the appointment of any person to fill that office shall be made in accordance with such amendment.

(c) CLERICAL AMENDMENT.—The analysis for part I of title 39, United States Code, is amended by inserting after the item relating to chapter 4 the following:

SEC. 602. AUTHORITY FOR POSTAL REGULATORY COMMISSION TO ISSUE SUBPOENAS.

Section 504 of title 39, United States Code (as so redesignated by section 601) is amended by adding at the end the following:

''(f)(1) Any Commissioner of the Postal Regulatory Commission, any administrative law judge appointed by the Commission under section 3105 of title 5, and any employee of the Commission designated by the Commission may administer oaths, examine witnesses, take depositions, and receive evidence.

''(2) The Chairman of the Commission, any Commissioner designated by the Chairman, and any administrative law judge appointed by the Commission under section 3105 of title 5 may, with respect to any proceeding conducted by the Commission under this title—

''(A) issue subpoenas requiring the attendance and presentation of testimony by, or the production of documentary or other evidence in the possession of, any covered person; and

''(B) order the taking of depositions and responses to written interrogatories by a covered person.

The written concurrence of a majority of the Commissioners then holding office shall, with respect to each subpoena under subparagraph (A), be required in advance of its issuance.

''(3) In the case of contumacy or failure to obey a subpoena issued under this subsection, upon application by the Commission, the district court of the United States for the district in which the person to whom the subpoena is addressed resides or is served may issue an order requiring such person to appear at any designated place to testify or produce documentary or other evidence. Any failure to obey the order of the court may be punished by the court as a contempt thereof.

''(4) For purposes of this subsection, the term 'covered person' means an officer, employee, agent, or contractor of the Postal Service.

''(g)(1) If the Postal Service determines that any document or other matter it provides to the Postal Regulatory Commission pursuant to a subpoena issued under subsection (f), or otherwise at the request of the Commission in connection with any proceeding or other purpose under this title, contains information which is described in section 410(c) of this title, or exempt from public disclosure under section 552(b) of title 5, the Postal Service shall, at the time of providing such matter to the Commission, notify the Commission, in writing, of its determination (and the reasons therefor).

''(2) No officer or employee of the Commission may, with respect to any information as to which the Commission has been notified under paragraph (1)—

''(A) use such information for purposes other than the purposes for which it is supplied; or

''(B) permit anyone who is not an officer or employee of the Commission to have access to any such information.

''(3) Paragraph (2) shall not prevent information from being furnished under any process of discovery established under this title in connection with a proceeding under this title. The Commission shall, by regulations based on rule 26(c) of the Federal Rules of Civil Procedure, establish procedures for ensuring appropriate confidentiality for any information furnished under the preceding sentence.''.

SEC. 603. APPROPRIATIONS FOR THE POSTAL REGULATORY COMMISSION.

(a) AUTHORIZATION OF APPROPRIATIONS.—Subsection (d) of section 504 of title 39, United States Code (as so redesignated by section 601) is amended to read as follows:

''(d) There are authorized to be appropriated, out of the Postal Service Fund, such sums as may be necessary for the Postal Regulatory Commission. In requesting an appropriation under this subsection for a fiscal year, the Commission shall prepare and submit to the Congress under section 2009 a budget of the Commission's expenses, including expenses for facilities, supplies, compensation, and employee benefits.''.

(b) BUDGET PROGRAM.—

(1) IN GENERAL.—The next to last sentence of section 2009 of title 39, United States Code, is amended to read as follows: ''The budget program shall also include separate statements of the amounts which (1) the Postal Service requests to be appropriated under subsections (b) and (c) of section 2401, (2) the Office of Inspector General of the United States Postal Service requests to be appropriated, out of the Postal Service Fund, under section 8G(f) of the Inspector General Act of 1978, and (3) the Postal Regulatory Commission requests to be appropriated, out of the Postal Service Fund, under section 504(d) of this title.''.

(2) CONFORMING AMENDMENT.—Section 2003(e)(1) of title 39, United States Code, is

amended by striking the first sentence and inserting the following: ''The Fund shall be available for the payment of (A) all expenses incurred by the Postal Service in carrying out its functions as provided by law, subject to the same limitation as set forth in the parenthetical matter under subsection (a); (B) all expenses of the Postal Regulatory Commission, subject to the availability of amounts appropriated pursuant to section 504(d); and (C) all expenses of the Office of Inspector General, subject to the availability of amounts appropriated pursuant to section 8G(f) of the Inspector General Act of 1978.''.

(c) EFFECTIVE DATE.—

(1) IN GENERAL.—The amendments made by this section shall apply with respect to fiscal years beginning on or after October 1, 2002.

(2) SAVINGS PROVISION.—The provisions of title 39, United States Code, that are amended by this section shall, for purposes of any fiscal year before the first fiscal year to which the amendments made by this section apply, continue to apply in the same way as if this section had never been enacted.

SEC. 604. REDESIGNATION OF THE POSTAL RATE COMMISSION.

(a) AMENDMENTS TO TITLE 39, UNITED STATES CODE.—Title 39, United States Code, is amended in sections 404, 503–504 (as so redesignated by section 601), 1001, 1002, by striking ''Postal Rate Commission'' each place it appears and inserting ''Postal Regulatory Commission'';

(b) AMENDMENTS TO TITLE 5, UNITED STATES CODE.—Title 5, United States Code, is amended in sections 104(1), 306(f), 2104(b), 3371(3), 5314 (in the item relating to Chairman, Postal Rate Commission), 5315 (in the item relating to Members, Postal Rate Commission), 5514(a)(5)(B), 7342(a)(1)(A), 7511(a)(1)(B)(ii), 8402(c)(1), 8423(b)(1)(B), and 8474(c)(4) by striking ''Postal Rate Commission'' and inserting ''Postal Regulatory Commission''.

(c) AMENDMENT TO THE ETHICS IN GOVERNMENT ACT OF 1978.—Section 101(f)(6) of the Ethics in Government Act of 1978 (5 U.S.C. App.) is amended by striking ''Postal Rate Commission'' and inserting ''Postal Regulatory Commission''.

(d) AMENDMENT TO THE REHABILITATION ACT OF 1973.—Section 501(b) of the Rehabilitation Act of 1973 (29 U.S.C. 791(b)) is amended by striking ''Postal Rate Office'' and inserting ''Postal Regulatory Commission''.

(e) AMENDMENT TO TITLE 44, UNITED STATES CODE.—Section 3502(5) of title 44, United States Code, is amended by striking ''Postal Rate Commission'' and inserting ''Postal Regulatory Commission''.

(f) OTHER REFERENCES.—Whenever a reference is made in any provision of law (other than this Act or a provision of law amended by this Act), regulation, rule, document, or other record of the United States to the Postal Rate Commission, such reference shall be considered a reference to the Postal Regulatory Commission.

TITLE VII—INSPECTORS GENERAL

SEC. 701. INSPECTOR GENERAL OF THE POSTAL REGULATORY COMMISSION.

(a) IN GENERAL.—Paragraph (2) of section 8G(a) of the Inspector General Act of 1978 is amended by inserting ''the Postal Regulatory Commission,'' after ''the United States International Trade Commission,''.

(b) ADMINISTRATION.—Section 504 of title 39, United States Code (as so redesignated by section 601) is amended by adding after subsection (g) (as added by section 602) the following:

''(h)(1) Notwithstanding any other provision of this title or of the Inspector General Act of 1978, the authority to select, appoint, and employ officers and employees of the Office of Inspector General of the Postal Regulatory Commission, and to obtain any temporary or intermittent services of experts or consultants (or an organization of experts or consultants) for such Office, shall reside with the Inspector General of the Postal Regulatory Commission.

''(2) Except as provided in paragraph (1), any exercise of authority under this subsection shall, to the extent practicable, be in conformance with the applicable laws and regulations that govern selections, appointments and employment, and the obtaining of any such temporary or intermittent services, within the Postal Regulatory Commission.''.

(c) DEADLINE.—No later than 180 days after the date of the enactment of this Act—

(1) the first Inspector General of the Postal Regulatory Commission shall be appointed; and

(2) the Office of Inspector General of the Postal Regulatory Commission shall be established.

SEC. 702. INSPECTOR GENERAL OF THE UNITED STATES POSTAL SERVICE TO BE APPOINTED BY THE PRESIDENT.

(a) DEFINITIONAL AMENDMENTS TO THE INSPECTOR GENERAL ACT OF 1978.—Section 11 of the Inspector General Act of 1978 is amended—

(1) in paragraph (1)—

(A) by striking ''and'' before ''the chief executive officer of the Resolution Trust Corporation'';

(B) by striking ''and'' before ''the Chairperson of the Federal Deposit Insurance Corporation''; and

(C) by inserting ''the Postmaster General;'' after ''Social Security Administration;''; and

(2) in paragraph (2)—

(A) by striking ''or'' before ''the Veterans' Administration''; and

(B) by inserting ''the United States Postal Service,'' after ''Social Security Administration,''.

(b) SPECIAL PROVISIONS CONCERNING THE UNITED STATES POSTAL SERVICE.—The Inspector General Act of 1978 is amended—

(1) by redesignating sections 8G (as amended by section 701(a)), 8H, and 8I as sections 8H through 8J, respectively; and

(2) by inserting after section 8F the following:

''SPECIAL PROVISIONS CONCERNING THE UNITED STATES POSTAL SERVICE

''SEC. 8G. (a) Notwithstanding the last two sentences of section 3(a), the Inspector General of the United States Postal Service shall report to and be under the general supervision of the Postmaster General, but shall not report to, or be subject to supervision by, any other officer or employee of the United States Postal Service or its Board of Governors. No such officer or employee (including the Postmaster General) or member of such Board shall prevent or prohibit the Inspector General from initiating, carrying out, or completing any audit or investigation, or from issuing any subpoena during the course of any audit or investigation.

''(b) In carrying out the duties and responsibilities specified in this Act, the Inspector General of the United States Postal Service shall have oversight responsibility for all activities of the Postal Inspection Service, including any internal investigation performed by the Postal Inspection Service. The Chief Postal Inspector shall promptly report the significant activities being carried out by the Postal Inspection Service to such Inspector General.

''(c) Any report required to be transmitted by the Postmaster General to the appropriate committees or subcommittees of the Congress under section 5(d) shall also be transmitted, within the 7-day period specified under such section, to the Committee on Government Reform of the House of Representatives and the Committee on Governmental Affairs of the Senate.

''(d) Notwithstanding any provision of paragraph (7) or (8) of section 6(a), the Inspector General of the United States Postal Service may select, appoint, and employ such officers and employees as may be necessary for carrying out the functions, powers and duties of the Office of Inspector General and to obtain the temporary or intermittent services of experts or consultants or an organization of experts or consultants, subject to the applicable laws and regulations that govern such selections, appointments, and employment, and the obtaining of such services, within the United States Postal Service.

''(e) Nothing in this Act shall restrict, eliminate, or otherwise adversely affect any of the rights, privileges, or benefits of employees of the United States Postal Service, or labor organizations representing employees of the United States Postal Service, under chapter 12 of title 39, United States Code, the National Labor Relations Act, any handbook or manual affecting employee labor relations with the United States Postal Service, or any collective bargaining agreement.

''(f) There are authorized to be appropriated, out of the Postal Service Fund, such sums as may be necessary for the Office of Inspector General of the United States Postal Service.

''(g) As used in this section, 'Board of Governors' and 'Board' each has the meaning given it by section 102 of title 39, United States Code.''.

(c) AUDITS OF THE POSTAL SERVICE.—

(1) AUDITS.—Subsection (e) of section 2008 of title 39, United States Code, is amended to read as follows:

''(e)(1) At least once each year beginning with the fiscal year commencing after the date of the enactment of the Postal Accountability and Enhancement Act, the financial statements of the Postal Service (including those used in determining and establishing postal rates) shall be audited by the Inspector General or by an independent external auditor selected by the Inspector General.

''(2) Audits under this section shall be conducted in accordance with applicable generally accepted government auditing standards.

''(3) Upon completion of the audit required by this subsection, the person who audits the statement shall submit a report on the audit to the Postmaster General.''.

(2) RESULTS OF INSPECTOR GENERAL'S AUDIT TO BE INCLUDED IN ANNUAL REPORT.—Section 2402 of title 39, United States Code, is amended by inserting after the first sentence the following: ''Each report under this section shall include, for the most recent fiscal year for which a report under section 2008(e) is available (unless previously transmitted under the following sentence), a copy of such report.''.

(3) COORDINATION PROVISIONS.—Section 2008(d) of title 39, United States Code, is amended—

(A) by striking ''(d) Nothing'' and inserting ''(d)(1) Except as provided in paragraph (2), nothing''; and

(B) by adding at the end the following:

''(2) An audit or report under paragraph (1) may not be obtained without the prior written approval of the Inspector General.''.

(4) SAVINGS PROVISION.—For purposes of any fiscal year preceding the first fiscal year commencing after the date of the enactment of this Act, the provisions of title 39, United States Code, shall be applied as if the amendments made by this subsection had never been enacted.

(d) REPORTS.—Section 3013 of title 39, United States Code, is amended by striking ''Postmaster General'' each place it appears and inserting ''Chief Postal Inspector''.

(e) TECHNICAL AND CONFORMING AMENDMENTS.—

(1) RELATING TO THE INSPECTOR GENERAL ACT OF 1978.—(A) Subsection (a) of section 8H of the Inspector General Act of 1978 (as amended by section 701(a) and redesignated by subsection (b) of this section) is further amended—

(i) in paragraph (2) by striking ''the Postal Regulatory Commission, and the United States Postal Service;'' and inserting ''and the Postal Regulatory Commission;'' and

(ii) in paragraph (4) by striking ''except that'' and all that follows through ''Code);'' and inserting ''except that, with respect to the National Science Foundation, such term means the National Science Board;''.

(B)(i) Subsection (f) of section 8H of such Act (as so redesignated) is repealed.

(ii) Subsection (c) of section 8H of such Act (as so redesignated) is amended by striking ''Except as provided under subsection (f) of this section, the'' and inserting ''The''.

(C) Section 8J of such Act (as so redesignated) is amended—

(i) by striking all after ''8D,'' and before ''of this Act'' and inserting '' 8E, 8F, 8G, or 8I''; and

(ii) by striking ''8G(a)'' and inserting ''8H(a)''.

(2) RELATING TO TITLE 39, UNITED STATES CODE.—(A) Subsection (e) of section 202 of title 39, United States Code, is repealed.

(B) Paragraph (4) of section 102 of such title 39 (as amended by section 101) is amended to read as follows:

''(4) 'Inspector General' means the Inspector General of the United States Postal Service, appointed under section 3(a) of the Inspector General Act of 1978;''.

(C) The first sentence of section 1003(a) of such title 39 is amended by striking ''chapters 2 and 12 of this title, section 8G of the Inspector General Act of 1978, or other provision of law,'' and inserting ''chapter 2 or 12 of this title, subsection (b) or (c) of section 1003 of this title, or any other provision of law,''.

(D) Section 1003(b) of such title 39 is amended by striking ''respective'' and inserting ''other''.

(E) Section 1003(c) of such title 39 is amended by striking ''included'' and inserting ''includes''.

(3) RELATING TO THE FEDERAL PROPERTY AND ADMINISTRATIVE SERVICES ACT OF 1949.—Section 304C(b)(1) of the Federal Property and Administrative Services Act of 1949 (41 U.S.C. 254d(b)(1)) is amended by striking ''8G'' and inserting ''8H''.

(4) RELATING TO THE ENERGY POLICY ACT OF 1992.—Section 160(a) of the Energy Policy Act of 1992 (42 U.S.C. 8262f(a)) is amended (in the matter before paragraph (1)) by striking all that follows ''(5 U.S.C. App.)'' and before ''shall—''.

(f) EFFECTIVE DATE; ELIGIBILITY OF PRIOR INSPECTOR GENERAL.—

(1) EFFECTIVE DATE.—

(A) IN GENERAL.—Except as provided in subparagraph (B) or subsection (c), this section and the amendments made by this section shall take effect on the date of the enactment of this Act.

(B) SPECIAL RULES.—

(i) IN GENERAL.—If the position of Inspector General of the United States Postal Service is occupied on the date of enactment of this Act (other than by an individual serving due to a vacancy arising in that position before the expiration of his or her predecessor's term), then, for purposes of the period beginning on such date of enactment and ending on January 5, 2004, or, if earlier, the date on which such individual ceases to serve in that position, title 39, United States Code, and the Inspector General Act of 1978 shall be applied as if the amendments made by this section had not been enacted, except—

(I) for those made by subsections (c) and (d); and

(II) as provided in clause (ii).

(ii) AUTHORIZATION OF APPROPRIATIONS.—

(I) IN GENERAL.—Notwithstanding any other provision of this paragraph, subsection (f) of section 8G of the Inspector General Act of 1978 (as amended by this section) shall be effective for purposes of fiscal years beginning on or after October 1, 2002.

(II) SAVINGS PROVISION.—For purposes of the fiscal year ending on September 30, 2002, funding for the Office of Inspector General of the United States Postal Service shall be made available in the same manner as if this Act had never been enacted.

(2) ELIGIBILITY OF PRIOR INSPECTOR GENERAL.—Nothing in this Act shall prevent any individual who has served as Inspector General of the United States Postal Service at any time before the date of the enactment of this Act from being appointed to that position pursuant to the amendments made by this section.

TITLE VIII—EVALUATIONS

SEC. 801. DEFINITION.

For purposes of this title, the term ''Board of Governors'' has the meaning given such term by section 102 of title 39, United States Code.

SEC. 802. ASSESSMENTS OF RATEMAKING, CLASSIFICATION, AND OTHER PROVISIONS.

(a) IN GENERAL.—The Postal Regulatory Commission shall, at least every 5 years, submit a report to the President and the Congress concerning—

(1) the operation of the amendments made by the Postal Accountability and Enhancement Act; and

(2) recommendations for any legislation or other measures necessary to improve the effectiveness or efficiency of the postal laws of the United States.

(b) POSTAL SERVICE VIEWS.—A report under this section shall be submitted only after reasonable opportunity has been afforded to the Postal Service to review such report and to submit written comments thereon. Any comments timely received from the Postal Service under the preceding sentence shall be attached to the report submitted under subsection (a).

(c) SPECIFIC INFORMATION REQUIRED.—The Postal Regulatory Commission shall include, as part of at least its first report under subsection (a), the following:

(1) COST-COVERAGE REQUIREMENT RELATING TO COMPETITIVE PRODUCTS COLLECTIVELY.—With respect to section 3633 of title 39, United States Code (as amended by this Act)—

(A) a description of how such section has operated; and

(B) recommendations as to whether or not such section should remain in effect and, if so, any suggestions as to how it might be improved.

(2) COMPETITIVE PRODUCTS FUND.—With respect to the Postal Service Competitive Products Fund (under section 2011 of title 39, United States Code, as amended by section 401), in consultation with the Secretary of the Treasury—

(A) a description of how such Fund has operated;

(B) any suggestions as to how the operation of such Fund might be improved; and

(C) a description and assessment of alternative accounting or financing mechanisms that might be used to achieve the objectives of such Fund.

(3) ASSUMED FEDERAL INCOME TAX ON COMPETITIVE PRODUCTS FUND.—With respect to section 3634 of title 39, United States Code (as amended by this Act), in consultation with the Secretary of the Treasury—

(A) a description of how such section has operated; and

(B) recommendations as to whether or not such section should remain in effect and, if so, any suggestions as to how it might be improved.

SEC. 803. STUDY ON EQUAL APPLICATION OF LAWS TO COMPETITIVE PRODUCTS.

(a) IN GENERAL.—The Federal Trade Commission shall prepare and submit to the President and Congress, within 1 year after the date of the enactment of this Act, a comprehensive report identifying Federal and State laws that apply differently to products of the United States Postal Service in the competitive category of mail (within the meaning of section 102 of title 39, United States Code, as amended by section 101) and similar products provided by private companies.

(b) RECOMMENDATIONS.—The Federal Trade Commission shall include such recommendations as it considers appropriate for bringing such legal discrimination to an end.

(c) CONSULTATION.—In preparing its report, the Federal Trade Commission shall consult with the United States Postal Service, the Postal Regulatory Commission, other Federal agencies, mailers, private companies that provide delivery services, and the general public, and shall append to such report any written comments received under this subsection.

SEC. 804. GREATER DIVERSITY IN POSTAL SERVICE EXECUTIVE AND ADMINISTRATIVE SCHEDULE MANAGEMENT POSITIONS.

(a) STUDY.—The Board of Governors shall study and, within 1 year after the date of the enactment of this Act, submit to the President and Congress a report concerning the extent to which women and minorities are represented in supervisory and management positions within the United States Postal Service. Any data included in the report shall be presented in the aggregate and by pay level.

(b) PERFORMANCE EVALUATIONS.—The United States Postal Service shall, as soon as practicable, take such measures as may be necessary to ensure that, for purposes of conducting performance appraisals of supervisory or managerial employees, appropriate consideration shall be given to meeting affirmative action goals, achieving equal employment opportunity requirements, and implementation of plans designed to achieve greater diversity in the workforce.

SEC. 805. CONTRACTS WITH WOMEN, MINORITIES, AND SMALL BUSINESSES.

The Board of Governors shall study and, within 1 year after the date of the enactment of this Act, submit to the President and the Congress a report concerning the number and value of contracts and subcontracts the Postal Service has entered into with women, minorities, and small businesses.

SEC. 806. RATES FOR PERIODICALS.

(a) IN GENERAL.—The United States Postal Service, acting jointly with the Postal Regulatory Commission and the General Accounting Office, shall study and submit to the President and Congress a report concerning—

(1) the quality, accuracy, and completeness of the information used by the Postal Service in determining the direct and indirect postal costs attributable to periodicals; and

(2) any opportunities that might exist for improving efficiencies in the collection, handling, transportation, or delivery of periodicals by the Postal Service, including any pricing incentives for mailers that might be appropriate.

(b) RECOMMENDATIONS.—The report shall include recommendations for any administrative action or legislation that might be appropriate.

SEC. 807. ASSESSMENT OF CERTAIN RATE DEFICIENCIES.

(a) IN GENERAL.—Within 12 months after the date of the enactment of this Act, the Office of Inspector General of the United States Postal Service shall study and submit to the President, the Congress, and the United States Postal Service, a report concerning the administration of section 3626(k) of title 39, United States Code.

(b) SPECIFIC REQUIREMENTS.—The study and report shall specifically address the adequacy and fairness of the process by which assessments under section 3626(k) of title 39, United States Code, are determined and appealable, including—

(1) whether the Postal Regulatory Commission or any other body outside the Postal Service should be assigned a role; and

(2) whether a statute of limitations should be established for the commencement of proceedings by the Postal Service thereunder.

TITLE IX—MISCELLANEOUS; TECHNICAL AND CONFORMING AMENDMENTS

SEC. 901. EMPLOYMENT OF POSTAL POLICE OFFICERS.

Section 404 of title 39, United States Code, as amended by sections 102 and 908(f), is further amended by adding at the end the following:

''(f)(1) The Postal Service may employ guards for all buildings and areas owned or occupied by the Postal Service or under the charge and control of the Postal Service, and such guards shall have, with respect to such property, the powers of special policemen provided by the first section of the Act cited in paragraph (2), and, as to such property, the Postmaster General (or his designee) may take any action that the Administrator of General Services (or his designee) may take under section 2 or 3 of such Act, attaching thereto penalties under the authority and within the limits provided in section 4 of such Act.

''(2) The Act cited in this paragraph is the Act of June 1, 1948 (62 Stat. 281), commonly known as the 'Protection of Public Property Act'.''.

SEC. 902. DATE OF POSTMARK TO BE TREATED AS DATE OF APPEAL IN CONNECTION WITH THE CLOSING OR CONSOLIDATION OF POST OFFICES.

(a) IN GENERAL.—Section 404(b) of title 39, United States Code, is amended by adding at the end the following:

''(6) For purposes of paragraph (5), any appeal received by the Commission shall—

''(A) if sent to the Commission through the mails, be considered to have been received on the date of the Postal Service postmark on the envelope or other cover in which such appeal is mailed; or

''(B) if otherwise lawfully delivered to the Commission, be considered to have been received on the date determined based on any appropriate documentation or other indicia (as determined under regulations of the Commission).''.

(b) EFFECTIVE DATE.—This section and the amendments made by this section shall apply with respect to any determination to close or consolidate a post office which is first made available, in accordance with paragraph (3) of section 404(b) of title 39, United States Code, after the end of the 3-month period beginning on the date of the enactment of this Act.

SEC. 903. PROVISIONS RELATING TO BENEFITS UNDER CHAPTER 81 OF TITLE 5, UNITED STATES CODE, FOR OFFICERS AND EMPLOYEES OF THE FORMER POST OFFICE DEPARTMENT.

(a) IN GENERAL.—Section 8 of the Postal Reorganization Act (39 U.S.C. 1001 note) is amended by inserting ''(a)'' after ''8.'' and by adding at the end the following:

''(b) For purposes of chapter 81 of title 5, United States Code, the Postal Service shall, with respect to any individual receiving benefits under such chapter as an officer or employee of the former Post Office Department, have the same authorities and responsibilities as it has with respect to an officer or employee of the Postal Service receiving such benefits.''.

(b) EFFECTIVE DATE.—This section and the amendments made by this section shall take effect on October 1, 2001.

SEC. 904. OBSOLETE PROVISIONS.

(a) REPEAL.—

(1) IN GENERAL.—Chapter 52 of title 39, United States Code, is repealed.

(2) CONFORMING AMENDMENTS.—(A) Section 5005(a) of title 39, United States Code, is amended—

(i) by striking paragraph (1), and by redesignating paragraphs (2) through (4) as paragraphs (1) through (3), respectively; and

(ii) in paragraph (3) (as so designated by clause (i)) by striking ''(as defined in section 5201(6) of this title)''.

(B) Section 5005(b) of such title 39 is amended by striking ''(a)(4)'' each place it appears and inserting ''(a)(3)''.

(C) Section 5005(c) of such title 39 is amended by striking ''by carrier or person under subsection (a)(1) of this section, by contract under subsection (a)(4) of this section, or'' and inserting ''by contract under subsection (a)(3) of this section or''.

(b) ELIMINATING RESTRICTION ON LENGTH OF CONTRACTS.—(1) Section 5005(b)(1) of title 39, United States Code, is amended by striking ''(or where the Postal Service determines that special conditions or the use of special equipment warrants, not in excess of 6 years)'' and inserting ''(or such length of time as may be determined by the Postal Service to be advisable or appropriate)''.

(2) Section 5402(c) of such title 39 is amended by striking ''for a period of not more than 4 years''.

(3) Section 5605 of such title 39 is amended by striking ''for periods of not in excess of 4 years''.

(c) CLERICAL AMENDMENT.—The analysis for part V of title 39, United States Code, is amended by repealing the item relating to chapter 52.

SEC. 905. EXPANDED CONTRACTING AUTHORITY.

(a) AMENDMENT TO TITLE 39, UNITED STATES CODE.—

(1) CONTRACTS WITH AIR CARRIERS.—Subsection (d) of section 5402 of title 39, United States Code, is amended to read as follows:

''(d)(1) The Postal Service may contract with any air carrier for the transportation of mail by aircraft in interstate air transportation, including the rates therefor, either through negotiations or competitive bidding.

''(2) Notwithstanding subsections (a) through (c), the Postal Service may contract with any air carrier or foreign air carrier for the transportation of mail by aircraft in foreign air transportation, including the rates therefor, either through negotiations or competitive bidding, except that—

''(A) any such contract may be awarded only to (i) an air carrier holding a certificate required by section 41101 of title 49 or an exemption therefrom issued by the Secretary of Transportation, (ii) a foreign air carrier holding a permit required by section 41301 of title 49 or an exemption therefrom issued by the Secretary of Transportation, or (iii) a combination of such air carriers or foreign air carriers (or both);

''(B) mail transported under any such contract shall not be subject to any duty-to-carry requirement imposed by any provision of subtitle VII of title 49 or by any certificate, permit, or corresponding exemption authority issued by the Secretary of Transportation under that subtitle;

''(C) every contract that the Postal Service awards to a foreign air carrier under this paragraph shall be subject to the continuing requirement that air carriers shall be afforded the same opportunity to carry the mail of the country to and from which the mail is transported and the flag country of the foreign air carrier, if different, as the Postal Service has afforded the foreign air carrier; and

''(D) the Postmaster General shall consult with the Secretary of Defense concerning actions that affect the carriage of military mail transported in foreign air transportation.

''(3) Paragraph (2) shall not be interpreted as suspending or otherwise diminishing the authority of the Secretary of Transportation under section 41310 of title 49.''.

(2) DEFINITIONS.—Subsection (e) of section 5402 of title 39, United States Code, is amended to read as follows:

''(e) For purposes of this section, the terms 'air carrier', 'air transportation', 'foreign air carrier', 'foreign air transportation', 'interstate air transportation', and 'mail' shall have the meanings given such terms in section 40102 of title 49.''.

(b) AMENDMENTS TO TITLE 49, UNITED STATES CODE.—

(1) AUTHORITY OF POSTAL SERVICE TO PROVIDE FOR INTERSTATE AIR TRANSPORTATION OF MAIL.—Section 41901(a) of title 49, United States Code, is amended to read as follows:

''(a) TITLE 39.—The United States Postal Service may provide for the transportation of mail by aircraft in air transportation under this chapter and under chapter 54 of title 39.''.

(2) SCHEDULES FOR CERTAIN TRANSPORTATION OF MAIL.—Section 41902(b)(1) of title 49, United States Code, is amended by inserting before the semicolon at the end the following: ''(other than foreign air transportation of mail)''.

(3) PRICES FOR FOREIGN TRANSPORTATION OF MAIL.—Section 41907 of title 49, United States Code, is amended—

(A) by striking ''(a) LIMITATIONS.—''; and

(B) by striking subsection (b).

(4) CONFORMING AMENDMENTS.—Sections 41107, 41901(b)(1), 41902(a), 41903(a), and 41903(b) of title 49, United States Code, are amended by striking ''in foreign air transportation or''.

SEC. 906. INVESTMENTS.

Subsection (c) of section 2003 of title 39, United States Code, is amended—

(1) by striking ''(c) If'' and inserting ''(c)(1) Except as provided in paragraph (2), if''; and

(2) by adding at the end the following:

''(2)(A) Nothing in this section shall be considered to authorize any investment in any obligations or securities of a commercial entity.

''(B) For purposes of this paragraph, the term 'commercial entity' means any corporation, company, association, partnership, joint stock company, firm, society, or other similar entity, as further defined under regulations prescribed by the Postal Regulatory Commission.''.

SEC. 907. REPEAL OF SECTION 5403.

(a) IN GENERAL.—Section 5403 of title 39, United States Code, is repealed.

(b) CLERICAL AMENDMENT.—The analysis for chapter 54 of title 39, United States Code, is amended by repealing the item relating to section 5403.

SEC. 908. TECHNICAL AND CONFORMING AMENDMENTS.

(a) REDUCED RATES.—Section 3626 of title 39, United States Code, is amended—

(1) in subsection (a)—

(A) by striking all before paragraph (4) and inserting the following:

''(a)(1) Except as otherwise provided in this section, rates of postage for a class of mail

or kind of mailer under former section 4358, 4452(b), 4452(c), 4554(b), or 4554(c) of this title shall be established in accordance with section 3622.

''(2) For the purpose of this subsection, the term 'regular-rate category' means any class of mail or kind of mailer, other than a class or kind referred to in section 2401(c).''; and

(B) by redesignating paragraphs (4) through (7) as paragraphs (3) through (6), respectively;

(2) in subsection (g) by adding at the end the following:

''(3) For purposes of this section and former section 4358(a) through (c) of this title, those copies of an issue of a publication entered within the county in which it is published, but distributed outside such county on postal carrier routes originating in the county of publication, shall be treated as if they were distributed within the county of publication.

''(4)(A) In the case of an issue of a publication, any number of copies of which are mailed at the rates of postage for a class of mail or kind of mailer under former section 4358(a) through (c) of this title, any copies of such issue which are distributed outside the county of publication (excluding any copies subject to paragraph (3)) shall be subject to rates of postage provided for under this paragraph.

''(B) The rates of postage applicable to mail under this paragraph shall be established in accordance with section 3622.

''(C) This paragraph shall not apply with respect to an issue of a publication unless the total paid circulation of such issue outside the county of publication (not counting recipients of copies subject to paragraph (3)) is less than 5,000.'';

(3) in subsection (j)(1)(D)—

(A) by striking ''and'' at the end of subclause (I); and

(B) by adding after subclause (II) the following:

''(III) clause (i) shall not apply to space advertising in mail matter that otherwise qualifies for rates under former section 4452(b) or 4452(c) of this title, and satisfies the content requirements established by the Postal Service for periodical publications.''; and

(4) by adding at the end the following:

''(n) In the administration of this section, matter that satisfies the circulation standards for requester publications shall not be excluded from being mailed at the rates for mail under former section 4358 solely because such matter is designed primarily for free circulation or for circulation at nominal rates, or fails to meet the requirements of former section 4354(a)(5).''.

(b) REIMBURSEMENT.—Section 3681 of title 39, United States Code, is amended by striking ''section 3628'' and inserting ''sections 3662 through 3664''.

(c) SIZE AND WEIGHT LIMITS.—Section 3682 of title 39, United States Code, is amended to read as follows:

''§ 3682. Size and weight limits

''The Postal Service may establish size and weight limitations for mail matter in the market-dominant category of mail consistent with regulations the Postal Regulatory Commission may prescribe under section 3622. The Postal Service may establish size and weight limitations for mail matter in the competitive category of mail consistent with its authority under section 3632.''.

(d) REVENUE FOREGONE, ETC.—Title 39, United States Code, is amended—

(1) in section 503 (as so redesignated by section 601) by striking ''this chapter.'' and inserting ''this title.''; and

(2) in section 2401(d) by inserting ''(as last in effect before enactment of the Postal Accountability and Enhancement Act)'' after ''3626(a)'' and after ''3626(a)(3)(B)(ii)''.

(e) APPROPRIATIONS AND REPORTING REQUIREMENTS.—

(1) APPROPRIATIONS.—Subsection (e) of section 2401 of title 39, United States Code, is amended—

(A) by striking ''Committee on Post Office and Civil Service'' each place it appears and inserting ''Committee on Government Reform''; and

(B) by striking ''Not later than March 15 of each year,'' and inserting ''Each year,''.

(2) REPORTING REQUIREMENTS.—Sections 2803(a) and 2804(a) of title 39, United States Code, are amended by striking ''2401(g)'' and inserting ''2401(e)''.

(f) AUTHORITY TO FIX RATES AND CLASSES GENERALLY; REQUIREMENT RELATING TO LETTERS SEALED AGAINST INSPECTION.—Section 404 of title 39, United States Code (as amended by section 102) is further amended by redesignating subsections (b) and (c) as subsections (d) and (e), respectively, and by inserting after subsection (a) the following:

''(b) Except as otherwise provided, the Governors are authorized to establish reasonable and equitable classes of mail and reasonable and equitable rates of postage and fees for postal services in accordance with the provisions of chapter 36. Postal rates and fees shall be reasonable and equitable and sufficient to enable the Postal Service, under best practices of honest, efficient, and economical management, to maintain and continue the development of postal services of the kind and quality adapted to the needs of the United States.

''(c) The Postal Service shall maintain one or more classes of mail for the transmission of letters sealed against inspection. The rate for each such class shall be uniform throughout the United States, its territories, and possessions. One such class shall provide for the most expeditious handling and transportation afforded mail matter by the Postal Service. No letter of such a class of domestic origin shall be opened except under authority of a search warrant authorized by law, or by an officer or employee of the Postal Service for the sole purpose of determining an address at which the letter can be delivered, or pursuant to the authorization of the addressee.''.

(g) LIMITATIONS.—Section 3684 of title 39, United States Code, is amended by striking all that follows ''any provision'' and inserting ''of this title.''.

(h) MISCELLANEOUS.—Title 39, United States Code, is amended—

(1) in section 410(b), by moving the left margin of paragraph (10) 2 ems to the left;

(2) in section 1005(d)(2)—

(A) by striking ''subsection (g) of section 5532,''; and

(B) by striking ''8344,'' and inserting ''8344'';

(3) in the analysis for part III, by striking the item relating to chapter 28 and inserting the following:

''28. Strategic Planning and Performance Management ..... 2801'';

(4) in subsections (h)(2) and (i)(2) of section 3001, by moving the left margin of subparagraph (C) of each 2 ems to the left;

(5) in section 3005(a)—

(A) in the matter before paragraph (1), by striking all that follows ''nonmailable'' and precedes ''(h),'' and inserting ''under section 3001(d),''; and

(B) in the sentence following paragraph (3), by striking all that follows ''nonmailable'' and precedes ''(h),'' and inserting ''under such section 3001(d),'';

(6) in section 3210(a)(6)(C), by striking the matter after ''if such mass mailing'' and before ''than 60 days'' and inserting ''is postmarked fewer'';

(7) in section 3626(a), by moving the left margin of paragraphs (3), (5), and (6) (as so redesignated by subsection (a)(1)(B), and including each subparagraph thereunder (if any)) 2 ems to the left;

(8) by striking the heading for section 3627 and inserting the following:

''§ 3627. Adjusting free rates''

; and

(9) in section 5402(g)(1), by moving the left margin of subparagraph (D) (including each clause thereunder) 2 ems to the left.

By Mr. LEAHY (for himself, Mr. DASCHLE, Mr. KENNEDY, Mr. FEINGOLD, and Mr. BINGAMAN):

S. 1286. A bill to combat nursing home fraud and abuse, increase protections for victims of telemarketing fraud, enhance safeguards for pension plans and health care benefit programs, and enhance penalties for crimes against seniors, and for other purposes; to the Committee on the Judiciary.

Mr. LEAHY. Madam President, today I am introducing the Seniors Safety Act of 2003, a bill to protect older Americans from crime. I am pleased to have Senators DASCHLE, KENNEDY, FEINGOLD, and BINGAMAN as cosponsors for this anti-crime bill.

The Seniors Safety Act is a comprehensive bill that addresses the most prevalent crimes perpetrated against seniors, including health care fraud, nursing home abuse, telemarketing fraud—and bribery, graft and fraud in pension and employee benefit plans. In addition, this legislation would help seniors obtain restitution if their pension plans are defrauded.

Older Americans are the most rapidly growing population group in our society, making them an even more attractive target for criminals. The Department of Health and Human Services has predicted that the number of older Americans will grow from 13 percent of the U.S. population in 2000 to 20 percent by 2030. In Vermont, seniors comprise about 12 percent of the population, a number that is expected to increase to 20 percent by 2025.

Crime against seniors has remained stubbornly resistant over the last decade. According to a 2000 Justice Department study, more than 90 percent of crimes committed against older Americans were property crimes, with theft the most common. As our Nation addressed our violent crime problem, we did not take a comprehensive approach to deterring the crimes that so affect the elderly, like telemarketing fraud, health care fraud, and pension fraud. The Seniors Safety Act provides such a comprehensive approach, and I urge the Senate to pass it.

The Seniors Safety Act instructs the U.S. Sentencing Commission to review current sentencing guidelines and, if appropriate, amend the guidelines to include the age of a crime victim as a criteria for determining whether a sentencing enhancement is proper. The bill also requires the Commission to review sentencing guidelines for health care benefit fraud, increases statutory penalties both for fraud resulting in serious injury or death and for bribery

and graft in connection with employee benefit plans, and increases criminal and civil penalties for defrauding pension plans.

Telemarketing fraud is one crime that disproportionately harms Americans over age 50. The Seniors Safety Act seeks to fight the perpetrators of fraud—schemes that often succeed in swindling seniors of their life savings. Some of these schemes are directed from outside the United States, making criminal prosecution more difficult.

The Act would provide the Attorney General with a new and substantial tool to prevent telemarketing fraud the power to block or terminate service to telephone facilities that are being used to defraud innocent people. The Justice Department could use this authority to disrupt telemarketing fraud schemes directed from foreign sources by cutting off the swindlers' telephone service. Even if the criminals acquire a new telephone number, temporary interruptions will prevent some seniors from being victimized.

The bill also establishes a ''Better Business Bureau''-style clearinghouse at the Federal Trade Commission to provide seniors, their families, and others who may be concerned about a telemarketer with information about prior law enforcement actions against the particular company. In addition, the FTC would refer seniors and other consumers who believe they have been swindled to the appropriate law enforcement authorities.

Criminal activity that undermines the safety and integrity of pension plans and health benefit programs threatens all Americans, but most especially those seniors who have relied on promised benefits in planning their retirements. Seniors who have worked faithfully and honestly for years should not reach their retirement years only to find that the funds they relied upon were stolen.

The Seniors Safety Act would add to the arsenal that federal prosecutors can draw upon to prevent and punish fraud against retirement plans. Specifically, the Act would create new criminal and civil penalties for defrauding pension plans or obtaining money or property from such plans by means of false or fraudulent pretenses. In addition, the Act would enhance penalties for bribery and graft in connection with employee benefit plans. The only people enjoying the benefits of pension plans should be the people who have worked hard to fund those plans, not crooks who get the money by fraud.

Health care spending consists of about 15 percent of the gross national product, or more than $1 trillion each year. Estimated losses due to fraud and abuse are astronomical. A December 1998 report by the National Institute of Justice, NIJ, states that these losses ''may exceed 10 percent of annual health care spending, or $100 billion per year.''

As more health care claims are processed electronically, more sophisticated computer-generated fraud schemes are surfacing. Some of these schemes generate thousands of false claims designed to pass through automated claims processing to payment, and result in the theft of millions of dollars from federal and private health care programs. Fraud against Medicare, Medicaid and private health plans increases the financial burden on taxpayers and beneficiaries alike. In addition, some forms of fraud may result in inadequate medical care, harming patients' health as well. Unfortunately, the NIJ reports that many health care fraud schemes ''deliberately target vulnerable populations, such as the elderly or Alzheimer's patients, who are less willing or able to complain or alert law enforcement.''

We saw a dramatic increase in criminal convictions for health care fraud cases during the 1990s. These cases included convictions for submitting false claims to Medicare, Medicaid, and private insurance plans; fraudulent billings by foreign doctors; and needless prescriptions for durable medical equipment by doctors in exchange for kickbacks from manufacturers.

We can and must do more. The Seniors Safety Act would allow the Attorney General to bring injunctive actions to stop false claims and illegal kickback schemes involving federal health care programs. The bill would also provide law enforcement authorities with additional investigatory tools to uncover, investigate, and prosecute health care offenses in both criminal and civil proceedings.

In addition, whistle-blowers who tip off law enforcement officers about health care fraud would be authorized under the Seniors Safety Act to seek court permission to review information obtained by the government to enhance their assistance in False Claims Act lawsuits. Such qui tam, or whistleblower, suits have dramatically enhanced the government's ability to uncover health care fraud. The Act would allow whistle-blowers and their qui tam suits to become even more effective.

Finally, the Act would extend antifraud and anti-kickback safeguards to the Federal Employees Health Benefits program. These are all important steps that will help cut down on the enormous health care fraud losses.

As life expectancies continue to increase, long-term care planning specialists estimate that over 40 percent of those turning 65 eventually will need nursing home care, and that 20 percent of those seniors will spend five years or more in homes. Indeed, many of us already have experienced having our parents, family members or other loved ones spend time in a nursing home. We owe it to them and to ourselves to give the residents of nursing homes the best and safest care they can get.

The Justice Department has cited egregious examples of nursing homes that pocketed Medicare funds instead of providing residents with adequate care. In one case, five patients died as a result of the inadequate provision of nutrition, wound care and diabetes management by three Pennsylvania nursing homes. Yet another death occurred when a patient, who was unable to speak, was placed in a scalding tub of 138-degree water.

This Act provides additional peace of mind to nursing home residents and their families by providing federal law enforcement with the authority to investigate and prosecute operators of nursing homes for willfully engaging in patterns of health and safety violations in the care of nursing home residents. The Act also protects whistle-blowers from retaliation for reporting such violations.

This title of the Seniors Safety Act would authorize the Attorney General to use forfeited funds to pay restitution to victims of fraudulent activity, and authorize the courts to require the forfeiture of proceeds from retirement-related offenses. In addition, it would exempt false claims actions from being stayed in bankruptcy proceedings and ensure that debts due to the United States from false claims actions are not dischargeable in bankruptcy.

We all deserve to age with dignity and free of the threat of abuse or fraud. No one can guarantee that this will happen, but the Senior Safety Act can be a powerful new tool to help crack down on those who prey upon older Americans. This effort is about all of us and our families.

These are problems that have persisted too long. It is past the time for the Senate to act. I ask unanimous consent that the text of the legislation be printed in the RECORD.

There being no objection, the bill was ordered to be printed in the RECORD, as follows:

S. 1286

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

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the ''Seniors Safety Act of 2003''.

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

SEC. 2. FINDINGS AND PURPOSES.

(a) FINDINGS.—Congress makes the following findings:

(1) The number of older Americans is rapidly growing in the United States. According to the 2000 census, 21 percent of the United States population is 55 years of age or older.

(2) In 1997, 7 percent of victims of serious violent crime were 50 years of age or older.

(3) In 1997, 17.7 percent of murder victims were 55 years of age or older.

(4) According to the Department of Justice, persons 65 years of age and older experienced approximately 2,700,000 crimes a year between 1992 and 1997.

(5) Older victims of violent crime are almost twice as likely as younger victims to be raped, robbed, or assaulted at or in their own homes.

(6) Approximately half of all Americans who are 50 years of age or older are afraid to walk alone at night in their own neighborhoods.

(7) Seniors over 50 years of age reportedly account for 37 percent of the estimated $40,000,000,000 in losses each year due to telemarketing fraud.

(8) A 1996 American Association of Retired Persons survey of people 50 years of age and older showed that 57 percent were likely to receive calls from telemarketers at least once a week.

(9) In 1998, Congress enacted legislation to provide for increased penalties for telemarketing fraud that targets seniors.

(10) It has been estimated that—

(A) approximately 43 percent of persons turning 65 years of age can expect to spend some time in a long-term care facility; and

(B) approximately 20 percent can expect to spend 5 years or more in a such a facility.

(11) In 1997, approximately $82,800,000,000 was spent on nursing home care in the United States and over half of this amount was spent by the Medicaid and Medicare programs.

(12) Losses to fraud and abuse in health care reportedly cost the United States an estimated $100,000,000,000 in 1996.

(13) The Inspector General for the Department of Health and Human Services has estimated that about $12,600,000,000 in improper Medicare benefit payments, due to inadvertent mistake, fraud, and abuse were made during fiscal year 1998.

(14) Incidents of health care fraud and abuse remain common despite awareness of the problem.

(b) PURPOSES.—The purposes of this Act are to—

(1) combat nursing home fraud and abuse;

(2) enhance safeguards for pension plans and health care programs;

(3) develop strategies for preventing and punishing crimes that target or otherwise disproportionately affect seniors by collecting appropriate data—

(A) to measure the extent of crimes committed against seniors; and

(B) to determine the extent of domestic and elder abuse of seniors; and

(4) prevent and deter criminal activity, such as telemarketing fraud, that results in economic and physical harm against seniors, and ensure appropriate restitution.

SEC. 3. DEFINITIONS.

In this Act:

(1) CRIME.—The term ''crime'' means any criminal offense under Federal or State law.

(2) NURSING HOME.—The term ''nursing home'' means any institution or residential care facility defined as such for licensing purposes under State law, or if State law does not employ the term nursing home, the equivalent term or terms as determined by the Secretary of Health and Human Services, pursuant to section 1908(e) of the Social Security Act (42 U.S.C. 1396g(e)).

(3) SENIOR.—The term ''senior'' means an individual who is more than 55 years of age.

TITLE I—COMBATING CRIMES AGAINST SENIORS

SEC. 101. ENHANCED SENTENCING PENALTIES BASED ON AGE OF VICTIM.

(a) DIRECTIVE TO THE UNITED STATES SENTENCING COMMISSION.—Pursuant to its authority under section 994(p) of title 28, United States Code, and in accordance with this section, the United States Sentencing Commission (referred to in this section as the ''Commission'') shall review and, if appropriate, amend section 3A1.1(a) of the Federal sentencing guidelines to include the age of a crime victim as one of the criteria for determining whether the application of a sentencing enhancement is appropriate.

(b) REQUIREMENTS.—In carrying out this section, the Commission shall—

(1) ensure that the Federal sentencing guidelines and the policy statements of the Commission reflect the serious economic and physical harms associated with criminal activity targeted at seniors due to their particular vulnerability;

(2) consider providing increased penalties for persons convicted of offenses in which the victim was a senior in appropriate circumstances;

(3) consult with individuals or groups representing seniors, law enforcement agencies, victims organizations, and the Federal judiciary as part of the review described in subsection (a);

(4) ensure reasonable consistency with other Federal sentencing guidelines and directives;

(5) account for any aggravating or mitigating circumstances that may justify exceptions, including circumstances for which the Federal sentencing guidelines provide sentencing enhancements;

(6) make any necessary conforming changes to the Federal sentencing guidelines; and

(7) ensure that the Federal sentencing guidelines adequately meet the purposes of sentencing set forth in section 3553(a)(2) of title 18, United States Code.

(c) REPORT.—Not later than December 31, 2004, the Commission shall submit to Congress a report on issues relating to the age of crime victims, which shall include—

(1) an explanation of any changes to sentencing policy made by the Commission under this section; and

(2) any recommendations of the Commission for retention or modification of penalty levels, including statutory penalty levels, for offenses involving seniors.

SEC. 102. STUDY AND REPORT ON HEALTH CARE FRAUD SENTENCES.

(a) DIRECTIVE TO THE UNITED STATES SENTENCING COMMISSION.—Pursuant to its authority under section 994(p) of title 28, United States Code, and in accordance with this section, the United States Sentencing Commission (referred to in this section as the ''Commission'') shall review and, if appropriate, amend the Federal sentencing guidelines and the policy statements of the Commission with respect to persons convicted of offenses involving fraud in connection with a health care benefit program (as defined in section 24(b) of title 18, United States Code).

(b) REQUIREMENTS.—In carrying out this section, the Commission shall—

(1) ensure that the Federal sentencing guidelines and the policy statements of the Commission reflect the serious harms associated with health care fraud and the need for aggressive and appropriate law enforcement action to prevent such fraud;

(2) consider providing increased penalties for persons convicted of health care fraud in appropriate circumstances;

(3) consult with individuals or groups representing victims of health care fraud, law enforcement agencies, the health care industry, and the Federal judiciary as part of the review described in subsection (a);

(4) ensure reasonable consistency with other Federal sentencing guidelines and directives;

(5) account for any aggravating or mitigating circumstances that might justify exceptions, including circumstances for which the Federal sentencing guidelines provide sentencing enhancements;

(6) make any necessary conforming changes to the Federal sentencing guidelines; and

(7) ensure that the Federal sentencing guidelines adequately meet the purposes of sentencing as set forth in section 3553(a)(2) of title 18, United States Code.

(c) REPORT.—Not later than December 31, 2004, the Commission shall submit to Congress a report on issues relating to offenses described in subsection (a), which shall include—

(1) an explanation of any changes to sentencing policy made by the Commission under this section; and

(2) any recommendations of the Commission for retention or modification of penalty levels, including statutory penalty levels, for those offenses.

SEC. 103. INCREASED PENALTIES FOR FRAUD RESULTING IN SERIOUS INJURY OR DEATH.

Sections 1341 and 1343 of title 18, United States Code, are each amended by inserting before the last sentence the following: ''If the violation results in serious bodily injury (as defined in section 1365), such person shall be fined under this title, imprisoned not more than 20 years, or both, and if the violation results in death, such person shall be fined under this title, imprisoned for any term of years or life, or both.''.

SEC. 104. SAFEGUARDING PENSION PLANS FROM FRAUD AND THEFT.

(a) IN GENERAL.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''§ 1351. Fraud in relation to retirement arrangements

''(a) DEFINITION.—

''(1) RETIREMENT ARRANGEMENT.—In this section, the term 'retirement arrangement' means—

''(A) any employee pension benefit plan subject to any provision of title I of the Employee Retirement Income Security Act of 1974;

''(B) any qualified retirement plan within the meaning of section 4974(c) of the Internal Revenue Code of 1986;

''(C) any medical savings account described in section 220 of the Internal Revenue Code of 1986; or

''(D) a fund established within the Thrift Savings Fund by the Federal Retirement Thrift Investment Board pursuant to subchapter III of chapter 84 of title 5.

''(2) CERTAIN ARRANGEMENTS INCLUDED.—The term 'retirement arrangement' shall include any arrangement that has been represented to be an arrangement described in any subparagraph of paragraph (1) (whether or not so described).

''(3) EXCEPTION FOR GOVERNMENTAL PLAN.—Except as provided in paragraph (1)(D), the term 'retirement arrangement' shall not include any governmental plan (as defined in section 3(32) of title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1002(32))).

''(b) PROHIBITION AND PENALTIES.—Whoever executes, or attempts to execute, a scheme or artifice—

''(1) to defraud any retirement arrangement or other person in connection with the establishment or maintenance of a retirement arrangement; or

''(2) to obtain, by means of false or fraudulent pretenses, representations, or promises, any of the money or property owned by, or under the custody or control of, any retirement arrangement or other person in connection with the establishment or maintenance of a retirement arrangement;

shall be fined under this title, imprisoned not more than 10 years, or both.

''(c) ENFORCEMENT.—

''(1) IN GENERAL.—Subject to paragraph (2), the Attorney General may investigate any violation of, and otherwise enforce, this section.

''(2) EFFECT ON OTHER AUTHORITY.—Nothing in this subsection may be construed to preclude the Secretary of Labor or the head of any other appropriate Federal agency from investigating a violation of this section in relation to a retirement arrangement subject to title I of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1001 et seq.) or any other provision of Federal law.''.

(b) TECHNICAL AMENDMENT.—Section 24(a)(1) of title 18, United States Code, is amended by inserting ''1351,'' after ''1347,''.

(c) CONFORMING AMENDMENT.—The analysis for chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1351. Fraud in relation to retirement arrangements.''.

SEC. 105. ADDITIONAL CIVIL PENALTIES FOR DEFRAUDING PENSION PLANS.

(a) IN GENERAL.—

(1) ACTION BY ATTORNEY GENERAL.—Except as provided in subsection (b)—

(A) the Attorney General may bring a civil action in the appropriate district court of the United States against any person who engages in conduct constituting an offense under section 1351 of title 18, United States Code, or conspiracy to violate such section 1351; and

(B) upon proof of such conduct by a preponderance of the evidence, such person shall be subject to a civil penalty in an amount equal to the greatest of—

(i) the amount of pecuniary gain to that person;

(ii) the amount of pecuniary loss sustained by the victim; or

(iii) not more than—

(I) $50,000 for each such violation in the case of an individual; or

(II) $100,000 for each such violation in the case of a person other than an individual.

(2) NO EFFECT ON OTHER REMEDIES.—The imposition of a civil penalty under this subsection does not preclude any other statutory, common law, or administrative remedy available by law to the United States or any other person.

(b) EXCEPTION.—No civil penalty may be imposed pursuant to subsection (a) with respect to conduct involving a retirement arrangement that—

(1) is an employee pension benefit plan subject to title I of the Employee Retirement Income Security Act of 1974; and

(2) for which the civil penalties may be imposed under section 502 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1132).

(c) DETERMINATION OF PENALTY AMOUNT.—In determining the amount of the penalty under subsection (a), the district court may consider the effect of the penalty on the violator or other person's ability to—

(1) restore all losses to the victims; or

(2) provide other relief ordered in another civil or criminal prosecution related to such conduct, including any penalty or tax imposed on the violator or other person pursuant to the Internal Revenue Code of 1986.

SEC. 106. PUNISHING BRIBERY AND GRAFT IN CONNECTION WITH EMPLOYEE BENEFIT PLANS.

(a) IN GENERAL.—Section 1954 of title 18, United States Code, is amended to read as follows:

''§ 1954. Bribery and graft in connection with employee benefit plans

''(a) DEFINITIONS.—In this section—

''(1) the term 'employee benefit plan' means any employee welfare benefit plan or employee pension benefit plan subject to any provision of title I of the Employee Retirement Income Security Act of 1974;

''(2) the terms 'employee organization', 'administrator', and 'employee benefit plan sponsor' mean any employee organization, administrator, or plan sponsor, as defined in title I of the Employment Retirement Income Security Act of 1974; and

''(3) the term 'applicable person' means—

''(A) an administrator, officer, trustee, custodian, counsel, agent, or employee of any employee benefit plan;

''(B) an officer, counsel, agent, or employee of an employer or an employer any of whose employees are covered by such plan;

''(C) an officer, counsel, agent, or employee of an employee organization any of whose members are covered by such plan;

''(D) a person who, or an officer, counsel, agent, or employee of an organization that, provides benefit plan services to such plan; or

''(E) a person with actual or apparent influence or decisionmaking authority in regard to such plan.

''(b) BRIBERY AND GRAFT.—Whoever—

''(1) being an applicable person, receives or agrees to receive or solicits, any fee, kickback, commission, gift, loan, money, or thing of value, personally or for any other person, because of or with the intent to be corruptly influenced with respect to any action, decision, or duty of that applicable person relating to any question or matter concerning an employee benefit plan;

''(2) directly or indirectly, gives or offers, or promises to give or offer, any fee, kickback, commission, gift, loan, money, or thing of value, to any applicable person, because of or with the intent to be corruptly influenced with respect to any action, decision, or duty of that applicable person relating to any question or matter concerning an employee benefit plan; or

''(3) attempts to give, accept, or receive any thing of value with the intent to be corruptly influenced in violation of this section;

shall be fined under this title, imprisoned not more than 5 years, or both.

''(c) EXCEPTIONS.—Nothing in this section may be construed to apply to any—

''(1) payment to, or acceptance by, any person of bona fide salary, compensation, or other payments made for goods or facilities actually furnished or for services actually performed in the regular course of his duties as an applicable person; or

''(2) payment to, or acceptance in good faith by, any employee benefit plan sponsor, or person acting on behalf of the sponsor, of anything of value relating to the decision or action of the sponsor to establish, terminate, or modify the governing instruments of an employee benefit plan in a manner that does not violate—

''(A) title I of the Employee Retirement Income Security Act of 1974;

''(B) any regulation or order promulgated under title I of the Employee Retirement Income Security Act of 1974; or

''(C) any other provision of law governing the plan.''.

(b) CONFORMING AMENDMENT.—The analysis for chapter 95 of title 18, United States Code, is amended by striking the item relating to section 1954 and inserting the following:

''1954. Bribery and graft in connection with employee benefit plans.''.

TITLE II—PREVENTING TELEMARKETING FRAUD

SEC. 201. CENTRALIZED COMPLAINT AND CONSUMER EDUCATION SERVICE FOR VICTIMS OF TELEMARKETING FRAUD.

(a) CENTRALIZED SERVICE.—

(1) REQUIREMENT.—The Federal Trade Commission shall, after consultation with the Attorney General, establish procedures to—

(A) log the receipt of complaints by individuals who claim that they have been the victim of fraud in connection with the conduct of telemarketing (as that term is defined in section 2325 of title 18, United States Code, as amended by section 202(a) of this Act);

(B) provide to individuals described in subparagraph (A), and to any other persons, if requested, information on telemarketing fraud, including—

(i) general information on telemarketing fraud, including descriptions of the most common telemarketing fraud schemes;

(ii) information on means of referring complaints on telemarketing fraud to appropriate law enforcement agencies, including the Director of the Federal Bureau of Investigation, the attorneys general of the States, and the national toll-free telephone number on telemarketing fraud established by the Attorney General; and

(iii) information, if available, on any record of civil or criminal law enforcement action for telemarketing fraud against a particular company for which a specific request has been made; and

(C) refer complaints described in subparagraph (A), as appropriate, to law enforcement authorities, including State consumer protection agencies or entities, for potential action.

(2) COMMENCEMENT.—The Federal Trade Commission shall commence carrying out the service not later than 1 year after the date of enactment of this Act.

(b) FRAUD CONVICTION DATA.—

(1) ENTRY OF INFORMATION ON CONVICTIONS INTO FTC DATABASE.—The Attorney General shall provide information on the corporations and companies that are the subject of civil or criminal law enforcement action for telemarketing fraud under Federal and State

law to the Federal Trade Commission in such electronic format as will enable the Federal Trade Commission to automatically enter the information into a database maintained in accordance with subsection (a).

(2) INFORMATION.—The information described in paragraph (1) shall include a description of the type and method of the fraud scheme that prompted the law enforcement action against each such corporation or company.

(3) USE OF DATABASE.—The Attorney General shall make information in the database available to the Federal Trade Commission for purposes of providing information as part of the service under subsection (a).

(c) AUTHORIZATION OF APPROPRIATIONS.—There is authorized to be appropriated such sums as may be necessary to carry out this section.

SEC. 202. BLOCKING OF TELEMARKETING SCAMS.

(a) EXPANSION OF SCOPE OF TELEMARKETING FRAUD SUBJECT TO ENHANCED CRIMINAL PENALTIES.—Section 2325(1) of title 18, United States Code, is amended by striking ''telephone calls'' and inserting ''wire communications utilizing a telephone service''.

(b) BLOCKING OR TERMINATION OF TELEPHONE SERVICE ASSOCIATED WITH TELEMARKETING FRAUD.—

(1) IN GENERAL.—Chapter 113A of title 18, United States Code, is amended by adding at the end the following:

''§ 2328. Blocking or termination of telephone service

''(a) DEFINITIONS.—In this section:

''(1) REASONABLE NOTICE TO THE SUBSCRIBER.—

''(A) IN GENERAL.—The term 'reasonable notice to the subscriber', in the case of a subscriber of a common carrier, means any information necessary to provide notice to the subscriber that—

''(i) the wire communications facilities furnished by the common carrier may not be used for the purpose of transmitting, receiving, forwarding, or delivering a wire communication in interstate or foreign commerce for the purpose of executing any scheme or artifice to defraud in connection with the conduct of telemarketing; and

''(ii) such use constitutes sufficient grounds for the immediate discontinuance or refusal of the leasing, furnishing, or maintaining of the facilities to or for the subscriber.

''(B) INCLUDED MATTER.—The term includes any tariff filed by the common carrier with the Federal Communications Commission that contains the information specified in subparagraph (A).

''(2) WIRE COMMUNICATION.—The term 'wire communication' has the same meaning given that term in section 2510(1).

''(3) WIRE COMMUNICATIONS FACILITY.—The term 'wire communications facility' means any facility (including instrumentalities, personnel, and services) used by a common carrier for purposes of the transmission, receipt, forwarding, or delivery of wire communications.

''(b) BLOCKING OR TERMINATING TELEPHONE SERVICE.—If a common carrier subject to the jurisdiction of the Federal Communications Commission is notified in writing by the Attorney General, acting within the jurisdiction of the Attorney General, that any wire communications facility furnished by that common carrier is being used or will be used by a subscriber for the purpose of transmitting or receiving a wire communication in interstate or foreign commerce for the purpose of executing any scheme or artifice to defraud, or for obtaining money or property by means of false or fraudulent pretenses, representations, or promises, in connection with the conduct of telemarketing, the common carrier shall discontinue or refuse the leasing, furnishing, or maintaining of the facility to or for the subscriber after reasonable notice to the subscriber.

''(c) PROHIBITION ON DAMAGES.—No damages, penalty, or forfeiture, whether civil or criminal, shall be found or imposed against any common carrier for any act done by the common carrier in compliance with a notice received from the Attorney General under this section.

''(d) RELIEF.—

''(1) IN GENERAL.—Nothing in this section may be construed to prejudice the right of any person affected thereby to secure an appropriate determination, as otherwise provided by law, in a Federal court, that—

''(A) the leasing, furnishing, or maintaining of a facility should not be discontinued or refused under this section; or

''(B) the leasing, furnishing, or maintaining of a facility that has been so discontinued or refused should be restored.

''(2) SUPPORTING INFORMATION.—In any action brought under this subsection, the court may direct that the Attorney General present evidence in support of the notice made under subsection (b) to which such action relates.''.

(2) CONFORMING AMENDMENT.—The analysis for chapter 113A of title 18, United States Code, is amended by adding at the end the following:

''2328. Blocking or termination of telephone service.''.

TITLE III—PREVENTING HEALTH CARE FRAUD

SEC. 301. INJUNCTIVE AUTHORITY RELATING TO FALSE CLAIMS AND ILLEGAL KICKBACK SCHEMES INVOLVING FEDERAL HEALTH CARE PROGRAMS.

(a) IN GENERAL.—Section 1345(a) of title 18, United States Code, is amended—

(1) in paragraph (1)—

(A) in subparagraph (B), by striking '', or'' and inserting a semicolon;

(B) in subparagraph (C), by striking the period at the end and inserting ''; or''; and

(C) by adding at the end the following:

''(D) committing or about to commit an offense under section 1128B of the Social Security Act (42 U.S.C. 1320a–7b);''; and

(2) in paragraph (2), by inserting ''a violation of paragraph (1)(D),'' before ''a banking''.

(b) CIVIL ACTIONS.—

(1) IN GENERAL.—Section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended by adding at the end the following:

''(g) CIVIL ACTIONS.—

''(1) IN GENERAL.—The Attorney General may bring an action in the appropriate district court of the United States to impose upon any person who carries out any activity in violation of this section with respect to a Federal health care program a civil penalty of not more than $50,000 for each such violation, or damages of 3 times the total remuneration offered, paid, solicited, or received, whichever is greater.

''(2) EXISTENCE OF VIOLATION.—A violation exists under paragraph (1) if 1 or more purposes of the remuneration is unlawful, and the damages shall be the full amount of such remuneration.

''(3) PROCEDURES.—An action under paragraph (1) shall be governed by—

''(A) the procedures with regard to subpoenas, statutes of limitations, standards of proof, and collateral estoppel set forth in section 3731 of title 31, United States Code; and

''(B) the Federal Rules of Civil Procedure.

''(4) NO EFFECT ON OTHER REMEDIES.—Nothing in this section may be construed to affect the availability of any other criminal or civil remedy.

''(h) INJUNCTIVE RELIEF.—The Attorney General may commence a civil action in an appropriate district court of the United States to enjoin a violation of this section, as provided in section 1345 of title 18, United States Code.''.

(2) CONFORMING AMENDMENT.—The heading of section 1128B of the Social Security Act (42 U.S.C. 1320a–7b) is amended by inserting ''AND CIVIL'' after ''CRIMINAL''.

SEC. 302. AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.

Section 3486 of title 18, United States Code, is amended—

(1) in subsection (a), by inserting '', or any allegation of fraud or false claims (whether criminal or civil) in connection with a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f))),'' after ''Federal health care offense'' each place it appears; and

(2) by adding at the end the following:

''(f) PRIVACY PROTECTION.—

''(1) IN GENERAL.—Except as provided in paragraph (2), any record (including any book, paper, document, electronic medium, or other object or tangible thing) produced pursuant to a subpoena issued under this section that contains personally identifiable health information may not be disclosed to any person, except pursuant to a court order under subsection (e)(1).

''(2) EXCEPTIONS.—A record described in paragraph (1) may be disclosed—

''(A) to an attorney for the Government for use in the performance of the official duty of the attorney (including presentation to a Federal grand jury);

''(B) to government personnel (including personnel of a State or subdivision of a State) as are determined to be necessary by an attorney for the Government to assist an attorney for the Government in the performance of the official duty of that attorney to enforce Federal criminal law;

''(C) as directed by a court preliminarily to, or in connection with, a judicial proceeding;

''(D) as permitted by a court at the request of a defendant in an administrative, civil, or criminal action brought by the United States, upon a showing that grounds may exist for a motion to exclude evidence obtained under this section; or

''(E) at the request of an attorney for the Government, upon a showing that such matters may disclose a violation of State criminal law, to an appropriate official of a State or subdivision of a State for the purpose of enforcing such law.

''(3) MANNER OF COURT ORDERED DISCLOSURES.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), if a court orders the disclosure of any record described in paragraph (1), the disclosure—

''(i) shall be made in such manner, at such time, and under such conditions as the court may direct; and

''(ii) shall be undertaken in a manner that preserves the confidentiality and privacy of individuals who are the subject of the record.

''(B) EXCEPTION.—If disclosure is required by the nature of the proceedings, the attorney for the Government shall request that the presiding judicial or administrative officer enter an order limiting the disclosure of the record to the maximum extent practicable, including redacting the personally identifiable health information from publicly disclosed or filed pleadings or records.

''(4) DESTRUCTION OF RECORDS.—Any record described in paragraph (1), and all copies of that record, in whatever form (including electronic), shall be destroyed not later than 90 days after the date on which the record is produced, unless otherwise ordered by a

court of competent jurisdiction, upon a showing of good cause.

''(5) EFFECT OF VIOLATION.—Any person who knowingly fails to comply with this subsection may be punished as in contempt of court.

''(g) PERSONALLY IDENTIFIABLE HEALTH INFORMATION DEFINED.—In this section, the term 'personally identifiable health information' means any information, including genetic information, demographic information, and tissue samples collected from an individual, whether oral or recorded in any form or medium, that—

''(1) relates to the past, present, or future physical or mental health or condition of an individual, the provision of health care to an individual, or the past, present, or future payment for the provision of health care to an individual; and

''(2) either—

''(A) identifies an individual; or

''(B) with respect to which there is a reasonable basis to believe that the information can be used to identify an individual.''.

SEC. 303. EXTENDING ANTIFRAUD SAFEGUARDS TO THE FEDERAL EMPLOYEE HEALTH BENEFITS PROGRAM.

Section 1128B(f)(1) of the Social Security Act (42 U.S.C. 1320a–7b(f)(1)) is amended by striking ''(other than the health insurance program under chapter 89 of title 5, United States Code)''.

SEC. 304. GRAND JURY DISCLOSURE.

Section 3322 of title 18, United States Code, is amended—

(1) by redesignating subsections (c) and (d) as subsections (d) and (e), respectively; and

(2) by inserting after subsection (b) the following:

''(c) GRAND JURY DISCLOSURE.—Subject to section 3486(f), upon ex parte motion of an attorney for the Government showing that a disclosure in accordance with that subsection would be of assistance to enforce any provision of Federal law, a court may direct the disclosure of any matter occurring before a grand jury during an investigation of a Federal health care offense (as defined in section 24(a) of this title) to an attorney for the Government to use in any investigation or civil proceeding relating to fraud or false claims in connection with a Federal health care program (as defined in section 1128B(f) of the Social Security Act (42 U.S.C. 1320a–7b(f))).''.

SEC. 305. INCREASING THE EFFECTIVENESS OF CIVIL INVESTIGATIVE DEMANDS IN FALSE CLAIMS INVESTIGATIONS.

Section 3733 of title 31, United States Code, is amended—

(1) in subsection (a)(1), in the second sentence, by inserting '', except to the Deputy Attorney General or to an Assistant Attorney General'' before the period at the end; and

(2) in subsection (i)(2)(C), by adding at the end the following: ''Disclosure of information to a person who brings a civil action under section 3730, or the counsel of that person, shall be allowed only upon application to a United States district court showing that such disclosure would assist the Department of Justice in carrying out its statutory responsibilities.''.

TITLE IV—PROTECTING RESIDENTS OF NURSING HOMES

SEC. 401. SHORT TITLE.

This title may be cited as the ''Nursing Home Resident Protection Act of 2002''.

SEC. 402. NURSING HOME RESIDENT PROTECTION.

(a) PROTECTION OF RESIDENTS IN NURSING HOMES AND OTHER RESIDENTIAL HEALTH CARE FACILITIES.—Chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''§ 1352. Pattern of violations resulting in harm to residents of nursing homes and related facilities

''(a) DEFINITIONS.—In this section:

''(1) ENTITY.—The term 'entity' means—

''(A) any residential health care facility (including facilities that do not exclusively provide residential health care services);

''(B) any entity that manages a residential health care facility; or

''(C) any entity that owns, directly or indirectly, a controlling interest or a 50 percent or greater interest in 1 or more residential health care facilities including States, localities, and political subdivisions thereof.

''(2) FEDERAL HEALTH CARE PROGRAM.—The term 'Federal health care program' has the same meaning given that term in section 1128B(f) of the Social Security Act.

''(3) PATTERN OF VIOLATIONS.—The term 'pattern of violations' means multiple violations of a single Federal or State law, regulation, or rule or single violations of multiple Federal or State laws, regulations, or rules, that are widespread, systemic, repeated, similar in nature, or result from a policy or practice.

''(4) RESIDENTIAL HEALTH CARE FACILITY.—The term 'residential health care facility' means any facility (including any facility that does not exclusively provide residential health care services), including skilled and unskilled nursing facilities and mental health and mental retardation facilities, that—

''(A) receives Federal funds, directly from the Federal Government or indirectly from a third party on contract with or receiving a grant or other monies from the Federal Government, to provide health care; or

''(B) provides health care services in a residential setting and, in any calendar year in which a violation occurs, is the recipient of benefits or payments in excess of $10,000 from a Federal health care program.

''(5) STATE.—The term 'State' means each of the several States of the United States, the District of Columbia, and any commonwealth, territory, or possession of the United States.

''(b) PROHIBITION AND PENALTIES.—Whoever knowingly and willfully engages in a pattern of violations that affects the health, safety, or care of individuals residing in a residential health care facility or facilities, and that results in significant physical or mental harm to 1 or more of such residents, shall be punished as provided in section 1347, except that any organization shall be fined not more than $2,000,000 per residential health care facility.

''(c) CIVIL PROVISIONS.—

''(1) IN GENERAL.—The Attorney General may bring an action in a district court of the United States to impose on any individual or entity that engages in a pattern of violations that affects the health, safety, or care of individuals residing in a residential health care facility, and that results in physical or mental harm to 1 or more such residents—

''(A) a civil penalty; or

''(B) in the case of—

''(i) an individual (other than an owner, operator, officer, or manager of such a residential health care facility), not more than $10,000;

''(ii) an individual who is an owner, operator, officer, or manager of such a residential health care facility, not more than $100,000 for each separate facility involved in the pattern of violations under this section;

''(iii) a residential health care facility, not more than $1,000,000 for each pattern of violations; or

''(iv) an entity, not more than $1,000,000 for each separate residential health care facility involved in the pattern of violations owned or managed by that entity.

''(2) OTHER APPROPRIATE RELIEF.—If the Attorney General has reason to believe that an individual or entity is engaging in or is about to engage in a pattern of violations that would affect the health, safety, or care of individuals residing in a residential health care facility, and that results in or has the potential to result in physical or mental harm to 1 or more such residents, the Attorney General may petition an appropriate district court of the United States for appropriate equitable and declaratory relief to eliminate the pattern of violations.

''(3) PROCEDURES.—In any action under this subsection—

''(A) a subpoena requiring the attendance of a witness at a trial or hearing may be served at any place in the United States;

''(B) the action may not be brought more than 6 years after the date on which the violation occurred;

''(C) the United States shall be required to prove each charge by a preponderance of the evidence;

''(D) the civil investigative demand procedures set forth in the Antitrust Civil Process Act (15 U.S.C. 1311 et seq.) and regulations promulgated pursuant to that Act shall apply to any investigation; and

''(E) the filing or resolution of a matter shall not preclude any other remedy that is available to the United States or any other person.

''(d) PROHIBITION AGAINST RETALIATION.—Any person who is the subject of retaliation, either directly or indirectly, for reporting a condition that may constitute grounds for relief under this section may bring an action in an appropriate district court of the United States for damages, attorneys' fees, and other relief.''.

(b) AUTHORIZED INVESTIGATIVE DEMAND PROCEDURES.—Section 3486(a)(1) of title 18, United States Code, as amended by section 302 of this Act, is amended by inserting '', act or activity involving section 1352 of this title'' after ''Federal health care offense''.

(c) CONFORMING AMENDMENT.—The analysis for chapter 63 of title 18, United States Code, is amended by adding at the end the following:

''1352. Pattern of violations resulting in harm to residents of nursing homes and related facilities.''.

TITLE V—PROTECTING THE RIGHTS OF ELDERLY CRIME VICTIMS

SEC. 501. USE OF FORFEITED FUNDS TO PAY RESTITUTION TO CRIME VICTIMS AND REGULATORY AGENCIES.

Section 981(e) of title 18, United States Code, is amended—

(1) in each of paragraphs (3), (4), and (5), by striking ''in the case of property referred to in subsection (a)(1)(C),'' and inserting ''in the case of property forfeited in connection with an offense resulting in a pecuniary loss to a financial institution or regulatory agency,''; and

(2) in paragraph (7), by striking ''In the case of property referred to in subsection (a)(1)(D)'' and inserting ''in the case of property forfeited in connection with an offense relating to the sale of assets acquired or held by any Federal financial institution or regulatory agency, or person appointed by such agency, as receiver, conservator, or liquidating agent for a financial institution''.

SEC. 502. VICTIM RESTITUTION.

Section 413 of the Controlled Substances Act (21 U.S.C. 853) is amended by adding at the end the following:

''(r) VICTIM RESTITUTION.—

''(1) SATISFACTION OF ORDER OF RESTITUTION.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), a defendant may not use property subject to forfeiture under this section to satisfy an order of restitution.

''(B) EXCEPTION.—If there are 1 or more identifiable victims entitled to restitution from a defendant, and the defendant has no assets other than the property subject to forfeiture with which to pay restitution to the victim or victims, the attorney for the Government may move to dismiss a forfeiture allegation against the defendant before entry of a judgment of forfeiture in order to allow the property to be used by the defendant to pay restitution in whatever manner the court determines to be appropriate if the court grants the motion. In granting a motion under this subparagraph, the court shall include a provision ensuring that costs associated with the identification, seizure, management, and disposition of the property are recovered by the United States.

''(2) RESTORATION OF FORFEITED PROPERTY.—

''(A) IN GENERAL.—If an order of forfeiture is entered pursuant to this section and the defendant has no assets other than the forfeited property to pay restitution to 1 or more identifiable victims who are entitled to restitution, the Government shall restore the forfeited property to the victims pursuant to subsection (i)(1) once the ancillary proceeding under subsection (n) has been completed and the costs of the forfeiture action have been deducted.

''(B) DISTRIBUTION OF PROPERTY.—On a motion of the attorney for the Government, the court may enter any order necessary to facilitate the distribution of any property restored under this paragraph.

''(3) VICTIM DEFINED.—In this subsection, the term 'victim'—

''(A) means a person other than a person with a legal right, title, or interest in the forfeited property sufficient to satisfy the standing requirements of subsection (n)(2) who may be entitled to restitution from the forfeited funds pursuant to section 9.8 of part 9 of title 28, Code of Federal Regulations (or any successor to that regulation); and

''(B) includes any person who is the victim of the offense giving rise to the forfeiture, or of any offense that was part of the same scheme, conspiracy, or pattern of criminal activity, including, in the case of a money laundering offense, any offense constituting the underlying specified unlawful activity.''.

SEC. 503. BANKRUPTCY PROCEEDINGS NOT USED TO SHIELD ILLEGAL GAINS FROM FALSE CLAIMS.

(a) CERTAIN ACTIONS NOT STAYED BY BANKRUPTCY PROCEEDINGS.—

(1) IN GENERAL.—Notwithstanding any other provision of law, the commencement or continuation of an action under section 3729 of title 31, United States Code, does not operate as a stay under section 105(a) or 362(a)(1) of title 11, United States Code.

(2) CONFORMING AMENDMENT.—Section 362(b) of title 11, United States Code, is amended—

(A) in paragraph (17), by striking ''or'' at the end;

(B) in paragraph (18), by striking the period at the end and inserting ''; or''; and

(C) by adding at the end the following:

''(19) the commencement or continuation of an action under section 3729 of title 31.''.

(b) CERTAIN DEBTS NOT DISCHARGEABLE IN BANKRUPTCY.—Section 523 of title 11, United States Code, is amended by adding at the end the following:

''(f) A discharge under section 727, 1141, 1228(a), 1228(b), or 1328(b) does not discharge a debtor from a debt owed for violating section 3729 of title 31.''.

(c) REPAYMENT OF CERTAIN DEBTS CONSIDERED FINAL.—

(1) IN GENERAL.—Chapter 1 of title 11, United States Code, is amended by adding at the end the following:

''§ 111. False claims

''No transfer on account of a debt owed to the United States for violating section 3729 of title 31, or under a compromise order or other agreement resolving such a debt may be avoided under section 544, 545, 547, 548, 549, 553(b), or 742(a).''.

(2) CONFORMING AMENDMENT.—The analysis for chapter 1 of title 11, United States Code, is amended by adding at the end the following:

''111. False claims.''.

SEC. 504. FORFEITURE FOR RETIREMENT OFFENSES.

(a) CRIMINAL FORFEITURE.—Section 982(a) of title 18, United States Code, is amended by adding at the end the following:

''(9) CRIMINAL FORFEITURE.—

''(A) IN GENERAL.—The court, in imposing a sentence on a person convicted of a retirement offense, shall order the person to forfeit property, real or personal, that constitutes or that is derived, directly or indirectly, from proceeds traceable to the commission of the offense.

''(B) RETIREMENT OFFENSE DEFINED.—In this paragraph, if a violation, conspiracy, or solicitation relates to a retirement arrangement (as defined in section 1351 of title 18, United States Code), the term 'retirement offense' means a violation of—

''(i) section 664, 1001, 1027, 1341, 1343, 1351, 1951, 1952, or 1954 of title 18, United States Code; or

''(ii) section 411, 501, or 511 of the Employee Retirement Income Security Act of 1974 (29 U.S.C. 1111, 1131, 1141).''.

(b) CIVIL FORFEITURE.—Section 981(a)(1) of title 18, United States Code, is amended by adding at the end the following:

''(I) Any property, real or personal, that constitutes or is derived, directly or indirectly, from proceeds traceable to the commission of, criminal conspiracy to violate, or solicitation to commit a crime of violence involving, a retirement offense (as defined in section 982(a)(9)(B)).''.

By Mr. DOMENICI:

S. 1287. A bill to amend section 502(a)(5) of the Higher Education Act of 1965 regarding the definition of a Hispanic-serving institution; to the Committee on Health, Education, Labor, and Pensions.

Mr. DOMENICI. Madam President, I rise today to introduce a bill that will amend Title V of the Higher Education Act. Specifically, this bill will eliminate the ''50 percent'' low-income assurance constraint currently required for Hispanic Serving Institutions to be eligible for grants under Title V of the Higher Education Act.

Title V of the Higher Education Act is the primary vehicle used to target urgently needed funds to Hispanic Serving Institutions so that they can strengthen and expand their institutional capacity. Grants under this section can be used by higher education institutions to improve academic quality, institutional management, and financial stability. These grants are essential to institutions that provide and increase the number of educational opportunities available to Hispanic students.

Under current guidelines, in order to qualify for a grant under Title V, an institution must have at least 25 percent full time, Hispanic undergraduate student enrollment, and not less than 50 percent of its Hispanic student population must be low income. Title V grants are awarded for 5 years, with a minimum two year wait out period after the termination of a grant period before eligibility to apply for another grant. During fiscal year 2002, 191 institutions were awarded grants.

Title V's current ''50 percent'' low-income assurance requirement is an unnecessary bureaucratic regulation that constrains Hispanic Serving Institutions abilities to implement programs designed to provide long range solutions to Hispanic higher education challenges. Currently, there are no government authorized means to collect student financial data, and, although some information can be extrapolated from student financial aid forms, it is not enough information to complete the Title V forms.

The bill I am introducing today will improve the HSI eligibility requirements by allowing applicants for Title V funding to satisfy the 50 percent low-income Hispanic student population criterion with appropriate evidence of student eligibility for Title IV, need-based, aid. The revised Title V section will retain the requirement that to be eligible for title V funds, an institution must have an enrollment of needy students. However, rather than conditioning grant qualification upon the cumbersome requirement that institutions prove 50 percent of their Hispanic students are low income, it will allow institutions to qualify for Title V money if 50 percent of the students are receiving need-based assistance under title IV or a substantial percentage of the students are receiving Pell Grants.

The Higher Education Act of 1965 was signed into law for the purpose of increasing access to higher education for all citizens of the United States and of strengthening the capacity of higher education institutions to better serve their communities. The reauthorization of the Higher Education Act during the 108th Congress presents a powerful opportunity for the nation to address the higher education needs of the nation's Hispanic-Serving Institutions, which serve the largest concentrations of Hispanic higher education students in the United States.

Hispanic Serving Institutions provide the quality education essential to full participation in today's society. Many students in my home state of New Mexico have benefited from the academic excellence that Hispanic Serving Institutions seek to provide. Title V grants are intended to provide assistance to these less advantaged, developing institutions. However, by convoluting the application process, Congress is preventing these institutions from applying for grants and obstructing their development.

I ask unanimous consent that the text of the bill be printed in the RECORD.

There being no objection, the text of the bill was ordered to be printed in the RECORD, as follows:

S. 1287

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

SECTION 1. DEFINITION OF A HISPANIC-SERVING INSTITUTION.

Section 502(a)(5) of the Higher Education Act of 1965 (20 U.S.C. 1101a(a)(5)) is amended—

(1) in subparagraph (A), by inserting ''and'' after the semicolon;

(2) in subparagraph (B), by striking ''; and'' and inserting a period; and

(3) by striking subparagraph (C).

By Mr. CHAMBLISS (for himself and Mr. MILLER):

S. 1288. A bill to amend title XVIII of the Social Security Act to exclude brachytherapy devices from the prospective payment system for outpatient hospital services under the medicare program; to the Committee on Finance.

Mr. CHAMBLISS. Madam President, I rise today to introduce legislation, along with my colleague Senator MILLER of Georgia, that would amend the Medicare portion of the Social Security Act to exclude brachytherapy devices from the prospective payment system for outpatient hospital services under the Medicare Program. Currently, the number of devices reimbursed by Medicare is one set number and non-specific to the prostate cancer patient.

Prostate cancer accounts for 43 percent of all cancers found in men—more than triple the rate of lung cancer. The American Cancer Society estimates that nearly 221,000 men in the United States will be diagnosed with prostate cancer in 2003 and approximately 27,000 of these men will die as a result. The American Cancer Society also estimates that about 5,700 men diagnosed will be from Georgia and nearly 700 of them may die. This legislation will help some of these men fight and survive this indiscriminate killer. Over 130,000 men and their sons nationwide have been treated with brachytherapy Theraseeds to date.

Brachytherapy is an important form of radiation treatment for prostate cancer in which radioactive ''seeds'' are implanted into the patient. While there are several ways to treat prostate cancer, patients need the freedom to choose the treatment that best suits them and their situation. Tremendous variations exist that may effect the clinical requirements for cancer patients using brachytherapy theraseeds, including variations in the types of radioactive isotopes, as well as the number and radioactive intensity of the seeds. The brachytherapy community indicates that these variations result in considerable differences in total brachytherapy costs among patients, varying from several hundred dollars to over $10,000 per patient. Prostate brachytherapy is different from many other clinical interventions because of the dramatic variability in the type, number and radioactivity of brachytherapy seeds needed to treat each patient. This variability is due to differences in the clinical presentation from patient to patient, including the type, staging, and size of a patient's cancer. This variability also results in a broad range of costs per patient. This legislation will allow a more fair reimbursement for physicians who are using brachytherapy to treat prostate cancer patients. This bill will also allow Medicare patients to receive another type of therapy when making decisions and dealing with the reality of being diagnosed with prostate cancer.

I encourage all of my colleagues to support this piece of legislation so that men suffering with prostate cancer will have more coverage under Medicare should they choose brachytherapy for their treatment.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 174—DESIGNATING THURSDAY, NOVEMBER 20, 2003, AS ''FEED AMERICA THURSDAY''

Mr. HATCH submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 174

Whereas Thanksgiving Day celebrates the spirit of selfless giving and an appreciation for family and friends;

Whereas the spirit of Thanksgiving Day is a virtue upon which our Nation was founded;

Whereas 33,000,000 Americans, including 13,000,000 children, continue to live in households that do not have an adequate supply of food;

Whereas almost 3,000,000 of those children experience hunger; and

Whereas selfless sacrifice breeds a genuine spirit of Thanksgiving, both affirming and restoring fundamental principles in our society: Now, therefore, be it

Resolved, That the Senate

(1) designates Thursday, November 20, 2003, as ''Feed America Thursday''; and

(2) requests that the President issue a proclamation calling upon the people of the United States to sacrifice 2 meals on Thursday, November 20, 2003, and to donate the money that they would have spent on food to a religious or charitable organization of their choice for the purpose of feeding the hungry.

SENATE RESOLUTION 175—DESIGNATING THE MONTH OF OCTOBER 2003, AS ''FAMILY HISTORY MONTH''

Mr. HATCH submitted the following resolution; which was referred to the Committee on the Judiciary:

S. RES. 175

Whereas it is the family, striving for a future of opportunity and hope, that reflects our Nation's belief in community, stability, and love;

Whereas the family remains an institution of promise, reliance, and encouragement;

Whereas we look to the family as an unwavering symbol of constancy that will help us discover a future of prosperity, promise, and potential;

Whereas within our Nation's libraries and archives lie the treasured records that detail the history of our Nation, our States, our communities, and our citizens;

Whereas individuals from across our Nation and across the world have embarked on a genealogical journey by discovering who their ancestors were and how various forces shaped their past;

Whereas an ever-growing number in our Nation and in other nations are collecting, preserving, and sharing genealogies, personal documents, and memorabilia that detail the life and times of families around the world;

Whereas 54,000,000 individuals belong to a family where someone in the family has used the Internet to research their family history;

Whereas individuals from across our Nation and across the world continue to research their family heritage and its impact upon the history of our Nation and the world;

Whereas approximately 60 percent of Americans have expressed an interest in tracing their family history;

Whereas the study of family history gives individuals a sense of their heritage and a sense of responsibility in carrying out a legacy that their ancestors began;

Whereas as individuals learn about their ancestors who worked so hard and sacrificed so much, their commitment to honor their ancestors' memory by doing good is increased;

Whereas interest in our personal family history transcends all cultural and religious affiliations;

Whereas to encourage family history research, education, and the sharing of knowledge is to renew the commitment to the concept of home and family; and

Whereas the involvement of National, State, and local officials in promoting genealogy and in facilitating access to family history records in archives and libraries are important factors in the successful perception of nationwide camaraderie, support, and participation: Now, therefore, be it

Resolved, That the Senate—

(1) designates the month of October 2003, as ''Family History Month''; and

(2) requests that the President issue a proclamation calling upon the people of the United States to observe the month with appropriate ceremonies and activities.

AMENDMENTS SUBMITTED & PROPOSED

SA 929. Mr. NELSON, of Nebraska submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table.

SA 930. Mrs. HUTCHISON submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 931. Ms. STABENOW (for herself, Mrs. BOXER, Mr. GRAHAM, of Florida, Mr. ROCKEFELLER, Mr. HARKIN, Ms. CANTWELL, Mr. KERRY, Mr. BINGAMAN, Mr. REED, Mrs. CLINTON, Ms. MIKULSKI, Mr. LEVIN, Mr. KOHL, Mr. DODD, Mr. LIEBERMAN, Mr. REID, Mr. DAYTON, and Mr. JOHNSON) proposed an amendment to the bill S. 1, supra.

SA 932. Mr. ENZI (for himself and Mr. PRYOR) proposed an amendment to the bill S. 1, supra.

SA 933. Mr. BINGAMAN proposed an amendment to the bill S. 1, supra.

SA 934. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

SA 935. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the bill S. 1, supra; which was ordered to lie on the table.

TEXT OF AMENDMENTS

SA 929. Mr. NELSON of Nebraska submitted an amendment intended to be proposed by him to the 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; which was ordered to lie on the table; as follows:

At the end of title VI, insert the following:

SEC. ___. MEDICARE BENEFICIARY ACCESS TO REHABILITATION FACILITIES.

(a) DEFINITIONS OF REHABILITATION HOSPITAL; REHABILITATION UNIT.—Section 1886(j)(42 U.S.C. 1395ww(j)) is amended by adding at the end the following new subsection:

''(8) DEFINITIONS OF REHABILITATION HOSPITAL; REHABILITATION UNIT.—

''(A) IN GENERAL.—The Secretary shall by regulation define the terms 'rehabilitation hospital' and 'rehabilitation unit' in a manner fully consistent with all the rehabilitation impairment categories (except miscellaneous) used to classify patients into case-mix groups pursuant to paragraph (2).

''(B) PERIODIC UPDATE REQUIRED.—The Secretary shall update the regulations promulgated under subparagraph (A) periodically to ensure that such definitions remain fully consistent with the rehabilitation impairment categories used to classify patients into case-mix groups pursuant to paragraph (2).''.

(b) PROHIBITION ON RETROACTIVE ENFORCEMENT.—Notwithstanding any other provision of law, the Secretary of Health and Human Services shall not seek to recoup any overpayment, take any enforcement action, or impose any sanction or penalty, with respect to a rehabilitation hospital, or a converted rehabilitation unit, (as such terms are defined for purposes of the medicare program under title XVIII of the Social Security Act) insofar as such overpayment, enforcement action, sanction or penalty, is for failure to satisfy the requirement of section 412.23(b)(2) of title 42, Code of Federal Regulations, that 75 percent of the patients of the rehabilitation hospital or converted rehabilitation unit are in 1 or more of 10 listed treatment categories (commonly referred to as the ''75 Percent Rule'').

SA 930. Mrs. HUTCHISON submitted an amendment intended to be proposed by her to the 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; which was ordered to lie on the table; as follows:

At the end of subtitle A of title IV, add the following:

SEC. ___. FREEZING INDIRECT MEDICAL EDUCATION (IME) ADJUSTMENT PERCENTAGE AT 6.5 PERCENT.

(a) IN GENERAL.—Section 1886(d)(5)(B)(ii)(42 U.S.C. 1395ww(d)(5)(B)(ii)) is amended—

(1) in subclause (V), by inserting ''and'' at the end; and

(2) by striking subclauses (VI) and (VII) and inserting the following new subclause:

''(VI) on or after October 1, 2001, 'c' is equal to 1.6.''.

(b) CONFORMING AMENDMENT RELATING TO DETERMINATION OF STANDARDIZED AMOUNT.—Section 1886(d)(2)(C)(i) (42 U.S.C. 1395ww(d)(2)(C)(i)) is amended—

(1) by striking ''1999 or'' and inserting ''1999,''; and

(2) by inserting '', or the Prescription Drug and Medicare Improvement Act of 2003'' after ''2000''.

(c) EFFECTIVE DATE.—The amendments made by this section shall apply to discharges occurring on or after October 1, 2002.

SA 931. Ms. STABENOW (for herself, Mrs. BOXER, Mr. GRAHAM of Florida, Mr. ROCKEFELLER, Mr. HARKIN, Ms. CANTWELL, Mr. KERRY, Mr. BINGAMAN, Mr. REED, Mrs. CLINTON, Ms. MIKULSKI, Mr. LEVIN, Mr. KOHL, Mr. DODD, Mr. LIEBERMAN, Mr. REID, Mr. DAYTON, and Mr. JOHNSON) proposed an amendment to the 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; as follows:

''(e) MEDICARE GUARANTEED OPTION.—

''(1) ACCESS.—

''(A) IN GENERAL.—The Administrator shall enter into a contract with an entity in each area (established under section 1860D–10) to provide eligible beneficiaries enrolled under this part (and not, except for an MSA plan or a private fee-for-service plan that does not provide qualified prescription drug coverage, enrolled in a MedicareAdvantage plan) and residing in the area with standard prescription drug coverage (including access to negotiated prices for such beneficiaries pursuant to section 1860D–6(e)). An entity may be awarded a contract for more than 1 area but the Administrator may enter into only 1 such contract in each such area.

''(B) ENTITY REQUIRED TO MEET BENEFICIARY PROTECTION AND OTHER REQUIREMENTS.—An entity with a contract under subparagraph (A) shall meet the requirements described in section 1860D–5 and such other requirements determined appropriate by the Administrator.

''(C) COMPETITIVE PROCEDURES.—Competitive procedures (as defined in section 4(5) of the Office of Federal Procurement Policy Act (41 U.S.C. 403(5))) shall be used to enter into a contract under subparagraph (A).

''(D) SAME TIMEFRAME AS MEDICARE PRESCRIPTION DRUG PLANS.—The Administrator shall apply similar timeframes for the submission of bids and entering into to contracts under this subsection as the Administrator applies to Medicare Prescription Drug plans.

''(2) MONTHLY BENEFICIARY OBLIGATION FOR ENROLLMENT.—In the case of an eligible beneficiary receiving access to qualified prescription drug coverage through enrollment with an entity with a contract under paragraph (1)(A), the monthly beneficiary obligation of such beneficiary for such enrollment shall be an amount equal to the applicable percent (as determined under section 1860D–17(c) before any adjustment under paragraph (2) of such section) of the monthly national average premium (as computed under section 1860D–15 before any adjustment under subsection (b) of such section) for the year.

''(3) PAYMENTS UNDER THE CONTRACT.—

''(A) IN GENERAL.—A contract entered into under paragraph (1)(A) shall provide for—

''(i) payment for the negotiated costs of covered drugs provided to eligible beneficiaries enrolled with the entity; and

''(ii) payment of prescription management fees that are tied to performance requirements established by the Administrator for the management, administration, and delivery of the benefits under the contract.

''(B) PERFORMANCE REQUIREMENTS.—The performance requirements established by the Administrator pursuant to subparagraph (A)(ii) shall include the following:

''(i) The entity contains costs to the Prescription Drug Account and to eligible beneficiaries enrolled under this part and with the entity.

''(ii) The entity provides such beneficiaries with quality clinical care.

''(iii) The entity provides such beneficiaries with quality services.

''(C) ENTITY ONLY AT RISK TO THE EXTENT OF THE FEES TIED TO PERFORMANCE REQUIREMENTS.—An entity with a contract under paragraph (1)(A) shall only be at risk for the provision of benefits under the contract to the extent that the management fees paid to the entity are tied to performance requirements under subparagraph (A)(ii).

''(4) TERM OF CONTRACT.—A contract entered into under paragraph (1)(A) shall be for a period of at least 2 years but not more than 5 years.

''(5) NO EFFECT ON ACCESS REQUIREMENTS.—The contract entered into under subparagraph (1)(A) shall be in addition to the plans required under subsection (d)(1).

''(6) AUTHORITY TO PREVENT INCREASED COSTS.—If the Administrator determines that Federal payments made with respect to eligible beneficiaries enrolled in a contract under paragraph (1)(A) exceed on average the Federal payments made with respect to eligible beneficiaries enrolled in a Medicare Prescription Drug plan or a MedicareAdvantage plan (with respect to qualified prescription drug coverage), the Administrator may adjust the requirements or payments under such a contract to eliminate such excess.

SA 932. Mr. ENZI (for himself and Mr. PRYOR) proposed an amendment to the 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; as follows:

On page 57, between lines 21 and 22, insert the following:

''(3) DISCLOSURE.—The eligible entity offering a Medicare Prescription Drug plan and the MedicareAdvantage organization offering a MedicareAdvantage plan shall disclose to the Administrator (in a manner specified by the Administrator) the extent to which discounts, direct or indirect subsidies, rebates, or other price concessions or direct or indirect remunerations made available to the entity or organization by a manufacturer are passed through to enrollees through pharmacies and other dispensers or otherwise. The provisions of section 1927(b)(3)(D) shall apply to information disclosed to the Administrator under this paragraph in the same manner as such provisions apply to information disclosed under such section.

''(4) AUDITS AND REPORTS.—To protect against fraud and abuse and to ensure proper disclosures and accounting under this part, in addition to any protections against fraud and abuse provided under section 1860D–7(f)(1), the Administrator may periodically audit the financial statements and records of an eligible entity offering a Medicare Prescription Drug plan and a MedicareAdvantage organization offering a MedicareAdvantage plan.

On page 37, between lines 20 and 21, insert the following:

''(C) LEVEL PLAYING FIELD.—An eligible entity offering a Medicare Prescription Drug plan 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 cost paid by such enrollees.

''(D) PARTICIPATING PHARMACIES NOT REQUIRED TO ACCEPT INSURANCE RISK.—An eligible entity offering a Medicare Prescription

Drug plan may not require participating pharmacies to accept insurance risk as a condition of participation.

SA 933. Mr. BINGAMAN proposed an amendment to the 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; as follows:

On page 120, between lines 16 and 17, insert the following:

''(I) ELIMINATION OF APPLICATION OF ASSET TEST.—With respect to eligibility determinations for premium and cost-sharing subsidies under this section made on or after October 1, 2008, such determinations shall be made without regard to subparagraph (C) of section 1905(p)(1) (to the extent a State, as of such date, has not already eliminated the application of such subparagraph).

SA 934. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the 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; which was ordered to lie on the table; as follows:

On page 9, line 7, insert ''(including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Administrator)'' before the semicolon.

On page 170, line 10, insert ''(including syringes, and necessary medical supplies associated with the administration of insulin, as defined by the Secretary)'' before the comma.

SA 935. Mrs. LINCOLN submitted an amendment intended to be proposed by her to the 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; which was ordered to lie on the table; as follows:

Strike section 410 and insert the following:

SEC. 410. EXCEPTION TO INITIAL RESIDENCY PERIOD FOR GERIATRIC RESIDENCY OR FELLOWSHIP PROGRAMS.

(a) CLARIFICATION OF CONGRESSIONAL INTENT.—Congress intended section 1886(h)(5)(F)(ii) of the Social Security Act (42 U.S.C. 1395ww(h)(5)(F)(ii)), as added by section 9202 of the Consolidated Omnibus Budget Reconciliation Act of 1985 (Public Law 99–272), to provide an exception to the initial residency period for geriatric residency or fellowship programs such that, where a particular approved geriatric training program requires a resident to complete 2 years of training to initially become board eligible in the geriatric specialty, the 2 years spent in the geriatric training program are treated as part of the resident's initial residency period, but are not counted against any limitation on the initial residency period.

(b) INTERIM FINAL REGULATORY AUTHORITY AND EFFECTIVE DATE.—The Secretary shall promulgate interim final regulations consistent with the congressional intent expressed in this section after notice and pending opportunity for public comment to be effective for cost reporting periods beginning on or after October 1, 2003.

AUTHORITY FOR COMMITTEES TO MEET

COMMITTEE ON AGRICULTURE, NUTRITION, AND FORESTRY

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Committee on Agriculture, Nutrition, and Forestry be authorized to meet during the session of the Senate on Wednesday, June 18, 2003. The purpose of this meeting will be to discuss the nomination of Thomas Dorr to be Under Secretary of Agriculture for Rural Development.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on June 18, 2003, at 10:00 a.m., to conduct an oversight hearing on ''Review of the New Basel Capital Accord.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON BANKING, HOUSING, AND URBAN AFFAIRS

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Committee on Banking, Housing, and Urban Affairs be authorized to meet during the session of the Senate on June 18, 2003, at 2:00 p.m., to conduct a mark-up of ''The Check Truncation Act of 2003'' and of ''S. 498, the Rev. Joseph A. De Laine Congressional Gold Medal Bill.''

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Wednesday, June 18, 2003, at 2:30 p.m. to hold a hearing on A Review of the Development of Democracy in Burma.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON FOREIGN RELATIONS

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Committee on Foreign Relations be authorized to meet during the session of the Senate on Wednesday, June 18, 2003, at 4:00 p.m. to hold a Nomination hearing.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON GOVERNMENTAL AFFAIRS

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Committee on Governmental Affairs be authorized to meet on Wednesday, June 18, 2003 at 9:30 a.m. in SD–342 to consider the nominations of Fern Flanagan Saddler to be an Associate Judge, Superior Court of the District of Columbia; Judith Nan Macaluso to be an Associate Judge, Superior Court of the District of Columbia (new position created by District of Columbia Family Court Act of 2002); J. Michael Ryan to be an Associate Judge, Superior Court of the District of Columbia (new position created by District of Columbia Family Court Act of 2002); and Jerry S. Byrd to be an Associate Judge, Superior Court of the District of Columbia (new position created by District of Columbia Family Court Act of 2002).

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON HEALTH, EDUCATION, LABOR AND PENSIONS

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Committee on Health, Education, Labor, and Pensions, Subcommittee on Employment, Safety, and Training be authorized to meet for a hearing on ''Reauthorization of the Workforce Investment Act'' during the session of the Senate on Wednesday, June 18, 2003 at 10:00 a.m. in SD–430.

The PRESIDING OFFICER. Without objection, it is so ordered.

COMMITTEE ON INDIAN AFFAIRS

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Committee on Indian Affairs be authorized to meet on Wednesday, June 18, 2003, at 10:00 a.m. in Room 485 of the Russell Senate Office Building to conduct a HEARING on Native American Sacred Places.

The PRESIDING OFFICER. Without objection, it is so ordered.

SELECT COMMITTEE ON INTELLIGENCE

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Select Committee on Intelligence be authorized to meet during the session of the Senate on Wednesday, June 18, 2003 at 2:30 p.m. to hold a closed business meeting.

The PRESIDING OFFICER. Without objection, it is so ordered.

SUBCOMMITTEE ON ANTITRUST, COMPETITION POLICY AND CONSUMER RIGHTS

Mr. GRASSLEY. Mr. President, I ask unanimous consent that the Committee on the Judiciary Subcommittee on Antitrust, Competition Policy and Consumer Rights be authorized to meet to conduct a hearing on ''The NewsCorp/DirecTV Deal: The Marriage of Content and Global Distribution'' on Wednesday, June 18, 2003, at 2:30 p.m. in Room 226 of the Dirksen Senate Office building.

Tentative Witness List

Panel I: Mr. Rupert Murdoch, Chairman and CEO, News Corporation; Mr. Eddy Hartenstein, Chairman and CEO, DirecTV; Mr. Gene Kimmelman, Director, Consumer Union, Washington, DC; Mr. Robert Miron, Chairman and CEO, Advance/Newhouse Communications; Mr. Scott Cleland, CEO, The Precursor Group, Washington, DC.

The PRESIDING OFFICER. Without objection, it is so ordered.

PRIVILEGE OF THE FLOOR

Ms. STABENOW. Mr. President, I ask unanimous consent that Oliver Kim, a fellow in my office, be granted floor privileges during the consideration of S. 1.

The PRESIDING OFFICER. Without objection, it is so ordered.

EXECUTIVE SESSION

EXECUTIVE CALENDAR

Mr. GRASSLEY. On the Executive Calendar, I ask unanimous consent that the Senate immediately proceed to executive session to consider the following nominations on today's calendar: Calendar No. 228 and the two military promotions reported by the Armed Services Committee during today's session.

I further ask unanimous consent that the nominations be confirmed en bloc, the motion to reconsider be laid upon the table, the President be immediately notified of the Senate's action, and the Senate then return to legislative session.

The PRESIDING OFFICER. Without objection, it is so ordered.

The nominations considered and confirmed are as follows:

DEPARTMENT OF JUSTICE

Richard James O'Connell, of Arkansas, to be United States Marshal for the Western District of Arkansas for the term of four years.

ARMY

The following named officer for appointment in the United States Army to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be lieutenant general

Lt. Gen. William S. Wallace, 0000

NAVY

The following named officer for appointment in the United States Navy to the grade indicated while assigned to a position of importance and responsibility under title 10, U.S.C., section 601:

To be admiral

Adm. Edmund P. Giambastiani, Jr., 0000

LEGISLATIVE SESSION

The PRESIDING OFFICER. Under the previous order, the Senate will return to legislative session.

STRENGTHEN AMERICORPS PROGRAM ACT

Mr. GRASSLEY. Madam President, in regard to S. 1276, I ask unanimous consent that the Senate immediately proceed to this bill, which was introduced earlier today and is being held at the desk.

The PRESIDING OFFICER. The clerk will report the bill by title.

The legislative clerk read as follows:

A bill (S. 1276) to improve the manner in which the Corporation for National and Community Service approves, and records obligations relating to, national service positions.

There being no objection, the Senate proceeded to consider the bill.

Mr. BOND. Madam President, I rise today to support legislation that will strengthen the Corporation for National and Community Service's AmeriCorps program. The Strengthen AmeriCorps Program Act of 2003 is a bipartisan bill that I introduce with my colleague and good friend, Senator BARBARA MIKULSKI, and a number of my other colleagues. As the ranking member and chair of the Corporation's appropriations committee and members of the authorizing committee, Senator MIKULSKI and I believe that this bill will not only address the Corporation's accounting problems, but more importantly, it will protect and expand volunteer service opportunities across our Nation.

Many of my colleagues have heard from their constituents and the media in recent weeks about the potential cuts to the AmeriCorps program. This bill addresses those concerns and the long-standing concerns about the management and financial problems of the Corporation by creating a budgeting mechanism that ensures the Corporation has the funds needed to pay educational awards. Under our bill, the Corporation would be able to enroll about 50,000 AmeriCorps members, without the need for additional funds.

As many of my colleagues know, the President has asked every American to volunteer in their communities and has made the AmeriCorps program a central vehicle in meeting volunteer needs. I support the President's call to service and if harnessed in the right fashion, the AmeriCorps program can play an important and effective role in improving the lives of many Americans and communities it serves.

The Corporation, unfortunately, has been plagued by significant and long-standing management problems that have been neglected for several years. One notable result of this neglect has been the inappropriate and illegal practice of enrolling more AmeriCorps members than the Corporation had budgeted. According to the Corporation's Inspector General, the number of approved AmeriCorps volunteer positions for program years 2000, 2001, and 2002, were approximately 59,000, 61,000, and 67,000, respectively, even though its budget estimates were based on enrollment levels that were around 50,000. Last year, the Corporation over-enrolled the AmeriCorps program by more than 20,000. Fortunately, the VA-HUD and Independent Agencies Appropriations Subcommittees were able to provide $43 million more than requested in the fiscal year 2003 appropriations bill to meet the needs of these members and more. Because of continued poor budgeting practices, the VA-HUD Subcommittee also approved another $64 million in a deficiency appropriation in the fiscal year 2003 supplemental appropriations to cover additional shortfalls.

When the over-enrollment problem first surfaced, I immediately asked the General Accounting Office and the Corporation's Inspector General to review the accounting practices of the Corporation and its internal controls to determine the causes of this problem. Further, I asked the GAO's Comptroller General to review the Corporation's underlying statute to determine whether the Corporation's practices complied with this law and other fiscal laws such as the Antideficiency Act.

Both the GAO and the IG found that the Corporation did not comply with the law by incorrectly recording its funding obligations. In a statement for the record for the VA-HUD and Independent Agencies Appropriations Subcommittee hearing on April 10, 2003, GAO identified several factors that led to the Corporation's incorrect accounting practice. The factors included inappropriate obligation practices, little or no communication among key Corporation executives, too much flexibility given to grantees regarding enrollments, and unreliable data on the number of AmeriCorps participants.

The GAO also found that the Corporation was not following the law in recording its legal liabilities. The GAO's finding is described in the Comptroller General's two legal opinions that were issued on April 9, 2003—B–300480, and June 6, 2003—B–300480.2. The first opinion concluded that the Corporation incurs a legal liability for the award of educational benefits of AmeriCorps participants when it enters into a grant agreement. At the time it enters a grant agreement, the Corporation approves a specified number of new participants in the AmeriCorps program. By this action:

the Corporation incurs a legal duty that once fully matured, by action of the grantee and participants outside the Corporation's control, will require the Corporation to pay education benefits to qualified participants from the National Service Trust.

The Comptroller General opinion further states that as:

the Corporation incurs an obligation for education benefits, it must record the obligation against the budget authority available in the Trust.

In other words, to ensure compliance with the law, the Corporation must record and track its obligations based on the value of the educational award multiplied by all approved positions.

We understand that recording obligations based on the approved level of AmeriCorps members in the program does not reflect the true performance of the program. We know from historical data that not all AmeriCorps volunteers successfully complete service. We also know that not all AmeriCorps members who successfully complete service use their educational award benefit. Accordingly, this bill recognizes the realities of the AmeriCorps program and allows the Corporation to maximize the number of AmeriCorps that can participate in the program.

In short, the bill allows the Corporation to fund AmeriCorps grants based on estimates of the number of members who will likely complete and use their education award. Further, the bill requires an annual actuarial audit of the National Service Trust to ensure that the Federal Government is able to

meet its liabilities. The bill also requires the chief executive officer to certify that the Corporation has properly recorded and tracked its obligations.

To ensure that the AmeriCorps program is accountable to the taxpayer and its volunteers, it is our expectation that the Corporation will use conservative assumptions in developing its funding formula. This especially is important since the Corporation has repeatedly failed to meet funding obligations resulting in actions by the Congress to provide additional funding, including a deficiency appropriation. While the program has been in place for about 10 years, there is little data on the performance of the program. Until there is reliable data, I strongly believe that the Corporation should assume a 100 percent enrollment rate for every volunteer slot approved in the grant agreements. I also believe that the Corporation should assume at least an 80 percent earnings rate for the program and at least an 80 percent education award usage rate. Further, because of poor data, the bill requires a central reserve fund to give the Corporation an extra cushion in case the actual usage rate exceeds the assumptions used in the formula.

It is my hope that we can pass this legislation as quickly as possible. This legislation provides clarification for the Corporation in determining grant award allocations to its grantees and the states. Without this legislation, uncertainty and disagreement will delay and limit the enrollment of AmeriCorps volunteers. Considering the demand and the need for this program, we cannot afford to wait.

We designed this legislation with input from the administration. I think it is a reasonable and fair approach to address this issue. It mitigates harm to AmeriCorps programs in a manner that will ensure accountability and fiscal integrity in the programs. Keeping in mind the problems identified by the auditors, which led to the enrollment freeze last November, we designed this legislation to ensure that we do not repeat those past mistakes. The enrollment freeze was an unfortunate but avoidable mistake if the Corporation had properly managed and monitored its programs.

Finally, we need to put these enrollment issues behind us. This program has had a difficult and star-crossed history, and it is unfortunate that we are here in June revisiting the implementation of the program to ensure both accountability and credibility. We need to ensure that the State and local programs are meeting both program requirements and community needs.

Before closing, I want to raise a technical issue regarding the enrollment cap of 50,000 AmeriCorps members. The Corporation enrolls members based on full-time equivalent or FTE levels since some AmeriCorps members serve part-time and others serve full-time. The cap should be based on FTE levels so that it is consistent with normal AmeriCorps business practices.

I urge my colleagues to support this legislation and pass it as quickly as possible. Senator MIKULSKI and I have tried to construct this bill in a thoughtful and fair manner to address the concerns about the program. This bill ensures that volunteers across this Nation and the taxpayers will have confidence in the AmeriCorps program.

Mr. KENNEDY. Madam President, it is a privilege to join my colleagues Senator MIKULSKI and Senator BOND on this legislation to head off the cuts in AmeriCorps announced this week that will be so devastating to so many Americorps programs in so many States.

Our bill directs the Corporation for National Service to calculate membership by a reasonable formula, and ensure that every person who commits to a year of service to their community in AmeriCorps will receive the education award.

The fiscal mismanagement at the Corporation is a serious continuing problem, but State and local programs should not have to pay for those mistakes by slashing their programs. Today, we take the first step in preserving service opportunities for this year and the future. We will continue to do all we can to increase the funds available, so that programs do not suffer because the Corporation over-enrolled 20,000 members last year. That over-enrollment is a clear signal that Americorps is reviving the spirit of volunteerism in our country and we should make these opportunities available for people of all ages to serve their communities. In this struggling economy, too many after-school and summer school programs are being cut back, and health clinics and food kitchens are serving more people than ever. AmeriCorps helps these programs help others.

I commend Senator MIKULSKI and Senator BOND for their impressive bipartisan leadership on this issue, and I urge the Senate to join us in maintaining these successful programs.

Mr. GRASSLEY. I ask unanimous consent that the bill be read the third time and passed, the motion to reconsider be laid upon the table, and that any statements relating to the bill be printed in the RECORD.

The PRESIDING OFFICER. Without objection, it is so ordered.

The bill (S. 1276) was read the third time and passed, as follows:

S. 1276

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

SECTION 1. SHORT TITLE.

This Act may be cited as the ''Strengthen AmeriCorps Program Act''.

SEC. 2. PROCESS OF APPROVAL OF NATIONAL SERVICE POSITIONS.

(a) DEFINITIONS.—In this Act, the terms ''approved national service position'' and ''Corporation'' have the meanings given the terms in section 101 of the National and Community Service Act of 1990 (42 U.S.C. 12511).

(b) TIMING AND RECORDING REQUIREMENTS.—

(1) IN GENERAL.—Notwithstanding subtitles C and D of title I of the National and Community Service Act of 1990 (42 U.S.C. 12571 et seq., 12601 et seq.), and any other provision of law, in approving a position as an approved national service position, the Corporation—

(A) shall approve the position at the time the Corporation—

(i) enters into an enforceable agreement with an individual participant to serve in a program carried out under subtitle E of title I of that Act (42 U.S.C. 12611 et seq.) or title I of the Domestic Volunteer Service Act of 1973 (42 U.S.C. 4951 et seq.); or

(ii) except as provided in clause (i), awards a grant to (or enters into a contract or cooperative agreement with) an entity to carry out a program for which such a position may be approved under section 123 of the National and Community Service Act of 1990 (42 U.S.C. 12573); and

(B) shall record as an obligation an estimate of the net present value of the national service educational award associated with the position, based on a formula that takes into consideration historical rates of enrollment in such a program, and of earning and using national service educational awards for such a program.

(2) FORMULA.—In determining the formula described in paragraph (1)(B), the Corporation shall consult with the Director of the Congressional Budget Office.

(3) CERTIFICATION REPORT.—The Chief Executive Officer of the Corporation shall annually prepare and submit to Congress a report that contains a certification that the Corporation is in compliance with the requirements of paragraph (1).

(4) APPROVAL.—The requirements of this subsection shall apply to each approved national service position that the Corporation approves—

(A) during fiscal year 2003 (before or after the date of enactment of this Act); and

(B) during any subsequent fiscal year.

(c) RESERVE ACCOUNT.—

(1) ESTABLISHMENT AND CONTENTS.—

(A) ESTABLISHMENT.—Notwithstanding subtitles C and D of title I of the National and Community Service Act of 1990 (42 U.S.C. 12571 et seq., 12601 et seq.), and any other provision of law, within the National Service Trust established under section 145 of the National and Community Service Act of 1990 (42 U.S.C. 12601), the Corporation shall establish a reserve account.

(B) CONTENTS.—To ensure the availability of adequate funds to support the awards of approved national service positions for each fiscal year, the Corporation shall place in the account—

(i) during fiscal year 2003, a portion of the funds that were appropriated for fiscal year 2003 or a previous fiscal year under section 501(a)(2) (42 U.S.C. 12681(a)(2)), were made available to carry out subtitle C or D of title I of that Act, and remain available; and

(ii) during fiscal year 2004 or a subsequent fiscal year, a portion of the funds that were appropriated for that fiscal year under section 501(a)(2) and were made available to carry out subtitle C or D of title I of that Act.

(2) OBLIGATION.—The Corporation shall not obligate the funds in the reserve account until the Corporation—

(A) determines that the funds will not be needed for the payment of national service educational awards associated with previously approved national service positions; or

(B) obligates the funds for the payment of such awards for such previously approved national service positions.

(d) AUDITS.—The accounts of the Corporation relating to the appropriated funds for approved national service positions, and the records demonstrating the manner in which the Corporation has recorded estimates described in subsection (b)(1)(B) as obligations, shall be audited annually by independent certified public accountants or independent licensed public accountants certified or licensed by a regulatory authority of a State or other political subdivision of the United States in accordance with generally accepted auditing standards. A report containing the results of each such independent audit shall be included in the annual report required by subsection (b)(3).

(e) AVAILABILITY OF AMOUNTS.—Except as provided in subsection (c), all amounts included in the National Service Trust under paragraphs (1), (2), and (3) of section 145(a) of the National and Community Service Act of 1990 (42 U.S.C. 12601(a)) shall be available for payments of national service educational awards under section 148 of that Act (42 U.S.C. 12604).

ORDERS FOR THURSDAY, JUNE 19, 2003

Mr. GRASSLEY. Madam President, I ask unanimous consent that when the Senate completes its business today, it stand in adjournment until 9:30 a.m., Thursday, June 19. I further ask unanimous consent that following the prayer and pledge, the morning hour be deemed expired, the Journal of proceedings be approved to date, the time of the two leaders be reserved for their use later in the day, and the Senate resume at that point consideration of S. 1, the prescription drug benefits bill.

The PRESIDING OFFICER. Without objection, it is so ordered.

PROGRAM

Mr. GRASSLEY. For the information of all Senators, then, the Senate will resume consideration of the bill now before the Senate, S. 1, the prescription drug benefits bill. There are two amendments currently pending to the bill. One is the Enzi amendment relating to disclosure and the other is Senator BINGAMAN's amendment regarding asset tests. These amendments are being reviewed and it is the leader's hope we will be able to set votes in relation to these amendments sometime tomorrow.

As mentioned earlier, we have now begun the amendment process and I hope we will continue to make progress on the bill each day until we are done with it, and the chairman and ranking member will be working together to try to get Senators in a queue to offer amendments.

Rollcall votes will occur throughout the day during Thursday's session of the Senate.

ADJOURNMENT UNTIL 9:30 A.M. TOMORROW

Mr. GRASSLEY. If there is no further business to come before the Senate, I ask unanimous consent that the Senate stand adjourned under the previous order.

There being no objection, the Senate, at 5:38 p.m., adjourned until Thursday, June 19, 2003, at 9:30 a.m.

NOMINATIONS

Executive nominations received by the Senate June 18, 2003:

THE JUDICIARY

ROGER W. TITUS, OF MARYLAND, TO BE UNITED STATES DISTRICT JUDGE FOR THE DISTRICT OF MARYLAND, VICE MARVIN J. GARBIS, RETIRED.

FEDERAL HOUSING FINANCE BOARD

ALICIA R. CASTANEDA, OF THE DISTRICT OF COLUMBIA, TO BE A DIRECTOR OF THE FEDERAL HOUSING FINANCE BOARD FOR A TERM EXPIRING FEBRUARY 27, 2004, VICE J. TIMOTHY O'NEILL, TERM EXPIRED.

ALICIA R. CASTANEDA, OF THE DISTRICT OF COLUMBIA, TO BE A DIRECTOR OF THE FEDERAL HOUSING FINANCE BOARD FOR A TERM EXPIRING FEBRUARY 27, 2011. (REAPPOINTMENT)

IN THE AIR FORCE

THE FOLLOWING NAMED UNITED STATES AIR FORCE OFFICER FOR REAPPOINTMENT AS THE CHAIRMAN OF THE JOINT CHIEFS OF STAFF AND APPOINTMENT TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10 U.S.C., SECTIONS 601 AND 152:

To be general

GEN. RICHARD B. MYERS, 0000

THE FOLLOWING AIR NATIONAL GUARD OF THE UNITED STATES OFFICER FOR APPOINTMENT IN THE RESERVE OF THE AIR FORCE TO THE GRADE INDICATED UNDER TITLE 10, U.S.C., SECTION 12203:

To be major general

BRIG. GEN. ROBERT P. MEYER JR., 0000

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be general

LT. GEN. JOHN P. ABIZAID, 0000

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be general

LT. GEN. BRYAN D. BROWN, 0000

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

LT. GEN. DAN K. MCNEILL, 0000

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. WILLIAM G. BOYKIN, 0000

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. CLAUDE V. CHRISTIANSON, 0000

IN THE MARINE CORPS

THE FOLLOWING NAMED MARINE CORPS OFFICER FOR REAPPOINTMENT AS THE VICE CHAIRMAN OF THE JOINT CHIEFS OF STAFF AND APPOINTMENT TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601 AND 154:

To be general

GEN. PETER PACE, 0000

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES MARINE CORPS TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

To be lieutenant general

MAJ. GEN. ROBERT R. BLACKMAN JR., 0000

IN THE NAVY

THE FOLLOWING NAMED OFFICERS FOR APPOINTMENT TO THE GRADE INDICATED IN THE UNITED STATES NAVY UNDER TITLE 10, U.S.C., SECTION 624:

To be commander

LINSLY G. M. BROWN, 0000
DAWN E. CUTLER, 0000
GREGORY P. GEISEN, 0000
RONALD L. HILL, 0000
JOSEPH S. NAVRATIL, 0000
DENISE M. SHOREY, 0000

CONFIRMATIONS

Executive Nomination Confirmed by the Senate June 18, 2003:

DEPARTMENT OF JUSTICE

RICHARD JAMES O'CONNELL, OF ARKANSAS, TO BE UNITED STATES MARSHAL FOR THE WESTERN DISTRICT OF ARKANSAS FOR THE TERM OF FOUR YEARS.

IN THE ARMY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES ARMY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

to be lieutenant general

LT. GEN. WILLIAM S. WALLACE

IN THE NAVY

THE FOLLOWING NAMED OFFICER FOR APPOINTMENT IN THE UNITED STATES NAVY TO THE GRADE INDICATED WHILE ASSIGNED TO A POSITION OF IMPORTANCE AND RESPONSIBILITY UNDER TITLE 10, U.S.C., SECTION 601:

to be admiral

ADM. EDMUND P. GIAMBASTIANI, JR.