STATEMENTS ON INTRODUCED BILLS AND JOINT RESOLUTIONS

By Mr. CLELAND (for himself and Mr. MILLER):

S. 1184. A bill to designate the facility of the United States Postal Service located at 2853 Candler Road in Decatur, Georgia, as the ''Earl T. Shinhoster Post Office''; to the Committee on Governmental Affairs.

Mr. CLELAND. Mr. President, I rise today to recognize Mr. Earl Shinhoster for his distinguished career of service to the public and the cause of civil and human rights. In tribute to Mr. Shinhoster I hereby introduce legislation to designate the facility of the United States Postal Service located at 2853 Candler Road in Decatur, Georgia, as the ''Earl T. Shinhoster Post Office.'' Before his tragic death on June 12, 2000, he had been an active member of the National Association for the Advancement of Colored People, NAACP, for more than 30 years as both a volunteer and staff member, most recently as Acting Executive Director and Chief Executive Officer of its National Board of Directors in 1996, and Southeast Regional Director from 1978–1994.

In May 1998, Mr. Shinhoster was Chairman of the Georgia Delegation to the National Summit on Africa and he was the Field Director for the National Democratic Institute in Accra, Ghana from 1996 to 1997 where he observed and monitored the 1996 Presidential and Parliamentary elections. He also monitored and observed the electoral process in South Africa and Nigeria. He was active on both the State and local level serving in the administration of Georgia Governor George Busbee from 1975 to 1978 as Director of the Governor's Office of Human Affairs. In 1998, Mr. Shinhoster served as Coordinator of Voter Education for the State's Election Division.

Earl Shinhoster earned his Bachelor of Arts degree in political science from Morehouse College in Atlanta, GA in 1972 before pursuing legal studies at Cleveland State University College of Law in Cleveland, OH. The particular Post Office to be named after him is the same Post Office in South DeKalb where he retrieved his mail and is located in the same community where his family and friends still reside today. I, along with Senator MILLER, urge my colleagues to support this legislation and recognize Mr. Shinhoster's long and distinguished career as a public servant promoting civil and human rights in Georgia, the United States, and around the world. 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. 1184

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. DESIGNATION OF EARL T. SHINHOSTER POST OFFICE.

(a) IN GENERAL.—The facility of the United States Postal Service located at 2853 Candler Road in Decatur, Georgia, shall be known and designated as the ''Earl T. Shinhoster Post Office''.

(b) REFERENCES.—Any reference in a law, map, regulation, document, paper, or other record of the United States to the facility referred to in subsection (a) shall be deemed to be a reference to the Earl T. Shinhoster Post Office.

By Mr. WYDEN (for himself and Ms. SNOWE):

S. 1185. A bill to amend title XVIII of the Social Security Act to assure access of Medicare beneficiaries to prescription drug coverage through the SPICE drug benefit program; to the Committee on Finance.

Mr. WYDEN. Mr. President, today Senator SNOWE and I are introducing our bipartisan legislation to provide a Medicare prescription drug benefit. Yesterday, I spoke about our proposal, The Senior Prescription Insurance Coverage Equity Act of 2001. 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. 1185

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 Prescription Insurance Coverage Equity (SPICE) Act of 2001''.

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

SEC. 2. SPICE DRUG BENEFIT PROGRAM.

(a) IN GENERAL.—Title XVIII of the Social Security Act (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—SPICE DRUG BENEFIT PROGRAM

''ESTABLISHMENT OF SPICE DRUG BENEFIT PROGRAM

''SEC. 1860A. (a) ACCESS TO SPICE PRESCRIPTION DRUG COVERAGE.—

''(1) IN GENERAL.—Beginning in 2003, the SPICE Board (established under section 1860M) shall provide for a SPICE drug benefit program under which all eligible medicare beneficiaries who voluntarily enroll under this part shall be entitled to obtain SPICE prescription drug coverage (meeting the terms and conditions under this part) as follows:

''(A) MEDICARE+CHOICE PLAN.—If the eligible medicare beneficiary is eligible to enroll in a Medicare+Choice plan, the beneficiary may enroll in the plan and obtain SPICE prescription drug coverage (as defined in section 1860B(a)) through such plan.

''(B) MEDICARE SUPPLEMENTAL POLICY.—If the eligible medicare beneficiary is not enrolled in a Medicare+Choice plan but is enrolled in a medicare supplemental policy, the beneficiary may—

''(i) obtain SPICE prescription drug coverage through such policy; or

''(ii) waive basic coverage (as defined in section 1860B(b)) pursuant to section 1860C(a)(3) and obtain financial assistance pursuant to section 1860K(c) for stop-loss coverage (as defined in section 1860B(c)) provided under such policy.

''(C) MEDICARE DRUG PLAN FOR NONCOMPETITIVE AREAS.—If the eligible medicare beneficiary is not enrolled in a Medicare+Choice plan, a medicare supplemental policy, or a basic coverage plan under section 1860F, and there is a Medicare Drug Plan for Noncompetitive Areas available in the area in which the beneficiary resides, the beneficiary may obtain SPICE prescription drug coverage under this part through enrollment in such plan.

''(D) BASIC COVERAGE ONLY THROUGH A PRIVATE ENTITY.—If the eligible medicare beneficiary is not enrolled in a Medicare+Choice plan, a medicare supplemental policy, or a Medicare Drug Plan for Noncompetitive Areas, the beneficiary may obtain basic coverage (including financial assistance for such coverage under section 1860K(b) and access to negotiated prices under section 1860B(d)) through enrollment in a plan offered by a private entity with a contract to offer such plan under section 1860F.

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

''(3) ADMINISTRATION OF BENEFITS.—In providing SPICE prescription drug coverage to an eligible medicare beneficiary under this part, an entity offering a medicare supplemental policy, a Medicare+Choice plan, a Medicare Drug Plan for Noncompetitive Areas, or a basic coverage plan under section 1860F may—

''(A) directly administer the benefits under such coverage; or

''(B) contract with an entity that meets the applicable requirements under this part to administer such benefits.

''(b) ACCESS TO ALTERNATIVE PRESCRIPTION DRUG COVERAGE.—In the case of an eligible medicare beneficiary who has creditable prescription drug coverage (as defined in section 1860C(b)(4)) under a policy or plan, such beneficiary—

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

''(2) pursuant to section 1860C(b)(3), is permitted to subsequently enroll under this

part and obtain SPICE prescription drug coverage without any penalty if such policy or plan terminated, ceased to provide, or substantially reduced the value of the prescription drug coverage under such plan or policy.

''(c) FINANCIAL ASSISTANCE.—

''(1) UNDER SPICE DRUG BENEFIT PROGRAM.—Under the SPICE drug benefit program, the SPICE Board shall provide financial assistance, with such assistance varying depending upon the income of such beneficiary, for any eligible medicare beneficiary enrolled under this part who voluntarily obtains—

''(A) basic coverage (pursuant to subsection (b) of section 1860K); or

''(B) stop-loss coverage (pursuant to subsection (c) of such section).

''(2) ASSISTANCE TO GROUP HEALTH PLANS THAT PROVIDE PRESCRIPTION DRUG COVERAGE TO ELIGIBLE MEDICARE BENEFICIARIES.—Pursuant to the Employer Incentive Program established under section 1860L, the SPICE Board shall make payments to employers and other sponsors of employment-based health care coverage to encourage such employers and sponsors to provide adequate prescription drug coverage to retired individuals.

''(d) ELIGIBLE MEDICARE BENEFICIARY DEFINED.—For purposes of this part, the term 'eligible medicare beneficiary' means an individual who is entitled to benefits under part A and enrolled under part B.

''(e) FINANCING.—The costs of providing benefits under this part shall be payable from the SPICE Prescription Drug Account (as established under section 1860N) within the Federal Supplementary Medical Insurance Trust Fund under section 1841.

''SPICE PRESCRIPTION DRUG COVERAGE

''SEC. 1860B. (a) IN GENERAL.—For purposes of this part, the term 'SPICE prescription drug coverage' means coverage consisting of the following:

''(1) BASIC COVERAGE.—Basic coverage (as defined in subsection (b)) and access to negotiated prices under subsection (d), except as waived pursuant to section 1860C(a)(3).

''(2) STOP-LOSS COVERAGE.—Stop-loss coverage (as defined in subsection (c)).

''(b) BASIC COVERAGE.—For purposes of this part, the term 'basic coverage' means coverage of covered outpatient drugs (as defined in subsection (e)) that meets the following requirements:

''(1) DEDUCTIBLE.—The coverage has an annual deductible—

''(A) for 2003, that is equal to $350; or

''(B) for a subsequent year, that is equal to the amount specified under this paragraph for the previous year increased by the percentage specified in paragraph (4) for the year involved.

Any amount determined under subparagraph (B) that is not a multiple of $5 shall be rounded to the nearest multiple of $5.

''(2) COINSURANCE.—The coverage has coinsurance (for the cost of a covered outpatient drug above the annual deductible specified in paragraph (1) for the year and up to the initial coverage limit specified in paragraph (3) for the year) that does not exceed 25 percent of the cost of such drug.

''(3) INITIAL COVERAGE LIMIT.—

''(A) IN GENERAL.—The coverage has an initial coverage limit for covered outpatient drugs in a year that is reached when the eligible medicare beneficiary has incurred the applicable amount of out-of-pocket expenses in the year.

''(B) APPLICABLE AMOUNT DEFINED.—For purposes of subparagraph (A), the term 'applicable amount' means—

''(i) for 2003, $3,000; or

''(ii) for a subsequent year, the amount specified in this subparagraph for the previous year, increased by the annual percentage increase described in paragraph (4) for the year involved.

Any amount determined under clause (ii) that is not a multiple of $25 shall be rounded to the nearest multiple of $25.

''(C) APPLICATION.—In applying paragraph (1)—

''(i) incurred out-of-pocket expenses shall only include expenses incurred for the annual deductible (described in paragraph (1)) and coinsurance (described in paragraph (2)); and

''(ii) such expenses shall be treated as incurred without regard to whether the individual or another person, including a State program or other third-party coverage, has paid for such expenses.

''(4) 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 benefits under this title, as determined by the Secretary for the 12-month period ending in July of the previous year.

''(c) STOP-LOSS COVERAGE.—For purposes of this part, the term 'stop-loss coverage' means coverage of covered outpatient drugs in a year without any coinsurance after the eligible medicare beneficiary has reached the initial coverage limit specified in subsection (b)(3) for the year.

''(d) ACCESS TO NEGOTIATED PRICES.—Under SPICE prescription drug coverage offered under a policy or plan, the entity offering the policy or plan (or the administering entity pursuant to subsection (a)(3)(B)) shall provide beneficiaries with access to negotiated prices (including applicable discounts) used for payment for covered outpatient drugs, regardless of the fact that no benefits may be payable under the coverage with respect to such drugs because of the application of the annual deductible.

''(e) COVERED OUTPATIENT DRUGS DEFINED.—

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

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

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

and such term includes any use of a covered outpatient drug for a medically accepted indication (as defined in section 1927(k)(6)).

''(2) EXCLUSIONS.—

''(A) IN GENERAL.—Such term does not include drugs or classes of drugs, or their medical uses, which may be excluded from coverage or otherwise restricted under section 1927(d)(2), other than subparagraph (E) thereof (relating to smoking cessation agents) and except to the extent otherwise specifically provided by the SPICE Board with respect to a drug in any of such classes.

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

''(3) APPLICATION OF FORMULARY RESTRICTIONS.—A drug prescribed for an individual that would otherwise be a covered outpatient drug under this part shall not be so considered under a policy or plan if the policy or plan excludes the drug under a formulary that meets the requirements of section 1860I(c)(3) (including providing an appeal process).

''(4) APPLICATION OF GENERAL EXCLUSION PROVISIONS.—An entity may exclude from SPICE prescription drug coverage any covered outpatient drug—

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

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

Such exclusions are determinations subject to reconsideration and appeal pursuant to section 1860I(c)(6).

''ENROLLMENT UNDER SPICE DRUG BENEFIT PROGRAM

''SEC. 1860C. (a) ESTABLISHMENT OF PROCESS.—

''(1) ESTABLISHMENT.—

''(A)IN GENERAL.—The SPICE Board, in consultation with the Secretary, the National Association of Insurance Commissioners, issuers of medicare supplemental policies, and Medicare+Choice organizations, shall establish a process through which an eligible medicare beneficiary (including an eligible medicare beneficiary enrolled in a Medicare+Choice plan) may enroll under this part.

''(B) SIMILAR TO PART B.—

''(i) IN GENERAL.—Except as provided in clause (ii), the process established under subparagraph (A) shall be similar to the process for enrollment in part B under section 1837.

''(ii) BENEFICIARY MUST AFFIRMATIVELY ENROLL.—Notwithstanding section 1837(f), such process shall require that an eligible medicare beneficiary affirmatively enroll under this part rather than deeming the beneficiary to be so enrolled if certain requirements are met.

''(2) REQUIREMENT OF ENROLLMENT.—An eligible medicare beneficiary must enroll under this part in order to be eligible to receive SPICE prescription drug coverage, including financial assistance for basic and stop-loss coverage under section 1860K.

''(3) WAIVER OF BASIC COVERAGE FOR MEDIGAP ENROLLEES.—

''(A) IN GENERAL.—The process established under paragraph (1) shall permit a beneficiary enrolled under this part and enrolled under a medicare supplemental policy to—

''(i) waive the basic coverage available under this part; and

''(ii) rescind such waiver in order to obtain such coverage.

''(B) RULES.—If a beneficiary waives basic coverage pursuant to subparagraph (A)(i), the following rules shall apply:

''(i) Such waiver shall not effect the stop-loss coverage that the beneficiary receives under the medicare supplemental policy, including the entitlement to financial assistance under section 1860K(c) for such coverage.

''(ii) The beneficiary shall not be liable for the basic monthly premium under section 1860H(a).

''(iii) The beneficiary shall not receive basic coverage but shall be entitled to negotiated prices for covered outpatient drugs as if the beneficiary had not waived such coverage.

''(iv) If the beneficiary subsequently rescinds such waiver pursuant to subparagraph (A)(ii), the beneficiary shall be subject to the late enrollment penalty under subsection (b).

''(b) LATE ENROLLMENT PENALTY.—

''(1) IN GENERAL.—Subject to the succeeding provisions of this subsection, in the case of an eligible medicare 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 subsection (c), the SPICE

Board shall establish procedures for increasing the amount of the basic monthly premium under section 1860H(a) applicable to such beneficiary—

''(A) by an amount that is equal to 25 percent of such premium for each full 12-month period (in the same continuous period of eligibility) in which the eligible medicare beneficiary could have been enrolled under this part but was not so enrolled; or

''(B) if determined appropriate by the SPICE Board, by an amount that the SPICE Board determines is actuarily sound for each such period.

''(2) PERIODS TAKEN INTO ACCOUNT.—For purposes of calculating any 12-month period under paragraph (1), there shall be taken into account—

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

''(B) in the case of an eligible medicare 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; and

''(C) in the case of an eligible medicare beneficiary who is enrolled under this part but has waived basic coverage pursuant to subsection (a)(3), the months which elapsed between the effective date of such waiver and the effective date of the rescission of such waiver.

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

''(A) IN GENERAL.—For purposes of calculating any 12-month period under paragraph (1), subject to subparagraph (B), there shall not be taken into account months for which the eligible medicare beneficiary can demonstrate that the beneficiary—

''(i) met such exceptional conditions (including conditions recognized under section 1851(e)(4)(D)) as the SPICE Board may provide; or

''(ii) had creditable prescription drug coverage (as defined in paragraph (4)).

''(B) APPLICATION.—The exception described in subparagraph (A)(ii) shall only apply with respect to a coverage period the enrollment for which occurs before the end of the 63-day period that begins on the first day of the month which includes the date on which the policy or plan involved terminates, ceases to provide, or substantially reduces the value of the prescription drug coverage under such policy or plan.

''(4) PRESCRIPTION DRUG COVERAGE.—For purposes of this part, the term 'creditable prescription drug coverage' means any of the following:

''(A) MEDICAID PRESCRIPTION DRUG COVERAGE.—Prescription drug coverage under a medicaid plan under title XIX, including through the Program of All-inclusive Care for the Elderly (PACE) under section 1934, through a social health maintenance organization (referred to in section 4104(c) of the Balanced Budget Act of 1997), or through a Medicare+Choice project that demonstrates the application of capitation payment rates for frail elderly medicare beneficiaries through the use of a interdisciplinary team and through the provision of primary care services to such beneficiaries by means of such a team at the nursing facility involved.

''(B) PRESCRIPTION DRUG COVERAGE UNDER GROUP HEALTH PLAN.—Any outpatient prescription drug coverage under a group health plan, including a health benefits plan under the Federal Employees Health Benefit Plan under chapter 89 of title 5, United States Code, and a qualified retiree prescription drug plan as defined in section 1860L(e)(3).

''(C) PRESCRIPTION DRUG COVERAGE UNDER CERTAIN MEDIGAP POLICIES.—Coverage under a medicare supplemental policy under section 1882 that provides benefits for prescription drugs but only if the policy was in effect on December 31, 2002, and only until the date such coverage is terminated.

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

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

''(5) PERIODS TREATED SEPARATELY.—Any increase in an eligible medicare beneficiary's basic monthly premium under paragraph (1) 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.

''(6) CONTINUOUS PERIOD OF ELIGIBILITY.—

''(A) IN GENERAL.—Subject to subparagraph (B), for purposes of this subsection, an eligible medicare 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 this part and ends with the beneficiary's death.

''(B) SEPARATE PERIOD.—Any period during all of which an eligible medicare beneficiary satisfied paragraph (1) of section 1836 and which terminated during 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 subparagraph).

''(c) OPEN ENROLLMENT PERIOD FOR CURRENT BENEFICIARIES IN WHICH LATE ENROLLMENT PROCEDURES DO NOT APPLY.—The SPICE Board shall establish an applicable period, which shall begin on the date on which the SPICE Board first begins to accept enrollments under this part, during which any eligible medicare beneficiary may enroll under this part without the application of the late enrollment procedures established under subsection (b)(1).

''(d) PERIOD OF COVERAGE.—

''(1) IN GENERAL.—Except as provided in paragraph (2), an eligible medicare 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 ENROLLMENT.—An eligible medicare beneficiary who enrolls under the program under this part pursuant to subsection (c) 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) RESCISSION OF WAIVER.—The SPICE Board shall establish procedures regarding coverage periods for an eligible medicare beneficiary enrolled under this part who previously waived basic coverage under subsection (a)(3) and now wishes to rescind such waiver.

''(4) LIMITATION.—Coverage under this part shall not begin prior to January 1, 2003.

''(e) TERMINATION.—

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

''(2) COVERAGE TERMINATED BY TERMINATION OF COVERAGE UNDER PARTS A AND B.—

''(A) IN GENERAL.—In addition to the causes of termination described in paragraph (1), the SPICE Board shall terminate an individual's coverage under this part if the individual is no longer enrolled in either part A or 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 OR POLICY.—The SPICE Board shall establish procedures for determining the status of an eligible medicare beneficiary's enrollment under this part if the beneficiary's enrollment in a medicare supplemental policy, a Medicare+Choice plan, a Medicare Drug Plan for Noncompetitive Areas, or a basic coverage plan under section 1860F is terminated by the entity offering such policy or plan for cause (under the applicable requirements established under this title).

''ENROLLMENT IN A POLICY OR PLAN

''SEC. 1860D. (a) ENROLLMENT IN MEDICARE DRUG PLAN FOR NONCOMPETITIVE AREAS.—The SPICE Board shall establish a process through which an eligible medicare beneficiary who is enrolled under this part (but not enrolled in a medicare supplemental policy, a Medicare+Choice plan, or a basic coverage plan under section 1860F) and resides in an area in which a Medicare Drug Plan for Noncompetitive Areas is available may enroll in such plan. Such process shall include rules for enrollment, disenrollment, and termination of enrollment in such plan.

''(b) ENROLLMENT IN A MEDICARE SUPPLEMENTAL POLICY OR A MEDICARE+CHOICE PLAN.—Enrollment in a medicare supplemental policy or a Medicare+Choice plan is subject to the rules for enrollment in such policy or plan under sections 1882 and 1851, respectively.

''(c) ENROLLMENT IN A BASIC COVERAGE PLAN OFFERED BY A PRIVATE ENTITY WITH A CONTRACT UNDER THIS PART.—The SPICE Board shall establish a process through which an eligible medicare beneficiary who is enrolled under this part (but not enrolled in a medicare supplemental policy, a Medicare+Choice plan, or a Medicare Drug Plan for Noncompetitive Areas) may enroll in a basic coverage plan offered by a private entity with a contract under section 1860F to offer such plan. Such process shall include rules for enrollment, disenrollment, and termination of enrollment in such plan.

''(d) COORDINATION OF ENROLLMENTS, DISENROLLMENTS, AND TERMINATIONS OF ENROLLMENTS.—The SPICE Board shall establish procedures for coordinating enrollments, disenrollments and terminations of enrollments under plans described in subsections (a) and (c) with enrollments, disenrollments and terminations of enrollments under part C.

''MEDICARE DRUG PLAN FOR NONCOMPETITIVE AREAS

''SEC. 1860E. (a) IN GENERAL.—The SPICE Board shall provide for a Medicare Drug Plan for Noncompetitive Areas that—

''(1) provides enrollees with SPICE prescription drug coverage; and

''(2) is available to eligible medicare beneficiaries residing in an area that has been designated by the SPICE Board as a noncompetition area.

''(b) DESIGNATION OF NONCOMPETITION AREA.—

''(1) IN GENERAL.—The SPICE Board shall establish procedures for designating areas as noncompetition areas.

''(2) NONCOMPETITION AREA DEFINED.—

''(A) IN GENERAL.—For purposes of this section, the term 'noncompetition area' means an area in which only 1 or no medicare supplemental policy is available to eligible medicare beneficiaries residing in the area.

''(B) CONSTRUCTION REGARDING MULTIPLE POLICIES OFFERED BY SINGLE ISSUER.—If there is an entity that offers more that 1 type of

medicare supplemental policy in an area, then that area is not a noncompetition area for purposes of this section.

''(c) CONTRACTS.—In order to provide the Medicare Drug Plan for Noncompetitive Areas under this section, the SPICE Board shall do 1 of the following:

''(1) SINGLE CONTRACT THAT COVERS ALL NONCOMPETITION AREAS.—Enter into a contract with 1 entity to administer and deliver the benefits under the plan in every designated noncompetition area.

''(2) MULTIPLE CONTRACTS.—Enter into a contract with 1 entity to administer and deliver the benefits under the plan in 1 or more (but less than all) of the designated noncompetition areas.

''(d) BIDDING PROCESS.—

''(1) IN GENERAL.—The SPICE Board shall establish procedures under which the SPICE Board accepts bids submitted by entities and awards a contract (or contracts pursuant to subsection (c)(2)) to an entity in order to administer and deliver the benefits under the Medicare Drug Plan for Noncompetitive Areas to eligible medicare beneficiaries.

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

''(e) REQUIREMENTS FOR ENTITIES.—

''(1) IN GENERAL.—The SPICE Board may not award a contract to an entity under this section unless the entity meets such terms and conditions as the SPICE Board shall specify, including the following:

''(A) The terms and conditions described in section 1860I(c).

''(B) The entity meets the quality and financial standards specified by the SPICE Board.

''(C) The entity meets applicable State licensure requirements.

''(2) PREMIUMS.—The terms and conditions specified under paragraph (1) shall—

''(A) permit an entity with a contract under this section to require that beneficiaries enrolled in the plan covered by the contract pay a premium for benefits provided under the contract; and

''(B) except as provided in section 1860H(b)(3) (relating to an increased premium for delayed enrollment under this part), require that the amount of any such premium is the same for all beneficiaries enrolled in the plan.

''SELECTION OF PRIVATE ENTITIES TO PROVIDE BASIC COVERAGE PLANS

''SEC. 1860F. (a) SELECTION OF ENTITIES.—

''(1) IN GENERAL.—The SPICE Board shall establish procedures under which the SPICE Board—

''(A) accepts bids submitted by private entities for the basic coverage plans which such entities intend to offer in an area established under subsection (b); and

''(B) awards contracts to such entities to provide such plans to eligible medicare beneficiaries in the area.

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

''(b) AREAS FOR CONTRACTS.—

''(1) IN GENERAL.—The SPICE Board shall determine the areas to award contracts under this section.

''(2) NO ADMINISTRATIVE OR JUDICIAL REVIEW.—The determination of contract areas under paragraph (1) shall not be subject to administrative or judicial review.

''(3) MULTIPLE CONTRACTS.—If determined appropriate, the SPICE Board may award more than 1 contract in a contract area.

''(c) REQUIREMENTS FOR ENTITIES.—

''(1) IN GENERAL.—The SPICE Board may not award a contract to a private entity under this section unless the entity meets such terms and conditions as the SPICE Board shall specify, including the following:

''(A) The terms and conditions described in section 1860I(c).

''(B) The entity meets the quality and financial standards specified by the SPICE Board.

''(C) The entity meets applicable State licensure requirements.

''(D) Under the plan, the entity will provide basic coverage with access to negotiated prices.

''(d) PRIVATE ENTITY DEFINED.—For purposes of this part, the term 'private entity' means any private entity that the SPICE Board determines to be appropriate to provide basic coverage plans to eligible medicare beneficiaries under this part, including—

''(1) a pharmacy benefit management company;

''(2) a retail pharmacy delivery system;

''(3) a health plan or insurer;

''(4) any other private entity approved by the SPICE Board; or

''(5) any combination of the entities described in paragraphs (1) through (4) approved by the SPICE Board.

''PROVIDING INFORMATION TO BENEFICIARIES

''SEC. 1860G. (a) ACTIVITIES.—

''(1) IN GENERAL.—The SPICE Board shall provide for activities that are designed to broadly disseminate information to eligible medicare beneficiaries (and prospective eligible medicare beneficiaries) on the SPICE drug benefit program under this part.

''(2) LATE ENROLLMENT PENALTIES TO BE WELL PUBLICIZED.—The SPICE Board shall ensure that information on the sanctions for delayed enrollment under section 1860C(b) and on the possibility of increased premiums for stop-loss coverage under section 1860H(b)(3) are well publicized.

''(3) SPECIAL RULE FOR INITIAL ENROLLMENT UNDER THE PROGRAM.—

''(A) CONSULTATION.—The SPICE Board shall consult with the Secretary, issuers of medicare supplemental policies, State insurance commissioners, Medicare+Choice organizations, and interested consumer organizations in developing the activities described in paragraph (1) that will be used to provide information regarding the initial enrollment under this part during the period described in section 1860C(c).

''(B) TIMEFRAME.—The activities described in paragraph (1) shall ensure that eligible medicare beneficiaries (and prospective eligible medicare beneficiaries) are provided with such information not later that December 1, 2002, in order to ensure that coverage under this part may be effective as of January 1, 2003.

''(4) COORDINATION WITH ACTIVITIES PERFORMED BY THE SECRETARY.—The SPICE Board shall work with the Secretary to ensure that the activities provided under this subsection are coordinated with the activities performed by the Secretary that provide information with respect to benefits under this title to eligible medicare beneficiaries and prospective eligible medicare beneficiaries.

''(b) REQUIREMENTS.—

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

''(A) be similar to the activities performed under section 1851 (including the approval of policy marketing materials and maintaining a toll-free number and an Internet site); and

''(B) include provisions to ensure that consumer counselors are available to provide face-to-face counseling to eligible medicare beneficiaries (and prospective eligible medicare beneficiaries) on the SPICE drug benefit program under this part.

''(2) CONTRACTS TO PROVIDE CONSUMER COUNSELING.—The SPICE Board may contract with private entities to provide the consumer counseling described in paragraph (1)(B).

''(c) COORDINATION WITH OTHER INFORMATION.—The SPICE Board shall, in cooperation with the Secretary, enter into such arrangements as may be appropriate to disseminate the information referred to in subsection (a) in coordination with materials distributed by the Secretary to medicare beneficiaries, including the medicare handbook under section 1804 and materials distributed under section 1851(d).

''PREMIUMS

''SEC. 1860H. (a) PREMIUM FOR BASIC COVERAGE FOR ALL BENEFICIARIES.—

''(1) ANNUAL ESTABLISHMENT OF BASIC MONTHLY PREMIUM RATES.—The SPICE Board shall, during September of each year (beginning in 2002), determine and promulgate a basic monthly premium rate for the succeeding year in accordance with the provisions of this subsection.

''(2) ACTUARIAL DETERMINATIONS.—

''(A) DETERMINATION OF ANNUAL BENEFIT AND ADMINISTRATIVE COSTS FOR BASIC COVERAGE.—The SPICE Board shall estimate annually for the succeeding year the amount equal to the total of the benefits (including financial assistance provided under subsections (b) and (c) of section 1860K and payments made to sponsors under section 1860L) and administrative costs that will be payable from the SPICE Prescription Drug Account within the Federal Supplementary Medical Insurance Trust Fund for providing benefits under this part in such calendar year.

''(B) DETERMINATION OF BASIC MONTHLY PREMIUM RATES.—

''(i) IN GENERAL.—The SPICE Board shall determine the basic monthly premium rate for such succeeding year, which shall be 1/12 of the amount determined under subparagraph (A), divided by the average total number of enrollees under this part who have not waived basic coverage under section 1860C(a)(3) (as estimated for the year), and rounded (if such rate is not a multiple of 10 cents) to the nearest multiple of 10 cents.

''(ii) PREMIUM REDUCED BY AMOUNT OF FINANCIAL ASSISTANCE.—The amount that shall be charged a beneficiary for basic coverage under this part is the basic monthly premium determined under clause (i), reduced by the amount of the financial assistance for basic coverage determined for the beneficiary under section 1860K(b).

''(3) PUBLICATION OF ASSUMPTIONS.—The SPICE Board shall publish, together with the promulgation of the basic monthly premium rates for the succeeding year, a statement setting forth the actuarial assumptions and bases employed in arriving at the amounts and rates determined under paragraphs (1) and (2).

''(4) COLLECTION OF PREMIUMS.—Any basic monthly premium applicable to an eligible medicare beneficiary pursuant to this subsection, after application of the reduction described in paragraph (2)(B)(ii) and any increase for late enrollment under section 1860C(b), shall be collected and credited to the SPICE 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.

''(b) PREMIUMS FOR STOP-LOSS COVERAGE.—

''(1) BENEFICIARY RESPONSIBLE FOR MAKING PAYMENT DIRECTLY TO ENTITY.—Subject to paragraph (2), any eligible medicare beneficiary who is receiving stop-loss coverage, either through enrollment in a medicare supplemental policy, a Medicare+Choice plan, or

a Medicare Drug Plan for Noncompetitive Areas, shall be responsible for making payments for any premiums required under the policy or plan for such coverage directly to the entity offering such policy or plan.

''(2) PREMIUM REDUCED BY AMOUNT OF FINANCIAL ASSISTANCE.—The entity offering such policy or plan shall reduce the premium described in paragraph (1) by the amount of the financial assistance for stop-loss coverage determined for the beneficiary under section 1860K(c).

''(3) INCREASE IN PREMIUM FOR LATE ENROLLMENT OR FOR LACK OF CONTINUOUS STOP-LOSS COVERAGE.—In the case of an eligible medicare beneficiary who is subject to a late enrollment penalty under section 1860C or who has not had continuous stop-loss coverage under this part because the beneficiary was enrolled in a basic coverage plan under section 1860F, the entity offering the medicare supplemental policy, the Medicare+Choice plan, or the Medicare Drug Plan for Noncompetitive Areas in which the beneficiary is enrolled may, notwithstanding any provision in this title, increase the portion of the premium attributable to stop-loss coverage that is otherwise applicable to such beneficiary for such enrollment in a manner that reflects the additional actuarial risk involved. Such a risk shall be established through an appropriate actuarial opinion of the type described in subparagraphs (A) through (C) of section 2103(c)(4).

''APPROVAL FOR ENTITIES OFFERING SPICE PRESCRIPTION DRUG COVERAGE

''SEC. 1860I. (a) APPROVAL.—No payments may be made to an entity offering a policy or plan that provides SPICE prescription drug coverage under section 1860J unless the entity has been approved by the SPICE Board.

''(b) PROCEDURES.—

''(1) IN GENERAL.—The SPICE Board shall establish procedures for approving entities that offer policies and plans that provide SPICE prescription drug coverage under this part, including an entity with a contract under section 1860F.

''(2) COORDINATION.—The procedures established under subparagraph (A) shall be coordinated with—

''(A) in the case of the approval of medicare supplemental policies, the procedures for approval of such policies under State law; and

''(B) in the case of the approval of Medicare+Choice plans, the procedures established by the Secretary for approval of such plans under part C.

''(c) TERMS AND CONDITIONS.—The SPICE Board may not approve an entity under subsection (b) unless the entity, with respect to such policy or plan, meets such terms and conditions as the SPICE Board shall specify, including the following:

''(1) DISSEMINATION OF INFORMATION.—

''(A) GENERAL INFORMATION.—The entity shall disclose, in a clear, accurate, and standardized form to each enrollee under the policy or plan at the time of enrollment and at least annually thereafter, the information described in section 1852(c)(1) relating to such policy or plan. Such information shall include the following:

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

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

''(iii) Coinsurance and deductible requirements.

''(iv) Grievance and appeals procedures.

''(B) DISCLOSURE UPON REQUEST OF GENERAL COVERAGE, UTILIZATION, AND GRIEVANCE INFORMATION.—Upon request of an individual eligible to enroll under the policy or plan, the entity shall provide the information described in section 1852(c)(2) (other than subparagraph (D)) to such individual.

''(C) RESPONSE TO BENEFICIARY QUESTIONS.—The entity shall have a mechanism for providing specific information regarding the policy or plan to enrollees upon request and shall make available, through the Internet website described in paragraph (7) and in writing upon request, information on specific changes in its formulary.

''(D) CLAIMS INFORMATION.—The entity shall furnish to each enrollee under the plan or policy in a form easily understandable to such enrollees an explanation of benefits (in accordance with section 1806(a) or in a comparable manner) and a notice regarding how close the enrollee is to getting stop-loss coverage for the year, whenever prescription drug benefits are provided under this part (except that such notice need not be provided more often than monthly).

''(2) ACCESS TO COVERED BENEFITS.—

''(A) ASSURING PHARMACY ACCESS.—The entity shall secure the participation of sufficient numbers of pharmacies to ensure convenient access (including adequate emergency access) for enrollees under the policy or plan. Nothing in the preceding sentence shall be construed as requiring the participation of all pharmacies in any area under a policy or plan.

''(B) ACCESS TO NEGOTIATED PRICES FOR PRESCRIPTION DRUGS.—The entity shall issue a card that may be used by an enrollee under the policy or plan to assure access to negotiated prices pursuant to section 1860B(d).

''(3) FORMULARIES.—If an eligible entity uses a formulary under the policy or plan, such entity shall—

''(A) establish the formulary based on the medical needs of eligible medicare beneficiaries;

''(B) ensure that the formulary includes drugs within all therapeutic categories and classes of covered outpatient drugs (although not necessarily for all drugs within such categories and classes);

''(C) have in place an appeals process—

''(i) under which any eligible medicare beneficiary could receive any medically necessary covered outpatient drug that is not on the formulary;

''(ii) that does not impose a significant financial burden on an eligible medicare beneficiary or delay the provision of medically necessary covered outpatient drugs to such a beneficiary; and

''(iii) that provides for at least a level of protection that is similar to or better than the level of protection provided with respect to benefits under Medicare+Choice plans under part C; and

''(D) provide notification to enrollees of any change in the formulary at least 60 days prior to such change.

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

''(A) IN GENERAL.—The entity shall have in place—

''(i) an effective cost and drug utilization management program, including appropriate incentives to use generic drugs when appropriate;

''(ii) quality assurance measures and systems to reduce medical errors and adverse drug interactions, including a medication therapy management program described in subparagraph (B); and

''(iii) a program to control fraud, abuse, and waste.

''(B) MEDICATION THERAPY MANAGEMENT PROGRAM.—

''(i) IN GENERAL.—A medication therapy management program described in this subparagraph is a program of drug therapy management and medication administration that is designed to assure that covered outpatient drugs under the policy or plan are appropriately used to achieve therapeutic goals and reduce the risk of adverse events, including adverse drug interactions.

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

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

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

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

''(iv) CONSIDERATIONS IN PHARMACY FEES.—The entity 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.

''(C) TREATMENT OF ACCREDITATION.—Section 1852(e)(4) (relating to treatment of accreditation) shall apply to policies and plans under this part with respect to the following requirements, in the same manner as they apply to Medicare+Choice plans under part C with respect to the requirements described in a clause of section 1852(e)(4)(B):

''(i) Subparagraph (A) (including quality assurance), including medication therapy management program under subparagraph (B).

''(ii) Paragraph (2)(A) (relating to access to covered benefits).

''(iii) Paragraph (8) (relating to confidentiality and accuracy of enrollee records).

''(5) GRIEVANCE MECHANISM.—The entity shall provide meaningful procedures for hearing and resolving grievances between the entity (including any entity or individual through which the entity provides covered benefits) and enrollees of the policy or plan under this part in accordance with section 1852(f).

''(6) COVERAGE DETERMINATIONS, RECONSIDERATIONS, AND APPEALS.—The entity shall meet the requirements of section 1852(g) with respect to covered benefits under the policy or plan it offers under this part 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.

''(7) PROVIDE INFORMATION ON THE INTERNET.—The entity shall maintain a web site on the Internet that provides eligible medicare beneficiaries with information regarding any policy or plan offered by the entity that provides SPICE prescription drug coverage.

''(8) CONFIDENTIALITY AND ACCURACY OF ENROLLEE RECORDS.—The entity shall meet the requirements of section 1852(h) with respect to enrollees under this part in the same manner as such requirements apply to a Medicare+Choice organization with respect to enrollees under part C.

''(d) SPICE BOARD MODELS FOR FORMULARIES.—

''(1) MODEL.—The SPICE Board may issue models for formularies for use in providing covered outpatient drugs under this part. Such models, and any revised models (pursuant to paragraph (3)) shall meet the requirements of subparagraphs (A) and (B) of subsection (c)(3).

''(2) EFFECT OF COMPLIANCE WITH A MODEL.—If the SPICE Board determines that a formulary used by an entity offering a policy or plan that provides SPICE prescription drug coverage is in compliance with a model formulary issued under paragraph (1), or the revised model (as the case may be), then the

entity shall be deemed to meet the requirements of subparagraphs (A) and (B) of subsection (c)(3).

''(3) REVISIONS OF MODELS.—

''(A) IN GENERAL.—The SPICE Board may periodically (but not more frequently than annually) revise any model established under this subsection.

''(B) PERIOD TO COMPLY WITH REVISION.—If the SPICE Board revises a model formulary pursuant to subparagraph (A), the SPICE Board shall provide for an appropriate period of time for entities who were in compliance with such model before such revision to comply with the revised model.

''(e) RULE OF CONSTRUCTION REGARDING COST-EFFECTIVE PROVISION OF BENEFITS.—Nothing in this part shall be construed as preventing an entity that provides SPICE prescription drug coverage under a policy or plan from employing mechanisms to provide such coverage economically, including the use of—

''(1) formularies (pursuant to subsection (c)(3));

''(2) alternative methods of distribution;

''(3) generic drug substitution;

''(4) pharmacy networks; and

''(4) mail order pharmacies.

''PAYMENTS TO ENTITIES

''SEC. 1860J. (a) PAYMENTS FOR ADMINISTERING BASIC COVERAGE.—

''(1) IN GENERAL.—The SPICE Board shall establish procedures for making payments to an entity offering a medicare supplemental policy, a Medicare+Choice plan, a Medicare Drug Plan for Noncompetitive Areas, or a basic coverage plan under section 1860F for—

''(A) in accordance with the provisions of this part, the costs of covered outpatient drugs provided under basic coverage to eligible medicare beneficiaries—

''(i) enrolled under such policy or plan and under this part; and

''(ii) entitled to such coverage; and

''(B) pursuant to paragraph (2), administering the basic coverage on behalf of beneficiaries described in subparagraph (A).

''(2) ADMINISTRATIVE FEE.—

''(A) PROCEDURES.—The procedures established pursuant to paragraph (1) shall provide for payment to the entity of an administrative fee for each prescription filled by the entity for an eligible medicare beneficiary enrolled in the policy or plan offered by such entity. Subject to paragraph (3), the entity shall not be at risk for providing basic coverage for a beneficiary.

''(B) AMOUNT.—The fee described in paragraph (1) shall be—

''(i) negotiated by the SPICE Board; and

''(ii) consistent with such fees paid under private sector pharmaceutical benefit contracts.

''(C) REDUCTION OF ADMINISTRATIVE COSTS.—The SPICE Board shall work with entities receiving payments under this section on ways to control the administrative costs associated with providing basic coverage under this part.

''(3) RISK CORRIDORS TIED TO PERFORMANCE MEASURES AND OTHER INCENTIVES FOR ENTITY PROVIDING MEDICARE DRUG PLAN FOR NONCOMPETITIVE AREAS.—In the case of payments to an entity with a contract to provide a Medicare Drug Plan for Noncompetitive Areas, the procedures established under paragraph (1) may include the use of—

''(A) risk corridors tied to performance measures that have been agreed to between the entity and the SPICE Board under the contract; and

''(B) any other incentives that the SPICE Board determines appropriate.

''(4) SECONDARY PAYER PROVISIONS.—The provisions of section 1862(b) shall apply to basic coverage provided under this part.

''(b) PAYMENT OF FINANCIAL ASSISTANCE TO ENTITIES FOR PROVISION OF STOP-LOSS COVERAGE.—

''(1) IN GENERAL.—The SPICE Board shall establish procedures for making financial assistance payments for stop-loss coverage to an entity offering a medicare supplemental policy, a Medicare+Choice plan, or a Medicare Drug Plan for Noncompetitive Areas on behalf of an eligible medicare beneficiary enrolled in such policy or plan and under this part.

''(2) AMOUNT OF FINANCIAL ASSISTANCE PAYMENT.—The amount of the financial assistance payments on behalf of an eligible medicare beneficiary for stop-loss coverage is equal to the amount determined for the beneficiary under section 1860K(c).

''(3) ENTITY PROVIDING STOP-LOSS COVERAGE AT RISK.—The entity providing stop-loss coverage, and not the SPICE Board, shall be at risk for the provision of such coverage.

''FINANCIAL ASSISTANCE TO OBTAIN SPICE PRESCRIPTION DRUG COVERAGE

''SEC. 1860K. (a) IN GENERAL.—The SPICE Board shall provide financial assistance, in accordance with this section, with respect to eligible medicare beneficiaries who have SPICE prescription drug coverage through enrollment in a medicare supplemental policy, a Medicare+Choice plan, a Medicare Drug Plan for Noncompetitive Areas, or a basic coverage plan under section 1860F.

''(b) ASSISTANCE FOR BASIC COVERAGE.—

''(1) IN GENERAL.—The amount of financial assistance with respect to an eligible medicare beneficiary for basic coverage is equal to the following percentage of the basic monthly premium determined under subsection (a) of section 1860H (without regard to any increase for late enrollment under subsection (b) of such section):

''(A) 100 PERCENT IF INCOME BELOW 150 PERCENT OF POVERTY.—In the case of an eligible medicare beneficiary who applies for enhanced financial assistance under subsection (d) and whose income (as determined under such subsection) does not exceed 150 percent of the poverty line, the percentage is 100 percent.

''(B) OTHER PERCENT IF INCOME BETWEEN 150 AND 175 PERCENT OF POVERTY.—In the case of an eligible medicare beneficiary who applies for enhanced financial assistance under subsection (d) and whose income (as determined under such subsection) is greater than 150 percent, but does not exceed 175 percent, of the poverty line, the SPICE Board shall specify the percentage consistent with the following rules:

''(i) RANGE.—The percentage may not exceed 100 percent nor be less than 25 percent.

''(ii) SLIDING SCALE.—The percentage may not be higher for eligible medicare beneficiaries whose income is higher.

''(C) 25 PERCENT FOR OTHER BENEFICIARIES.—In the case of any other eligible medicare beneficiary, the percentage is 25 percent.

''(2) FORM OF ASSISTANCE.—Financial assistance under this subsection shall be provided in the form of a reduction of the basic monthly premium pursuant to section 1860H(a)(2)(B)(ii).

''(c) ASSISTANCE FOR STOP-LOSS COVERAGE.—

''(1) AMOUNT.—

''(A) IN GENERAL.—The amount of financial assistance for stop-loss coverage with respect to an eligible medicare beneficiary enrolled under this part and in a medicare supplemental policy, a Medicare+Choice plan, or a Medicare Drug Plan for Noncompetitive Areas for stop-loss coverage is equal to the following percentage of the national average medigap stop-loss monthly premium for the region in which the beneficiary resides (as determined under paragraph (2)):

''(i) 100 PERCENT IF INCOME BELOW 150 PERCENT OF POVERTY.—In the case of an eligible medicare beneficiary described in subsection (b)(1)(A), the percentage is 100 percent.

''(ii) OTHER PERCENT IF INCOME BETWEEN 150 AND 175 PERCENT OF POVERTY.—In the case of an eligible medicare beneficiary described in subsection (b)(1)(B), the SPICE Board shall specify the percentage consistent with the rules described in clauses (i) and (ii) of such subsection.

''(iii) 25 PERCENT FOR OTHER BENEFICIARIES.—In the case of any other eligible medicare beneficiary, the percentage is 25 percent.

''(B) FORM OF ASSISTANCE.—Financial assistance under this subsection for beneficiaries shall be provided in the form of a payment to the entity offering the policy or plan in which the beneficiary is receiving stop-loss coverage pursuant to section 1860J(b).

''(2) ESTABLISHMENT OF NATIONAL AVERAGE MEDIGAP STOP-LOSS MONTHLY PREMIUM.—

''(A) IN GENERAL.—The SPICE Board shall, during September of each year (beginning in 2002), estimate a national average medigap stop-loss monthly premium for each region (as determined by the Board) of the total geographic area served by the programs under this part that will be applicable for the succeeding year.

''(B) DEFINITION OF NATIONAL AVERAGE MEDIGAP STOP-LOSS MONTHLY PREMIUM.—For purposes of subparagraph (A), the term 'national average medigap stop-loss monthly premium' means, with respect to a region, the average of the portion of the monthly premiums charged by medicare supplemental policies in that region for providing stop-loss coverage to beneficiaries enrolled under this part.

''(3) LIMITATIONS.—

''(A) FINANCIAL ASSISTANCE MAY NOT EXCEED PREMIUM.—In the case of financial assistance provided under this subsection with respect to stop-loss coverage provided under a policy or plan, the amount of the financial assistance may not exceed the amount of the portion of the premium charged for enrollment in the policy or plan that is related to the provision of stop-loss coverage.

''(B) ENTITY MUST REDUCE PREMIUM.—No financial assistance shall be made available with respect to stop-loss coverage provided by an entity to an eligible medicare beneficiary unless the entity provides assurances satisfactory to the SPICE Board that the entity shall reduce the amount otherwise charged the beneficiary for such coverage by an amount equal to the amount of such assistance.

''(d) APPLICATION FOR ENHANCED FINANCIAL ASSISTANCE.—

''(1) IN GENERAL.—The SPICE Board shall establish procedures under which a beneficiary who desires enhanced financial assistance under this section may voluntarily apply for an income determination.

''(2) REQUIREMENTS REGARDING INFORMATION.—

''(A) INFORMATION FROM BENEFICIARY.—The procedures established under paragraph (1) shall require the beneficiary to submit with the application for enhanced financial assistance such information that the SPICE Board determines necessary to make the income determination with respect to such beneficiary.

''(B) INFORMATION FROM OTHER GOVERNMENT AGENCIES.—Under the procedures established under paragraph (1), if an individual voluntarily applies for enhanced financial assistance under this section, the individual is deemed to have consented to the SPICE Board seeking and using income-related information from other Government agencies

in order to make the income determination with respect to such beneficiary.

''(C) RESTRICTION ON USE OF INFORMATION.—Information obtained under subparagraph (A) or (B) may be used by officers and employees of the SPICE Board only for the purposes of, and to the extent necessary in, carrying out their responsibilities under this part.

''(3) PERIODIC REDETERMINATIONS.—Such income determinations shall be valid for a period (of not less than 1 year) specified by the SPICE Board.

''(e) INCOME DETERMINATIONS.—The SPICE Board shall establish procedures for making income determinations under this section.

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

''EMPLOYER INCENTIVE PROGRAM FOR EMPLOYMENT-BASED RETIREE DRUG COVERAGE

''SEC. 1860L. (a) PROGRAM AUTHORITY.—The SPICE Board shall develop and implement a program under this section to be known as the 'Employer Incentive Program' that encourages employers and other sponsors of employment-based health care coverage to provide adequate prescription drug benefits to retired individuals by subsidizing, in part, the sponsor's cost of providing coverage under qualifying plans.

''(b) SPONSOR REQUIREMENTS.—In order to be eligible to receive an incentive payment under this section with respect to coverage of an individual under a qualified retiree prescription drug plan (as defined in subsection (e)(3)), a sponsor shall meet the following requirements:

''(1) ASSURANCES.—The sponsor shall—

''(A) annually attest, and provide such assurances as the SPICE Board may require, that the coverage offered by the sponsor is a qualified retiree prescription drug plan, and will remain such a plan for the duration of the sponsor's participation in the program under this section; and

''(B) guarantee that it will give notice to the SPICE Board and covered retirees—

''(i) at least 120 days before terminating its plan; and

''(ii) immediately upon determining that the actuarial value of the prescription drug benefit under the plan falls below the actuarial value of the basic coverage under the SPICE prescription drug coverage under this part.

''(2) BENEFICIARY INFORMATION.—The sponsor shall report to the SPICE Board, for each calendar quarter for which it seeks an incentive payment under this section, the names and social security numbers of all retirees (and their spouses and dependents) covered under such plan during such quarter and the dates (if less than the full quarter) during which each such individual was covered.

''(3) AUDITS.—The sponsor and the employment-based retiree health coverage plan seeking incentive payments under this section shall agree to maintain, and to afford the SPICE Board access to, such records as the SPICE Board may require for purposes of audits and other oversight activities necessary to ensure the adequacy of prescription drug coverage, the accuracy of incentive payments made, and such other matters as may be appropriate.

''(4) OTHER REQUIREMENTS.—The sponsor shall provide such other information, and comply with such other requirements, as the SPICE Board may find necessary to administer the program under this section.

''(c) INCENTIVE PAYMENTS.—

''(1) IN GENERAL.—A sponsor that meets the requirements of subsection (b) with respect to a quarter in a calendar year shall be entitled to have payment made by the SPICE Board on a quarterly basis (to the sponsor or, at the sponsor's direction, to the appropriate employment-based health plan) of an incentive payment, in the amount determined in paragraph (2), for each retired individual (or spouse) who—

''(A) was covered under the sponsor's qualified retiree prescription drug plan during such quarter; and

''(B) was eligible for, but was not enrolled in, the SPICE drug benefit program under this part.

''(2) AMOUNT OF INCENTIVE.—The payment under this section with respect to each individual described in paragraph (1) for a month shall be equal to 25 percent of the basic monthly premium amount payable by an eligible medicare beneficiary enrolled under this part, as set for the calendar year pursuant to section 1860H(a) and without application of and financial assistance for such premium under section 1860K(b).

''(3) PAYMENT DATE.—The incentive under this section with respect to a calendar quarter shall be payable as of the end of the next succeeding calendar quarter.

''(d) CIVIL MONEY PENALTIES.—A sponsor, health plan, or other entity that the SPICE Board determines has, directly or through its agent, provided information in connection with a request for an incentive payment under this section that the entity knew or should have known to be false shall be subject to a civil monetary penalty in an amount up to 3 times the total incentive amounts under subsection (c) that were paid (or would have been payable) on the basis of such information.

''(e) DEFINITIONS.—In this section:

''(1) EMPLOYMENT-BASED RETIREE HEALTH COVERAGE.—The term 'employment-based retiree health coverage' means health insurance coverage or other coverage 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.

''(2) EMPLOYER.—The term 'employer' has the meaning given the term in section 3(5) of the Employee Retirement Income Security Act of 1974 (except that such term shall include only employers of 2 or more employees).

''(3) QUALIFIED RETIREE PRESCRIPTION DRUG PLAN.—The term 'qualified retiree prescription drug plan' means health insurance coverage or other coverage of health care costs included in employment-based retiree health coverage that—

''(A) provides coverage of the cost of prescription drugs whose actuarial value (as defined by the SPICE Board) to each retired beneficiary equals or exceeds the actuarial value of the basic coverage provided to an individual enrolled in the SPICE drug benefit program under this part; and

''(B) does not deny, limit, or condition the coverage or provision of prescription drug benefits for retired individuals based on age or any health status-related factor described in section 2702(a)(1) of the Public Health Service Act.

''(4) SPONSOR.—The term 'sponsor' has the meaning given the term 'plan sponsor' in section 3(16)(B) of the Employer Retirement Income Security Act of 1974.

''SPICE BOARD

''SEC. 1860M. (a) ESTABLISHMENT.—There is established within the Department of Health and Human Services, a Seniors Prescription Insurance Coverage Equity Office, which shall be—

''(1) outside of the Centers for Medicare & Medicaid Services; and

''(2) run by a board to be known as the SPICE Board.

''(b) DUTIES.—

''(1) ADMINISTRATION OF SPICE DRUG BENEFIT PROGRAM.—

''(A) IN GENERAL.—The SPICE Board shall administer the SPICE drug benefit program under this part.

''(B) NONINTERFERENCE.—In carrying out its duty under subparagraph (A), the SPICE Board may not—

''(i) require a particular formulary or institute a price structure for the reimbursement of covered outpatient drugs;

''(ii) interfere in any way with negotiations between entities providing SPICE prescription drug coverage under part D and drug manufacturers, wholesalers, or other suppliers of covered outpatient drugs; and

''(iii) otherwise interfere with the competitive nature of providing such coverage through such entities.

''(2) ONGOING STUDIES.—The SPICE Board shall conduct ongoing studies of the following issues:

''(A) The administration of this part.

''(B) The provision of information about the program under the health insurance information, counseling, and assistance grants under section 4360 of the Omnibus Budget Reconciliation Act of 1990.

''(C) Ways in which drug utilization can be used to provide better overall care for eligible medicare beneficiaries.

''(D) Savings and potential savings in Federal health care programs which may occur, or can be attributed to, eligible medicare beneficiary access to, and utilization of, covered outpatient drugs.

''(E) Trends in premium increases and factors that contribute to changes in premiums.

''(F) Integration of the SPICE drug benefit program into a reformed medicare program.

''(G) The ability of eligible medicare beneficiaries to afford SPICE prescription drug coverage.

''(H) The impact of the program on the prescription drug benefits offered under group health plans.

''(I) The appropriateness of the levels of financial assistance provided under this part.

''(3) ANNUAL REPORT.—

''(A) IN GENERAL.—Not later than June 1 of each year (beginning with 2004), the SPICE Board shall submit an annual report to Congress on the program under this part.

''(B) INFORMATION ON STUDIES.—Such report shall include a detailed statement on the issues studied under paragraph (2).

''(C) RECOMMENDATIONS.—Such report shall include such recommendations for legislation and administrative actions as the SPICE Board considers appropriate.

''(4) PROVISION OF RECOMMENDATIONS AND INFORMATION TO SECRETARY.—The SPICE Board shall provide recommendations and necessary information regarding the SPICE drug benefit program to the Secretary in order for the Secretary to—

''(A) integrate such information with information regarding the other programs under this title; and

''(B) provide health insurance information, counseling, and assistance grants under section 4360 of the Omnibus Budget Reconciliation Act of 1990.

''(c) DEMONSTRATION PROJECT AUTHORITY.—

''(1) IN GENERAL.—Subject to paragraph (2), the SPICE Board shall have the authority to conduct demonstration projects for the purpose of demonstrating ways to improve the quality of services provided under the SPICE drug benefit program, including ways to reduce medical errors.

''(2) CONSULTATION WITH SECRETARY.—The SPICE Board shall consult with the Secretary before conducting any demonstration project.

''(d) MEMBERSHIP OF SPICE BOARD.—

''(1) NUMBER AND APPOINTMENT.—

''(A) IN GENERAL.—The SPICE Board shall be composed of 7 members appointed by the President, by and with the advice and consent of the Senate.

''(B) SPECIFIC REPRESENTATIVES.—In making appointments under subparagraph (A), the President shall ensure that the following groups are represented on the SPICE Board:

''(i) Consumers.

''(ii) Private health plan insurers (including insurers that offer fee-for-service and managed care plans) with expertise in the quality, scope, and marketing of health care services.

''(iii) Certified geriatric pharmacists.

''(iv) The Centers for Medicare & Medicaid Services.

''(v) State insurance commissioners.

''(C) SECRETARY OF HHS.—In addition to the 7 members appointed under subparagraph (A), the Secretary shall be a nonvoting, ex officio member of the SPICE Board.

''(2) DEADLINE FOR INITIAL APPOINTMENT.—The initial members of the SPICE Board shall be appointed by not later than 6 months after the date of enactment of this section.

''(3) TERMS.—

''(A) IN GENERAL.—The terms of the members of the SPICE Board shall be for 6 years, except that of the members first appointed—

''(i) three shall be appointed for terms of 6 years;

''(ii) two shall be appointed for terms of 4 years; and

''(iii) two shall be appointed for terms of 2 years.

''(B) VACANCIES.—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.

''(4) CHAIRPERSON.—The President shall designate the chairperson of the SPICE Board, except that the representative from the Centers for Medicare & Medicaid Services may not be designated as chairperson.

''(e) OPERATION OF THE BOARD.—

''(1) MEETINGS.—The SPICE Board shall meet at the call of the chairperson or upon the written request of a majority of its members.

''(2) QUORUM.—A majority of the members of the SPICE Board shall constitute a quorum, but a lesser number of members may hold hearings.

''(f) POWERS OF THE SPICE BOARD.—

''(1) HEARINGS.—The SPICE Board may hold such hearings, sit and act at such times and places, take such testimony, and receive such evidence as the SPICE Board considers advisable to carry out the purposes of this part.

''(2) INFORMATION FROM FEDERAL AGENCIES.—Upon request of the chairperson of the SPICE Board, the head of any Federal department or agency shall furnish such information to the SPICE Board as is necessary to carry out the functions of the SPICE Board under this part.

''(3) POSTAL SERVICES.—The SPICE Board may use the United States mails in the same manner and under the same conditions as other departments and agencies of the Federal Government.

''(4) GIFTS.—The SPICE Board may accept, use, and dispose of gifts or donations of services or property.

''(g) BOARD PERSONNEL MATTERS.—

''(1) MEMBERS.—

''(A) COMPENSATION.—Each member of the SPICE Board who is not an officer or employee of the Federal Government shall be compensated at a rate equal to the daily equivalent of the annual rate of basic pay prescribed for level IV of the Executive Schedule under section 5315 of title 5, United States Code, for each day (including travel time) during which such member is engaged in the performance of the duties of the SPICE Board. All members of the SPICE Board who are officers or employees of the United States shall serve without compensation in addition to that received for their services as officers or employees of the United States.

''(B) TRAVEL EXPENSES.—The members of the SPICE Board 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 SPICE Board.

''(C) REMOVAL.—The President may remove a member of the SPICE Board only for neglect of duty or malfeasance in office.

''(2) STAFF.—

''(A) IN GENERAL.—The chairperson of the SPICE Board may, without regard to the civil service laws and regulations, appoint and terminate an executive director and such other additional personnel as may be necessary to enable the SPICE Board to perform its duties. The employment of an executive director shall be subject to confirmation by the SPICE Board.

''(B) COMPENSATION.—The chairperson of the SPICE Board may fix the compensation of the executive director and other personnel without regard to the provisions of chapter 51 and subchapter III of chapter 53 of title 5, United States Code, relating to classification of positions and General Schedule pay rates, except that the rate of pay for the executive director and other personnel may not exceed the rate payable for level V of the Executive Schedule under section 5316 of such title.

''(C) DETAIL OF GOVERNMENT EMPLOYEES.—Any Federal Government employee may be detailed to the SPICE Board without further reimbursement, and such detail shall be without interruption or loss of civil service status or privilege.

''(D) PROCUREMENT OF TEMPORARY AND INTERMITTENT SERVICES.—The chairperson of the SPICE Board may procure temporary and intermittent services under section 3109(b) of title 5, United States Code, at rates for individuals which do not exceed the daily equivalent of the annual rate of basic pay prescribed for level V of the Executive Schedule under section 5316 of such title.

''SPICE PRESCRIPTION DRUG ACCOUNT IN THE FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND

''SEC. 1860N. (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 'SPICE 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, such fund 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 SPICE Board certifies are necessary to make payments to operate the program under this part, including payments to entities under section 1860J, payments to sponsors under section 1860L, and 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 GOVERNMENT CONTRIBUTION.—There are authorized to be appropriated from time to time, out of any moneys in the Treasury not otherwise appropriated, to the Account an amount equal to the amount by which the benefits and administrative costs of providing the benefits under this part exceed the premiums collected under section 1860H(a)(4).''.

(b) CONFORMING AMENDMENTS TO FEDERAL SUPPLEMENTARY MEDICAL INSURANCE TRUST FUND.—Section 1841 of the Social Security Act (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 SPICE Prescription Drug Account established by section 1860N''; and

(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 SPICE Prescription Drug Account in the Trust Fund),''.

(c) ADDITIONAL CONFORMING CHANGES.—

(1) 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 E of such title (as in effect after such date).

(2) SECRETARIAL SUBMISSION OF LEGISLATIVE PROPOSAL.—Not later than 6 months after the date of enactment of this Act, the Secretary of Health and Human Services shall submit to the appropriate committees of Congress a legislative proposal providing for such technical and conforming amendments in the law as are required by the provisions of this Act.

SEC. 3. SPICE PRESCRIPTION DRUG COVERAGE UNDER MEDICARE+CHOICE PLANS.

(a) SPECIAL RULES.—Section 1851 of the Social Security Act (42 U.S.C. 1395w–21) is amended by adding at the end the following new subsection:

''(j) RULES FOR PROVISION OF SPICE PRESCRIPTION DRUG COVERAGE.—

''(1) PLAN REQUIRED TO PROVIDE COVERAGE IF BENEFICIARY ENROLLED IN PART D.—

''(A) IN GENERAL.—In the case of an individual that is enrolled in a Medicare+Choice plan and enrolled under part D, the basic benefits required to be provided under section 1852(a)(1)(A) shall include SPICE prescription drug coverage (as defined in section 1860B(a)) under the terms and conditions for such coverage established under part D, including the terms and conditions described in section 1860I(c).

''(B) VOLUNTARY ENROLLMENT IN PART D.—An individual enrolled in a Medicare+Choice plan shall not be required to enroll under part D.

''(2) LIMITATION ON ENROLLEE LIABILITY.—In the case of an individual described in paragraph (1)(A), with respect to SPICE prescription drug coverage, a Medicare+Choice organization may not require that such individual pay a deductible or a coinsurance percentage that exceeds the deductible or coinsurance percentage applicable for such coverage pursuant to part D.

''(3) PREMIUM FOR STOP-LOSS COVERAGE.—

''(A) IN GENERAL.—Subject to subparagraph (B), a Medicare+Choice organization offering

a Medicare+Choice plan on behalf of an individual described in paragraph (1)(A) may require the individual to pay a premium for stop-loss coverage (as defined in section 1860B(c). Any such premium shall be considered to be part of the Medicare+Choice monthly basic premium (as defined in section 1854(b)(2)(A)) that the individual is responsible for.

''(B) ORGANIZATION REQUIRED TO REDUCE PREMIUM BY AMOUNT OF FINANCIAL ASSISTANCE.—A Medicare+Choice organization receiving a payment for financial assistance for stop-loss coverage on behalf of an individual described in paragraph (1)(A) pursuant to subsection (b) of section 1860J shall reduce any premium described in subparagraph (A) by the amount of such financial assistance.

''(4) PAYMENTS TO ORGANIZATION FOR SPICE PRESCRIPTION DRUG COVERAGE PURSUANT TO PART D RULES.—The SPICE Board (established under section 1860M) shall make payments to a Medicare+Choice organization offering a Medicare+Choice plan on behalf of an individual described in paragraph (1)(A) pursuant to the payment mechanisms described in subsections (a) and (b) of section 1860J. Such payments shall be coordinated with payments made to such organization under section 1853.

''(5) COORDINATED ENROLLMENT.—The Secretary shall work with the SPICE Board to coordinate enrollment under this part with enrollment under part D.''.

(b) EFFECTIVE DATE.—The amendment made by this section shall apply to items and services provided under a Medicare+Choice plan on or after January 1, 2003.

SEC. 4. MEDIGAP REVISIONS AND TRANSITION PROVISIONS.

(a) ESTABLISHMENT OF SPICE MEDIGAP POLICIES.—Section 1882 of the Social Security Act (42 U.S.C. 1395ss) is amended by adding at the end the following new subsection:

''(v) SPICE MEDIGAP POLICIES.—

''(1) REVISION OF BENEFIT PACKAGES.—

''(A) IN GENERAL.—Notwithstanding subsection (p), the benefit packages established under such subsection shall be revised so that—

''(i) if the policyholder is enrolled under part D, basic coverage (as defined in section 1860B(b)) is available as part of each benefit package;

''(ii) each benefit package includes stop-loss coverage (as defined in section 1860B(c)) in the core group of basic benefits described in subsection (p)(2)(B);

''(iii) no benefit package (including each benefit package classified as 'H', 'I', or 'J' under the standards established by such subsection (p)(2), and the benefit package classified as 'J' with a high deductible feature described in subsection (p)(11)) includes prescription drug coverage other than the basic coverage required under clause (i) (if applicable), or the stop-loss coverage required under clause (ii); and

''(iv) except as revised under the preceding clauses or pursuant to subsection (p)(1)(E), the benefit packages are identical to the benefit packages that were available on the date of enactment of the Seniors Prescription Insurance Coverage Equity (SPICE) Act of 2001.

''(B) ADMINISTRATION OF BENEFITS.—Pursuant to section 1860A(a)(3), an issuer of a medicare supplemental policy revised under such subparagraph may directly administer the prescription drug benefits required under the policy or may contract with an entity that meets the applicable requirements under part D to administer such benefits.

''(C) MANNER OF REVISION.—The benefit packages revised under this section shall be revised in the manner described in subparagraph (E) of subsection (p)(1), except that for purposes of subparagraph (C) of such subsection, the standards established under this subsection shall take effect not later than January 1, 2003.

''(2) GUARANTEED ISSUANCE AND RENEWAL OF NEW POLICIES.—The provisions of subsections (q) and (s) shall apply to medicare supplemental policies revised under this subsection in the same manner as such provisions apply to medicare supplemental policies issued under the standards established under subsection (p).

''(3) OPPORTUNITY OF CURRENT POLICYHOLDERS TO PURCHASE REVISED POLICIES.—

''(A) IN GENERAL.—No medicare supplemental policy of an issuer with a benefit package that is revised under paragraph (1) shall be deemed to meet the standards in subsection (c) unless the issuer—

''(i) provides written notice during the 60-day period immediately preceding the period established under section 1860C(c), to each policyholder or certificate holder of a medicare supplemental policy issued by that issuer (at the most recent available address) of the offer described in clause (ii) and of the fact that, so long as they retain coverage under such policy, they are unable to obtain SPICE prescription drug coverage (as defined in section 1860B(a)) under part D; and

''(ii) offers the policyholder or certificate holder under the terms described in subparagraph (B), during at least the period established under subsection (c) of section 1860C, institution of coverage effective for the period described in subsection (d) of such section, a medicare supplemental policy with the benefit package that has been revised under paragraph (1) of this subsection that the Secretary determines is most comparable to the policy in which the individual is enrolled.

''(B) TERMS OF OFFER DESCRIBED.—The terms described under this subparagraph are terms which do not—

''(i) deny or condition the issuance or effectiveness of a medicare supplemental policy described in subparagraph (A)(ii) that is offered and is available for issuance to new enrollees by such issuer;

''(ii) discriminate in the pricing of such policy because of health status, claims experience, receipt of health care, or medical condition; or

''(iii) impose an exclusion of benefits based on a preexisting condition under such policy.

''(4) OPPORTUNITY OF OTHER ELIGIBLE INDIVIDUALS TO PURCHASE REVISED POLICIES.—No medicare supplemental policy of an issuer with a benefit package that is revised under paragraph (1) shall be deemed to meet the standards in subsection (c) unless, during at least the period established under section 1860C(c), the issuer permits each eligible medicare beneficiary (as defined in section 1860A(d), but who is not described in paragraph (3)) to purchase any medicare supplemental policy that has been revised under paragraph (1) with institution of coverage effective for the period described in section 1860C(d) under the terms of the offer described in paragraph (3)(B).

''(5) GRANDFATHERING OF CURRENT POLICYHOLDERS.—

''(A) IN GENERAL.—Except as provided in subparagraph (B), no person may sell, issue, or renew a medicare supplemental policy with a benefit package that has not been revised under this subsection on or after January 1, 2003.

''(B) GRANDFATHERING.—Each policyholder or certificate holder of a medicare supplemental policy as of December 31, 2002, may continue to receive benefits under such policy and may renew such policy as if this subsection had not been enacted, except that such beneficiary shall not be eligible to enroll for SPICE prescription drug coverage (as defined in section 1860B(a)) under part D during the period in which such policy is in effect.

''(6) PENALTIES.—Each penalty under this section shall apply with respect to policies revised under this subsection as if such policies were issued under the standards established under subsection (p), including the penalties under subsections (a), (d), (p)(8), (p)(9), (q)(5), (r)(6)(A), (s)(4), and (t)(2)(D).''.

(b) NAIC STUDY AND REPORT.—

(1) STUDY.—The Secretary of Health and Human Services (in this subsection referred to as the ''Secretary'') shall contract with the National Association of Insurance Commissioners (in this subsection referred to as the ''NAIC'') to conduct a study—

(A) to determine whether the portion of the benefit packages revised under section 1882(v) of the Social Security Act (as added by subsection (a)) relating to parts A and B of the medicare program should be revised as a result of the establishment of SPICE prescription drug coverage (as defined in section 1860B(a) of such Act, as added by section 2) and whether the total number of such benefit packages should be reduced;

(B) to identify methods to ensure that any financial assistance paid to issuers of medicare supplemental policies on behalf of enrollees for providing stop-loss coverage (as defined in section 1860B(c) of the Social Security Act, as added by section 2) made available under the benefit packages revised under section 1882(v) of such Act (as so added) is not used to subsidize any other benefits, including the benefits relating to parts A and B of the medicare program; and

(C) to assess the practicality and viability of establishing a medicare supplemental policy that only provides SPICE prescription drug coverage (as so defined).

(2) REPORT.—Not later than 6 months after the date of enactment of this Act, the NAIC shall submit to Congress and the Secretary a report on the study conducted under paragraph (1) together with such recommendations as the NAIC determines appropriate.

SEC. 5. PROVISION OF INFORMATION ON SPICE DRUG BENEFIT PROGRAM UNDER HEALTH INSURANCE INFORMATION, COUNSELING, AND ASSISTANCE GRANTS.

Section 4360(b)(2)(A)(ii) of the Omnibus Budget Reconciliation Act of 1990 (42 U.S.C. 1395b–4(b)(2)(A)(ii)) is amended by striking ''and information'' and inserting '', information regarding the SPICE drug benefit program under part D of title XVIII of the Social Security Act, and information''.

SEC. 6. PERSONAL DIGITAL ACCESS TECHNOLOGY DEMONSTRATION PROJECT.

(a) DEMONSTRATION PROJECT.—

(1) IN GENERAL.—The SPICE Board (established under section 1860M of the Social Security Act (as added by section 2)) shall conduct a demonstration project for the purpose of increasing the use of Personal Digital Access Technology in prescribing covered outpatient drugs (as defined in section 1860B(e) (as so added)) for eligible medicare beneficiaries receiving SPICE prescription drug coverage under part D of title XVIII of such Act (as so added).

(2) ASPECTS OF PROJECT.—The demonstration project shall address ways in which the use of Personal Digital Access Technology can be used to—

(A) avoid adverse drug reactions among such beneficiaries, including problems due to therapeutic duplication, drug-disease contraindications, drug-drug interactions (including serious interactions with nonprescription or over-the-counter drugs), incorrect drug dosage or duration of drug treatment, drug-allergy interactions, and clinical abuse and misuse;

(B) transmit information about the coverage of covered outpatient drugs under the policy or plan in which such a beneficiary is receiving SPICE prescription drug coverage to prescribing physicians;

(C) increase the use of generic drugs by such beneficiaries; and

(D) increase the compliance of entities offering policies or plans that provide SPICE prescription drug coverage with the requirements under part D of title XVIII of the Social Security Act (as added by section 2).

(3) INCLUSION OF PROVIDERS.—In conducting the demonstration project, the SPICE Board shall include—

(A) physicians;

(B) pharmacists;

(C) entities that offer policies or plans that provide SPICE prescription drug coverage; and

(D) any entity (including a pharmacy benefits management company) that contracts with an entity described in subparagraph (C) to provide benefits under such policies or plans.

(4) DURATION OF PROJECTS.—The demonstration project shall be conducted over a 3-year period.

(b) REPORTS TO CONGRESS.—

(1) IN GENERAL.—

(A) INITIAL REPORT.—Not later than 18 months after the SPICE Board implements the demonstration project, the SPICE Board shall submit to Congress an initial report on the demonstration project.

(B) FINAL REPORT.—Not later that 6 months after the conclusion of the project, the SPICE Board shall submit to Congress a final report on the demonstration project.

(2) CONTENTS OF REPORTS.—The reports described in paragraph (1) shall include the following:

(A) A detailed description of the demonstration project.

(B) An evaluation of the demonstration project.

(C) Recommendations for legislation that the SPICE Board determines to be appropriate as a result of the demonstration project.

(D) Any other information regarding the demonstration project that the SPICE Board determines to be appropriate.

(c) FUNDING.—Expenditures made for carrying out the demonstration project shall be made from funds otherwise appropriated to the Secretary of Health and Human Services.

Ms. SNOWE. Mr. President, I am pleased to join with my friend and colleague, Senator RON WYDEN, in the introduction of the Seniors Prescription Insurance Coverage Equity Act of 2001, or ''SPICE.'' I want to thank him for his enthusiasm about and his commitment to this joint venture.

It was just about two years ago now that Senator WYDEN and I introduced this bill for the first time. SPICE 2001 is the product of almost three years of work and development. Since 1999, when we first tackled this issue, there has been much discussion about how to design a prescription drug coverage plan that is both comprehensive and affordable, that provides choice but guarantees availability of basic coverage. And, perhaps most importantly, one that is workable for seniors, the Medicare program and one that private providers will offer. We believe we have struck this balance in SPICE 2001.

I believe that this bill is a benchmark for the Senate's consideration of a comprehensive out-patient prescription drug program under Medicare. I offer this bill today, with my friend Senator WYDEN because it is the product of a three year collaborative effort to provide our Nation's seniors with prescription drug coverage, and I offer it with the hopes that it will be considered as part of a broader reform when the Senate takes one up.

Americans age 65 and older are only 12 percent of the population but account for over 40 percent of all drug spending. Which isn't surprising considering that over the past five years, per capita drug spending for the Medicare population has approximately doubled, reaching an estimated $1,756 this year.

This comes at a time where fewer retirees have health coverage from their former employers than ever before. In 1998, an estimated 66 percent of large employers offered retiree health coverage, fewer than 40 percent did so in 2000. At a time when fewer and fewer of our seniors have retiree health care coverage from their former employers, and when the cost of prescription drugs are skyrocketing, no one can argue that it isn't essential we ensure that Medicare beneficiaries have comprehensive coverage for outpatient prescription drugs. And, this is a problem, I might add, which will only grow when the 77 million Baby Boomers begin to enter Medicare in 2011.

For the past several years, Senator WYDEN and I have been united in our belief that we owe it to our seniors to develop the best and most practical solution. SPICE 2001 represents a straightforward, comprehensive, and responsible approach that should appeal to anyone who believes that seniors need prescription drug coverage.

To accomplish these goals we have built upon the model of the first SPICE bill and added components that have continued to be part of the larger debate on this issue—that of public programs versus private competition. As a result, SPICE 2001 now creates a partnership between the Federal Government and private insurers to share the cost, and the risk, of offering outpatient prescription drug coverage for our senior population.

Specifically, SPICE 2001 creates a prescription drug coverage program for all Medicare beneficiaries enrolled in both Part A and Part B, and who choose to enroll. SPICE offers a premium subsidy of at least 25 percent to all enrollees. To provide extra assistance to those who need it most, there is a 100 percent premium subsidy for those whose income is at or under 150 percent of poverty, $12,885 for a single person and $17,415 for a couple. Those whose income is between 150 percent and 175 percent of poverty, $15,033 for an individual and $20,318 for a couple, will receive a subsidy based on a sliding scale down to 25 percent of the cost of the premium.

SPICE 2001 offers two choices in the coverage so they can pick a plan to best serve their needs. One option is basic coverage, with a $350 deductible and a 25 percent coinsurance requirement. This can be purchased with a Stop-loss plan of $3,000 or separately.

The second option is stop-loss coverage. While only 17 percent of beneficiaries have costs above $3,000, they account for almost 54 percent of all spending on prescription drugs. This coverage is provided completely through the private insurer. According to CBO's January 2001 baseline projections, 83 percent of those enrolled in Medicare fee for service plans pay less than $3,000 for their drugs. For these seniors, they might only want to purchase the basic coverage. Those who need more than just the basic coverage can buy them both. For those who can manage their spending and only want to protect themselves from catastrophic expenses, they can purchase stop-loss coverage.

And, importantly, all SPICE enrollees receive the benefit of the negotiated discount on the cost of their prescription drugs, starting with their first prescription.

Choice is one of the cornerstones of this program. Seniors will not only have the choice of their level of coverage but will be able to choose from a variety to have their care delivered. SPICE can be run through Medigap, Medicare+Choice plans, or private entities. In areas where there are no insurers, the SPICE Board will have the authority to negotiate with entities to bring them into the market.

One of the perennial arguments against government sponsored or assisted prescription drug coverage for our retirees has been that if we did it, employers wouldn't. We already know that fewer employers are offering retiree health benefits than just 12 years ago, this is a trend we hope to discourage. This is why the SPICE Board is authorized to provide the 25 percent premium subsidy as an incentive to employers who provide prescription drug coverage for their retirees. It is critical we encourage employers to continue to offer this type of coverage and we acknowledge that in this bill.

According to a 1998 Wall Street Journal poll, 80 percent of retirees use a prescription drug every day. The average Medicare beneficiary fills a prescription 18 times a year. It is long past time that we ensure that these prescriptions are covered.

SPICE 2001 offers something for everyone interested in providing our seniors with prescription drug coverage. It is a program that can be incorporated in existing health plans, will be run through a government Board whose sole purpose is ensuring that this program runs well, and will foster competition and allow for choice in both coverage and providers.

By Mr. DOMENICI (for himself, Mr. INOUYE, Mr. CAMPBELL, Mr. BINGAMAN, Mr. BAUCUS, Mr. CRAPO, Mr. ALLARD, Mr. JOHNSON, and Mr. KYL):

S. 1186. A bill to provide a budgetary mechanism to ensure that funds will be available to satisfy the Federal Government's responsibilities with respect to negotiated settlements of disputes related to Indian water rights claims and Indian land claims; to the Committee on the Budget and the Committee on Governmental Affairs, jointly, pursuant to the order of August 4, 1977, with instructions that if one Committee reports, the other Committee have thirty days to report or be discharged.

Mr. DOMENICI. Mr. President, both as chairman and now as the ranking member on the Budget Committee, I have been working over the last year with the Western Governors' Association, the Western Regional Council, the Native American Rights Fund, the Western States Water Council, as well as several Indian tribes to correct what I believe to be a flaw in the Budget Enforcement Act as it relates to the Federal funding of Indian land and water settlements.

I, along with a group of bipartisan Senators, including the chairman and ranking member of the Indian Affairs Committee are introducing today legislation that will help Congress fulfill its commitment to authorized Indian land and water settlements.

In FY 2002, the President's request for Indian land and water settlements funding was $61 million. This represents an increase from fiscal year 2001 of $23 million. The increase is due to the authorization of several large settlements in California, Colorado, Michigan, New Mexico, and Utah.

I am pleased to report that the full request was included in both the Senate and House passed budget resolutions. In turn, the request was fully appropriated in both the House and Senate versions of the fiscal year 2002 Interior appropriations bill. This is a tremendous first step in making sure the Congress fulfills its obligation regarding these settlements. But it is only the first step.

In the near future, there are, at least, three additional large settlements likely to come before Congress. The States involved in these settlements are Arizona, Idaho, and Montana. Under current budgetary treatment these settlements will be difficult to fund without taking critical resources from other Bureau of Indian Affairs programs.

Currently, once the settlements have been agreed to by the parties involved, the settlements come to Congress for authorization and appropriation. When all appropriations have been distributed the Indians give up any future claims to the land or the water.

Appropriations for these settlements are usually spread over 3–10 years depending on the size of the settlement. The payout in one year for an individual settlement does not usually exceed $30 million.

I feel, however, that the current budget mechanisms have unfairly treated the handling of Indian land and water settlements in relation to other federally funded Indian programs.

The problem with the current status is that, due to the statutory discretionary caps, the perception exists that there is not enough money in BIA's budget to spend on settlements without taking money from other programs in their budget, such as Indian school construction, education, community development.

The legislation I am introducing today, the Fiscal Integrity of Indian Settlements Protection Act of 2001, provides for a cap adjustment similar to the one that deals with U.N. arrearages. It would be for authorized Indian land and water settlements and would set a ceiling on what could be spent in one year. Under this proposal, the settlements would still have to be authorized and appropriated, but it would hold the BIA budget harmless for the cost of the settlements.

Let me be clear, if these claims are not settled, the US government still can be held liable in court. Claims that go through the court process are authoritatively paid out of the Claims and Judgement Fund. In most cases, negotiated settlements provide more water to the tribes and a less expensive bill to the Federal Government.

Frankly, this simple cap adjustment for authorized and appropriated monies for settlements provides a win-win situation for all parties involved.

We have made good progress toward funding our Indian responsibilities these past few years. This legislation is a very important step.

I, along with Senators INOUYE, CAMPBELL, ALLARD, BAUCUS, BINGAMAN, CRAPO, JOHNSON, and KYL, urge my colleagues to support this bill and future funding of Indian land and water settlements.

I ask unanimous consent that a letter from the Ad Hoc Group on Indian Water Rights be printed in the RECORD.

There being no objection, the letter was ordered to be printed in the RECORD, as follows:

AD HOC GROUP ON
INDIAN WATER RIGHTS,
June 27, 2001.

Members of the United States Senate,
Washington, DC.

DEAR SENATOR: We write to urge your support and co-sponsorship of proposed legislation to be introduced shortly entitled the ''Fiscal Integrity of Indian Settlements Protection Act of 2001''. A ''Dear Colleague'' letter by Senators Domenici, Bingaman, Crapo, Inouye, Kyl, and Campbell was sent to your office on May 23, 2001, describing the bill.

Across the country, numerous negotiations are on-going to settle complex Indian land and water claims. Funding for these settlements is one of the biggest hurdles to overcome. This legislation is important so that Indian land and water right settlements can be completed in a timely manner, consistent with the federal government's responsibility and liability associated with them, and without taking scarce resources from other critical programs within the Department of the Interior.

Three settlements were approved by the last Congress and others are expected to be submitted to this Congress. Under current budgetary policy, funding of land and water right settlements must be offset by a corresponding reduction in some other discretionary component of the Interior Department's budget. It is difficult for the Administration, the states and the tribes to negotiate settlements knowing that they may not be funded because funding can occur only at the expense of some other tribe or essential Interior Department program.

We believe that the funding of land and water right settlements is an important obligation of the United States government. The obligation is analogous to, and no less serious than, the obligation of the United States to pay judgments which are rendered against it. We urge that steps be taken to change current budgetary policy to ensure that any land or water settlement, once authorized by the Congress and approved by the President, will be funded. If such a change is not made, these claims will likely be relegated to litigation, an outcome that should not be acceptable to the Administration, the Congress, the tribes or the states.

The members of the Ad Hoc Group on Indian Water Rights have consistently supported the negotiated settlement of Indian land and water right disputes, and have been actively engaged in drawing more awareness to the important issues associated with settlement of land and water right claims. We believe that unless the current budgetary processes for land and water settlements are changed, funding will continue to be a barrier to finalizing these settlements.

Again, we urge you to cosponsor the ''Fiscal Integrity of Indian Settlements Protection Act of 2001'' and support its passage to ensure congressional funding for Native American land and water rights settlements once they have been formally executed by the parties and authorized by Congress.

Sincerely,

JANE DEE HULL,
Co-Lead Governor on Indian Water Right Settlements, Western Governors' Association.
JOHN KUTZHABER,
Co-Lead Governor on Indian Water Right Settlements, Western Governors' Association.
KIT KIMBALL,
Director, Western Regional Council.
JOHN ECHOHAWK,
Executive Director, Native American Rights Fund.
MICHAEL BROPHY,
Chairman, Western States Water Council.

By Mr. ROCKEFELLER (for himself and Mr. CLELAND):

S. 1188. A bill to amend title 38, United States Code, to enhance the authority of the Secretary of Veterans Affairs to recruit and retain qualified nurses for the Veterans Health Administration, and for other purposes, to the Committee on Veterans' Affairs.

Mr. ROCKEFELLER. Mr. President, I am proud to introduce today with Senators CLELAND and SPECTER the Department of Veterans Affairs Nurse Recruitment and Retention Enhancement Act of 2001.

On June 14, 2001, the Committee on Veterans' Affairs held a hearing to explore reasons for the imminent shortage of professional nurses in the United

States, and how this shortage will affect health care for veterans served by Department of Veterans Affairs' health care facilities.

Working conditions for nurses, never easy, have become even more challenging in recent years. Managed care principles lead hospitals to admit only the very sickest of patients with the most complex health care needs. As the pool of highly trained nurses shrinks, many health care providers rely heavily upon mandatory staff overtime to meet staffing needs. Several registered nurses, including Sandra McMeans from my state of West Virginia, testified before the committee that unpredictable and dangerously long working hours lead to nurses' fatigue and frustration, and patient care suffers.

The legislation we introduce today includes a requirement that VA produce a policy on staffing standards. Such a policy shall be developed in consultation with the VA Under Secretary for Health, the Director of VA's National Center for Patient Safety, and VA's Chief Nurse. While we leave it up to VA to develop the standards, the policy must consider the numbers and skill mix required of staff in specific medical settings, such as critical care and long-term care.

Because mandatory overtime was frequently cited at the committee's June hearing as being of serious concern, the legislation includes a requirement that the Secretary report to the Committee on Veterans' Affairs on the use of overtime by licensed nursing staff and nursing assistants in each facility. This is a critical first step to determining what can be done to reduce the amount of mandatory overtime. We will continue to monitor this issue with rigor and pledge to work to reduce the burdens borne by our nurses.

In terms of providing sufficient pay, our legislation mandates that VA provide Saturday premium pay to certain health professionals. These group of professionals include licensed practical nurses, LPN's, certified or registered respiratory therapists, licensed physical therapists, licensed vocational nurses, pharmacists, and occupational therapists. This group of workers are known as ''hybrids'' as they straddle two different personnel authorities, titles 38 and 5 of the United States Code. Hybrid status allows for the direct hiring and a more flexible compensation system.

This is an issue of equity, especially for LPN's who work alongside other nurses on Saturday. While registered nurses, RN's are mandated to receive Saturday premium pay, they may be working alongside an LPN who is not. Factoring in the looming nurse shortage, we should be doing all we can to improve VA's ability to recruit and retain these caregivers.

Currently, hospital directors have the discretion to provide Saturday premium pay. Of the 17,000 hybrid employees, 8,000 are not receiving the pay premium.

In my own State of West Virginia, many LPN's are not receiving Saturday premium pay. Deborah Dixon is an LPN at the VA Medical Center in Huntington, WV. She works nights 6 days in a row, has 2 days off, works nights 5 days, then has 1 day off, then works 4 nights and has 3 days off. As a result, she has off every third weekend. She says that ''LPN's deserve Saturday premium pay. It feels like discrimination. It makes me wonder why LPN's are not being respected.

I believe this change in law will make pay more consistent and fair for our health care workers.

Programs initiated within VA to improve conditions for nurses and patients have focused on issues other than staffing ratios, pay, and hours. A highly praised scholarship program that I spearheaded allows VA nurses to pursue degrees and training in return for their service, thus encouraging professional development and improving the quality of health care. Included within the legislation we introduced today are modifications to the existing scholarship and debt reduction programs. These changes are intended to improve the programs by providing additional flexibility to recipients.

In the Upper Midwest, the special skills of nurses and nurse practitioners are being recognized in clinics that provide supportive care close to the veterans who need it. The legislation before us seeks to encourage more nurse-managed clinics and also includes a requirement that VA evaluate these clinics.

There are various other provisions included in the bill. One provision requires that VA nurses enrolled in the Federal Employee Retirement System have the same ability to include unused sick leave as part of the retirement year calculation that VA nurses enrolled in the Civilian Retirement System have. The legislation also would amend the treatment of part-time service performed by certain title 38 employees prior to April 7, 1986, for purposes of retirement credit. Currently, part-time service performed by title 5 employees prior to April 7, 1986, is treated as full-time service; however, title 38 employees' part-time services prior to April 7, 1986, is counted as part-time service and therefore results in lower annuities for these employees. Retired nurses, such as Tonya Rich from Morgantown, WV, who has contacted me, stress the inequity of the situation. In order to rectify this, our legislation exempts registered nurses, physician assistants, and expanded-function dental auxiliaries from the requirement that part-time service performed prior to April 7, 1986, be prorated when calculating retirement annuities.

This bill is a good start, but clearly, we must remain vigilant. Although the nursing crisis has not yet reached its projected peak, the shortage is already endangering patient safety in the areas of critical and long-term care, where demands on nurses are greatest. We must encourage higher enrollment in nursing schools, improve the work environment, and offer nurses opportunities to develop as respected professionals, while taking steps to ensure safe staffing levels in the short-term.

We do not have the luxury of reflecting upon this problem at length; we must act now. Fortunately, we have as allies hardworking nurses who are dedicated to helping us find ways to improve working conditions and to recruit more young people to the field.

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. 1188

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 ''Department of Veterans Affairs Nurse Recruitment and Retention Enhancement Act of 2001''.

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

SEC. 2. REFERENCES TO TITLE 38, UNITED STATES CODE.

Except as otherwise expressly provided, whenever in this Act an amendment or repeal 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 a section or other provision of title 38, United States Code.

TITLE I—ENHANCEMENT OF RECRUITMENT AUTHORITIES

SEC. 101. ENHANCEMENT OF EMPLOYEE INCENTIVE SCHOLARSHIP PROGRAM.

(a) PERMANENT AUTHORITY.—(1) Section 7676 is repealed.

(2) The table of sections at the beginning of chapter 76 is amended by striking the item relating to section 7676.

(b) MINIMUM PERIOD OF DEPARTMENT EMPLOYMENT FOR ELIGIBILITY.—Section 7672(b) is amended by striking ''2 years'' and inserting ''one year''.

(c) SCHOLARSHIP AMOUNT.—Subsection (b) of section 7673 is amended—

(1) in paragraph (1), by striking ''for any one year'' and inserting ''for the equivalent of one year of full-time coursework''; and

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

''(2) in the case of a participant in the Program who is a part-time student, shall bear the same ratio to the amount that would be paid under paragraph (1) if the participant were a full-time student in the course of education or training being pursued by the participant as the coursework carried by the student bears to full-time coursework in that course of education or training.''.

(d) LIMITATION ON PAYMENT.—Subsection (c) of section 7673 is amended to read as follows:

''(c) LIMITATIONS ON PERIOD OF PAYMENT.—(1) The maximum number of school years for which a scholarship may be paid under subsection (a) to a participant in the Program shall be six school years.

''(2) A participant in the Program may not receive a scholarship under subsection (a) for more than the equivalent of three years of full-time coursework.''.

(e) FULL-TIME COURSEWORK.—Section 7673 is further amended by adding at the end the following new subsection:

''(e) FULL-TIME COURSEWORK.—For purposes of this section, full-time coursework shall consist of the following:

''(1) In the case of undergraduate coursework, 30 semester hours per undergraduate school year.

''(2) In the case of graduate coursework, 18 semester hours per graduate school year.''.

(f) ANNUAL ADJUSTMENT OF MAXIMUM SCHOLARSHIP AMOUNT.—Section 7631 is amended—

(1) in subsection (a)(1), by striking ''and the maximum Selected Reserve member stipend amount'' and inserting ''the maximum Selected Reserve member stipend amount, the maximum employee incentive scholarship amount,''; and

(2) in subsection (b)—

(A) by redesignating paragraph (4) as paragraph (6); and

(B) by inserting after paragraph (3) the following new paragraph (4):

''(4) The term 'maximum employee incentive scholarship amount' means the maximum amount of the scholarship payable to a participant in the Department of Veterans Affairs Employee Incentive Scholarship Program under subchapter VI of this chapter, as specified in section 7673(b)(1) of this title and as previously adjusted (if at all) in accordance with this section.''.

SEC. 102. ENHANCEMENT OF EDUCATION DEBT REDUCTION PROGRAM.

(a) PERMANENT AUTHORITY.—(1) Section 7684 is repealed.

(2) The table of sections at the beginning of chapter 76 is amended by striking the item relating to section 7684.

(b) ELIGIBLE INDIVIDUALS.—Subsection (a)(1) of section 7682 is amended—

(1) by striking ''under an appointment under section 7402(b) of this title in a position'' and inserting ''in a position (as determined by the Secretary) providing direct-patient care services or services incident to direct-patient care services''; and

(2) by striking ''(as determined by the Secretary)'' and inserting ''(as so determined)''.

(c) MAXIMUM DEBT REDUCTION AMOUNT.—Section 7683(d)(1) is amended—

(1) by striking ''for a year''; and

(2) by striking ''exceed—'' and all that follows through the end of the paragraph and inserting ''exceed $44,000 over a total of five years of participation in the Program, of which not more than $10,000 of such payments may be made in each of the fourth and fifth years of participation in the Program.''.

(d) ANNUAL ADJUSTMENT OF MAXIMUM DEBT REDUCTION PAYMENTS AMOUNT.—(1) Section 7631, as amended by section 101(f) of this Act, is further amended—

(A) in subsection (a)(1), by inserting before the period at the end of the first sentence the following: ''and the maximum education debt reduction payments amount''; and

(B) in subsection (b), by inserting after paragraph (4) the following new paragraph (5):

''(5) The term 'maximum education debt reduction payments amount' means the maximum amount of education debt reduction payments payable to a participant in the Department of Veterans Affairs Education Debt Reduction Program under subchapter VII of this chapter, as specified in section 7683(d)(1) of this title and as previously adjusted (if at all) in accordance with this section.''.

(2) Notwithstanding section 7631(a)(1) of title 38, United States Code, as amended by paragraph (1), the Secretary of Veterans Affairs shall not increase the maximum education debt reduction payments amount under that section in calendar year 2002.

(e) TEMPORARY EXPANSION OF INDIVIDUALS ELIGIBLE FOR PARTICIPATION IN PROGRAM.—(1) Notwithstanding section 7682(c) of title 38, United States Code, the Secretary of Veterans Affairs may treat a covered individual as being a recently appointed employee in the Veterans Health Administration under section 7682(a) of that title for purposes of eligibility in the Education Debt Reduction Program if the Secretary determines that the participation of the individual in the Program under this subsection would further the purposes of the Program.

(2) For purposes of this subsection, a covered individual is any individual otherwise described by section 7682(a) of title 38, United States Code, as in effect on the day before the date of the enactment of this Act, who—

(A) was appointed as an employee in a position described in paragraph (1) of that section, as so in effect, between January 1, 1999, and September 30, 2000; and

(B) is an employee in such position, or in another position described in paragraph (1) of that section, as so in effect, at the time of application for treatment as a covered individual under this subsection.

(3) The Secretary shall make determinations regarding the exercise of the authority in this subsection on a case-by-case basis.

(4) The Secretary may not exercise the authority in this subsection after December 31, 2001. The expiration of the authority in this subsection shall not affect the treatment of an individual under this subsection before that date as a covered individual for purposes of eligibility in the Education Debt Reduction Program.

(5) In this subsection, the term ''Education Debt Reduction Program'' means the Department of Veterans Affairs Education Debt Reduction Program under subchapter VII of chapter 76 of title 38, United States Code.

SEC. 103. REPORT ON REQUESTS FOR WAIVERS OF PAY REDUCTIONS FOR REEMPLOYED ANNUITANTS TO FILL NURSE POSITIONS.

(a) REPORT.—Not later than November 30 of each of 2001 and 2002, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report describing each request of the Secretary, during the fiscal year preceding such report, to the Director of the Office of Personnel Management for the following:

(1) A waiver under subsection (i)(1)(A) of section 8344 of title 5, United States Code, of the provisions of such section in order to meet requirements of the Department of Veterans Affairs for appointments to nurse positions in the Veterans Health Administration.

(2) A waiver under subsection (f)(1)(A) of section 8468 of title 5, United States Code, of the provisions of such section in order to meet requirements of the Department for appointments to such positions.

(3) A grant of authority under subsection (i)(1)(B) of section 8344 of title 5, United States Code, for the waiver of the provisions of such section in order to meet requirements of the Department for appointments to such positions.

(4) A grant of authority under subsection (f)(1)(B) of section 8468 of title 5, United States Code, for the waiver of the provisions of such section in order to meet requirements of the Department for appointments to such positions.

(b) INFORMATION ON RESPONSES TO REQUESTS.—The report under subsection (a) shall specify for each request covered by the report—

(1) the response of the Director to such request; and

(2) if such request was granted, whether or not the waiver or authority, as the case may be, assisted the Secretary in meeting requirements of the Department for appointments to nurse positions in the Veterans Health Administration.

TITLE II—ENHANCEMENT OF RETENTION AUTHORITIES

SEC. 201. ADDITIONAL PAY FOR SATURDAY TOURS OF DUTY FOR ADDITIONAL HEALTH CARE PROFESSIONAL IN THE VETERANS HEALTH ADMINISTRATION.

(a) IN GENERAL.—Section 7454(b) is amended—

(1) by inserting ''(1)'' after ''(b)''; and

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

''(2) Health care professionals employed in positions referred to in paragraph (1) shall be entitled to additional pay on the same basis as provided for nurses in section 7453(c) of this title.''.

(b) APPLICABILITY.—The amendments made by subsection (a) shall take effect on the date of the enactment of this Act, and shall apply with respect to pay periods beginning on or after that date.

SEC. 202. UNUSED SICK LEAVE INCLUDED IN ANNUITY COMPUTATION OF REGISTERED NURSES WITH THE VETERANS HEALTH ADMINISTRATION.

(a) ANNUITY COMPUTATION.—Section 8415 of title 5, United States Code, is amended by adding at the end the following:

''(i) In computing an annuity under this subchapter, the total service of an employee who retires from the position of a registered nurse with the Veterans Health Administration on an immediate annuity, or dies while employed in that position leaving any survivor entitled to an annuity, includes the days of unused sick leave to the credit of that employee under a formal leave system, except that such days shall not be counted in

determining average pay or annuity eligibility under this subchapter.''.

(b) DEPOSIT NOT REQUIRED.—Section 8422(d) of title 5, United States Code, is amended—

(1) by inserting ''(1)'' before ''Under such regulations''; and

(2) by adding at the end the following:

''(2) Deposit may not be required for days of unused sick leave credited under section 8415(i).''.

(c) EFFECTIVE DATE.—The amendments made by this section shall take effect 60 days after the date of the enactment of this Act, and shall apply to individuals who separate from service on or after that effective date.

SEC. 203. EVALUATION OF DEPARTMENT OF VETERANS AFFAIRS NURSE MANAGED CLINICS.

(a) EVALUATION.—The Secretary of Veterans Affairs shall carry out an evaluation of the efficacy of the nurse managed health care clinics of the Department of Veterans Affairs. The Secretary shall complete the evaluation not later than 18 months after the date of the enactment of this Act.

(b) CLINICS TO BE EVALUATED.—(1) In carrying out the evaluation under subsection (a), the Secretary consider nurse managed health care clinics, including primary care clinics and geriatric care clinics, located in three different Veterans Integrated Service Networks (VISNs) of the Department.

(2) If there are not nurse managed health care clinics located in three different Veterans Integrated Service Networks as of the commencement of the evaluation, the Secretary shall—

(A) establish nurse managed health care clinics in additional Veterans Integrated Services Networks such that there are nurse managed health care clinics in three different Veterans Integrated Service Networks for purposes of the evaluation; and

(B) include such clinics, as so established, in the evaluation.

(c) MATTERS TO BE EVALUATED.—In carrying out the evaluation under subsection (a), the Secretary shall address the following:

(1) Patient satisfaction.

(2) Provider experiences.

(2) Cost of care.

(4) Access to care, including waiting time for care.

(5) The functional status of patients receiving care.

(6) Any other matters the Secretary considers appropriate.

(d) REPORT.—Not later than 18 months after the date of the enactment of this Act, the Secretary shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the evaluation carried out under subsection (a). The report shall address the matters specified in subsection (c) and include any other information, and any recommendations, that the Secretary considers appropriate.

SEC. 204. STAFFING LEVELS FOR OPERATIONS OF MEDICAL FACILITIES.

(a) IN GENERAL.—Section 8110(a) is amended—

(1) in paragraph (1), by inserting after ''complete care of patients,'' in the fifth sentence the following: ''and in a manner consistent with the policies of the Secretary on overtime,''; and

(2) in paragraph (2)—

(A) by inserting '', including the staffing required to maintain such capacities,'' after ''all Department medical facilities'';

(B) by striking ''and to minimize'' and inserting '', to minimize''; and

(C) by inserting before the period the following: '', and to ensure that eligible veterans are provided such care and services in an appropriate manner''.

(b) NATIONWIDE POLICY ON STAFFING.—Paragraph (3) of that section is amended—

(1) in subparagraph (A), by inserting ''the adequacy of staff levels for compliance with the policy established under subparagraph (C),'' after ''regarding''; and

(2) by inserting after subparagraph (B) the following new subparagraph:

''(C) The Secretary shall, in consultation with the Under Secretary for Health, establish a nationwide policy on the staffing of Department medical facilities in order to ensure that such facilities have adequate staff for the provision to veterans of appropriate, high-quality care and services. The policy shall take into account the staffing levels and mixture of staff skills required for the range of care and services provided veterans in Department facilities.''.

SEC. 205. ANNUAL REPORT ON USE OF AUTHORITIES TO ENHANCE RETENTION OF EXPERIENCED NURSES.

(a) ANNUAL REPORT.—(1) Subchapter II of chapter 73 is amended by adding at the end the following new section:

''§ 7324. Annual report on use of authorities to enhance retention of experienced nurses

''(a) ANNUAL REPORT.—Not later than January 31 each year, the Secretary, acting through the Under Secretary for Health, shall submit to Congress a report on the use during the preceding year of authorities for purposes of retaining experienced nurses in the Veterans Health Administration, as follows:

''(1) The authorities under chapter 76 of this title.

''(2) The authority under VA Directive 5102.1, relating to the Department of Veterans Affairs nurse qualification standard, dated November 10, 1999, or any successor directive.

''(3) Any other authorities available to the Secretary for those purposes.

''(b) REPORT ELEMENTS.—Each report under subsection (a) shall specify for the period covered by such report, for each Department medical facility and for each Veterans Integrated Service Network, the following:

''(1) The number of waivers requested under the authority referred to in subsection (a)(2), and the number of waivers granted under that authority, to promote to the Nurse II grade or Nurse III grade under the Nurse Schedule under section 7404(b)(1) of this title any nurse who has not completed a bachelors of science in nursing in a recognized school of nursing, set forth by age, race, and years of experience of the individuals subject to such waiver requests and waivers, as the case may be.

''(2) The programs carried out to facilitate the use of nursing education programs by experienced nurses, including programs for flexible scheduling, scholarships, salary replacement pay, and on-site classes.''.

(2) The table of sections at the beginning of chapter 73 is amended by inserting after the item relating to section 7323 the following new item:

''7324. Annual report on use of authorities to enhance retention of experienced nurses.''.

(b) INITIAL REPORT.—The initial report required under section 7324 of title 38, United States Code, as added by subsection (a), shall be submitted in 2002.

SEC. 206. REPORT ON MANDATORY OVERTIME FOR NURSES AND NURSE ASSISTANTS IN DEPARTMENT OF VETERANS AFFAIRS FACILITIES.

(a) REPORT.—Not later than 180 days after the date of the enactment of this Act, the Secretary of Veterans Affairs shall submit to the Committees on Veterans' Affairs of the Senate and the House of Representatives a report on the mandatory overtime required of licensed nurses and nurse assistants providing direct patient care at Department of Veterans Affairs medical facilities during 2001.

(b) MANDATORY OVERTIME.—For purposes of the report under subsection (a), mandatory overtime shall consist of any period in which a nurse or nurse assistant is mandated or otherwise required, whether directly or indirectly, to work or be in on-duty status in excess of—

(1) a scheduled workshift or duty period;

(2) 12 hours in any 24-hour period; or

(3) 80 hours in any period of 14 consecutive days.

(c) ELEMENTS.—The report under subsection (a) shall include the following:

(1) A description of the amount of mandatory overtime described in that subsection at each Department medical facility during the period covered by the report.

(2) A description of the mechanisms employed by the Secretary to monitor overtime of the nurses and nurse assistants referred to in that subsection.

(3) An assessment of the effects of the mandatory overtime of such nurses and nurse assistants on patient care, including its contribution to medical errors.

(4) Recommendations regarding mechanisms for preventing requirements for amounts of mandatory overtime in other than emergency situations by such nurses and nurse assistants.

(5) Any other matters that the Secretary considers appropriate.

TITLE III—OTHER MATTERS

SEC. 301. ORGANIZATIONAL RESPONSIBILITY OF THE DIRECTOR OF THE NURSING SERVICE.

Section 7306(a)(5) is amended by inserting '', and report directly to,'' after ''responsible to''.

SEC. 302. COMPUTATION OF ANNUITY FOR PART-TIME SERVICE PERFORMED BY CERTAIN HEALTH-CARE PROFESSIONALS BEFORE APRIL 7, 1986.

Section 7426 is amended—

(1) by redesignating subsection (c) as subsection (d); and

(2) by inserting after subsection (b) the following new subsection (c):

''(c) The provisions of subsection (b) shall not apply to the part-time service before April 7, 1986, of a registered nurse, physician assistant, or expanded-function dental auxiliary. In computing the annuity under the applicable provision of law specified in that subsection of an individual covered by the preceding sentence, the service described in that sentence shall be credited as full-time service.''.

SEC. 303. MODIFICATION OF NURSE LOCALITY PAY AUTHORITIES.

Section 7451 is amended—

(1) in subsection (d)(3)—

(A) in subparagraph (A), by striking ''beginning rates of'' each time it appears;

(B) in subparagraph (B), by striking ''beginning rates of''; and

(C) in subparagraph (C)(i), by striking ''beginning rates of'' each time it appears;

(2) in subsection (d)(4)—

(A) by striking ''or at any other time that an adjustment in rates of pay is scheduled to take place under this subsection'' in the first sentence; and

(B) by striking the second sentence; and

(3) in subsection (e)(4)—

(A) in subparagraph (A), by striking ''grade in a'';

(B) in subparagraph (B)—

(i) by striking ''grade of a''; and

(ii) by striking ''that grade'' and inserting ''that position''; and

(C) in subparagraph (D), by striking ''grade of a''.

SEC. 304. TECHNICAL AMENDMENTS.

Section 7631(b) is amended by striking ''this subsection'' each place it appears and inserting ''this section''.

By Mr. HOLLINGS (for himself, Mr. INOUYE, and Mr. DORGAN):

S. 1189. A bill to require the Federal Communications Commission to amend its daily newspaper cross-ownership rules, and for other purposes; to the Committee on Commerce, Science, and Transportation.

Mr. HOLLINGS. Mr. President, I rise to introduce legislation, the Media Ownership Act of 2001, designed to rectify the increasing trend toward consolidation and away from a vibrant exchange of news and information in today's media marketplace. I am joined in this effort by my colleagues, Senators INOUYE and DORGAN, who for years have demonstrated their tireless pursuit of the public interest in the sensible regulation of media ownership.

This legislation is necessary to stem the tide toward concentration in the broadcast and newspaper industries and force a thorough and reasoned examination of the claims that further consolidation will serve the public interest. While the phrase ''public interest'' may have a vague ring to it, its meaning should be quite clear to the five members of the Federal Communications Commission, which itself observed just a few months ago that it has both ''the duty and authority under the Communications Act to promote diversity and competition among media voices.''

Notwithstanding that duty, it has come to my attention that the FCC is planning a Notice of Proposed Rulemaking to relax or eliminate the newspaper-broadcast cross ownership rule. In addition, I understand that the FCC may consider revising, among other media ownership restrictions, the 35 percent national broadcast ownership cap later this year. I do not believe that those rules should be changed at this time. Others disagree. This legislation will enhance our debate on these issues.

Locally relevant, independent programmers and distributors of media content are critically important energizers of civic discourse in this country. Indeed, that independence, localism and diversity are what separate our nation from countries where information is not allowed to flow freely. Accordingly, any proceeding to revisit existing ownership rules involving broadcast, print, or cable television must examine the potential impact that undue influence over local and national media outlets may have on our democracy.

Because Congress understood the difficulty the Commission faces in quantifying democratic values such as localism and diversity, it gave the Commission the explicit and implicit statutory authority and responsibility to establish and maintain ownership caps in the media industry. Pursuant to that authority, the FCC has imposed limits on the ownership of broadcast and cable television properties, and on the cross-ownership within a market between broadcast and cable television stations, broadcast television and radio stations, and broadcast television and radio stations and newspapers.

These ownership restrictions are based on factors outside the bounds of a traditional competitive analysis, and carry with them the authority to prevent consolidation before it rises to the level necessary to trigger antitrust intervention. for example, in light of the importance of promoting localism and diversity, a higher importance must be ascribed to preserving the balance of power between the networks and local stations than would otherwise be expected under traditional competition analysis.

The reasons for this are simple, diversity in ownership promotes competition. Diversity in ownership creates opportunities for smaller companies, and local businessmen and women. Diversity in ownership allows creative programming and controversial points of views to find an outlet. Diversity in ownership promotes choices for advertisers. And diversity in ownership and the related restriction on national ownership groups preserves localism. And what in turn does this mean? Millions of Americans regularly receive their local news by watching their local broadcast stations or reading their daily newspaper. For these citizens, localism still matters.

The proponents of increased consolidation, however, claim that the transformed media landscape demands a deregulatory response. In my view, the burden should rest on those who wish to change the rules of the game to justify those changes. If localism and diversity can be preserved in a consolidated marketplace, prove it. Arguments alone are not persuasive.

Prior to the 1996 Telecommunications Act, the top radio station group owned 39 stations and generated annual revenues of $495 million. Today, the top group owns over 1100 stations and generates revenues of almost $3.2 billion annually. This consolidation directly undercut diversity and localism in the radio marketplace. A year before Congress passed the Telecommunications Act, the FCC lifted the rules that prohibited broadcast networks from owning and creating their own television programming. This sanctioned consolidation freed the networks to seek economic stakes in, and ownership of, television programs. As the Washington Post reported last fall in an article entitled, ''Even Hits can Miss in TV's New Economy'', ''Just as supermarket might reserve its best shelf space for its house brands, the networks have begun to favor their in house programs over shows created by others, which are often less profitable in the long term.'' So we see what deregulation has brought us with radio and the market for television programming. Similar consolidation among other major media outlets should only be allowed after a thorough analysis that justifies permitting such concentration.

The legislation that we introduce today addresses the FCC's lack of enforcement of the newspaper-broadcast cross ownership rule. The FCC's jurisdiction over newspaper broadcast ownership combinations arises from its authority to oversee broadcast communications licenses. In practice, the FCC has applied the rule only when there is a transfer or renewal of a broadcast license. So, if a broadcast station owner acquires a newspaper in the same market, there is no FCC review of the cross ownership until the station's license is up for renewal. If a newspaper owner acquires a broadcast station, however, the rule is immediately triggered because the FCC has to approve the transfer of the station's broadcast license for the transaction to go forward. When the rule was adopted, television broadcast licenses were renewed every three years. Accordingly, even when the FCC did not immediately enforce the rule, the combined entity was aware it would have to come into compliance, either by requesting a waiver, or divesting either the station or newspaper, within a short period of time.

Today, however, broadcast station licenses are only renewed every eight years, thereby creating a significant loophole in the cross ownership rule, if it is only enforced by the Commission at the time of license renewals. Our bill would require the FCC to review immediately existing cross ownership combinations. The legislation requires a broadcast licensee to inform the FCC when it acquires a newspaper that would place the license in violation of the newspaper-broadcast cross ownership rule. Upon receipt of this information, the FCC could take a range of action under the legislation, including forcing divestiture, or granting a waiver to allow the combination to go forward.

In addition, our legislation steps up a process whereby we in Congress can scrutinize any alternative that the Commission devises to replace the current media ownership rules, and compare the efficacy of a new cap or ownership measurement system against the current rules, to determine whether a new measurement provides a better mechanism to promote diversity and localism. Accordingly, our bill requires the FCC to provide to the House and Senate Commerce Committees, any proposed media ownership rule changes eighteen months before they become effective. These proposals must be transmitted to the Commerce committees along with clear and ample explanation of how the new formulations will better meet the Commission's public interest obligation to promote competition, diversity, and localism.

The legislation we are introducing takes two important steps. First, it forces the FCC to enforce the current version of the FCC's newspaper-broadcast cross ownership rule. Second, it provides a check on those who might otherwise move quickly to repeal other media ownership limits without regard

to the impact of the consequent consolidation on diversity, localism, and competition in the media marketplace.

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. 1189

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. FCC DAILY NEWSPAPER CROSS-OWNERSHIP RULE.

(a) IMMEDIATE REVIEW.—

(1) IN GENERAL.—The Federal Communications Commission shall modify section 73.3555(d) of its regulations (47 C.F.R. 73.3555(d)) to provide for the immediate review of a license for any AM, FM, or TV broadcast station held by any party (including all parties under common control) that acquires direct or indirect ownership, operation, or control of a daily newspaper.

(2) NOTICE TO COMMISSION.—The modification under paragraph (1) shall require that any licensee covered by that paragraph notify the Committee of the acquisition of the ownership, operation, or control of a daily newspaper upon the acquisition of such ownership, operation, or control.

(b) REMEDIAL ACTION.—The Commission shall further modify section 73.3555(d) of its regulations (47 C.F.R. 73.3555(d)) to require modification or revocation of the license, or divestiture of such ownership, operation, or control of the daily newspaper, unless the Commission determines that direct or indirect ownership, operation, or control of the daily newspaper by that party will not cause a result described in paragraph (1), (2), or (3) of that section.

(c) 6-MONTH DEADLINE FOR COMPLIANCE.—Under the regulations as modified under subsection (b), if the Commission does not make a determination described in subsection (b), the Commission shall require the modification, revocation, or divestiture to be completed not later than the earlier of—

(1) the date that is 180 days after the date on which the Commission issues the order requiring the modification, revocation, or divestiture; or

(2) the date by which the Commission's regulations require the license to be renewed.

(d) APPLICATION TO EXISTING ARRANGEMENTS.—

(1) IN GENERAL.—In applying its regulations, as modified pursuant to this section, to any license for an AM, FM, or TV broadcast station that is held on the date of the enactment of this Act by a party that also, as of that date, has direct or indirect ownership, operation, or control of a daily newspaper, the Commission—

(A) may grant a permanent or temporary waiver from the modification, revocation, or divestiture requirements of the modified regulation if the Commission determines that the waiver is consistent with the principles of competition, diversity, and localism in the public interest; and

(B) shall not apply the modified regulation so as to require modification, revocation, or divestiture in circumstances in which section 73.3555(d) of the Commission's regulations (47 C.F.R. 73.3555(d)) does not apply because of Note 4 to that section.

(2) NOTICE TO COMMISSION.—A licensee of a license described by paragraph (1) shall notify the Commission not later than 30 days after the date of the enactment of this Act that the license is covered by paragraph (1).

SEC. 2. REVIEW BASED ON TRANSACTIONS.

The Federal Communications Commission shall further modify section 73.3555 of its regulations (47 C.F.R. 73.3555) so that the Commission will determine compliance with section 73.3555(d) of its regulations, as modified by the Commission pursuant to section 1 of this Act, whenever a party (including all parties under common control)—

(1) that holds a license for an AM, FM, or TV broadcast station acquires direct or indirect ownership, operation, or control of a daily newspaper; or

(2) that directly or indirectly owns, operates, or controls a daily newspaper acquires a license for an AM, FM, or TV broadcast station.

SEC. 3. FCC TO JUSTIFY REPEAL OR MODIFICATION OF REGULATIONS UNDER REGULATORY REFORM.

Section 11 of the Communications Act of 1934 (47 U.S.C. 161) is amended—

(1) by redesignating subsection (b) as subsection (c); and

(2) by inserting after subsection (a) the following new subsection (b):

''(b) RELAXATION OR ELIMINATION OF MEDIA OWNERSHIP RULES.—If, as a result of a review under subsection (a)(1), the Commission makes a determination under subsection (a)(2) with respect to its regulations governing multiple ownership (47 C.F.R. 73.3555), then not less than 18 months before the proposed repeal or modification under subsection (c) is to take effect, the Commission shall transmit to the Committee on Commerce, Science, and Transportation of the Senate and the Committee on Commerce of the House of Representatives—

''(1) a statement of the proposed repeal or modification; and

''(2) an explanation of the basis for its determination, including an explanation of how the proposed repeal or modification is expected to promote competition, diversity, and localism in the public interest.''.

SEC. 4. DEADLINE FOR MODIFICATION OF REGULATIONS.

The Federal Communications Commission shall complete the modifications of its regulations required by sections 1 and 2 of this Act not later than 1 year after the date of the enactment of this Act.

SUBMITTED RESOLUTIONS

SENATE RESOLUTION 135—HONORING DRS. ARVID CARLSSON, PAUL GREENGARD, AND ERIC R. KANDEL FOR BEING AWARDED THE NOBEL PRIZE IN PHYSIOLOGY OR MEDICINE FOR 2000, AND FOR OTHER PURPOSES

Mr. BIDEN submitted the following resolution; which was referred to the Committee on Foreign Relations:

S. RES. 135

Whereas on October 9, 2000, the Nobel Assembly at the Karolinska Institute awarded the Nobel Prize in Physiology or Medicine for 2000 to Drs. Arvid Carlsson, Paul Greengard, and Eric R. Kandel for their pioneering discoveries in the field of neuroscience;

Whereas these discoveries have been crucial in achieving a fuller understanding of the normal function of the brain and the mechanisms by which brain cells communicate with each other at the molecular level to create moods and memories in individuals;

Whereas the World Health Organization has found that 4 of the 10 leading causes of disability for persons age 5 and older are mental disorders;

Whereas schizophrenia, depression, bipolar disorder, Alzheimer's disease, and other mental disorders affect nearly 1 in 5 people in the United States each year;

Whereas the work of Drs. Carlsson, Greengard, and Kandel has laid a foundation for the development of drugs and other treatments for mental illnesses and neurological disorders that promise to be more effective and to have fewer or less acute side effects; and

Whereas the National Institutes of Health contributed to advances in the field of neuroscience by providing grants and research support to Drs. Carlsson, Greengard, and Kandel for a period exceeding 30 years: Now, therefore, be it

Resolved, That the Senate—

(1) recognizes and honors Drs. Arvid Carlsson, Paul Greengard, and Eric R. Kandel for their cumulative achievements in advancing scientific understanding in the field of neuroscience;

(2) expresses support for the ongoing efforts of the National Institutes of Health to fund and assist researchers in developing treatments for mental illnesses and neurological disorders;

(3) expresses support for the ongoing efforts of the American College of Neuropsychopharmacology, a scientific society whose principal functions are to further research and education in neuropsychopharmacology and related fields, and to encourage scientists to enter research careers in fields related to the treatment of diseases of the nervous system including psychiatric, neurological, behavioral, and addictive disorders; and

(4) expresses support for efforts to promote mental health for all people in the United States through advances in science and overcoming societal attitudes, fears, and misunderstandings concerning mental illness.

SENATE CONCURRENT RESOLUTION 60—EXPRESSING THE SENSE OF THE CONGRESS THAT THE CONTINUED PARTICIPATION OF THE RUSSIAN FEDERATION IN MEETINGS OF THE GROUP OF EIGHT COUNTRIES MUST BE CONDITIONED ON THE RUSSIAN FEDERATION'S VOLUNTARY ACCEPTANCE AND ADHERENCE TO THE NORMS AND STANDARDS OF DEMOCRACY

Mr. HELMS (for himself, Mr. SMITH of Oregon, Mr. LOTT, and Mr. ALLEN) submitted the following concurrent resolution; which was referred to the Committee on Foreign Relations:

S. CON. RES. 60

Whereas the Group of Seven (G–7) was established as a forum of the heads of state or heads of government of the world's largest, industrialized democracies to meet annually in a summit meeting;

Whereas those countries which are members of the Group of Seven are pluralistic societies, with democratic political institutions and practices committed to the promotion of universally recognized standards of human rights, individual liberties, and rule of law;

Whereas, in 1991 and subsequent years, the G-7 invited the Russian Federation to a postsummit dialogue, and in 1998 the G-7 formally invited the Russian Federation to participate in an annual gathering that thereafter became known as the Group of Eight (G–8);